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Nursing Against The Odds: How Health Care Cost Cutting, Media Stereotypes, and Medical Hubris Undermine Nurses and Patient Care

Suzanne Gordon

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Nursing Against The Odds: How Health Care Cost Cutting, Media Stereotypes, and Medical Hubris Undermine Nurses and Patient Care

Abstract

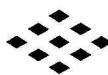
In the United States and throughout the industrialized world, just as the population of older and sicker patients is about to explode, there is a major shortage of nurses. In *Nursing against the Odds*, one of North America's leading health care journalists draws on in-depth interviews, research studies, and extensive firsthand reporting to help readers better understand the myriad causes of and possible solutions to the current crisis. To promote better care, Gordon calls for a broad agenda that includes safer staffing, improved scheduling, and other policy changes that would give nurses a greater voice at work. She explores how doctors and nurses can collaborate more effectively and what medical and nursing education must do to foster such cooperation. Finally, Gordon outlines ways in which RNs can successfully take their case to the public while campaigning for health care system reform that actually funds necessary nursing care.

Keywords

nurse, doctor, work, medical, disruptive, system, hospital, care, intern, patient, cancer, pain, physicians, teaching

Comments

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Manufacturing the Dominant Doctor

It was the first week in July at the Beth Israel Hospital in Boston and a new crop of interns has just arrived in the teaching hospital. A nurse named Deborah Madison* was taking care of Ella, a forty-two-year-old woman with pancreatic cancer who was about to begin her first round of chemotherapy. Madison had worked on this cancer unit for the past five years. When she examined her patient, she found that Ella was anxious about the chemotherapy and was also in excruciating pain from the cancer.

As Ella's primary nurse, Madison had great deal of experience diagnosing and treating cancer pain. She immediately recognized that Ella needed intravenous morphine to control her suffering. But she worked in a system where doctors—even doctors with as little experience as interns beginning their residency training—were the only ones permitted to diagnose, treat, and prescribe. Indeed, for internal medicine services, newly minted doctors, under the supervision of residents, fellows, and attending physicians, were nominally in charge of hospitalized patients—and also of their nurses.

Reassuring Ella that she would do something to ease her pain, Madison walked down to the nurses' station in search of the intern in charge of the case. The young man, upon whose orders much of her work depended, was in his late twenties, tall, clean-shaven, with close-cropped black hair. He listened as Madison explained the problem and related her treatment recommendation.

* An asterisk following a name indicates a pseudonym.

22 “I don’t know,” the intern said nervously. “I don’t think the patient is really in pain. I think she’s just anxious about the chemo she’ll be getting tomorrow. I’ll write an order for Xanax (a tranquilizer) and that should do it.”

Cognizant that she was there not only to care for patients, but also to teach novice physicians, Madison calmly repeated that the patient was having cancer pain. Xanax, while useful to treat any anxiety she might have also been feeling, would not alleviate her cancer pain. Morphine would. The intern, who like many novice physicians was extremely wary of narcotics, resisted the suggestion. No, he said adamantly, adding that he would go and see the patient.

About five minutes later, if that, he returned.

The patient, he informed Madison, was not in pain. It was just as he thought. She was anxious about her chemo.

“Did she say that?” Madison asked.

“No,” he said, “the patient complained of pain.” “But,” he added, as he wrote the order for the Xanax, “she can’t really be in pain because people who are in pain don’t smile at their doctors.”

Although frustrated that this young physician seemed unaware that, as one recent federal report documented, “patients may be experiencing excruciating pain even while smiling and using laughter as coping mechanisms,” Madison once again tried to teach the young man about cancer pain as well as patients’ responses to vulnerability and dependence.¹ Patients, she counseled, often smile at their doctors and may not be assertive about their complaints, because they don’t want to bother, contradict, or potentially alienate someone upon whom they depend for their very lives.

The intern was unmovable.

Over the course of the next two hours, Madison shifted tactics. Following the appropriate channels, she paged the resident who ranked above this intern in the medical chain of command. She would try to convince him to talk to the novice doctor and secure pain medication for her patient. When the resident responded to the page, he agreed with Madison. Morphine was just what the intern should order. The two went off to find the intern and the resident repeated to the young man exactly, almost word for word, what Madison had said about the rationale for this particular choice of drug. Listening to the senior doctor and ignoring the nurse, the intern nodded and dutifully wrote the order for the narcotic.

Madison went back to the patient and told her that the doctor had ordered the drug. She then administered the medication and monitored its effectiveness. Ella was finally able to relax. Although Madison diagnosed the patient’s problem and recommended the correct treatment for it, when the interaction was recorded in the patient’s chart, the intern was

given credit for both making the diagnosis and ordering the medication. When Ella was about to leave the hospital several days later, she wrote notes to thank her caregivers. Although she jotted a short thank-you note to her nurses, there was no mention of what the nurse did to help relieve her pain. In fact, she saved most of her gratitude for her doctors. "Thank you so much," she told the intern, "for all you did for me."

Risky Business

When nurses go to work in a hospital or other health care institution, they expect to confront a certain number of predictable risks. They may injure their backs if they try to turn a patient without help, or lift a patient who's fallen in the cramped space of a hospital bathroom. They may stick themselves with an infected needle because another hospital worker has failed to dispose of it correctly or because some hospital administrators do not purchase safe needles. They may contract a new and mysterious disease like SARS. They may be verbally or physically attacked by a mentally ill patient who becomes violent or by a patient or family member frustrated with an increasingly impersonal health care system. Through a variety of workplace and legislative measures, nurses try to minimize these risks.

Other less publicized risks that nurses encounter jeopardize their patients. On a daily basis, nurses work with physicians who fail to communicate with them about critical clinical issues, deny them access to needed information and resources, subject them to verbal abuse when they try to do their job, and misinterpret collegial disagreements about clinical issues as challenges to medical authority and hierarchy. Some physicians rudely overrule nurses' clinical concerns and subject nurses to verbal abuse and humiliation. In rarer cases, some physicians physically abuse RNs. Added to this is the fact that the medical system often gives physicians credit for nurses' contributions. This means nurses have little experience with positive credit but have a great deal of experience with negative accountability. All of these patterns of communication and behavior make nursing a very risky job, and not only for the so-called uppity nurse who refuses to couch her questions and concerns in the demure rituals of medical dominance.

Even nurses who work hard at staying in their assigned place by observing the accepted rules of deference may find that MD-RN relationships can be hazardous to their professional self-esteem, as well as to their personal health and well-being. The incident I described above, for example, happened at a hospital in which nurses received a great deal of credit for their work. It occurred during the heyday of nurse empower-

- 24** ment in the early 1990s. But no matter how much institutional support nurses had—support that has, we shall see, largely disappeared today—they were still stuck in a medical system characterized by rigid inequality. While there is increasing attention to the problem of “disruptive physicians”—who often bully those they consider to be inferiors—little systematic attention is paid to the fact that the medical system as a whole is a disruptive, sometimes toxic environment for many who work in it.

Relationship Interruptus

Over the past thirty years, many articles have been written about this structured inequality. Two of the most famous—“The Doctor-Nurse Game” and “The Doctor-Nurse Game Revisited,” published in 1967 and 1990 respectively—were written by the psychiatrist Leonard Stein.² The original article analyzed why doctors failed to consult with nurses and why nurses adopted indirect or even passive-aggressive strategies to deal with doctors. Then in 1990, during the last nursing shortage, Stein and two other physicians reexamined the state of nurse-physician relationships. The authors argued that the women’s and civil-rights movements had fomented a rebellion among nurses. More nurses, the authors insisted, were socialized outside the old hospital schools, had advanced degrees, and wanted to be viewed as “autonomous,” “independent” professionals. The “new” nurse was more than willing to make direct recommendations. In fact, many bluntly challenged physicians. Others exhibited outright hostility to MDs. Some seemed to want to replace physicians and claim, as their own “domain,” disease prevention, patient education, management of chronic illness, and holistic care or “treatment of the whole person”—things which doctors should do but too often ignore.

The “Doctor-Nurse Game Revisited” suggested that nurse-physician relationships were improving, because nurses were no longer tolerating medicine’s traditional dominance. Twelve years later, however, one of the only systematic, quantitative studies of the impact of physician-nurse relationships on nurse retention painted a much more sobering picture. The principal investigator on the study, which was published in the *American Journal of Nursing*, was Alan H. Rosenstein, a physician and vice president and medical director of the VHA’s West Coast hospitals.³ He and his coinvestigators sent out surveys to RNs and MDs in the VHA, which runs a quarter of the community-owned hospitals in the United States and is the largest employer of RNs in the country. The survey was designed to determine how physicians and nurses in the VHA system “viewed nurse-physician relationships, disruptive physician behavior, the institutional re-

sponse to such behavior, and how such behavior affected nurse satisfaction, morale, and retention." The article reported on preliminary findings from the first 1,200 responses analyzed. Of these, 720 were from nurses and 173 from physicians from eighty-four different hospitals.

Respondents reported that nurse-physician relationships, which seemed less of an issue to physicians, were extremely important to nurses. Almost all nurses had experienced or witnessed some form of "disruptive physician behavior," which included screaming, berating of colleagues or patients, use of abusive language, and other instances of disrespect or condescension toward nurse colleagues. Nurses believed that disruptive physician behavior had a serious impact on morale and nurse retention. Many respondents cited examples of nurses who had, because of such problems, left a hospital or asked to be switched from a unit or shift because of them. Nurses also felt that physicians did not give them enough respect or understand the impact of their behavior. Most nurses stated that their institution did not deal effectively with the problem.

The psychologist Larry Harmon is the codirector of the Physicians' Development Program in Miami, which evaluates, educates, and monitors physicians and nurses and other health care providers. Harmon defines "disruptive behavior" as "any behavior which results in diminishing team members' ability to do their best work." He classifies such behavior as verbal, physical, and indirect behavior.

"Disruptive verbal behavior," Harmon explains, "includes sarcastic comments, snapping at others when frustrated, or talking down to people. Physical disruption occurs when doctors throw small objects when angry, raise their fists at someone, give someone the finger, or actually strike or assault someone." Indirect disruptive behavior includes things like criticizing people behind their back, spreading rumors, or pouting or intentional selective ignoring. "For example," Harmon says, "the physician won't talk to one particular nurse as a way of punishing him or her."

This kind of behavior has become such a problem that, in its 2002 alert about the nursing shortage, the Joint Commission on the Accreditation of Health Care Organizations (JCAHCO) also raised the issue of nurse-physician relationships. "Incidents of verbal abuse of nurses, typically by physicians, are unfortunately well known, even commonplace," the report stated.⁴ It called for a voluntary policy of zero tolerance in the workplace and suggested that medical societies develop guidelines to deal with abusive physicians.

In Canada, the Status of Women Sector of the Quebec Federation of Nurses conducted research to ascertain the level of violence against nurses in Quebec. Nurses told of being humiliated, screamed at, and subjected to temper tantrums as well as physical abuse. Ninety percent of the

26 union's members said they'd been "victims of at least one act of assault or aggression during their career."⁵ Among abusers of nurses, doctors figured prominently. The number of incidents, the union said, indicated "that doctors can express their anger against their closest workers as they see fit."⁶

In my interviews with nurses, their most common complaints were that physicians do not understand what role nurses play in the health care system, misunderstand whom nurses serve, do not value the knowledge and skill that nurses have amassed during their careers, and fail to appreciate that collaborative, cooperative, collegial relationships between physicians and nurses are central to quality patient care. Most nurses feel that although nurses work closely with doctors and respect their training, skill, and expertise, doctors do not reciprocate.

In his study of the hospital workplace, the sociologist Daniel Chambliss recorded similar complaints. "If there is a single dominant theme of nurses' complaints about their work, it is the lack of respect they feel, from laypersons, from coworkers, and especially from physicians. It is nearly universally felt and resented. 'The docs never listen to us,' they say, 'you don't get any recognition from doctors'; doctors don't read the nurse's notes in the patients' chart, don't ask her what she has seen or what she thinks, they don't take her seriously." Chambliss, who spent over ten years observing nurses and physicians interact, agreed with the nurses. The "daily evidence" of physician disregard, he wrote, was "truly pervasive; I was genuinely surprised at how common the obvious disrespect is."⁷

When I was recently in Adelaide, Australia, a nurse manager of a cardiac unit related an illustrative incident. Because of the closure of an oncology service in the area, cardiac nurses were being asked to treat oncology patients at a cardiac unit that was being prepared to take on an extra load of cancer patients. The nurses were given a quick course to teach them how to deal with oncology patients. Before their hasty tutorial was even complete, an oncologist in the hospital admitted a patient to the unit. When the nurse manager told the physician that the RNs didn't yet know how to deal with chemotherapy drugs, and had not mastered the complexities of inserting needles into porta catheters (devices that are surgically inserted into the subclavian vein to allow easier, and over time less painful, access for chemotherapy and blood tests), he became irate. No oncologist would ever imagine that a cardiologist could simply stroll in and replace him. Nonetheless, this physician insisted that a cardiac nurse could easily replace an oncology nurse. "Surely someone around here can manage this. You are nurses after all," he fumed.

See One, Do One, Teach One

In medical schools, doctors in training are taught to do procedures through the process of “see one, do one, teach one.” That also seems to be the way novice physicians are taught to look down on nurses. Listen to John E. Heffner, MD, medical director of the Medical University of South Carolina, “complimenting” nurses in the introduction he wrote in 2002 to a brochure about nursing that the hospital distributed for Nurses Week:

“We physicians at MUSC have much to appreciate in working with our nursing staff. Nurses amplify by their extended bedside presence the value of our brief daily patient encounters. The expertise and personal touch of our nurses drive much of the community’s perception of our health care facilities. And the vigilance and judgment of our nurses permit us to travel to our daily duties yet still respond to any sudden clinical event.”⁸

One hopes that nurses can recognize whether a doctor is competent or not before they “amplify” his actions. Imagine, for example, what would have happened to the cancer patient we met at the beginning of this chapter had her nurse “amplified” the inexperience of the intern.

In the eyes of many physicians, the title “Registered Nurse” often diminishes the bearer. Even the RN who graduates from a top program or who has a list of initials trailing her name is defined as someone who is not a member of the medical club, who does not have much medical knowledge, and whose concerns can be discounted because she doesn’t know medicine. Denise Webster, in her 1985 study of medical students’ views about nurses, writes that “one of the challenges facing medical students entering the clinical phase of their education is to ascertain who does what. As the role of the physician became narrower and more specific in the student’s mind, i.e., the diagnosis and treatment of illness, the answer regarding the nurse’s role became no clearer as a consequence of exposure to nurses and nursing in clinical settings.” Webster explained that few medical students had “an awareness that nurses had legitimate roles that were independent of physician’s orders and expectations.”⁹ “Many doctors (and many nurses),” Daniel Chambliss writes, “regard nursing as a sort of ‘lesser’ medicine, with the subordination of nursing dictated by the shorter period of training.”¹⁰

Laurie Gottlieb, a nurse who holds a PhD and is a former director of the McGill School of Nursing, once told me an illustrative story. A physician with whom she worked complimented her on her skill and knowledge by exclaiming, “You’re so smart. You could be a doctor.” For him,

- 28** this was the highest compliment he could bestow. For her, it reflected his disdain for nursing. It would be like a male colleague telling her, "You're so smart. You could be a man."

Even male nurses are subject to this kind of disregard. As Dave Latham* explains, "No matter how much experience a nurse has, doctors still consider us to be second-class citizens." The doctors' attitude, says Latham, a nurse in Illinois, is: "I have a medical degree and you don't."

Where and how do doctors learn to devalue nurses and nursing? Is it in the classroom, in their apprenticeship training, or both? More than most professionals, doctors gain a sense of professional self (and self-regard) during a protracted period of apprenticeship training.¹¹ The first two years of their schooling is spent in the classroom. In the past, schools of medicine rarely mentioned the role of the nurse in classroom training. Today some schools of medicine invite the occasional nurse in to give a lecture to medical students. But most younger doctors report that they learned next to nothing about nurses during their medical school years. Few medical students are taught alongside nursing students. Most don't know about the various kinds of nurses, nursing programs, or nursing research as a field.

After the first two years of medical school, doctors-in-training spend little time in formal classroom work. In their third year, medical students move directly onto hospital wards. Once they graduate from medical school, they spend between three and six years (or sometimes more) as residents in internal medicine, surgery, pediatrics, or psychiatry. Doctors who choose to specialize further will extend their training in, say, oncology, vascular surgery, pediatric cardiac surgery, pediatric psychiatry, or endocrinology.

Throughout their years on the wards, doctors attend daily lectures and study a great deal to pass a variety of exams. But most of their years in training are spent in a system in which they are mentored by older, more experienced physicians. "Tribalism is encouraged," write D. C. Aron and L. A. Headrick, "by the apprenticeship style of medical education in which students learn to be doctors as part of tightly knit physician teams, especially in the hospital."¹²

During their long training, what doctors learn about nurses—or for that matter about most other members of health care "teams"—is shaped by the behavior and attitudes of their seniors and mentors. Some of these mentors are residents who have only a few more years on the job than they have. Some are attending physicians who are vastly more experienced and who clearly convey that the physician is the captain of the ship.

"In medical training," says Dr. Timothy McCall a forty-seven-year-old internist, journalist, and author of *Examining Your Doctor: A Patient's Guide*

to Avoiding Harmful Medical Care, “most of the socialization of the doctor happens between the cracks in the third and fourth year and beyond, when you come into contact with clinicians in the university teaching hospital. That’s when the values carefully inculcated in you by your well-meaning public health professor in the first two years are basically blown off in five minutes. In the first couple of years you learn that primary care and prevention are important, for example. Then when you get into third year, you are surrounded by specialists and you learn what they think of primary care and prevention. Which is not much.”

“There is no formal training for medical students on how to interact with other medical professionals,” writes Robert C. McKersie, a Chicago family physician who recently finished his training. “How doctors relate to and interact with nurses, nutritionists, other members of the medical team, and even patients, is learned by following the example of the senior residents and attending physicians. Medicine has a strict pecking order, in which one does not question superiors even if they have been disrespectful to a patient or a fellow health care worker. This system often leaves the more sensitive and caring medical students and residents feeling that they are in the minority and powerless.”¹³

Senior doctors may never specifically tell medical students, interns, and residents that nurses are their inferiors. But by innuendo or example they are taught that most nurses are probably not that bright to begin with, are minimally educated, and are meant to work for doctors and make it easier for them to take care of patients.

When she was still an intern at Lincoln Hospital in the Bronx, says Alice Rothchild, she and her fellow trainees were taught nothing about nurses and had little or no significant contact with bedside nurses. Dr. Rothchild is now a fifty-five-year-old obstetrician/gynecologist at Boston’s Beth Israel Deaconess Medical Center. “We went on rounds with the chief resident,” Rothchild recalls. “Residents would present each case. The head nurse would follow us and then stand at the back of the cluster taking notes on medical changes and orders.”

“If a nurse asked a clarifying question, it was just background noise,” Rothchild says. “It didn’t reflect her curiosity, her need to do her job. She was asking a question to help us do our jobs by better following our orders. The nurse was not viewed as someone who had important information about a patient, but as a scribe whose job was to take notes.”

In my book *Life Support*, I borrowed Lillian Rubin’s term “intimate strangers” to describe the relationships between most doctors and nurses.¹⁴ The parallel universes that doctors and nurses have long inhabited make it difficult for doctors to see nurses work. “What nurses did,” Rothchild says, “was pretty much a mystery. You wrote the orders, and

30 then they happened. But how did they happen? We didn't think about that. You don't think about whether nurses are thinking about their work as opposed to just doing it. The reigning idea was that the doctor understood what was going on and the nurses just did a bunch of pretty mindless tasks."

"Nurses were, in some ways, below notice," agrees Emily Lowry, a fifty-six-year-old internist. "When nurses were good and helpful, they were like a good tool or a sharp pencil. When they were bad, or made a mistake, they were a nuisance. But nobody would try to figure out why. They were just there. They either gave you a hard time or helped you out. You, as the doctor, were what mattered. Nurses were there to maintain the *doctor's* orders, or to carry out *your* plans."

"Most medical students are simply thrown on to the floors with no explanation about the other clinicians they will be working with," says Margo Woods, a nutritionist and researcher who teaches medical students, interns, and residents at Tufts Medical School. "Medical training is extremely unsupportive," she continues. "The doctor-in-training quickly learns that he or she is constantly being judged. He quickly learns never to put himself in a one-down position by admitting that he is insecure about his knowledge or that he does not know something." Physicians, she says, are discouraged from asking for help, because they are reluctant to admit to feelings of insecurity or vulnerability, or to expose gaps in their knowledge. This will make doctors even unwilling to listen to or attend to nurses.

In some medical schools and hospitals, medical students or interns are told that nurses can be useful assets in their education and that they may actually learn something from nurses. But again, this depends on the mentor. A female resident at Boston Children's Hospital told me she didn't learn anything about nurses during her years at Harvard Medical School. In her residency, she picked things up as she went along. She learned that there is a nursing hierarchy, that there is such a thing as nursing research, and that nurses too had their specialties. Because the resident who mentored her told her never to see patients without stopping in and checking with the nurse who was taking care of them, she did what she'd been advised to do and always talked to the nurses. From the nurses' reactions, she learned that this practice was unusual. "You're practically the only one who consults with us," they told her.

Most of the physicians in training I have interviewed tended to define the nurse in negative terms. "If you're not nice to the nurse, she can make your life hell." "Better not get in bad with the nurses, they can be a real pain if you do." This negative description reflects not only a view of the

subordinate as a potential problem but also a view about how subordinates are likely to feel about their subordination. Nurses may not appreciate that they are expected to train doctors how to be their superiors, and some may respond in a passive-aggressive manner, which of course just reproduces the cycle of dysfunction.

"One of the things that happens when interns are introduced to a rotation in our hospital is they're warned about rotations when nurses are tough on them," explains Bonnie O'Connor, an associate professor and researcher in the Department of Pediatrics at Brown Medical School/Rhode Island Hospital and a folklorist and ethnographer who has worked in medical education for fifteen years. "Interns can't understand why this would be. What they don't understand is that experienced nurses are supposed to put up with the fact that interns slow up the process of care, that they're clumsy, and that they have authority over a nurse with years of experience."

These tensions are an inevitable result of working in a teaching hospital where you are confronted by a constantly revolving set of learners. But for nurses these tensions are different from the ones physicians encounter. Unlike physicians who teach new classes of medical students, nurses don't get paid to teach medical students and residents. Their teaching load is usually not factored into their patient load, and they get little recognition and no status as teachers in a teaching hospital. In spite of the fact that they constantly teach doctors-in-training, there is no formal acknowledgment of this fact. Quite to the contrary, doctors-in-training are usually not taught to view the nurses as formal or even informal instructors. Instead, as we've seen, they're generally taught to worry about how hard nurses will be on them. For most doctors, the teaching hospital has one set of teachers and one set of learners—physicians. Most physicians are unaware that nurses also learn in teaching hospitals.

Several years ago, I gave a workshop for nurses at the McGill University Health Center. Several of the RNs from one of the MUHC hospitals were frustrated because they constantly had to explain what they did to each individual intern or resident who rotated into their unit. To simplify their working lives, they decided to write a description of their role in caring for patients and helping to teach doctors-in-training. The material never saw the light of day. The nurses said the physicians in charge of the unit wouldn't let the nurses print and distribute it. Nurses, they seemed to feel, should not have the temerity to teach doctors-in-training.

Rather than teach residents, nurses are constantly asked to reproduce their own subordination to each new generation of doctors. Listen to conversations that veteran nurses have with junior doctors and you con-

- 32** stantly hear them list a set of signs and symptoms in catalogue fashion and then ask the doctor, "What do you think?" "What do you want to do about this?" "Would you like to get this or that lab test?"

The nurse may know what's wrong and what to do about it. Yet, year after year, she's supposed to teach interns and residents how to exert their authority in spite of their lack of knowledge. Not surprisingly, given their socialization, many doctors ignore nurses' concerns. They may even fail to read the nurses' notes, which form a critical part of the chronology of the patient's progress as recorded in the patient's chart.

The Issue of Nurses' Notes

"Did I read nurses' notes when I was in medical school or training? I'm not sure I even knew they existed or if they were even in the charts," says Rothchild. And McCall confesses that "of course we were never taught to read nurses' notes. I don't even remember if they were written in the charts in my years of training. But even when I did read them, I was always struck by how silly they seemed." McCall says that if, by some accident, he found himself reading a nursing note, he like many other physicians found them a baffling, incomprehensible, and sometimes ridiculous parody of the physician's progress notes. Nurses would use terms like "alteration in skin condition, and alteration in bowel function." They would mobilize complex circumlocutions that would, in his view, dance around the problem rather than define it. This simply confirmed the doctor's view that nurses and their notes had nothing to add to the clinical picture.

Marge Cohen, an attending physician and director of Women's HIV Research at Cook County Hospital in Chicago, explains her frustration with how nurses in her institution write their notes in the patient charts. "We say a patient has congestive heart failure. In our progress notes—or SOAP (Subjective, Objective, Assessment, Plan) notes—we document that the subjective phenomenon is that the patient complains of shortness of breath. The objective phenomena we collect include vital signs, like the results of a chest X ray or lung exam on which rales were found. Then comes the assessment, which is that CHF is still present, exacerbated, or worsening, and the plan is that we will say, 'increase diuretics or search for other reasons for the decompensation.'"

Rather than connecting her activities or concerns to the medical diagnosis, Cohen says that, no matter what the medical diagnosis or patient's condition, nurses always write notes on two categories: injury prevention and knowledge deficit. "This just appeared a few years ago. It seems incomprehensible to me or not particularly helpful. The patient may be in a coma and the nurse is told to talk about 'knowledge deficits.'"

Cohen says she understands that nurses need to be able to discuss what they do and chart their contributions to care, but she feels that this particular way of doing it does not allow the physician or other members of the team to understand what the patient is experiencing, what the nurse is concluding, or what the nurse is encountering in dealing with the patient. “We obviously need a way to communicate with one another, but if this kind of charting makes doctors not want to read the nurses’ notes, I don’t think this is the right way.”

What many modern doctors find so baffling is the “nursing diagnosis.” As we’ll see in a later chapter, nurses have been, in their view, chained to medicine, medicine’s descriptions of diseases, and medical orders, while feeling simultaneously restricted in their use of the language of medical diagnosis and opinion. Like other oppressed groups, they have struggled to find a way to communicate to one another and to explain the work they do. Nursing diagnosis, which was developed in the 1950s, was their attempt to professionalize and liberate themselves from these peculiar restrictions and give language to their work. In modern systems of financial reimbursement, doctors, for example, have numerous descriptions of their treatments and procedures, which are then translated into health insurance billing codes. Nursing activities have been bundled with the sheets and blankets in a patient’s room charge. Nursing diagnosis, many academic nurses believe, allows them to describe their specific contributions and activities. Doctors find some of this language confusing. Nurses, as they see it, are trying to say or describe the same things doctors say and describe, but in an unnecessarily roundabout way.

“You have a conversation with a nurse that’s great, and then you look at the nurse’s note and all you can get out of it are the vital signs or things like ‘alteration in comfort,’ ” says Emily Lowry. “But of course the nurse doesn’t say that in conversation to you. They say, ‘He hasn’t had a bowel movement in three days,’ ‘He’s not eating,’ or ‘His wife is sick,’ and then you look at the note in the chart and it says ‘alteration in nutrition,’ . . . and it doesn’t say anything useful except for the vital signs.”

Dress and Address

Nursing’s subordination to medicine is also reflected in modern modes of address. Linguists, anthropologists, and sociologists who study power and authority in the modern workplace and in relationships of dominance and subordination have developed a sophisticated analysis of how “discourse” reflects either power or solidarity. “The key to power is asymmetry,” writes Deborah Tannen. “Power governs asymmetrical relationships where one is subordinate to another; solidarity governs symmetrical rela-

- 34** tionships characterized by social equality and similarity.” In many languages power and deference are embedded in forms of address, notably in the use of personal pronouns, like the French *tu* and *vous* or German *Sie* and *Du*. “In English the closest parallel is to be found in forms of address: first name versus title-last name,” Tannen writes. “In Brown and Gilman’s system, power is associated with nonreciprocal use of pronouns; in English the parallel would be a situation in which one speaker addresses the other by first name but is addressed by title-last name.”¹⁵

This is precisely what occurs in medicine. In many modern workplaces, differences of power are muted by the fact that workers, even of different social classes and professional categories, tend to be on a first-name basis and remain so when people from outside their workplace enter it. Medicine is an exception to the increasing informality and egalitarianism of modern culture. When they talk to nurses, many physicians tend to call RNs by their first names, while they expect to be addressed by their last name and title, as in “Hello, Jane. I’m Dr. Smith. Would you hand me the patient’s chart?” Nurses are expected to refer to physicians as “Dr. Smith” while they introduce themselves as “Joan” or “Jim.”

Of course, a nurse and a physician may be on a first-name basis. But in the presence of a patient, the same doctor will usually expect that a nurse will refer to him as “Doctor—.” He will continue to refer to the nurse by her or his first name.¹⁶ In some countries, like France, doctors use similar means to assert even more authority over the nurse. Though they may use the formal pronoun when talking to the nurse, they will call her by her first name, while they are called by their last name and title.

Dress is another workplace “language” and similarly indicates power or solidarity. In her book *Of Two Minds*, the anthropologist T. M. Luhrmann explains that modes of dress are very important to doctors. Doctors want to signal unambiguously that they are not nurses. “Every hospital I was in had an implicit dress code in which doctors looked like one another and emphatically not like the nurses.”¹⁷ To indicate the fact, physicians in the medical workplace usually dress in business clothes, sometimes protected by a long lab coat, or in the case of the doctor-in-training by a short white coat. Surgeons wear dark-colored scrubs (so do surgical nurses). In the past, nurses dressed for status as well as comfort with the starched white uniform and cap. Today, physicians still dress for status as well as easy identification, while nurses have jettisoned the starched whites for—well, anything goes. Particularly in North America, nurses today tend to dress in pajama-like outfits with heart, flower, and angel designs or in pastels. Only nurse practitioners, clinical specialists, or other advanced practice nurses routinely don white lab coats. In fact, since nonnursing personnel also wear the same kind of outfits as bedside nurses, it is often hard to tell by dress alone who is a nurse. Nurses blend into an undifferentiated mass

of people whose outfits signal an asymmetrical power relationship with **35** wearers of lab coats or business suits.

As a rule, deference and subordination lead people to overlook the concerns of others and even to justify abusing them physically or verbally. This is true in medicine. "You watched older doctors scream and yell at nurses, and it was pretty appalling," says Alice Rothchild. "When we were in surgery, a few doctors threw things at medical students and at nurses. There were a lot of compassionate docs but there were also the yellers in the ORs and on the floors. They yelled at med students and at nurses. That was the way doctors had been taught to express authority—to yell at people below them. It's part of the pathology of the system."

Doctors who verbally abuse subordinates often do so because a system in which they are superiors and nurses subordinates allows doctors to avoid accountability. If a nurse makes a mistake and the physician yells at her, this behavior may be reinforced if the nurse doesn't complain, as Larry Harmon explains. "If a physician yells at a nurse because she makes a mistake and then no mistakes occur for a month, then that's reinforcing. The physician unconsciously feels, 'Well, if I yell, that will improve behavior.'" As Harmon observes, some of the most disruptive physicians are highly perfectionistic, which adds to the pattern of abuse. "Some physicians demand the best. They want the best. But they may be so overextended that they don't have the time or communication skills to express their expectations clearly. As a result they feel an omnipotence that enables them to expect something without communicating it. When they don't get it, because they're very high-strung, they overreact."

If the physician uses verbal abuse as a tension-releasing strategy, this pattern of behavior may be similarly reinforced. The doctor feels stressed. She yells at a nurse. He doesn't complain—which means the doctor doesn't have to deal with the added stress of responding to that complaint. The hospital doesn't act to curb the behavior. So the physician feels his tactics worked: "I got it off my chest. It felt good." Harmon continues, "Many physicians do feel guilty, but they're on to the next thing. They may never get around to expressing their regrets to the nurse."

On the other hand, some doctors are unable to apologize for their disruptive behavior because they are emotionally incapable of taking responsibility for their conduct. They have, as Harmon puts it, no self-insight. "All they focus on is the mistake the nurse made, not the way they reacted to it," Harmon says. "Their attitude is 'she made me do it. I would never have done that if she had filled my request properly.' This is the response of the typical batterer: 'she drove me to it.'"

Whether doctors abuse nurses because they are too stressed, are too perfectionistic, or have more serious emotional problems, their behavior is aided and abetted by institutional attitudes and assumptions. Doctors

- 36** often get away with abuse because, Harmon explains, “the most disruptive physicians are sometimes the best and the brightest. They’re hardworking. They’re high-volume and high-revenue producers and they’re highly perfectionistic and high stress, which often comprises the profile of a disruptive physician. Physicians enjoy a unique role in that they don’t often work for the hospital, so they have no direct boss to reprimand them.”

By failing to reduce the long workdays of medical training, hospitals have encouraged the doctors’ tendency to berate or belittle. Chronic sleep deprivation makes matters much worse. Physicians-in-training have been traditionally used as cheap hospital labor and worked nearly to death—between eighty and a hundred hours per week. Timothy McCall wrote an important early article on the impact of resident hours on quality of care. He referred to the case of patient Libby Zion, who died in a New York hospital. A grand jury investigating the case found that long resident hours were involved.¹⁸ A number of studies on sleep deprivation in medical training have documented that it “has a significant effect on human functioning.”¹⁹ While there seems to be some debate about whether and how chronic sleep deprivation affects the actual performance of physicians’ work, there is little debate about the fact that it severely affects their moods.²⁰ Chronic sleep deprivation makes them irritable, angry, and resentful.

Some doctors-in-training understandably develop a sense of entitlement. They must give up a normal life for years, often postponing marriage and family; they end up saddled with huge medical school debts that delay their ability to enjoy their earning potential; and they are often screamed at and abused by their physician mentors. “Doctors go through this terrible training,” McCall explains, “and cope with a great deal of insecurity. Many doctors end up feeling like everybody owes them something. The public owes them a very good living, their patients owe them respect and deference, and nurses owe them obedience and assistance and should tolerate their outbursts.”

Painful as it is, the hazing period the doctor-in-training is expected to endure has a definite end point. Once the boot camp of residency is over, the apprentice doctor who was ritually abused can look forward to freedom from such abuse. Or, like some abused children, he can in turn become an abuser.

Health Care Team—“Plus ça change . . .”

Today the metaphor of the captain of the ship is increasingly being supplemented by the more fashionable notion of the physician as leader of the “interdisciplinary health care team.” The problem is that doctors are

not taught how to work in teams or manage them. "Doctors are now taught a bit about how to cooperate more with other doctors. Which is an important step forward," says Margo Woods, speaking from long experience. "As for interdisciplinary teamwork, there is little practice in this." Doctors are also taught more about patient communication. But communication instruction tends to focus on dyads—doctor-doctor, doctor-patient—not on members of the health care team.

International studies of medical errors and injuries in various health care systems point to a medical culture in which rigid hierarchies, fear of vulnerability, and the lack of understanding of the interdependent nature of patient care make effective team work and communication difficult. "Few newly qualified physicians have the skills necessary to improve care and patient safety," D. C. Aron and L. A. Headrick write. "These include the ability to perceive and work effectively in interdependencies; the ability to understand work as a process; skill in collecting, aggregating, analyzing, and displaying data on processes and outcomes of care; skills in designing healthcare processes; the ability to work in teams and in collaboration with managers and patients; and the willingness to examine honestly and learn from mistakes."²¹

There is even less incentive for doctors to collaborate with nurses, whom they consider to have an inferior education. "Doctors simply never learn how to say to someone—like a nurse—'Have you noticed anything that would be pertinent to this problem?'" Woods elaborates: "They don't learn how to say, 'What do you think about this? I'm thinking about doing such and such.' If doctors have a hard time doing this with other doctors, then to admit gaps in knowledge or really consult with people like nurses, whom they think of as subordinates, is positively embarrassing."

Since conflicts between team members have usually been resolved by a doctor giving an order that a nurse is supposed to obey, doctors acquire little skill in negotiating or consulting with nurses. When I asked the resident at Children's Hospital how she was taught to deal with conflicts that arise between nurses and physicians, she said that she received no training at all. Medical training, she said, didn't teach people how to handle conflict. The young woman also added that during training, health care professionals are rarely complimented for their successes and mastery. It's just assumed that you'll do it right, she said. So when you do it right, no one praises you.

When members of the University of Texas Human Factors Research Project compared physicians and airline pilots in their study of medical errors and injuries, they noted how socialization of workers can affect teamwork. Pilots—hardly known as a group of sensitive New Age guys—

- 38** have been recently taught to view their own work realistically and genuine teamwork favorably. They were, for example, far less likely to deny weakness (the effect of fatigue, stress, or personal problems on performance) than were surgeons and anesthetists. "Most pilots (97%) and intensive care staff (94%) rejected steep hierarchies (in which senior team members are not open to input from junior members), but only 55% of consultant surgeons rejected such hierarchies." Surgical nurses, anesthetic nurses, and anesthetic residents gave their teams rather poor scores for teamwork. On the other hand, surgeons and surgical residents rated their teams very highly. Not surprisingly then, 70 percent of the respondents in the study "did not agree that junior team members should not question the decisions made by senior team members." Consultant or attending surgeons were the least likely to tolerate real intrateam discussion around critical issues or disagreements.²²

Bonnie O'Connor describes a common attitude: "When it comes to collaboration, doctors tend to view collaboration as 'Why don't you come over to my house and see what I'm doing? Then we'll work together.' It's not seen as 'Why don't I come and spend some time in your neighborhood and see what I can learn there?' The assumption is that there's nothing of interest to the physician going on in your neighborhood or that what is going on is wrong."

The definition of teamwork, O'Connor elaborates, is very medico-centric. O'Connor, who proudly calls herself a "card-carrying pluralist," believes that to have a real team people must value each other's independent contributions and recognize that the team has an identity of its own. "This doesn't mean that everyone can do surgery, or have the skills a nurse has to help a patient recover, or the social worker has to do discharge planning. It does mean that people recognize that the whole is greater than the sum of its parts and does not exist to support just one of its players—that is, the physician."

Today, changes in the health care environment may actually be making physicians less eager to participate as members on a team in which they share knowledge and control. "I notice a lot of resistance and defensiveness about interdisciplinary teamwork among doctors today," O'Connor notes. "Physicians feel very assailed by nonphysicians and even nonclinicians. There are now patient activist movements. Ethicists are trying to tell them what to do. So are hospital and insurance company administrators, who are business people. People like me are coming in and saying: Here's how you pay attention to cultural stuff. You're not doing it right, here's how to do it. So there's a lot of discomfort about being on an interdisciplinary team without asserting that the physician is going to be the boss."

"Because doctors are always operating on the edge of their knowledge," says Woods, "they become very uncomfortable venturing into unfamiliar territory. They don't have enough information about what the different members of the team know and do. If something another member of the team recommends doesn't work right away, the doctor's tendency is not to find out why, but just to cut them out of the loop. Whether it is discussing a patient's nutritional status or wishes at the end of life, the doctor has neither the time nor training to deal, nor does he or she learn the psychological or communication skill to deal with these things, so what happens is it simply doesn't get done, or is done poorly."

This is a particularly acute problem in the area of palliative and end-of-life care. When patients are not doing well and it is time to initiate DNR (Do Not Resuscitate) orders or discuss palliative care, nurses are often the ones with a more accurate read on patients' and families' willingness or ability to confront these issues. They may also have valuable insights about the clinical appropriateness of discontinuing treatment or shifting to more aggressive pain and symptom control. Doctors, on the other hand, may be reluctant to stop futile aggressive treatment, tend not to be well schooled in conducting discussions with patients, and are not well remunerated for taking the time to do so. Doctors, in the United States at least, are paid for performing procedures on patients, not spending hours explaining the ins and outs of palliative care and how to manage chronic illness.

Nurses may be in an optimal position to confront these issues and hold such discussions with patients and families. But to discuss these matters is to step on the treacherous territory of patient prognosis. "It all goes back to power and authority," says Cynda Rushton, assistant professor at the Johns Hopkins School of Nursing and an expert in pediatric palliative care. "It has been one of the sacred cows of medicine that physicians own the patient's prognosis and that 'medical' judgment is the only judgment that counts in this area."

In 1995 the *Journal of the American Medical Association (JAMA)* documented the extent of the problem of nurse-physician communication around end-of-life care in a highly publicized study of patients' suffering at the end of life.²³ To help patients die with less aggressive treatment and in greater comfort, doctors were provided with up-to-date information on patient prognoses. Expert nurses communicated with patients and families and relayed information about patient wishes to physicians, and great attention was paid to pain control. Yet the results were abysmal. Physicians did not understand or heed patient's wishes or nurses' concerns, and too many patients spent too much time in ICUs, and too many died in pain. In media interviews following the release of the study, and in

- 40 a *JAMA* editorial by Dr. Bernard Lo,²⁴ none of the physician commentators talked about the problem of physician-nurse communication, which was, in fact, one of the major problems uncovered in the study. Instead they focused almost exclusively on doctor-patient communication, which can't really be remedied if doctors won't listen to nurses who are trying to convey important patient information to them.

Eight years after that study, too little has changed. Nurses, Rushton says, still get a lot of "negative responses when they even venture tentatively into that area [communicating with patients and doctors]. I've seen some really ugly encounters, where the doctor will become very emotional and really threaten the nurse. 'I'm going to take you off this case.' 'I don't want you talking to my patient.' 'You have no role to play here.' Sometimes, it borders on verbal abuse," Rushton adds.

If doctors spent more time meeting with nurses, all those involved in a patient's treatment might share similar views about its potential course and outcome. That doctors don't take that time—and increasingly, in the world of managed care and cost cutting, don't have much time to spend with either patients or nurses—means that nurses risk rebuke if they talk to patients about pain and symptom management or other aspects of their condition. This is a particular problem for nurses trying to do end-of-life care, because they feel that many doctors want to *own* the patient's prognosis. Such an attitude makes it difficult for nurses to initiate conversations about the patient's wishes and to effectively manage their pain and symptoms. As Aron and Headrick put it, "Improvement in health care delivery (even one's own practice) is almost always an interdisciplinary process, requiring the expertise and collaboration of everyone who works in the system to be redesigned. The professionals involved must be ready to contribute their own knowledge and skills and be willing to learn from the expertise of others."²⁵

Teamwork, thus defined, requires spending time and energy to meet with others on the health care team. Just as doctors take little time to consult informally with nurses to clarify issues or work through differing opinions, they don't tend to take the time to meet formally with the team.

Ten years ago, when I observed doctors and nurses at the hematology/oncology clinic at the Beth Israel Hospital, they seemed to communicate in what I've come to think of as hit-and-run conversations. They would talk briefly before going into an exam room or when exiting. They would converse during a patient meeting. Doctors would meet with doctors to discuss clinical issues. Nurses would meet with nurses. Nurses and social workers also set aside time each week to meet and talk about patients. Apart from their conversations on the fly, doctors, nurses, and social workers never met together. When I asked a physician friend who still

works in the clinic if things had changed in the past ten years, he told me **41** that, unfortunately, they had not.

Although they are involved in surgeries and have insights into surgical mishaps, nurses are often excluded from one of the most venerable traditions in medicine, the morbidity and mortality conference, or M&M. In teaching hospitals, this is when surgeons conduct a weekly review of mistakes made in the operating theater. The problem with these discussions is that they include only one set of the players, the physicians.²⁶

"Discussions in the M&M conference can be very direct," says Robert M. Wachter, professor of medicine and epidemiology and associate chair of the Department of Medicine at the UCSF Medical Center, "but part of the problem is that there aren't the other people in the room who need to understand these problems and need to make necessary changes happen." Some of these key players, Wachter says, are hospital administrators and people who control the budgets, "but a very big piece of this is that only one species of team members is sitting in the room." Wachter points out that this "species," if left alone to discuss problems, has a tendency to "trash" the people who have been left outside. "If doctors are talking about an error, it's easy to point fingers at anyone who is not in the room and who can't defend themselves. *If only* the nurses had just done this. *If only* radiology had done that. *If only* the ER knew what they were doing.' That's what you hear. When there's a major failure of communication and teamwork, the other people on the team and other parties in the communication are not there to be part of the conversation."

Not having all the relevant players take part in the discussion, Wachter says, also means that the job of conveying information about what actually happened during the M&M conference can become a cumbersome exercise in second- or thirdhand reporting. "From time to time we would come up with an error in the interaction between our service and others. Yet these others were not in the room. So my job as chief of service was to find them, tell them what went on, get their take on it, and come up with a robust solution—which, of course, involves after-the-fact secondhand recounting of what should have gone on with the entire group."

These after-the-fact ways of dealing with problems are meant to prevent future mishaps, but prevention is stymied by the absence of mechanisms that allow a nurse, or even a junior physician, to leap over status hierarchies to save a patient in immediate jeopardy. Medical hierarchies, of course, aren't designed to silence and intimidate only nurses. They also silence doctors who are in or have recently completed residency. These new folks on the block may be afraid to rock the boat or challenge those upon whom their careers depend. Similarly, doctors may play the "knowledge game" with doctors who challenge them. "You're an anesthetist,"

- 42** an incompetent surgeon says, “What do you know about cardiac surgery?” “You’re an internist. What do you know about OB?” The difference between the discounting of doctors and of nurses is that doctors may be told they don’t have enough knowledge about a particular medical field. But “not enough” is quite different from “none at all.”

Should a nurse thus have an urgent problem with a doctor’s actions, he or she can call in the nursing manager or an administrator on call. The higher-up can then address the problem. In some instances, this mechanism works. Sometimes they don’t. Sometimes it appears that formal mechanisms to address problems aren’t used because they are poorly advertised, or because no one knows that such an administrator or senior clinician is available. They may also be ineffective because the people that nurses rely on to state their case—nurse managers—may themselves be as disempowered as staff nurses. The nurse manager may not feel she has the power to go over the doctor’s head. She may have witnessed senior doctors scream at junior doctors or other nurses or have experienced a brow-beating herself, which would discourage her from standing up for the nurses whose interests she is supposed to represent. Often neither nursing nor medical higher-ups are any better at interdisciplinary communication than their so-called subordinates.

Similarly, nurses may be discouraged from appealing to higher-ups because such efforts have fallen on deaf ears. “Nurses who speak out, particularly in a manner that is critical of doctors, are still seen as committing an act of disloyalty, regardless of the legitimacy of the concern,” Justice Murray Sinclair wrote in a provincial inquest report on pediatric deaths in Winnipeg, Canada. “Alternatively, the hospital may not be interested in investigating the issue, perhaps for reasons of legal liability.”²⁷

Have Things Really Changed?

“But now that women are doctors, haven’t things changed?” That’s a question I’m often asked when I talk to friends or other members of the public about nurse-doctor relationships. Surely, many people think, since so many women have given up the white cap for the white coat, gender stereotypes are a thing of the past and female physicians eagerly exhibit solidarity with their nursing sisters. Thus when I mentioned doctor-nurse relationships to a sociologist studying women and medicine, one of his first questions was, Did I find any touching examples of solidarity between female doctors and female nurses?

Occasionally I have observed female doctors who are more egalitarian with nurses they worked with, but I confess that I have never observed a joint endeavor to overcome male status and privilege. In my observations

of doctors and nurses at work in the postfeminist workplace, female physicians were neither much more nor less supportive of nurses than male doctors. When efforts were made to prevent pediatric surgery deaths in Winnipeg, female anesthetists and intensivists were supportive of nurses who tried to raise the alarm about a dangerous surgeon, but both, to varying degrees, were put down by male surgeons. In Massachusetts, when female nurses in labor and delivery tried to warn female residents and a female obstetrician that a baby was getting into serious trouble, female doctors apparently refused to listen to female nurses.

I have heard female surgeons complain that they have to dress in the same room as the nurses. And even now, in the twenty-first century, some medical women are joining medical men in fretting about the dangers of the “overtrained RN.” In her book *PC, M.D.* the physician Sally Satel attacks “a growing cabal of feminist nurses” who are fueled by “a fiery resentment of the medical establishment, the so-called male medical elite,” and whose “antipathy represents a thoroughly postmodern rejection of the prevailing medical culture wherein doctors direct the patient’s treatment and nurses carry out many of those directives.” Like nineteenth-century physicians who worried about nurses who wanted to venture from the practical to the theoretical, Satel cautions against nurses who dare to dally in alternative therapies, consider the spiritual side of patient care, or study the philosophies of French intellectuals like Michel Foucault and Jacques Derrida.²⁸

Claire Fagin, dean emerita of the University of Pennsylvania School of Nursing, who has studied nurse-physician collaboration, sums up the situation, “What’s been the biggest disappointment is women in medicine. It’s not surprising to us when male doctors are abusive and disregard nurses. Because of their conflicted situation in the field, some female physicians can be just awful. As nurses, we get used to the disappointment, which is even sadder.”

Traditional male-female dominance and oppression sometimes erupts into violence against nurses. Although there are no statistics confirming this, most of the incidents of slapping, hitting, pulling, and throwing of objects I have heard about involve male physicians and female nurses. I have observed and heard about female physicians who are rude or humiliating or who have even thrown things at nurses. But no nurse I have spoken to has ever reported that a female doctor hit a female nurse. Nor have I ever heard about a female doctor hitting a male nurse.

Ironically, traditional gender expectations and stereotypes may impel some female doctors to treat nurses badly or adopt negative attitudes toward them. Such demeaning attitudes may also reflect their anxieties in the workplace. Insecure about their status, they find that “lording” it over

44 nurses is a way to prove that they're part of the medical boys' club. It also ensures that no one confuses the female doctor with a nurse—which is a significant problem for women in medicine. That's because while women have moved into medicine in far greater numbers over the past three decades, nursing has remained overwhelmingly female. Female doctors thus enter a medical workplace in which patients can realistically expect that most of the women who enter their exam or hospital rooms to care for them will be nurses. Which means that the female doctor may be routinely mistaken for a nurse.

"I would walk into a room," Alice Rothchild remembers, "and the patient would say, 'Can you get me a bedpan? Can you take my tray?' 'God-damn it,' I would think. 'I've worked really hard for this MD. Can't you just get it? I'm a doctor. Can't you understand that women can be in positions you don't expect them to be in?' The challenge is to figure out a way to make it clear who's who without ever belittling nurses."

"When you're in training and you're insecure, those moments when you're taken for a nurse are off-putting," says Emily Lowry. "As you gain more confidence and you mature, you take it in stride and it's easier to make it clear who you are with grace and good humor. I say, 'No, I'm not a nurse. I'm just a useless doctor.'"

Tension between female doctors and female nurses arises out of a lack of grace and good humor at just such moments of role confusion. Nurses have long complained about the physician who considered himself too busy and important to take the seconds needed to give a patient a glass of water, or shift the position of a pillow. When asked, the male physician would tell the patient that he'd get the nurse to do it. Some nurses expected, perhaps naively, more of women doctors.

Some female doctors, on the other hand, feel that female nurses ask things of them that they would not ask male doctors. They are right: the female nurse may indeed have a double standard—one born of oppression and frustration. Lowry recounts a scenario. "I'll ask the nurse to do something, and she'll say, 'Why can't *you* take them to the bathroom?' I doubt they would have ever said that to a male physician." Similarly, nurses are also much more likely, Lowry says, to tell her about a male doctor who was a jerk and expect that she would commiserate in a sisterly fashion, which, if the complaint is justified, Lowry says she usually does.

Some nurses may greet the arrival of a female doctor with sullenness or passive aggression. This may be due to their own personal problems or insecurities, but it may also be due to their disappointed expectations. The way some female physicians not only reproduce status hierarchies but also choose less-than-optimal ways to distinguish themselves from nurses has produced some very disgruntled nurses.

Both physicians and nurses say that relationships are best when mutual respect is shown. Most nurses don't want to be doctors, but they do want to be respected by doctors. Female physicians who recognize this fact display an understanding of the importance of nursing. They also understand the complexities of the gender and status politics of the doctor-nurse relationship. "When a nurse tells me in nurse-speak that a woman has painful urination and frequency instead of saying she has dysuria, I know she thinks that the person has a urinary tract infection," Rothchild says. "When she uses classic nurse talk and asks me, 'Would you like to get a clean catch and send a culture to the lab?' I know she's making as much of a diagnosis as I am. I also know that some nurses know a lot more than I do. When I go into the ICU, I always talk to the nurses first. When I'm in a high-tech environment like that, I don't know the drugs, the tubes, and alarms and machines. Why is that blinking? Why is that alarm going off? That's not my turf. I realize I need help so that I can help participate in the care of patients."

Female physicians who have mentors like Rothchild might reproduce this collaborative behavior. But this is not how all female doctors have been mentored and thus seem to feel or act.

Young female physicians today seem no more likely to recognize the complex role that nurses play in diagnosis and treatment than were their forefathers. Denise Rich* is a thirty-two-year-old fellow in hematology-oncology at a Boston teaching hospital. She did her undergraduate work at Harvard, finished an MD/PhD at another prestigious medical school and went on to train in Boston. When I spoke to her, she was in her first year of a fellowship.

Rich explained that her first lessons about nursing came in her third year of study when students moved onto the hospital floors. Unlike many doctors in training, Rich says, "Our mentors repeated to us that you need to learn from nurses, that nurses are the people who are going to be taking care of the patients most of the time. They know more than you, as medical students, in most cases. Learn from them when you can."

As she advanced in her training, Rich described a subtle and important shift in her perceptions and tutorials. "In internship you learned: Don't abuse them, because there is more danger or potential for that. Don't yell at them, treat them well. But as residents it changed. It was harder because you know more than they do, and so it's more like teamwork than learning from them. You work with them, be respectful when you ask for things, be respectful of their time and energy. But you no longer learn from them. They don't have as much knowledge."

Rich's language is instructive and reflects the values of the system in which she is being trained. She does not say that the nurse has different or

- 46** complementary knowledge. She believes the nurse has less knowledge (and, one suspects, inferior knowledge).

If "knowledge" means the knowledge of disease processes that is gained in medical school or from medical journals, then of course few bedside nurses can compete with four years of college, four years of medical school and an MD/PhD and years of residency and fellowship training. If, however, one includes an in-depth knowledge of nursing and the practical know-how gained from piloting a legion of patients through cancer treatment to the shore of remission, then the nurse may know more than the doctor about any number of things. Similarly, if the nurse has extensive "local" knowledge of how one particular patient is coping with nausea, cancer pain, and the impact of chemotherapy, or how much social support she receives, then the nurse has quite a lot to teach the doctor.

Rich also faithfully mirrored male physicians in their attitudes toward the nurses' role in diagnosis and treatment. I asked Rich whether she considered nurses' suggestions about patient problems and what should be done about them as part of the diagnostic process.

"No," she replied adamantly. "I think they give us advice and their opinion. In general the diagnosis is left to us doctors."

What's the difference between opinion and diagnosis, I asked.

"A diagnosis means I tell you what it is," she answered. "Nurses don't do that. They tell you what they think it might be, give us a few options, and sometimes they say, 'Maybe you should consider this, or do you think it could possibly be this. Usually they are asking our opinion or bouncing things off us and seeing what we think as far as the diagnosis is concerned.' They'll say, 'Should I send a urine sample to the lab to get a culture, because maybe they have a UTI? Do you want to give them this?' They tend to ask and let us make a decision. We're the ones who have to come up with the diagnosis and what the patient has and write the prescription."

To Rich the game seems to be the reality. Unlike Alice Rothchild, she seems unaware that the nurse actually has judgments, not just advice and opinions, but that she is perhaps reluctant to share them for fear that the doctor would take umbrage.

To see if she would be offended, I ask Rich what she would do if a nurse directly stated what she thought was wrong and what treatment was needed. "If they said it in a nice, respectful way, I would do it. If they did it in a respectful way," she repeated, "and I agreed with them. But it's never happened to me. They've always asked me for my opinion."

Differences of status between female doctors and female nurses appear in even more subtle measures of hierarchy and deference. A number of

the female physicians I spoke to referred to nurses as personal possessions, as "my nurses." Even some of my most progressive female physician friends, who wouldn't tolerate a secretary or worker being ill-treated or dealt with as personal property, didn't seem to have a clue that they were doing the same to RNs. A friend didn't seem to find it disturbing that her nurse used to answer the phone with "Hello, this is Dr. Smith's nurse." When I talked to her about nursing, she constantly described the nurse as her object—there only to serve her.

The pediatric practice where I take my kids is pretty much a female-run show, with first-generation feminist docs and second-generation postfeminist ones. The practice has a fairly steady group of nurses. But the list of clinicians on a plaque in the waiting room includes only the names of doctors. No nurses. No nurse practitioners. Just docs.

Except for the most elite nurses, the social distance between female physicians and nurses sometimes seems even more pronounced than that between male doctors and female nurses. In the past, female nurses and male doctors may not have socialized much, but they did tend to date and sometimes marry. Now, with more women in medicine, male doctors often marry female ones. And female doctors don't seem to cross status boundaries by socializing much with female nurses. The resident at the Harvard teaching hospital said she is quite friendly with nurses at work. They share a superficial workplace camaraderie. She chats them up. They ask her questions about how she's doing. But it would never occur to her to suggest to a nurse with whom she has such amicable conversations that they go for a drink or cup of coffee after work.

Would she go for a drink or cup of coffee with a fellow doctor-in-training? "Of course," she said.

In many cases, this social distance reflects class differences. More nurses come from working- or middle-class backgrounds, while more doctors are from the upper middle class. But it also reflects the status hierarchies that don't seem to shift much, no matter what nurses do, at least in conventional ways, to challenge them. A number of the nurses the resident works with have bachelor's and master's degrees. Some may even have doctorates. Some are of the same class and social background. They have husbands who are professors, lawyers, and doctors. They may be patients of the doctor in question. While this may translate into polite sociability at the dinner party or courteous treatment in the exam room, once the two disciplines share the same occupational space, traditional patterns of behavior reassert themselves.

When I talk with both younger female and male doctors, I am struck by the peculiar problem women's liberation has created for nursing. Doctors trained in earlier periods, when there were few women physicians

- 48 and women had few professional options, may have been taught not to expect much of nurses, but they probably didn't blame women for becoming nurses. In an era when women's employment choices were so narrow, a woman who wanted or needed to work generally became a nurse, teacher, social worker, or secretary. To doctors-in-training today, there is nothing unusual about a woman in medicine. What is unusual to them is the woman who chooses nursing rather than medicine.

"I sometimes wonder why someone would choose nursing," a female pediatric resident said. Echoing her, many of the younger doctors I interviewed seemed unable to understand why a woman who can become a doctor would voluntarily choose to become a nurse. If you wanted a career in medicine, why wouldn't you become a doctor instead of settling for something so much less challenging, knowledgeable, ambitious, and important?

Creating the Invisible Nurse

The medical system consistently entangles nurses in a series of Catch-22s. The female nurse who is bright and ambitious should have become a female doctor. If she actually chooses nursing—particularly bedside nursing—how could she be bright and ambitious? If she isn't bright and ambitious and has no medical knowledge to boot, why should doctors consult with her and attend to her concerns? Even more significantly, when a nurse makes a contribution to patient care—one that could illuminate what she really knows and really does—the system often gives the credit for her action and contribution to the physician. This means that the nurse is stuck in the most pernicious Catch-22 of all: whatever the nurse does confers credit on the physician. The only credit the nurse is sure to get is discredit, which may be rapidly assigned if he makes a mistake or is "insubordinate" or "uppity."

"Every night, a thousand times a night, all over the country, nurses are calling doctors reporting that a patient has a fever and asking doctors what they should do about it, or asking the doctor whether they should give the patient Tylenol," says Gordon Schiff, an internist at Cook County Hospital in Chicago. "And every night, doctors are berating nurses for calling them up and bothering them, because they are reporting a fever, and the doctors are thinking to themselves, 'Why are you so stupid that you are asking me whether you should give Tylenol? Of course, you shouldn't give Tylenol. Everybody knows you shouldn't mask a fever. You need to do something about why the patient has the fever.'"

But that, Schiff points out, is the conundrum. Nurses are severely restricted in what they can do for patients without a doctor's order. "We

have structured the system in a way that gives the bedside nurse such a limited repertoire that she can't order a chest X ray or a urine culture. She can't order labs on her own. She can't get antibiotics. In a lot of places she can't tell the doctor what she really thinks and what she really knows and what she knows should be done. She can only make suggestions. And all of this then reinforces what the physician was likely taught either through formal or informal lessons and socialization, which is that the nurse is really stupid, because she uses dumb language, makes dumb suggestions, and doesn't know anywhere near what the physicians knows."

This doesn't only create problems between nurses and doctors, it creates problems and reinforces status hierarchies between nurses. When I was lecturing to a class at a prestigious nursing school, a student in the advanced practice cohort told me that she'd been at a dinner party at a physician's house. The physician received a call interrupting his dinner. It was from a nurse asking for clarification of an order. He was irate at being disturbed and his wife was even more so. "How can she be so stupid?" the wife exclaimed. The student relating this story, who was planning to become a nurse practitioner, was not at all disturbed by the doctor's reaction. She seemed to identify more with the physician than with the bedside nurse. "I have a real problem with the nurse part of being a nurse practitioner," she confided.

To avoid an endless series of late-night phone calls and interruptions, some institutions give nurses greater latitude. They create unit- or institution-wide protocols that grant nurses the temporary authority to undertake a specified range of actions. Similarly, physicians may write standing orders such as "Don't call me unless the patient has a fever over 100.5." Or "two Tylenol 650 mg. PO. Q 4 hours. PRN Pain" (i.e., give the patient two Tylenol by mouth every four hours as needed for pain).

In some institutions, nurses simply do a number of things on their own and the doctor rubber-stamps them afterward. On ICUs nurses put in catheters or even an arterial line and then tell doctors later. On oncology services, nurses may order antiemetics for patients with chemotherapy-induced nausea, or pain medication to relieve cancer pain. The doctor will then write an *ex post facto* order to legitimate the action the nurse has taken.

"Nurses are always ordering things that they consider to be pro forma when the doctor is unavailable," says Emily Lowry. "When I was recently on vacation, I came back and found that I had ordered a whole bunch of things from South Africa. They ordered Tylenol, lab tests—urine and culture for urinary symptoms. They ordered physical therapy when it was needed and it was too much trouble to call the on-call doctor. And they

- 50 felt it was all quite pro forma, which it was. And of course I signed them all when I got back."

Why do doctors tolerate these private "liberties" when their organizations are so vociferous in publicly denouncing nurses who want more authority? It's simple. If nurses "work to rule" by calling a doctor for every little thing, refusing to give medications, move patients, or change diets until they actually reached a physician, the system would grind to a halt. The sociologist Andrew Abbott calls this bypassing of onerous and extensive restrictions "workplace assimilations." "Boundaries between professional jurisdictions . . . tend to disappear in worksites, particularly in overworked worksites," Abbott writes. "Subordinate professionals, non-professionals, and members of related, equal professions learn on the job a craft version of a given profession's knowledge systems. While they lack theoretical training that justifies membership in that profession, they generally acquire much of the diagnostic, therapeutic, and inferential systems. . . . If the public knew the extent of workplace assimilation, it would profoundly suspect professionals' claim of comprehensive jurisdiction," Abbott concludes.²⁹

A great deal of effort, on the part of both doctors—and, ironically, nurses—is spent making sure the public doesn't know how much medical diagnosis, treatment, and prescription nurses actually undertake. Doctors do this by attributing a nurse's action to the physician. The nurse isn't really acting on her own knowledge and judgment when they take the actions described above, doctors argue, they are acting on the physician's. They don't really have any agency of their own; they are just temporarily borrowing the doctor's agency. They know "my own preferences," doctors tell me, and would never knowingly violate them or exceed their authority.

Credit for the judgments and knowledge guiding these actions still goes to the doctor or to higher-ups in the institution. The nurse is still seen as an agent without knowledge and judgment—and ultimately not an agent at all.

What is worse is that physicians often take credit for a nurse's knowledge, judgment, and action. Recall Deborah Madison's experience with the intern in charge of her patient. The very structure of the medical system conceals nurse's activities while giving credit for them to a physician who initially opposed her recommendations. The elimination of nursing's contributions to the complex story of medical decision making and treatment is so routine that most doctors do not consider it to be problematic. Patients don't know what nurses really do. And nurses view it as the very air they breathe.

This failure to account for nursing's contributions has been integrated into the formal process of medical accounting, both financial and reportorial. Hospitals, for example, account for the cost of medications, medical tools, equipment, and supplies. Before the bundling of charges under DRGs (diagnostic-related groups), you could find out what an aspirin cost, what a scalpel cost, even what a pencil cost. And physicians, of course, have always billed for their services. But hospitals did not include a financial accounting of nurses' services in any hospital bill or invoice. As if they were a sheet or pillowcase, nursing services were the original bundled service, integrated into the room charge. This, erroneously in my view, has led some American nursing elites to insist that the way nurses will finally make it onto the radar screen is to set up their own agencies and sell their services back to the hospital, just as physicians do.

In their discussion of how medical education, training, and work so often preclude a recognition of interdependence, Aron and Headrick explain that doctors have a limited ability to "understand work as a process."³⁰ Given the accounting structures of medicine, it is difficult for nurses' contributions to be included in the meetings, conferences, reports, and charting of medical care.

Medicine also routinely claims credit for nurses' work in the chronicling of medical care in books, articles, columns, letters to the editor, or comments from doctors describing their work to a broader public. An interesting example is a letter to the editor printed in the *New York Times*. Physician Arthur M. Magun, director of quality assurance at Columbia University, is opposing efforts to reduce the grueling schedules of interns and residents, which range from eighty hours per week to over a hundred. Doctors should remain at the bedside as long as possible, Magun argues, because "experienced doctors realize that long hours at the bedside of a sick patient watching the drama of illness unfold and being there to understand the results of one's intervention or lack of it are the best route to becoming an outstanding doctor."³¹

A year later, surgeon Steven G. Friedman wrote an op-ed for the same paper on the shortage of candidates for surgical programs. Echoing Magun, he cited shortened resident hours as one of the causes of the crisis. "Will patients now be better off with shift workers (i.e., doctors who work shorter shifts) who have never seen the complete progress of an illness than they were with tired doctors who cared for them throughout the night?"³²

For anyone who has actually tallied how much time surgeons spend at the patient's bedside after they leave the OR, this image of the surgeon hovering at the patient's bedside is almost laughable. Who actually spends

52 long hours at the bedside of a sick patient watching the drama of illness unfold or caring for patients “throughout the night”? Is it really the doctors? In most of the hospitals I’ve visited in my fifteen years as a health journalist, doctors typically spend only a few minutes at each patient’s bedside, and when surgeons are in the hospital, whether for 120 hours or 80, most of those hours are spent in the operating room, not in the recovery room or patient’s room. I recently met an Egyptian surgeon who had moved to the United States. Unable to transfer his medical license easily, he was working as a nursing assistant in a hospital and studying to become an RN. He said he was shocked at how little time doctors in the United States spend with their patients, particularly surgeons. “They come in the room for five minutes and the nurses do everything, and then they bill and make big bucks.” In Egypt and Saudi Arabia, where he practiced, doctors were there all the time and did the bulk of care that nurses do in the United States.

So if anyone truly has “a front-row seat to the spectacle of illness” and can assess the results of treatment interventions, it is nurses. And as we shall see, even they are rarely able to watch the drama of illness unfold. Today, as soon as patients are stabilized, they’re likely to be transferred to a nursing home or other subacute facility, or go home. In which case it’s nursing staff and family members who learn the most about the wisdom and efficacy of medical interventions, not physicians.

Even some of the most ethical and progressive doctors seem to take credit for nurses’ work without understanding the consequences. Consider, for example, the group Médecins sans Frontières—Doctors Without Borders—which won the Nobel Peace Prize in 1999 for its courageous international work. What is less well known is that the majority of its members are not doctors but nurses. Yet the organization is not called Doctors and Nurses Without Borders, or even Medicine Without Borders—names that would more correctly convey the role nurses and other nonphysicians play in the group.

On its international homepage, MSF includes a link to stories that have appeared about the group in the British paper the *Guardian* and posts a number of recent press releases. Most of the press releases have physicians as spokespeople and define the group as a medical group providing medical services. Given the group’s name and spokespeople, most readers would assume that the staff and those teams are made up of doctors.

Several years ago, I was talking with one of the leaders of the organization. When I politely asked this female physician leader about the choice of name, she became extremely annoyed. The organization now had “name recognition,” she insisted. I suggested that a small change in its title would hardly jeopardize its renown. She responded angrily, “Well, I

certainly hope we would never do anything that stupid." This medical confiscation of nurses' contributions assures, as one nurse put it, that "doctors get all the credit when something goes right. We get credit only when something goes wrong."

Ann Williamson, a nurse executive at the UCSF Medical Center (University of California, San Francisco) recounted an example of this problem of discredit. As happens every day in hospitals across the country, a nurse was working with doctors who were involved in the tricky maneuver of placing a feeding tube in the stomach of a patient on the intensive care unit. During the insertion it's easy to mistake the trachea for the esophagus and to insert the tube into the lungs rather than stomach or small intestine. To do so means that fluid and nutritional matter will go into the lungs, where it could cause a pneumonia or potentially drown the patient. So nurses and doctors use a variety of mechanisms to assure correct placement. Sometimes an X ray is taken to make sure the tube is correctly inserted. The nurse will also pump air into the tube and listen with a stethoscope placed over the abdomen to listen for gurgling in the stomach.

In this particular case an X ray was indeed taken, but the nurse wasn't confident that the X ray technicians had read the right film or read it correctly. When he pumped air into the tube, he was certain that he couldn't hear any gurgling in the stomach. On the other hand, he felt he could hear air moving through the tube when the patient breathed, a sign that the tube was misplaced.

The resident placing the tube disagreed. He insisted that the tube was correctly placed, that the X ray verified placement, and that it was safe to feed the patient through the tube.

Understanding the significance of a potential mistake, the nurse continued to object, insisting that another X ray be taken or that X-ray technicians verify that this X ray was read correctly. Again the doctor objected. But the nurse stood his ground.

Ten minutes into the debate, the X-ray department called. "I hope you haven't started the feedings yet," the technician said. The nurse was right. The tube had been placed incorrectly.

Although the tube was finally placed correctly and the mistake avoided, the nurse never got credit for his call. The doctor never came back to the unit to express appreciation for his persistence. What happened was not noted in the chart. Did the resident mention it in his discussions with his colleagues? Probably not. Was it used as part of a case study to teach medical students about the role nurses play in the hospital? Not that Williamson knew. The nurse saved the patient's life, but from the medical point of view, his action simply didn't exist.

NURSES AND DOCTORS AT WORK

54 Williamson invited me to think of what would have happened, had the nurse not fought with the resident and instead started tube feedings. He would have been blamed for what happened. Why didn't he listen harder, question further? In this instance, he received no credit for success. But had he remained silent, he would have shouldered lots of blame.

Dave Latham describes an even more interesting situation. While he was working on the neurological unit at an Illinois hospital, a patient came in to be diagnosed. The patient was just staring into space, almost catatonic. The nurse who was taking care of him told the doctor she thought that the patient was having seizures and suggested that they give him Valium. After much discussion, the doctor finally agreed. The patient got the Valium and woke right up. Instead of thanking the nurse, the doctor said, "I hate it when the nurses are right."