

Inter-professional Relationships Issues among Iranian Nurses and Physicians: A Qualitative Study

Abstract

Introduction: Nurse–physician inter-professional relationship is an important issue in health care system that can affect job satisfaction and patient care quality. The present study explores the major issues of nurse–physician inter-professional relationships in Iran. **Materials and Methods:** In this in-depth qualitative content analysis study conducted in 2014, 12 participants (5 physicians and 7 nurses) were recruited from two educational hospitals. The data were collected from deep, open, and unstructured interviews, and analyzed based on content analysis. **Results:** The participants in this study included 12 individuals, 6 females and 6 males, with the age ranging 27–48 years and tenure ranging 4–17 years. Four themes were identified, namely, divergent attitudes, uneven distribution of power, mutual trust destructors, and prudence imposed on nurses. **Conclusions:** The results revealed some major inter-professional issues and challenges in nurse–physician relationships, some of which are context-specific whereas others should be regarded as universal. It is through a deep knowledge of these issues that nurses and physicians can establish better collaborative inter-professional relationships.

Keywords: *Inter-professional relations, Iran, nurses, physicians, qualitative research*

Introduction

Interpersonal relationship is an integral part of daily life, which is of significant importance within the health care context.^[1] Nurses and physicians together as the largest component of healthcare providers are members of two different professions who have their own specialized expertise and responsibilities.^[2] Positive relationships between them can decrease the mortality rate, reduce the amount of patient's adverse complications, shorten the length of stay, and enhance the quality of care.^[1,3] Upsetting behavior, along with other negative workplace factors, can significantly increase burnout and workplace stress.^[4]

In spite of the importance of nurse–physician inter-professional relationships, their relationships do not flow as it should and is fraught with difficulties.^[5] These problems can originate from factors such as gender differences,^[6] differences in educational and socialization processes, overlaps of the two professions,^[7] gaps in educational and socioeconomic status, or lack of understanding and sympathy.^[6]

Attitudes and expectations formed by cultural norms have been argued to affect interpersonal relationships in health care systems. It is also argued that, in societies where nurses have little autonomy, nurse–physician relationship is usually “hierarchical,” physicians are at a higher position, and adversarial relationships can develop between the two professions.^[8]

Exploration of such important factors needs an inquiry in which experiences of both nurses and physicians are interpreted in detail. In this line, qualitative studies are more appropriate. The main contributor to effecting changes in inter-professional relationships is to know relations, experiences, and emotions of the individuals involved. Therefore, a perception of team members' relationship experiences can lead to higher awareness and reduced incorrect presuppositions and interpretations.^[9] Enquiries conducted in this regard in Iran tend to be quantitative in nature.^[10,11] One cannot base quantitative research to describe phenomena such as human values, culture, and human relationships. In such situations, qualitative

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research proves more appropriate in revealing behavior, attitudes, feelings, and experiences of people and what occurs in the context of their lives.^[12] In addition, few qualitative studies conducted in Iran have explored the issue from nurses' viewpoint only.^[1,9]

Because the researchers of the current study were nurses, both directly related with physicians in their working environment and aware of the positive and negative aspects of this relationship, they were interested in scientifically exploring in detail and the nature and dimensions of this relationship.

Moreover, we believe that conducting such studies on an international scale will contribute to developing a global perspective of the nurse–physician relationships. Therefore, this study aims to qualitatively explore issues concerning inter-professional relationships among Iranian nurses and physicians.

Materials and Methods

Design and participants

A qualitative design was used to explore the inter-professional relationships' issues among Iranian nurses and physicians. The study was conducted among 12 participants who were selected through purposeful sampling. The initial participants were selected from nurses and physicians working in the Vali-Asr Hospital of Birjand who were eligible for inclusion. Using maximum variation in terms of age (27–48 years), gender, marital status, education, working ward, and tenure (4–17 years), the sampling process continued along with the analysis of the data from the interviews. The inclusion criteria were willingness and provision of written consent to participate in the study and to be able to provide rich qualitative data. The participants included seven nurses with a BSc (one with an MSc) and five specialists—in total 6 male and 6 females working in two university hospitals all with experience of working in different wards (general and intensive).

Data collection

Data was collected through in-depth, face-to-face, unstructured interviews in a quiet and private room that was convenient for the participants. The interviews started by an open-ended question like “Can you describe your experience of working relationships with nurses/physicians in your workplace?” Later, probing questions were asked to follow the participants' thoughts more exactly and clarify their responses during the interview. The time and place of interviews were determined by the participants. The interviews took 30–90 minutes and were tape-recorded.

Those with high motivation to provide information were selected as the participants, and the interviews were conducted with maximum possible details, reinforced by probing wherever required. Interviewing stopped when data

saturation occurred, and no more codes or themes emerged in the last two interviews. Thus, data collection was done satisfactorily, using the least number of participants.

Data analysis

Data collection and analysis proceeded concurrently. The data were analyzed by conventional content analysis methods. This method is used to analyze qualitative data which was obtained from open-ended survey questions or interviews. Here, we used it to identify different themes and categories. The following steps were taken to analyze the collected data.^[13] First, the interviews were transcribed and carefully read several times in order to obtain a general sense of the entire interview. Then, the texts were divided into condensed meaningful units. Later, these condensed units were abstracted and labeled with codes. Following this stage, the codes were sorted into categories and subcategories based on their similarities and differences. Finally, themes were formulated as their presentation of the latent content of the text. For example, some codes such as servant, obedience, and grandeur were extracted and then after comparing and merging some of the concepts from “Super ordinate-subordinate relationships” and “Sense of superiority” sub-categories, the main sub-concept of “expansion of the physician's dominance” was formed. This category together with two other related categories formed the main concept of “uneven distribution of power.”

Trustworthiness

Trustworthiness of the data was established through member-checking and peer-checking. For member-checking, a copy of the encoded interviews was returned to 2 nurses and 2 physicians, which was confirmed by all of them. Peer-checking was carried out by four expert supervisors through analyzing and observing the analysis process and validating the codes and categories. Maximum variation sampling, prolonged engagement, and limited review of the literature along with data collection and analysis were made to increase trustworthiness.

Ethical considerations

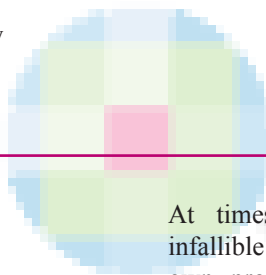
This study was reviewed and approved by the research ethics committee of the Birjand University of Medical Sciences. Moreover, participants entered the study only after obtaining their written informed consent besides being informed of the objectives and methodology of the research and confidentiality of information. They could voluntarily leave the study whenever they wished. The interviews were also tape-recorded with their consent.

Results

In this study, the participants described their experiences of inter-professional relationship. In general, four themes with their own categories emerged from the analysis of the interviews [Table 1].

Table 1: Nurse-physician inter-professional relationships themes, categories, and subcategories

Theme	Category	Subcategory
Divergent attitudes	Nonparticipatory approach towards the nurse	Therapeutic decision-making without participation of nurses Lack of consultation with nurses
	Opposing inference	Different perceptions of the same subjects Self-beneficial interpretation
	Unfriendly behavior	Cold and formal response to bad temperament Guarding against aggressive behavior
Uneven distribution of power	Expansion of the physician’s dominance	Super ordinate-subordinate relationships Sense of superiority
	Overlooking nurse’s dignity	Disregard for nurse’s legitimate needs discourteous behavior towards the nurse
	Self-weakening the nurses’ authority	Self-underestimation Backbiting nurses by other nurses
Mutual trust destructors	Ethical shortcomings	Attribution of mistakes to the nurses Arrogance of some physicians Shirking responsibility by some nurses Nurses’ disregard for others
		Nurse’s negligence of up-to-date information Nurses’ professional weakness Replacing professional principles with financial motivations
	Competency weakness	Obligatory flexibility Prudential silence in face of disrespect Documentation Prevention of possible disrespect
Prudence imposed on nurses	Expedient flexibility	
	Preventive countermeasures	



Theme 1: Divergent attitudes

Nonparticipatory approach toward the nurse

This study showed that the nurses are not satisfied with their underestimated roles in clinical decision-making as well as physicians’ ignorance of their ideas and experiences. As an instance, a nurse stated:

Nurses, especially experienced nurses, have worked with different physicians for years and have witnessed different cases. They are familiar with old and new drugs [...]. But it is a pity that physicians do not use nurses’ experience. (Nurse, female, age: 48 years, tenure: 13 years)

Along the same lines, another nurse complained: Most of the times we [nurses and physicians] behave as if we are separately working for ourselves and they are working for themselves without any shared goal. (Nurse, female, age: 31 years, tenure: 5 years)

Opposing inferences

Nurses and physicians viewed the same thing differently. For instance, physician’s admonishment to the nurse was considered a feedback and a promotional factor by physicians but faultfinding by nurses.

At times, these professionals consider themselves as infallible and interpret everything in favor of their own profession. One of the nurses talked about being reprimanded for minor mistakes:

God may forbid that a nurse should have a fault; it is badly magnified. But the physicians commit a thousand mistakes before our eyes! [...] and burdens so much extra expense on patients’ shoulders [...] but no one even mentions it. (Nurse, female, age: 38 years, tenure: 11 years)

However, a physician held the contrary opinion: The way a physician is reprimanded is more severe and more important, and I don’t believe that nurses are as much involved in litigations as physicians are... (Physician, female, age: 46 years, tenure: 17 years)

Unfriendly behavior

Unfriendly behavior was another category that suggested professional divergence. “Cold and formal response to bad temperament” was one of the concepts formed this category. Although nurses treat a good-tempered physician with more flexibility, they might react to a physician’s bad temperament by displaying cold and formal behavior.

Guarding against the aggressive behavior was also another form of behavior that can result in changes in the professional relationships by some nurses, as shown in one instance:

We had a physician who was terribly scurrilous! For this reason, the head-nurse had forbidden nurses from accompanying the physician during visits. (Nurse, female, age: 48 years, tenure: 13 years).

Theme 2: Uneven distribution of power

Expansion of the physician's dominance

One of the categories that emerged from the analysis of participants' experiences was "expansion of the physician's dominance" in inter-professional relationships:

Physicians perceive themselves as God's gift to mankind and everybody as subordinate to them; they see nurses as their servants who should unquestionably follow their orders [...]. (Nurse, female, age: 48 years, tenure: 13 years)

While opposing this view, a physician maintained:

Relationships in which there is obedience can be very contributing. (Physician, male, age: 42 years, tenure: 12 years).

In nurses' view, some of the physicians expect many tasks from the nurses that are not among their responsibilities but are part of their own (physicians) duty. This reflected a sense of superiority on the part of physicians:

Sometimes, they expect us to do things that are not among our duty. It is not at all my duty to bring him the gloves or clean the stethoscope with alcohol, or hand him the pen if it falls. (Nurse, female, age: 31 years, tenure: 5 years)

One of the physicians believed that some behaviors on the part of the nurses are wrong and need change:

We should not change our position as our grandeur shall be reduced this way; no one will count on us. (Physician, male, age: 42 years, tenure: 12 years).

Overlooking nurse's dignity

One of the nurses believed that some physicians overlooked the nurses' legitimate needs, such as having a short break time during working shift:

While visiting our resting room some physicians say: "What can it mean for the nurses to have a resting room [...]." (Nurse, female, age: 38 years, tenure: 11 years)

Another subcategory of the abovementioned ignorance of the nurses' dignity was *discourteous behavior* towards them. This may result in complaints by the nurses, as seen in the following case:

The doctor does the examination, takes off his gloves, and points towards the nurse asking her to throw them away in the garbage can. This is nothing but disdain. (Nurse, female, age: 38 years, tenure: 11 years).

Self-weakening the nurses' authority

Questioning the nurse's authority can sometimes result from their humiliating behaviors. Nurses always complain about fellows who perform physicians' personal affairs:

In our ward, the head nurse prepares breakfast table for the physicians and cleans their room. However, it is not her duty, but when she does such a thing, the physicians think... (Nurse, female, age: 31 years, tenure: 5 years)

Another factor that weakened the authority of the nurses was lack of nurses' support for one another. In this regard, one of the physicians put:

When the matron backbites the nurses before the manager or the physician of the ward for a problem, the physician thinks that there is nobody to back the nurses [...]. (Physician, female, age: 46 years, tenure: 17 years).

Theme 3: Mutual trust destructors

Ethical shortcomings

One of the ethical shortcomings involved in nurse–physician relationships was the attribution of physicians' mistakes to the nurses. In other words, some physicians attributed their own mistakes to nurses when a problem resulted from their own performance.

The arrogant and discourteous manner of some physicians in the presence of the patients has infused nurses with the idea that physicians are proud:

...When a patient was lying on the bed and the physician was examining his lungs, he said, "Raise the patient." One of the (medical) students tried immediately to help the patient sit, but the doctor exclaimed, "You shouldn't do this; ask the nurse to do it." (Nurse, female, age: 27 years, tenure: 4 years)

Shirking responsibility by some nurses was another subcategory that was revealed in our study. One of the physicians demonstrated the situation:

Some nurses discourage patients from doing such invasive tests as LP which need the patient's consent because they want to shirk their duties! (Physician, male, age: 42 years, tenure: 12 years)

Nurses' disregard for others was another ethical shortcoming that fuels the mistrust between nurses and physicians. In this study, a physician was displeased with nurse's lack of respect for the patients.

Competency weakness

Nurses' negligence of up-to-date information was among the subcategories of "competency weakness" that can result in mistrust. One of the physicians regretted regarding such a drawback:

Nurses do not make much use of the training and the scientific information they have received at the university... (Physician, male, age: 42 years, tenure: 12 years)

Nurses' professional weakness was another concept that led to inter-professional mistrust.

Replacing professional principles with financial motivations also led to mistrust in physicians. This was described by a nurse as follows:

... I wish their [physicians] only purpose was the patients' recovery; they are mostly financially oriented! (Nurse, female, age: 27 years, tenure: 4 years).

Theme 4: Prudence imposed on nurses

Expedient flexibility

Most of the nurses deal flexibly with the disrespect and illogical behaviors of the physicians:

Although sometimes the physician speaks badly, I respond with respect. (Nurse, female, age: 36 years, tenure: 8 years)

They assume the reason for such behaviors to be expedient considerations, namely they believe that an improper reaction could be risky since physicians are of more power in the health-care system and nurses are of less support in that context. Based on this, they prefer to keep silent and tolerate everything:

Since I don't have a long tenure, and I'm not supported by anyone, I keep silent in most cases [...] I have learned to be quiet and endure hardships (Nurse, female, age: 27 years, tenure: 4 years).

Preventive countermeasures

As mentioned before, some physicians in this study attributed their shortcomings to nurses and blamed them. To avoid this, nurses mostly tried to use documentation and precautions as a countermeasure:

We have learned by experience how to prevent them; we tick their orders from bottom to the top (so they cannot add any order in between) [...] (Nurse, female, age: 36 years, tenure: 8 years)

Similarly, another nurse said:

We try to do our duties as exactly as we can in order not prevent any probable risk of being blamed for something! (Nurse, female, age: 38 years, tenure: 11 years).

Discussion

This study aimed to describe issues surrounding the nurse–physician professional relationships in Iran. In this article, “divergent attitudes” was revealed to be a serious relationship challenge. A concept relevant to this was “*non-participatory approach towards the nurse.*” In fact, the essence of inter-professional relationships is recognition, incorporation, and the application of skills and viewpoints of other professionals to reach a common goal.^[14] Tang suggests that, if professionals do not value and respect each other's competencies, collaborative relationships cannot evolve.^[15]

In Malloy's study, both nurses and physicians showed that nurses' opinions were not valued.^[16] In nurses' view, as reported in Simpson, a good physician is one who respects what a nurse does, who asks for nurses' opinions, and trusts their judgement.^[17] Interestingly, Schmalenberg describes nurse–physician relationships as a teacher–student relationships where both parties can simultaneously act as ateacher and benefit from the other party's opinions and experience.^[18]

In our study, “uneven distribution of power” emerged as an important theme. In a similar manner, Thompson (2007) believes that physicians are mostly dominant over the nurses as a result of imbalance between a real and imagined power between the two professions.^[7] Hall also assumes that physicians get trained to assume roles of leaders and decision-makers in many settings.^[19]

In general, nurse–physician relations mostly lean toward a hierarchical status in the Iranian society,^[8,20] and physicians view nurses as assistants not professionals in care service.^[20] Shared-governance reduces the emphasis on hierarchical relationships and highlights the professionals right to be involved in governance of the profession within an organization. In the 1980s in USA, and somewhat later in the UK, nursing professionals adopted shared governance as a means of obtaining more control over their working environments.^[21] In spite of these facts, Hojat *et al.* suggest that attitudes of physicians and nurses toward inter-professional collaboration in countries such as Italy are more congruent than in the US and there is a deeper gap between physicians and nurses in societies where a complementary role model is encourage.^[8]

“Mutual trust destructors” were also among the themes identified in this study. One of the destructive factors in this category was “competency weakness.” According to Smith's study, competence is a basic aspect for constructing trust in others.^[22] Professional identity is related to demonstration of professional competence, in turn related to the development of mutual inter-professional respect and enduring inter-professional trust.^[23] According to Schmalenberg, many of the physicians consider nurses' low level of professional competence as the main barrier for inter-professional collaboration.^[18]

As the nature of qualitative studies, the results of the present study cannot be generalized completely to all settings. However, in view of the diversity of participants in this research, the findings can help nurses and physicians in all countries which are culturally similar to Iran.

Conclusion

In this study, the remarks made by the members of the two professions showed that they follow a divergent approach in their attitudes, actions, and ideas. Moreover,

an uneven distribution of power can be observed between the two professions. Based on the findings of this study, negative attitudes of the public from the outside and ethical shortcomings and wrong mentalities of members of each of the professions from the inside could have negative impacts on the inter-professional relationships of both the groups.

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Conflicts of interest

There are no conflicts of interest.

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