Collaboration between doctors and nurses

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As long ago as 1986 Steele said 'Without a doubt patients are better served by a union of nurses and doctors working collaboratively. The mutual goals of doctors and nurses providing quality patient care are achievable if the major providers of patient care work together to formulate that care. Neither nursing or medicine can "do it all" today as the patient demands for health care are too broad in scope, the curative techniques are too complex, and no one specialist (medicine or nursing) can be expected to generate all the potential possibilities for delivering health care today'.[1]

In 2010 the increase in prevalence of long-term conditions and the persistence of poverty, deprivation and the subsequent increased need for all types of care has raised the issue of collaboration between health professionals and brought it to the forefront of our thinking. Most of us accept that no single disciplinary group can provide complete care for patients with long-term conditions (or probably any condition) but, in practice, successful and genuine collaboration is not always achieved. The vast majority of nurses and doctors also say they do what they do because of a fundamental desire to provide service to people in need or to support individual health and well-being. As such, it is obviously of interest for these two major groups of clinicians to pull together, whenever possible, towards their shared goal.

So much has been written about the importance and value of collaboration. Why has it proved such a challenge to achieve? Recently in the course of conducting a number of focus groups in general practice settings I have come to reflect even more than usual on this sometimes elusive and multifaceted notion of collaboration. Having carried out these focus groups both 18 months ago and again just recently, it is good to report that in this second round there is a palpable sense of increased achievement behind the long-standing rhetoric of teamwork. I say 'rhetoric' because it has always been clear that, whilst nearly everyone thought teamwork to be important, there were certainly very few nurses at least who felt they were part of a genuine team and all that that entails.

I came away from several focus groups with a sense of real enthusiasm for the changes which had occurred in the 18-month period, and for the increased and clear articulation of the different but complementary roles of doctors and nurses in delivering primary health care. Both doctors and nurses so clearly expressed their quite different takes on patient need during encounters, in particular those associated with long-term conditions. I also heard a level of frustration from many doctors especially, suggesting more could be done with greater time and space and increased willingness from nurses to 'step up'.

It is certainly true to say that many nurses have long blamed doctors for the somewhat oppressive relationships they have experienced, and much has been written about doctors' 'captain of the ship' mentality. Undoubtedly there is no smoke without fire. Interestingly, however, my experiences conducting those focus groups, a very recent experience as a Visiting Professor at Yale University, and previous experiences in Vancouver and Edmonton have caused or allowed me to think a little differently. In those American and Canadian communities I spent some time with several superb nurse practitioners and their physician colleagues and I observed the more relaxed and clinically-relevant level of collegiality that reigned in such environments. It seemed to me that the more the nurses were confident and totally clear about their autonomy and their clinical expertise, the more they simply expected (and achieved) collegiality and collaboration.

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Similarly the more the doctors felt able to trust the nurse's ability, the more they let go of the need to captain the ship. Indeed many expressed the huge relief of knowing that the myriad of services at which nurses can or do excel at were being taken care of.

During the focus groups—in New Zealand (NZ)—a number of nurses expressed their lack of desire or, much more commonly, their lack of opportunity to undertake postgraduate education. I think this is a serious barrier to developing the level of practice that would most foster trust, collaboration and collegiality. It is certainly not the whole story, but probably quite pivotal in provoking changes to old patterns and old ways of doing things. In addition, the doctor participants with whom I spoke, who had had the experience of working with a nurse practitioner, were vociferous in their praise and desire to see that model of practice much more widely implemented. It became clear to me that nursing confidence and competence were quite fundamental to collaboration and every bit as important as medical willingness to relinquish the automatic captaincy and control of the ship.

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This nicely supports NZ work by Sue Pullon who wrote:

> The identification and separation of vocational and business roles, and the development of professional identity, form the basis for a theory of trust development in nurse–doctor inter-professional relationships in New Zealand primary care. Professional identity is related to demonstration of professional competence, in turn related to development of mutual inter-professional respect and enduring inter-professional trust. Professional identity is related to demonstration of professional competence, in turn related to development of mutual inter-professional respect and enduring inter-professional trust.[2]

Postgraduate education for primary health nurses is transformative both in developing clinical competence and increasing a sense of professional identity and confidence. Formal postgraduate education is qualitatively different from the vital array of short course learning, which also underpins practice. Contrary to popular belief, postgraduate work is also totally clinical in focus and relevance. I have now personally witnessed this transformation so many times, yet remain astonished and impressed with the degree to which it occurs. I understand the reluctance of nurses already juggling home, children and work to add the burden of study. But I can no longer see it as optional and I now believe that in the interests of quality care and effective collaboration, medicine and nursing could usefully combine their collective power and lobbying capacity. This could be directed towards ensuring that it is much more possible for primary health care nurses to both access study and to survive doing it because it is at least partially incorporated into their workload.

Further opportunities for meaningful collaboration exist at the policy level. Too often and for too long I have witnessed medicine and nursing at odds around the policy table. Mostly it comes down to medicine resisting or actively blocking proposed structural or legislative changes, which would free or expand the utilisation of nursing services. The fact that it has taken 10 years to reduce the number of identified legislative barriers to nursing innovation from 64 to 59 is a testament to extraordinary procrastination in the bureaucracy and perhaps some covert resistance.

Given our predicted workforce dynamics and the actual and predicted burdens of chronicity and unmet need, this seems highly counterproductive and a waste of limited energy. We all benefit from greater utilisation of nursing and we all enjoy collaborative and collegial relationships. At the simplest level they make work environments

more pleasant and the evidence certainly shows they increase patient safety and well-being.

It has been a significant pleasure to sense the small, but growing, and more genuine collaboration at team and practice level. The next challenge is to lift that collaboration to the policy and legislative table and I do not think nursing would be averse to harnessing the historically greater lobbying power of medicine towards such beneficial goals. If primary health care teams are to work as effective teams, and if people are going to have the access to services needed, a few key changes will release the potential of nursing to deliver on these goals. Medicine and nursing could collaborate powerfully to direct the reduction in legislative barriers, increase the funding and accessibility of nursing postgraduate education, increase understanding about the value of the nurse practitioner role and fast track nurse prescribing legislation. The large-scale establishment of nurse practitioner roles in primary care teams and in residential care or gerontological settings is also long overdue. The key beneficiaries would be patients and they are the goal we share above all others.

References

1. Steele JG, editor. Issues in collaborative practice. Orlando, Florida: Grune & Stratton Inc.; 1986.
2. Pullon S. Competence, respect and trust: Key features of successful interprofessional nurse-doctor relationships. J Interprof Care. 22(2):133–147, 2008. DOI: 10.1080/13561820701795069

1998 vision for year 2003 for members of Pegasus Medical Group

In 1998 **Les Toop** anticipates general practice in the year 2003

You arrive at 0800 to begin the week with the team meeting. Coffee and croissants and 45 minutes to review the tasks ahead for the week. Then on and into your consulting room—you sit down, switch on your workstation and survey the week ahead. The first screen has the week's visits (looks like a quiet week ahead)—to the hospital on Monday and Thursday for lunchtime ward rounds to see longstay patients and any of your flock who are in having elective surgery, a couple of rest homes and tennis on Wednesday. Next, you check email and voicemail from the weekend. There are a series of questions requiring your input—Can Mrs X be safely discharged home? Mr Y doesn't quite have enough points to have his cataracts done, but if you think it is *really* important he will be done anyway but it might not be until next month. Next, the patients who attended the After-Hours over the weekend flick up with the picture of the patient and a medical summary in the corner of the screen to remind you who they are. Next, up flicks the screen with the utilisation of labs, radiology and pharmaceuticals in the last three months. It looks scary and you decide to view this later in the week (in fact much later). Discharge summaries flash up next and after flagging the necessary follow-up actions are filed electronically on the patient records along with the x-ray and laboratory reports. A paper discharge letter from Australia provides a touch of nostalgia and you tut to yourself at the inconvenience of having to pop it into the scanner before shredding. The important lab and x-ray reports are next and there is an interesting report of someone with an arachnoid cyst. Never having seen one before you double click on the wee icon in the corner and the digital image of the scan pops up in a small window. 'Fascinating,' you think, and make an electronic note in your 'education to learn' folder. Interestingly it won't save, and a message pops up that you must allocate more storage space to this ever-expanding file.

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