In this article, 20 000 staff nurses tell their story about how they perceive, assess, and develop high-quality relationships with physicians in hospitals with the goal of improving patient care. This story is based on a synthesis of findings from 6 research studies, outlined in Table 1, as they pertain to nurse-physician relationships. In the Dimensions of Magnetism study and in the psychometric studies described, 20 616 staff nurses identified and described 5 types of nurse-physician relationships that prevail on almost all clinical units. In the 4 interview studies, 721 staff nurses, 334 nurse managers, 229 physicians, 46 other health professionals, and 29 nurse and hospital administrators who were interviewed about nurse-physician and interdisciplinary relationships described not only the different types of relationships but most importantly why “good” relationships were important to patient care and what organizational structures and leadership practices promoted the “best” relationship—collaboration and collegiality. The distribution of interviewees among professional groups may seem, and is, somewhat lopsided. Our intention was to focus on staff nurses’ perceptions of the quality of unit work environments. All excerpts are from staff nurse interviews unless otherwise noted.

The Problem
Throughout the 1990s, a great deal was written about the importance of “good” nurse-physician relationships, about how high-quality nurse-physician relationships were 1 of the 3 cornerstones of excellent (magnetic) work environments, about how the quality of nurse-physician relationships is more of a concern to nurses than to physicians, and about how physicians consistently rate the quality of these relationships higher than do nurses. In all of these writings, what constitutes good or high-quality relationships between physicians and nurses is seldom defined, and when an attempt is made to assess goodness, nurse-physician relationships are measured as though all interactions between nurses and physicians on
the unit or in the clinic result in the same kind of relationship. Staff nurse interviewees had this to say about the problem:

"Good" doctor-nurse relationships? That could mean anything from "the doctor doesn't yell at me," to "he comes when he's called," to "he consults the nurses and we discuss the plan of care for the patient." . . . You have different kinds of relationships with different physicians; they are not all the same. And, some are more important—no, not exactly more important. They’re all important because they affect patient care. What I mean is, for

**Table 1** Overview of 6 research studies conducted on the Essentials of Magnetism

<table>
<thead>
<tr>
<th>Year</th>
<th>Study</th>
<th>Purpose</th>
<th>Sample</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>Dimensions of magnetism</td>
<td>To ascertain steps and components of work processes/relationships that staff nurses identified as essential to productivity of high-quality patient care</td>
<td>279 staff nurses and 132 nurse managers and leaders in 14 magnet hospitals</td>
<td>Individual interviews with staff nurses, group interviews with nurse managers and nurse executives</td>
</tr>
<tr>
<td>2003</td>
<td>Essentials of Magnetism psychometric</td>
<td>To test the construct validity of the Essentials of Magnetism tool, that is, that staff nurses in magnet hospitals will score higher than their counterparts in nonmagnet hospitals, and to establish the psychometrics of the tool</td>
<td>3602 staff nurses in 26 magnet and comparison hospitals, plus an additional 1000 nurses nationwide online</td>
<td>Essentials of Magnetism tool</td>
</tr>
<tr>
<td>2004</td>
<td>Nurse-physician structure-identification</td>
<td>To identify structures and best practices that enable development of collegial/collaborative relationships between nurses and physicians</td>
<td>67 staff nurses, 43 nurse managers, and 31 physicians on 44 units in 5 hospitals with high scores for nurse-physician relationship</td>
<td>Essentials of Magnetism tool; individual interviews, single-item indicators</td>
</tr>
<tr>
<td>2005</td>
<td>Autonomy structure-identification</td>
<td>To identify, through Essentials of Magnetism scores, the clinical units with highest autonomous practice and to identify structures and best practices that support the practice of clinical autonomy</td>
<td>131 staff nurses, 81 nurse managers, and 55 physicians on 74 units in 8 magnet hospitals with high autonomy scores</td>
<td>Essentials of Magnetism tool; individual interviews, single-item indicators</td>
</tr>
<tr>
<td>2006</td>
<td>Six essentials structure-identification</td>
<td>To identify, through Essentials of Magnetism scores, the clinical units with the healthiest work environments as confirmed by staff nurses and to identify structures and best practices that support competent performance, education, control of practice, perceived adequacy of staffing, and a patient-centered culture and that foster supportive nurse manager relationships.</td>
<td>244 staff nurses, 105 nurse managers, and 97 physicians on 101 units in 8 hospitals with confirmed healthy work environments, 46 representatives from other professional departments</td>
<td>Essentials of Magnetism II; individual interviews, single-item indicators; participant observations in central and unit councils, interdisciplinary meetings, unit staff meetings, evidence-based practice team meetings</td>
</tr>
<tr>
<td>2007</td>
<td>Essentials of Magnetism II psychometric</td>
<td>To test the construct validity and establish the psychometrics properties of the Essentials of Magnetism II</td>
<td>10 514 staff nurses in 34 magnet and comparison hospitals</td>
<td>Essentials of Magnetism II</td>
</tr>
</tbody>
</table>

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physicians who only come to the unit once in a blue moon, you and your patients can tolerate poor relationships better than if it’s a physician who visits the unit daily or very frequently.¹

**High-Quality Nurse-Physician Relationships and Outcomes**

Relationships between nurses and physicians are important to study because how well these 2 groups work together affects the quality of care that patients receive.¹⁸ In a now classic study of all intensive care units (ICUs) in 13 large hospitals nationwide, Knaus et al²¹ reported that ICU patients cared for by nurses and physicians who worked collaboratively had lower “acuity-adjusted” mortality rates than did patients cared for by less collaborative nurses and physicians. Fewer deaths and transfers back to the ICU are positive outcomes for patients that have been cited in other studies.²³,²⁴ Collaborative nurse-physician relationships also lead to better patient and organizational outcomes such as decreased length of stay and net reduction in treatment costs without reduction in functional levels or decrease in satisfaction among patients.²⁵ In addition to patient outcomes, high-quality nurse-physician relations result in increased satisfaction among nurses and physicians and increased autonomy for nurses.⁵,¹²,²⁶,²⁷

**Types and Measurement of Nurse-Physician Relationships**

Before the Dimensions of Magnetism study in 2001 (see Table 1), 3 types of nurse-physician relationships were described in the literature. The earliest was a manipulative relationship termed the “Dr-Nurse Game.” In this relationship, the nurse was permitted to indirectly suggest changes or modifications in a patient’s treatment or care plan but only if proper deference was shown to the physician and if nurses maintained their subordinate position.²⁸ These Dr-Nurse Game relationships were assessed through observation and a compilation of anecdotes; they were not measured as such. A second, frequently described type was abusive-hostile-adversarial nurse-physician relationships. Rosenstein et al²⁹ have conducted an extensive study of adversarial-abusive relationships, measured by numerical count of instances of abusive behavior and numbers of nurses who left employment because of abusive-hostile incidents with physicians.

Concern about adversarial relationships gave rise to the formation of the National Joint Practice Commission on collaborative relationships supported by the American Nurses Association and the American Medical Association in 1971.²⁰ The demonstration-evaluation projects associated with this endeavor showed some successes, for example, more collaborative nurse-physician relationships and perceived improvements in patient care. These projects also served as an impetus for development of tools to measure “collaborative” nurse-physician relationships.³¹,³² A measurement problem discovered almost immediately was that physicians perceived the degree of nurse-physician collaboration to be much greater than what nurses perceived it to be. And the differences were quite large. Thomas et al²⁵ reported that 73% of physicians but only 33% of nurses in their study thought that their relationships were collaborative; Ferrand et al²⁶ found that 50% of the physicians but only 27% of the nurses identified relationships with physicians as collaborative. Studies also reported that nurses’ perceptions of the degree and quality of collaboration were a more accurate predictor of patient outcomes—deaths and transfer back to the ICU—than were physicians’ perceptions.²³,³² On the basis of the preceding findings, we concluded that physicians and nurses may not define collaborative nurse-physician relationships the same; measurement tools that fit one group’s definitions and conceptions may not fit those of the other group; and because of these factors, multiple nurse-physician relationships most likely exist on the same clinical unit/clinic.

In 2001, we set out to explore what staff nurses working in magnet hospitals meant by good nurse-physician relationships. We interviewed 279 staff nurses in 14 magnet hospitals¹ and discovered some interesting facts. Throughout the 1990s, good nurse-physician relationships were assessed by having the 2 groups complete the Weiss and Davis collaborative practice scales,³³ which operated on the principle that all nurse-physician relationships on a clinical unit were the same or highly similar. Staff nurses quickly informed us that such is not the case. Multiple relationships coexist on a clinical unit.⁵,¹⁰ A nurse may have a collaborative relationship with one physician, a hostile relationship with another, and a student-teacher type of relationship with a third. Moreover,
relationships are dynamic. They change over time.

From the examples of nurse-physician interactions described by the interviewees, we constructed the nurse-physician relationship subscale of the Essentials of Magnetism.1,7,9,10,17 This scale defines and measures the 5 types of nurse-physician relationships identified by the staff nurse interviewees:

- **Collegial** relationships, characterized by equal trust, power, and respect are illustrated by the following excerpt. Nurses and physicians frequently used the words peers or equals in describing these relationships. Doctors are excellent. They value our opinion and ask for input. The doctor asked me whether or not this patient was ready to go home, and I said, “No, he’s complicated and still needs 24 hour home care. We’ve got to get that completely arranged.” We discussed what type of central line to put in before the patient goes. It happens on a daily basis that the physicians seek us out because they know that we know.

- **Collaborative** relationships, marked by mutual trust, power, respect, and cooperation are based on mutuality rather than equality. Nurses freely say that the physicians and nurses listen to one another and plan care together, but the “doctor is still on top.”

- In the **student-teacher** relationship, either the physician or the nurse can be the teacher. With residents and at times with attending physicians who are dealing with comorbid diseases outside of their specialty, nurses may take a teaching/guiding role. Physicians who teach are identified as having a lot of knowledge and “always willing to explain or teach.”

- The **friendly stranger** relationship is characterized by a formal exchange of information and a somewhat neutral feeling tone.

  The physician comes in, checks the patient, writes orders, and leaves. That’s about it. . . or, if I watch for him to tell him something about his patient, he may listen, but then he just grunts and walks off. Sometimes, I don’t even know that the physician has been in until I see the orders on the patient’s chart.

  I’ve worked with that doctor for over 17 years and he still doesn’t know my name, although I address him by his name every morning.

  That’s just the way it is.

- **Hostile/adversarial** relationships are marked by anger, verbal abuse, real or implied threats, or resignation. Physicians are sharp; they snap at you, and it’s not just when they are tired, it’s all the time.

  Heads roll around here if the docs complain about anything. I watch myself very carefully.

The nurse-physician relationship **unit climate** is a composite of the interactions and relationships of nurses and all physicians who visit or care for patients on the unit—physicians who admit and care for many patients as well as physicians who admit and visit only periodically. All 5 relationships can and do exist on a clinical unit at the same time.1,5,10 Respondents complete each scale item by indicating their perception of relationships on a 4-point scale ranging from “most physicians, most of the time” to “not true for any physicians.” The first 3 categories are the more positive relationships, have a positive-feeling tone, and were weighted the heaviest by the 392 nurses from 7 magnet hospitals who participated in an item-weighting study based on which nurse-physician relationship was most beneficial to quality patient care. The friendly stranger relationship is a neutral one that can go either way. If left alone, it often deteriorates. Hostile/adversarial nurse-physician relationships are more common than might be expected. In a large, nationwide study, 96% of the 714 nurses surveyed indicated that they had either experienced or witnessed abusive behavior; 31% indicated that hostile nurse-physician relationships existed.29,35 The nurse-physician subscale of the Essentials of Magnetism measures the nurse-physician unit climate, the proportion of positive relationships to neutral or negative relationships.
Nurse-Physician Relationships in Magnet and Comparison Hospitals

The preceding picture is based primarily on the literature and on facts garnered from the 2001 interviews with staff nurses in 14 magnet hospitals, namely that it is the unit nurse-physician relationship climate that affects outcomes for patients and nurses, the quality of patient care, and nurses’ job satisfaction. The unit climate is composed of some combination of the 5 relationships explained in the previous paragraphs. What does the nurse-physician unit climate look like in excellent hospitals? Does the nurse-physician climate in magnet hospitals differ from that in comparison hospitals? What changes do staff nurses report over time? Table 2 presents a summary picture of the nurse-physician relationship climate on clinical units in magnet and comparison hospitals as evidenced by the percentage of staff nurses in agreement with each type of nurse-physician relationship. It is a picture at 2 different periods, 2003 and 2007, and is based on the 2 psychometric studies of the Essentials of Magnetism outlined in Table 1.

Findings

Percentage of Each Type of Relationship. In a 2003 study of 3602 staff nurses in 16 magnet and 10 comparison hospitals, the dominant unit climate (ie, an affirmative, weighted response to the 2 highest points on the 4-point scale) reported by staff nurses in magnet hospitals was collegial (86%) and collaborative (82%); the dominant unit climate reported by staff nurses in comparison hospitals was collaborative (64%) and friendly stranger (63%). In the magnet sample, 69% of the nurses reported that student-teacher relationships also existed with many physicians on their units; 54% cited friendly stranger relationships, and 13% reported that hostile/adversarial relationships with many or some physicians contributed to the unit nurse-physician relationship climate.

In the comparison hospital sample, about half of the nurses (49% and 54%) reported student-teacher relationships, 61% reported collegial relationships, and 29% reported adversarial relationships. The last figure is more than double that found in the magnet sample (Table 2).

In the 2007 study of 10 514 staff nurses in 18 magnet and 16 comparison hospitals, the magnet hospitals nurses still reported predominately collegial (81%) and collaborative (85%) relationships, although the percentage of friendly

<table>
<thead>
<tr>
<th>Relationship type</th>
<th>2003</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collegial</td>
<td>86</td>
<td>61</td>
</tr>
<tr>
<td>Collaborative</td>
<td>82</td>
<td>85</td>
</tr>
<tr>
<td>Student-teacher, physician in teaching role</td>
<td>69</td>
<td>54</td>
</tr>
<tr>
<td>Friendly stranger</td>
<td>54</td>
<td>63</td>
</tr>
<tr>
<td>Hostile/adversarial</td>
<td>13</td>
<td>29</td>
</tr>
</tbody>
</table>

Comparison of Nurse-Physician Relationship Unit Climate Scores. The total, weighted score for the 5 types of relationships on the nurse-physician subscale of the Essentials of Medicine provides a nurse-physician relationship unit climate score that permits statistical comparison of magnet and comparison hospitals for both 2003 and 2007. In 2003, staff nurses in magnet hospitals reported significantly higher unit climate scores than did their counterparts in comparison hospitals. The $F$ ratio was 21.279, significant at $P<.001$. In 2007, staff nurses in magnet hospitals again reported significantly higher unit climate scores (59%) and adversarial (17%) relationships had both increased by about 5% over the 2003 testing. Student-teacher relationships were slightly higher in 2007 than in 2003, and a shift toward physicians, rather than nurses, as teacher was apparent. Some of the largest percentage shifts in the 2007 study occurred among the comparison hospitals, which gained in all 3 of the positive relationship categories (collegial, collaborative, and student-teacher) and declined in the neutral (friendly stranger) and negative (hostile/adversarial) relationship categories (Table 2).
The impact of the larger percentage of critical care nurses in the 2007 comparison hospital sample and its positive effect on unit nurse-physician relationship scores cannot be directly assessed because we did not obtain the same sort of information from the 2003 sample. However, we do have some comparative information. In both the 2003 and the 2007 samples, specialized units, particularly ICUs, in both magnet and comparison hospitals scored higher in nurse-physician relationships than did less specialized units. Of the 44 high-scoring clinical units in 5 high-scoring hospitals in the nurse-physician structure-identification study (see Table 1), 3 were magnet, 1 was a Veterans Affairs hospital, and the other was 1 of 5 hospitals in a corporate group. Many specialized units were represented among the 44 high-scoring units but not a single general medical/surgical unit in any of the 5 hospitals scored high enough on the nurse-physician subscale to qualify as a “high-scoring” unit for the interview part of the study.

Emphasis on Interdisciplinary Interactions
A difference noted between the findings in the 2005 and the 2007 structure-identification studies with respect to the reported nurse-physician relationship climate on the unit was the increased emphasis on interdisciplinary interactions and collaboration rather than just interactions and collaboration between physicians and nurses. By 2007, regularly scheduled interdisciplinary rounds, particularly on medical ICUs and trauma, rehabilitation, and stroke units that included the active participation of all disciplines including staff nurses, were much more common.

In addition, when physicians, administrators, and representatives from other professional departments were interviewed, they were asked to rate the quality of interdisciplinary interactions on a scale of 1 to 10 with the following benchmarks provided: 1 = direct and teach others; 5 = collaborative planning and evaluation; and 10 = collegial interactions, a true partnership. Ratings ranged from 4 to 10, with a mean of 8.28. No significant rating differences were found between physicians (mean, 8.5) and representatives from other departments (mean, 8.1), although physicians’ ratings of the quality of interdisciplinary interactions were slightly higher.

For the physician group, 75% of the ratings were 8 or higher, 51% were 9 or higher, and 26% were at 10, the maximum benchmark. The picture for other departments was similar, with 70% of the ratings 8 or higher, 48% at 9 or higher, and 18% at 10. In situations in which therapists had a continuous and regular presence (eg, on orthopedic, rehabilitation, or critical care units), interdisciplinary interactions were reported to be particularly collaborative, almost collegial. When therapists provided care on a large number of units, the ratings of quality of interdisciplinary interactions were lower.

Increasing Physician Recognition of Nursing Sphere of Practice
One last finding from analysis of the interview transcripts was an increased understanding and recognition by physicians of the concept of unique and overlapping spheres...
of practice that is so vital for autonomous nursing practice and for collegial/collaborative relationships. A medical director demonstrates this feature in his orientation session with residents:

Nurses are our colleagues. Worst case, if you piss them off, they’re going to hurt you. Best-case scenario is that they overlap with you. They not only are an extension of you, they also have unique skills, knowledge, and talents that the patient needs. If you work collaboratively with nurses, patient outcomes will be better and you can trust that they will do and see that patients get what they need . . . they also are great at interpreting what the patient is trying to tell you.

**Summary**

When synthesizing results from several studies over time, the information may become overwhelming, suggesting the need for a summary. In the preceding section on the status of nurse-physician relationships on clinical units in hospitals and comparison of these relationships between magnet and comparison hospitals over time, the following major points are evidenced:

- Nurses in magnet hospitals consistently report higher quality unit nurse-physician relationships than do nurses in comparison hospitals.
- The dominant component of the unit nurse-physician climate in magnet hospitals is 80% collegial and collaborative; the next most prominent is student-teacher. These percentages have remained fairly constant for 4 years. Percentages for friendly stranger and hostile/ adversarial have remained about the same or are slightly higher. Comparison hospitals in the sample gained some ground with respect to the quality of nurse-physician relationships reported on their units.
- Specialized units, particularly critical care units, report better unit nurse-physician relationships than do nonspecialized medical-surgical units.
- Evidence of improved quality in interdisciplinary interactions and relationships is increasing.

- Physicians are demonstrating an increased understanding and recognition of the concept of unique/overlapping spheres of practice essential to staff nurses’ practice of clinical autonomy and collegial/collaborative relationships.

**How Can Clinical Nurses Improve Nurse-Physician Relationships?**

The purpose of the nurse-physician structure-identification study was to ascertain from nurses, managers, and physicians on units that had previously confirmed high-quality nurse-physician relationships what the organizational structures and best practices were that enabled staff nurses and physicians on that unit to develop collegial/collaborative relationships. Several of the structures supporting development of collegial/collaborative relationships that were identified by the 141 interviewees in the nurse-physician structure-identification study are particularly relevant to clinical nurses on the front line.

- A culture in which “concern for the patient is first” is essential to development of a high-quality nurse-physician unit climate.

---

**Collegial and collaborative nurse-physician relationships predominate on clinical units in Magnet hospitals.**

**Intensive care units and other specialized units score higher in nurse-physician relationships than do less specialized units.**

**Clinical nurses can improve relationships with physicians and quality of patient care by participating in interdisciplinary collaborative patient rounds, resolving conflict constructively, performing competently, and demonstrating self-confidence.**
Patient care is not about what is best for the physician or most convenient for the nurse, or what advances research; it is about what is best for the patient. All aspects of care must be examined from the framework of the patient. Interdisciplinary patient care rounds with participation from all involved disciplines, including the nurse caring for the patient, the patient, and the patient’s family are a manifestation of this cultural value.

- A second structure/practice that enables development of high-quality nurse-physician relationships is constructive conflict resolution. Policies related to conflict resolution must be in place so that everyone knows what they are and how to proceed. Many interviewees proclaimed that a policy of no tolerance or abuse of any kind must be in place, even if never or seldom used. The policy provides assurance, direction, and a “fall-back” position if needed. It also reflects the culture of the organization.

The increased reporting of adversarial relationships in magnet hospitals from 11% in 2001 to 14% in 2003 to 17% in 2007 is disconcerting, discouraging, and worrisome. Definitive steps must be taken to reverse this trend. The first step in constructive conflict resolution is to get the conflicting parties to talk with one another. As a staff nurse explained,

If there is a problem with the physician, then you go directly to the physician first. We stress that. The best place to resolve conflict is with the person. If things don’t get better for the patient, then you take the next step. If a physician has a problem with a nurse, the same expectation holds. In either case, the situation is pursued in accordance with the defined process until a satisfactory conclusion is reached.

Effective and constructive conflict resolution can also be done on a unit basis. In a unit operations or other interdisciplinary meeting, staff nurses and others can initiate a general discussion on approaches and best practices to use in handling disagreements, conflicts, and differences of opinion. Seek guidance from peers on how they approach situations that involve difficult interactions. It is well to particularly seek out those peers who seem to have “good” relationships with a “difficult” physician and ascertain how they approach the situation and initiate resolutions that work. Planned deliberative action is often successful in altering relationships.

- A third structure/practice suggested to improve both nurse-physician relationships and patient care is interactive, interdisciplinary collaborative patient rounds, which are becoming a dominant part of the scene in many excellent hospitals. Many ICUs, particularly medical ICUs and other specialized units such as oncology, rehabilitation, trauma, and stroke units, have such rounds well established. Nurses, managers and physicians report that such rounds may be difficult for many reasons: physicians and nurses come and go from the unit on an unscheduled basis; respiratory and physical therapists who need to provide care in many units may not be available at the time of rounds; patients go on and off the unit for tests; staff nurses may not participate because they are caring for another patient while the team is making rounds; and last, physicians may see themselves primarily as customers without responsibility for practice and system improvements.

The best practice of regular, interactive interdisciplinary patient rounds is facilitated when a medical director or physician such as a hospitalist or an intensivist is designated as responsible for the medical practice of the unit. This person is then responsible for organizing and conducting interdisciplinary patient rounds, eliciting everyone’s participation, and transmitting the group’s decision to private physicians who may or may not be in attendance.

For interdisciplinary patient rounds to truly be effective, physicians must shift their view of themselves from “customers” of the organization,
“stakeholders.” As a physician explained,

True alignment of all disciplines and true integration are more difficult to achieve in hospitals predominantly staffed by private practitioners or group practices. These hospitals need to reorient themselves and reorganize so that physicians are “stakeholders.” Physicians are the recipients of what hospitals have to offer, so morally and ethically, they are bound to reciprocate in efforts to control and improve practice and operations.

One community hospital that participated in the nurse-physician structure-identification study devised a plan to make interdisciplinary patient rounds truly effective and beneficial. This hospital was staffed 98% by physicians in group practices. Every 2 or 3 months, the practice designated 1 member of their group to be the medical director for the unit, responsible for conducting interdisciplinary collaborative patient rounds and communicating results and information to the appropriate practice physician. Nurses reported that this method worked quite well.

Staff nurses can also take steps to make effective collaborative practice rounds happen and to build collaborative relationships with physicians and other professionals. It is the responsibility of all professionals to attend and participate in such rounds. Because rounds are regularly scheduled, nurses can institute a system of “round coverage” so that all can attend and participate when their patients are being discussed. Through knowledgeable participation, staff nurses can ensure high-quality interdisciplinary patient care rounds so that the best possible patient care results. Staff nurses do a superb job of representing patients and interpreting physicians’ comments to patients and patients’ families. By coming to interdisciplinary rounds prepared, nurses are in a better position to represent the nursing-unique sphere of practice in the developing plan of care for a patient.

It is well to remember that the R in the acronym SBAR (situation-background-assessment-recommendation) stands for recommendations to the physician and to the interdisciplinary team. SBAR invites collaborative participation. By making evidence-based, thoughtful recommendations, nurses are not only helping the patient but building the cornerstones of future collegial, collaborative practice.

- Competent performance and self-confidence are the keys to both collaborative nurse-physician relationships and to clinical autonomy. When physicians were rating the degree of interdisciplinary collaboration on a unit, many volunteered that their perception of lack of nurses’ competence was the major factor behind lower ratings and a major barrier to collegial nurse-physician relationships. All nurses have the responsibility for developing, maintaining, and increasing their level of competent performance, not only in technical skills but also in the other competency domains.

Summary

Patient safety and high-quality patient care outcomes demand that clinical nurses engage in the practice of clinical autonomy and that physicians, nurses, and other professionals practice collegially and collaboratively. In the preceding article in this series, the structures and best practices related to autonomous practice were described. In this article, staff nurses, managers, and physicians have identified organizational structures and best practices conducive to building collegial/collaborative nurse-physician relationships. Many of these overlap. The structures and practices with particular relevance for clinical nurses were presented in this and in the preceding article. Staff nurses

can participate in improving the work environment by seeking clarification of the parameters, dimensions, and definition of clinical autonomy and by availing themselves of the opportunities offered or seeking new opportunities to participate in dialogue sessions to renegotiate scope of practice.

Nurse-physician relationships of any kind are forged by the day-to-day interactions on the clinical unit and can be shaped by staff nurses. Nurses must seek out and build collegial and collaborative relationships with physicians. The American Nurses Association noted in their 1980 social policy statement that clinical autonomy and nurse-physician collaborative relationships are true partnerships in which power is held and valued by both participants with recognition and acceptance of separate and combined spheres of activity, responsibility, and accountability. Results indicate that physicians and nurses in the magnet hospitals involved in the structure-identification studies outlined in Table 1 have learned this important principle.

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Financial Disclosures
This research was funded in part by a grant from the American Association of Critical-Care Nurses.

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