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***Original Research: Nurse–Physician Relationships***

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By Alan H. Rosenstein, MD, MBA

# Nurse–Physician Relationships: Impact on Nurse Satisfaction and Retention

## Disruptive physician behavior and the institutional response to it affect nurses' morale, according to findings of a recent survey.

**Overview:** The worsening state of the nation's nursing shortage has drawn attention to the need for more effective ways to recruit and retain nurses. For this reason, VHA West Coast (a regional division of VHA, Inc., a national network of community-owned hospitals and health care systems) conducted the *Nurse–Physician Relationship Survey,* targeting nurses, physicians, and executives in a large network of hospitals. VHA designed the survey to assess how these disparate groups viewed nurse–physician relationships, disruptive physician behavior, the institutional response to such behavior, and how such behavior affected nurse satisfaction, morale, and retention.

An analysis of the first 1,200 responses from nurses, physicians, and hospital executives suggests that daily interactions between nurses and physicians strongly influence nurses' morale. All respondents were very concerned with the significance of nurse–physician relationships and the atmosphere they create. And although all respondents saw a direct link between disruptive physician behavior and nurse satisfaction and retention, the groups differed in their beliefs about responsibility, barriers to progress, and potential solutions. The findings suggest that the quality of nurse–physician relationships must be addressed as facilities seek to improve nurse recruitment and retention.

**Key Words:** nurse–physician relationships
disruptive behavior
nurse recruitment and retention
code of conduct

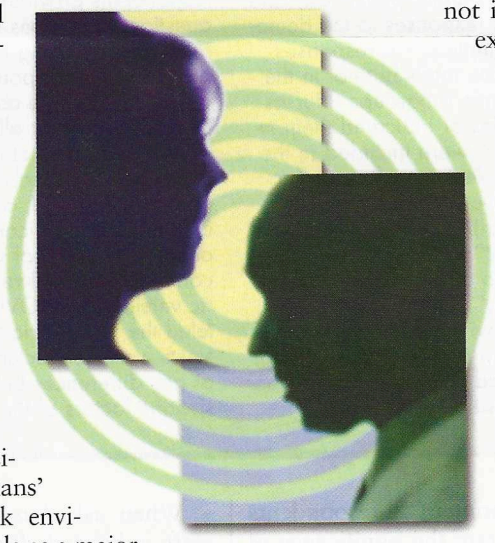
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The nursing shortage isn't affecting only nurses. Services have been reduced, surgeries canceled, and units closed in many facilities.[1,2] Consequently, patient satisfaction has decreased, quality of care and patient safety have been compromised, and the rate of medical errors has risen.[3] Therefore, the nursing shortage has become one of the most pressing concerns for hospitals nationwide. The American Hospital Association estimates that 126,000 nursing positions are unfilled in the United States.[4] The crisis will only deepen if the underlying causes aren't addressed.

A variety of reasons for the shortage have been cited: an aging workforce, fewer nursing school programs and applicants, hospital restructuring, poor public perceptions of nursing as a career, and rising burnout and job dissatisfaction among nurses.[5] A *Health Affairs* study of nurses in the United States, Canada, England, Scotland, and Germany showed

*Alan H. Rosenstein is the vice president and medical director of VHA West Coast in Pleasanton, CA.* *The author wishes to thank Gwen Rosenthal and Ernie Shippey for helping to develop the software template for recording, analyzing, and reporting the results of this survey.*

that 41% of hospital nurses were dissatisfied with their jobs, and 22% planned to leave them in less than one year (among nurses younger than 30, this figure was 33%).[6] The strongest reasons cited for respondents' discontent included overwork, staffing cutbacks, increased case loads, increased non–patient care duties, concerns about care quality, verbal abuse, and lack of administrative concern.



Findings of several other studies have suggested a relationship between workplace stress and nurses' morale, job satisfaction, commitment to the organization, and intention to quit.[7-11] In his 1999 keynote address to the annual meeting of the American Surgical Association, Lazar Greenfield, MD, discussed the troubled relationship between nurses and physicians, commenting on physicians' contributions to stressful work environments for nurses and their role as a major source of conflict.[12] He asserted that as many as two-thirds of nurses say they've been abused by physicians at least once every two to three months, and these claims are supported by the nursing literature.[13, 14]

The goal of the *Nurse–Physician Relationship Survey* was to assess the atmosphere and significance of nurse–physician relations and to determine the influence of disruptive physician behavior on nurse satisfaction and retention. For the purposes of this study, *disruptive physician behavior* refers to any inappropriate behavior, confrontation, or conflict, ranging from verbal abuse to physical and sexual harassment.

## METHODS

This convenience sample survey was conducted by VHA West Coast, one of 18 regional divisions of VHA, Inc., a network of community-owned health care systems with more than 2,200 member facilities representing more than one-fourth of the community-owned hospitals in the country. The survey is ongoing and was begun in July 2001. For the purposes of this analysis, the first 1,200 responses, which came from the employees of 84 hospitals or medical groups in VHA, Inc., were examined. The hospitals ranged from large metropolitan academic teaching centers to smaller, rural, not-for-profit community hospitals. Of the participants, 720 listed their titles as nurses, 173 listed their titles as physicians, and 26 listed their titles as administrative executives. The remaining 281 respondents did not identify their titles; their responses were counted in the aggregate totals but not in the nurse, physician, and executive subgroups.

The survey instrument was constructed for the purposes of this study after a search of the literature failed to produce a suitable instrument. The survey was sent by e-mail to each hospital's chief medical officer, chief nurse officer, and chief executive officer, with an introductory letter asking them to distribute the survey to registered nurses, physicians, and executive-level administrators at their hospitals. It was also posted on each regional division's Web site. Twelve percent of the responses gathered for this survey were submitted via the Internet.

The survey consisted of 24 items, allowing for three types of response: yes or no; Likert-type responses, which were based on a scale of 1 to 10, in which 10 shows the strongest agreement or the most positive response; and answers to open-ended questions. (See *More on Methods*, page 28, for a more complete description of this study's methods.)

## RESULTS

The differences between nurses' and physicians' responses to all questions were statistically significant at an alpha level of $P < 0.01$. Table 1 (page 30) presents a list of selected survey questions and a summary of the statistical findings.

**The overall atmosphere of nurse–physician relationships at the hospital and the significance of nurse–physician relationships at the hospital** were the focus of the first two questions. The mean rating of all respondents (n = 1,189) when asked to score the overall atmosphere of nurse–physician relationships at the hospital was 6.89 (in which 10 represented the most positive; SD = 1.79). Physicians rated this more positively than did nurses

## More on Methods

Designed by the investigator with the help of other VHA staff members and outside consultants, the survey was tested internally by distributing it to 20 physician executives, various leadership councils (the VHA's Nursing Leadership Council and Perioperative Nursing Council), and the Market Strategies Department; it was also distributed at a conference of nurses from VHA hospitals. Revisions were made accordingly.

**Data analysis.** Results were aggregated into total groups and subgroups (nurse, physician, and executive categories). When responses to the demographic questions were incomplete, the responses were counted in the aggregate totals but not in the nurse, physician, and executive subgroups. Nurses who either didn't list their titles or indicated them to be "supervisor" or "manager" were included in the nurse group if they did not select a preference for either clinical or administrative–management responsibilities. Nurses who listed their titles as "director" or "vice president" were included in the nurse group. Physicians who said they were "vice president of medical affairs," "chief medical officer," or "medical director" with administrative responsibilities were listed in the physician group. The executive group included all respondents who said their title was "president," "CEO," or "COO." Vice presidents who were not identified as either a nurse or physician were also included in this group.

Responses to open-ended questions were categorized by theme and reported as a percentage of respondents who identified the theme. All appropriate responses were recorded, regardless of whether the respondent partially or completely responded to the survey. Quantitative data are presented as numbers and percentages based on the number of respondents providing an answer for that particular question. Responses to open-ended questions were reported according to theme percentage (that is, the percentage of respondents whose comments fell into a particular theme category). The same themes were generally used for all types of respondents so as not to reflect the bias of response groups.

Results were analyzed by aggregate group total and by title (nurse, physician, and executive). Tests of statistical significance were performed using a one-way analysis of variance (ANOVA) and then confirmed by the Kruskal-Wallis test, a nonparametric version of ANOVA. Nonparametric results paralleled the parametric results. Independent sample t-tests were conducted to determine the significance of any differences between means for each of the specific factors of the dependent variables.

and executives. The mean rating of all respondents (n = 1,174) when asked to rate the significance of nurse–physician relationships at the hospital was 7.51 (10 = very significant; SD = 2.34). Physicians viewed nurse–physician relationships as less significant than did nurses or executives.

**Physician awareness of the importance of the nurse–physician relationship to nurse satisfaction.** The mean rating of all respondents (n = 1,164) answering this question was 5.12 (10 = highly aware; SD = 2.47), the lowest mean score in the survey. Nurses rated this significantly lower than did physicians and executives.

**Physicians' value of and respect for nurse input and collaboration.** The mean rating of all respondents (n = 1,173) was 6.15 (10 = highest value and respect; SD = 2.22), with both nurses and executives rating this lower than did physicians.

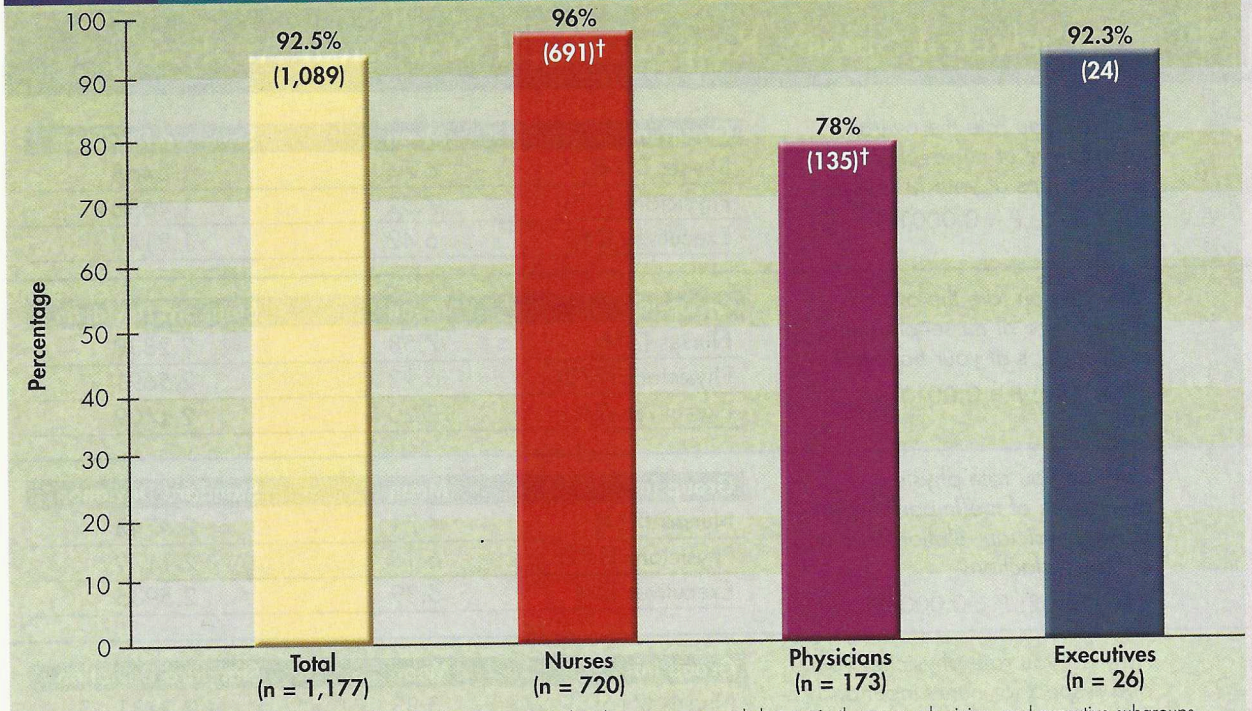
**Disruptive physician behavior** was the focus of several questions. When asked whether they had *witnessed disruptive behavior by physicians,* 92.5% (1,089) of respondents (n = 1,177) said they had (see Figure 1, page 29). When asked to categorize *the types of disruptive behavior witnessed or experienced,* respondents (n = 1,200) most frequently cited yelling or raising the voice, disrespect, condescension, berating colleagues, berating patients, and use of abusive language. (Some respondents answered this question without responding to the previous one.)

When asked *what percentage of the medical staff exhibited disruptive behavior,* respondents (n = 1,100) most commonly said 2% to 3% of the staff displayed this behavior (319 respondents; 29%); the second and third most common responses were 4% to 5% (219; 19.9%), and 1% (208; 18.9%). The same respondents were also asked *how frequently disruptive behavior occurred,* and most said it happened once or twice each month (308 respondents; 28%) or weekly (286 respondents; 26%). The mean rating of respondents (n = 1,155) who said *how serious an issue disruptive physician behavior was at the hospital* was 7 (10 = most serious; SD = 2.93), with physicians ranking it a less serious issue than did nurses and executives.

The mean rating of respondents (n = 1,149) who said *how important disruptive behavior was as a contributing factor to nurse satisfaction and morale* was 8.15 (10 = very important; SD = 2.25), the highest mean score in the survey. Physicians again rated this item lower than did nurses and executives (see Figure 2, page 29).

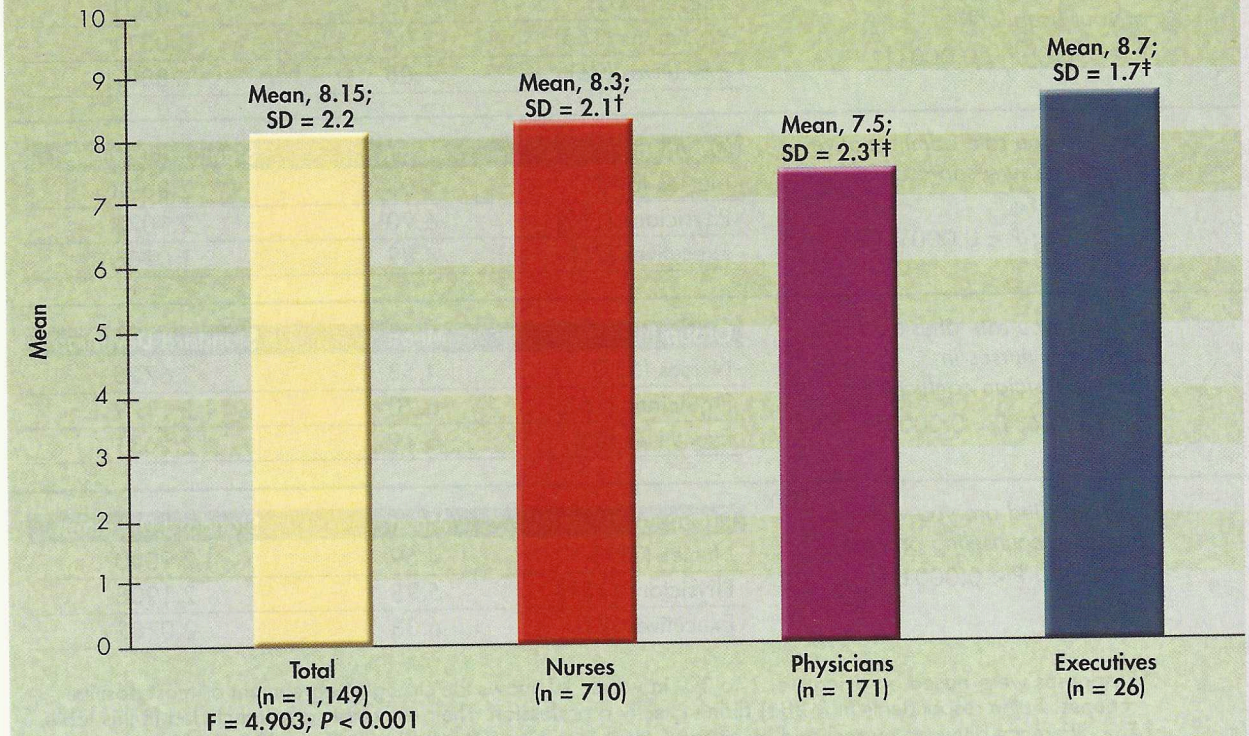
Respondents were asked whether they knew of *any nurses leaving the hospital as a result of disruptive behavior.* Three hundred and forty-four (30.7%) of the 1,121 people who responded to this question said they did. The survey then asked *how many nurses, on average, left each year for*

## FIGURE 1 Respondents Who Have Witnessed or Experienced Disruptive Behavior of a Physician*




*Respondents who didn't identify their titles were counted in the aggregate totals but not in the nurse, physician, and executive subgroups.
†The difference between nurses' and physicians' responses was statistically significant ($P < 0.01$).

## FIGURE 2 The Importance of Disruptive Behavior to Nurse Satisfaction and Morale*




*On a scale of 0 to 10 in which 10 represents the greatest importance; respondents who didn't identify their titles were counted in the aggregate totals but not in the nurse, physician, and executive subgroups; mean responses have been rounded; SD = standard deviation.
† The difference between nurses' and physicians' responses was statistically significant ($P < 0.01$).
‡ The difference between physicians' and executives' responses was statistically significant ($P < 0.05$).

## TABLE 1 Selected Survey Responses and Statistical Analysis*

*How do you rate the overall atmosphere of nurse–physician relationships at your hospital?*
F = 7.175; $P < 0.0001$†‡

| Group (n) | Mean | Standard Deviation |
|---|---|---|
| Nurses (714) | 6.74 | 1.8468 |
| Physicians (173) | 7.52 | 1.4690 |
| Executives (26) | 6.42 | 1.8149 |

*How do you rate the overall significance of nurse–physician relationships at your hospital?*
F = 4.452; $P < 0.001$†‡

| Group (n) | Mean | Standard Deviation |
|---|---|---|
| Nurses (716) | 7.58 | 2.2830 |
| Physicians (173) | 6.92 | 2.5691 |
| Executives (26) | 8.20 | 2.1409 |

*How do you rate physician awareness of the importance of nurse–physician relationships on nurse satisfaction?*
F = 12.702; $P < 0.0001$†

| Group (n) | Mean | Standard Deviation |
|---|---|---|
| Nurses (714) | 4.71 | 2.4743 |
| Physicians (172) | 6.18 | 2.1179 |
| Executives (26) | 5.39 | 2.5935 |

*How do you rate physician value and respect for nurse input and collaboration?*
F = 15.880; $P < 0.0001$†‡

| Group (n) | Mean | Standard Deviation |
|---|---|---|
| Nurses (716) | 5.83 | 2.2131 |
| Physicians (173) | 7.26 | 1.7998 |
| Executives (26) | 5.72 | 2.1894 |

*How serious an issue is disruptive physician behavior at your hospital?*
F = 6.440; $P < 0.0001$†‡

| Group (n) | Mean | Standard Deviation |
|---|---|---|
| Nurses (703) | 7.13 | 2.8291 |
| Physicians (165) | 5.96 | 3.0311 |
| Executives (26) | 7.85 | 2.8802 |

*How do you rate administrative support of nurses in conflicts with physicians?*
F = 9.529; $P < 0.0001$†‡§

| Group (n) | Mean | Standard Deviation |
|---|---|---|
| Nurses (670) | 6.03 | 2.8693 |
| Physicians (159) | 6.90 | 2.1078 |
| Executives (26) | 8.89 | 1.0706 |

*How do you rate physician support of nurses in nurse–physician conflicts?*
F = 23.706; $P < 0.0001$†§

| Group (n) | Mean | Standard Deviation |
|---|---|---|
| Nurses (657) | 4.58 | 2.6725 |
| Physicians (162) | 6.70 | 2.1179 |
| Executives (26) | 6.19 | 2.2631 |

*How satisfied are you with the physician counseling process?*
F = 5.649; $P < 0.0001$†§

| Group (n) | Mean | Standard Deviation |
|---|---|---|
| Nurses (327) | 4.69 | 2.9040 |
| Physicians (151) | 5.98 | 2.1908 |
| Executives (21) | 6.33 | 2.0782 |

* Responses were based on a scale of 1 to 10, in which 10 shows the strongest agreement or most positive reponse. Some respondents (n = 281) didn't specify a profession. Their responses aren't included in this table.
† The difference between nurses' and physicians' responses was statistically significant ($P < 0.01$).
‡ The difference between physicians' and executives' responses was statistically significant ($P < 0.05$).
§ The difference between nurses' and executives' responses was statistically significant ($P < 0.01$).

*this reason.* The respondents (n = 367) said, on average, 2.4 nurses left the facility each year because of disruptive behavior. (Some respondents answered this question without responding to the previous one.) Interestingly, 269 (24%) of the 1,121 respondents who said they knew nurses who left the hospital for this reason said that disruptive behavior also led nurses to make other changes—such as revising schedules, switching shifts, or changing departments—to avoid contact with certain physicians.

**Support for resolution of conflicts between nurses and physicians.** Those surveyed were asked to rate their *perceptions of administrative support of nurses in conflicts with physicians.* The mean response rate was 6.49 (10 = most supportive; SD = 2.78) among the 1,108 respondents. Nurses perceived less support than did executives or physicians. Those surveyed were then asked to rate *their perceptions of physician support of nurses in nurse–physician conflicts,* and 1,094 did so. The mean response rate was 5.29 (SD = 2.68)—the second lowest mean score among all scores in the survey. Nurses rated physician support lower than any other item, and they rated it lower than did physicians and executives.

Those surveyed were asked whether their facilities had a *code of conduct policy for handling disruptive physicians.* Of the 1,115 who responded, 729 (65.4%) said their institutions had such a policy. Four hundred sixty-four (64.8%) of the 716 nurses and 115 (67.6%) of the 170 physicians who responded to this question said their institutions had such a code; 22 (84.6%) of the 26 executives who responded said their facilities did. Respondents who reported that their institutions had a code of conduct were then asked if *the policy for handling disruptive behavior was effective.* Of the 581 people who answered this question, 282 (48.5%) thought their facility's policy was effective, with 105 (69.5%) of the 151 physician respondents indicating the policy was effective, compared with 81 (43.1%) of the 188 nurse respondents and 15 (62.5%) of the 24 executive respondents.

Respondents who knew of physicians who had been counseled about their behavior were asked to rate how *satisfied they were with the physician counseling process;* 623 of those surveyed answered the question. All groups scored this question relatively low, with a mean rating of 5.45 (SD = 2.79). Nurses were least satisfied, compared with physicians and executives.

Asked whether there was a *nonpunitive reporting environment for nurses who witness or experience disruptive behavior,* 983 people responded. One hundred and thirty-six (88%) of the 153 physician respondents and 22 (91.6%) of the 24 executives who responded did so affirmatively, whereas only 438 (78%) of the 561 nurses who responded said "yes." Of the 1,043 respondents who answered a question about *barriers or resistance to the reporting of disruptive physicians,* 495 (47.5%) responded affirmatively. Executives perceived more barriers or resistance than did nurses or physicians. The most common barriers these respondents cited were:

- fear of retribution
- the belief that "nothing ever changes"
- lack of confidentiality
- lack of administrative support
- physician lack of awareness or unwillingness to change

"Fear of retribution" was the most common response among the groups, with 139 (44.1%) of 315 nurses, 67 (51.9%) of 129 physicians, and 15 (57.7%) of 26 executives specifying this as the primary barrier to reporting disruptive physicians.

**Recommendations for improvement.** In an open-ended question in which respondents could provide more than one answer, those surveyed were asked to suggest strategies that might improve relations between nurses and physicians. Of the 980 people who responded, 161 (29%) of the 556 nurse respondents identified greater opportunities for collaboration and communication as the most important factors, whereas 133 (24%) nurses said education and training of nurses and physicians through programs designed to improve working relationships were needed. Also mentioned were the need for more open forums and group discussions (38; 6.8%) and greater accountability among nurses and physicians for their actions (37; 6.7%).

Thirty-two (21.3%) of the 150 physician respondents recommended education and training; the same number indicated that greater opportunities for collaboration might improve relations between nurses and physicians. The need for more open forums and group discussions was cited by 15 (10%) physicians, whereas 10 (6.6%) said improved organizational processes that would reduce the causes of frustration were necessary. A few physicians mentioned the importance of ensuring appropriate nurse competencies (eight; 5.3%); the same number supported a zero-tolerance policy toward disruptive physician behavior.

Of the 24 executives who responded, five (20.8%) identified educational programs as their number-one concern, whereas four (16.6%) recommended greater opportunities to improve collaboration and communication and three (12.5%) wanted to see more open forums and group discussions. One executive (4.2%) noted the importance of improved organizational processes to reduce frustration, whereas three (12.5%) said stronger administrative support was necessary. Two (8.3%) executives thought nurses and physicians should be held more accountable for their actions, and one (4.2%) cited the need for fair, timely, and appropriate discipline.

## DISCUSSION

Designed to assess the views of nurses, physicians, and executives in a large network of hospitals, this survey examined nurse–physician relationships, disruptive physician behavior, institutional responses to such behavior, and its impact on nurses' job satisfaction, morale, and retention. Although almost all respondents reported disruptive behavior in their institutions, respondents viewed this behavior and its consequences differently. These preliminary data are relevant to all health care systems and institutions seeking to address the nursing shortage.

Although only a small percentage of physicians were reported to exhibit disruptive behavior, both physicians and nurses agreed that it influences nurses' as well as other staff members' attitudes toward patient care and inhibits teamwork, affecting the efficiency, accuracy, safety, and outcomes of care. Disruptive behavior often leads to confrontation and unease among those working closely with these physicians, and it can cause widespread frustration among staff members who question why the facility tolerates such behavior. Most importantly, losing just one employee—particularly a nurse—can profoundly affect the hospital's ability to operate and can add to the already high costs of recruitment and replacement.

**Support in the literature.** This survey's results are consistent with those reported in the literature. In a random survey of nurses nationwide regarding physician abuse of nurses, Cox reported on the high rate of verbal abuse (which was defined as "communication that is perceived to be a harsh, condemnatory attack towards the victim, either professionally or personally") and its negative effect on nurse satisfaction, morale, productivity, and turnover.[13] According to a 1997 article in the *Journal of Professional Nursing*, 90% of nurses reported that they had witnessed at least one episode of verbal abuse during the previous year, occurring at an average rate of six to 12 incidents per year.[14]

The *Nurse–Physician Relationship Survey* results, as well as a number of studies reported in the literature,[13-16] point to disruptive physician behavior as a disturbing, stressful force in the workplace, raising the question: How many physicians are aware that their day-to-day interactions with nurses can significantly affect nurses' job satisfaction?

**Causes of disruptive behavior.** Respondents were asked to identify issues, circumstances, or events that precipitated disruptive physician behavior. Nurses indicated that this type of behavior most commonly occurred

- after placing calls to physicians.
- after questioning or seeking to clarify physicians' orders.
- when physicians thought their orders were not being carried out correctly or in a timely manner.
- after perceived delays in delivery of care.
- after sudden changes in patient status.

Physicians rated orders not being carried out correctly or in a timely manner as the primary cause of disruptive behavior, followed by ill-timed calls to physicians, the need to question or clarify orders, and general communication breakdowns between physicians and nursing staff. Physicians also registered concern over nurses placing such calls without first having gathered all necessary patient information available to them. Executives indicated that disruptive behavior was often precipitated by orders not being carried out correctly or in a timely manner, physicians not getting their way or not having their preferences met, and attempts to question and clarify physician orders.

**Barriers to reporting.** Nearly 50% of the respondents reported barriers or resistance to reporting physicians' disruptive behavior. Among nurses, the most common barriers cited were intimidation, fear of retaliation, concerns about a report's impact on future relations, and the belief that "nothing ever changes." Some nurses indicated that concerns about confidentiality, peer pressure, and potential legal ramifications often deterred them from reporting disruptive behavior.

Nurses also expressed concern about administrative tolerance of disruptive physicians; they cited a failure of appropriate follow-up and "old-school" traditions including gender bias—assigning a subservient role to women—and ignoring the disruptive behavior of physicians who bring a great deal of revenue to the hospital. Many nurses also noted a lack of support from executive physicians (those in leadership positions), asserting that physician leaders underestimated the significance of the situation or were reluctant to counsel their peers. Thus, it's crucial that institutions focus on developing, implementing, and enforcing appropriate policies, as well as removing barriers to reporting and providing feedback on the outcomes of reporting.

**Need for improvement.** Nurses said they want a respectful work atmosphere and want physicians to acknowledge the importance of the nurse's role in the health care team. Physicians said that disruptive behavior is not unique to physicians, (the implication being that nurses, too, can exhibit disruptive behavior), and that it's important to distinguish disruptive behavior from the effort to "get things done" (that is, when physicians need to be demanding and domineering in a crisis, ensuring that tasks and procedures are completed quickly and effectively).

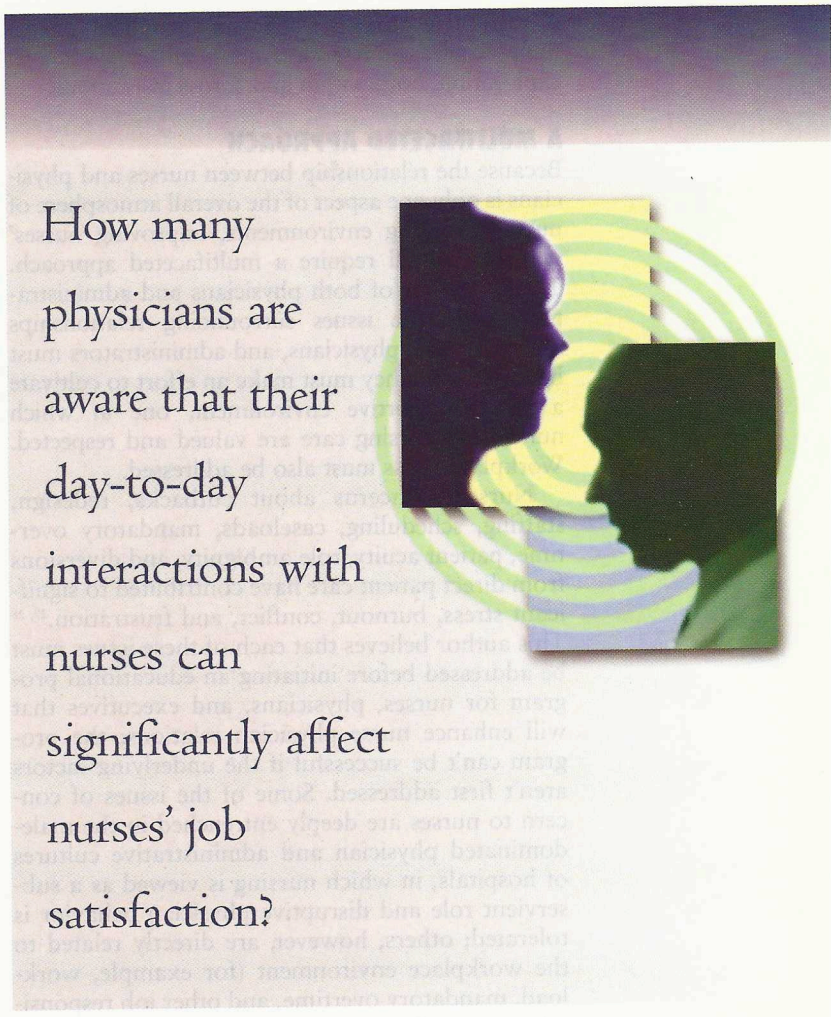
Improvement strategies recommended by respondents include the following, which are ranked by frequency:

- Create more opportunities for collaboration and communication through open forums, group discussions, and collaborative workshops.

- Increase availability of training and educational programs for nurses and physicians that focus on improving teamwork and working relationships (for example, sensitivity training, assertiveness training, conflict management, collaboration skills, stress management, time management, and phone etiquette, with emphasis on courtesy, respect, promptness, and preparation).
- Improve organizational processes by requiring administrators to take a more proactive approach to avoiding potential confrontations related to staffing, scheduling, and equipment.
- Establish a zero-tolerance policy for disruptive behavior, holding nurses and physicians more accountable for their actions.
- Disseminate code-of-conduct policies and reporting guidelines to both nurses and physicians, and apply policies consistently and quickly, providing feedback to all involved.
- Ensure appropriate nurse competencies.
- Have physicians sign a code-of-conduct policy when they are credentialed or recredentialed.
- Appoint a physician leader who will take charge of training and educational programs.
- Provide an ongoing forum to increase physician awareness of the issues addressed in this survey and raise awareness of other factors that increase nurses' stress levels.
- Place physicians on nurse recruitment teams, enabling them to gain a better understanding and appreciation of the factors that are important to nurses as they consider employment opportunities.
- Provide a case study or conduct role-play exercises that allow physicians a firsthand understanding of nurses' responsibilities and workflow.

Respondents also emphasized the need to highlight the connection between communication, collaboration, and teamwork and improved quality, safety, and patient outcomes. This is particularly important because recent surveys have revealed a growing concern among nurses that patients are receiving a lower quality of care.[6, 17-19] Additional studies have supported many of these concerns by showing a link between poor communication and disruptive behavior, as well as a link between team collaboration and patient safety, error rates, and patient outcomes.[20-26]

Some hospitals have tried to handle disruptive physician behavior by initiating a code-of-conduct policy. In this survey, nearly two-thirds of respondents indicated that code-of-conduct policies were in place at their facilities, and 80% indicated they worked in nonpunitive reporting environments. Nevertheless, fewer than 50% of the respondents thought the policy was effective, and few were satisfied with the results of physician counseling. In some cases, a code-of-conduct policy exists on paper, unbeknownst to the staff; in other cases, staff members are aware of the code of conduct but never see it enforced. Even if codes of conduct are enforced, staff members rarely are told the outcome, so they don't believe the policy is successful.




**Limitations.** The study has two primary limitations. First, nonrandom convenience sampling permits respondent bias. For example, it's unknown what percentage of survey recipients chose to respond. Were those who had experienced or witnessed physicians' disruptive behavior more or less likely to respond? And although more than 90% of respondents said they had witnessed some form of disruptive behavior by a physician, it's not known whether the respondents were representative of all nurses, physicians, and executives in the VHA network. In addition, the survey was examined for face validity only. Future studies of this issue should test the content validity and reliability of the instrument and employ random sampling techniques.

Because of these limitations, the findings reported here should be interpreted with caution. However, they appear to be supported by the literature,[14] and the consistency of the findings suggests that the effect

of disruptive physician behavior on nurse satisfaction, morale, and retention merits further systematic exploration, both within and across institutions.

## A MULTIFACETED APPROACH

Because the relationship between nurses and physicians is only one aspect of the overall atmosphere of nurses' working environments, improving nurses' workplaces will require a multifaceted approach. The awareness of both physicians and administrators about the issues surrounding relationships among nurses, physicians, and administrators must be raised, and they must make an effort to cultivate a more supportive environment, one in which nurses and nursing care are valued and respected. Workplace stress must also be addressed.

Nurses' concerns about cutbacks, redesign, staffing, scheduling, caseloads, mandatory overtime, patient acuity, role ambiguity, and diversions from direct patient care have contributed to significant stress, burnout, conflict, and frustration.[27, 28] This author believes that each of these issues must be addressed before initiating an educational program for nurses, physicians, and executives that will enhance nurse–physician relations; the program can't be successful if the underlying factors aren't first addressed. Some of the issues of concern to nurses are deeply entrenched in the male-dominated physician and administrative cultures of hospitals, in which nursing is viewed as a subservient role and disruptive physician behavior is tolerated; others, however, are directly related to the workplace environment (for example, workload, mandatory overtime, and other job responsibilities as well as the stress and burnout caused by lack of respect from physician colleagues) or to work design (responsibilities, changes in daily routine, time spent with patients, and the impact of this on quality of care, for example).

Problems in the nurse–physician relationship may be easier to remedy than are other issues of concern to nurses, and finding solutions to these relationship problems will certainly help enhance the atmosphere in which nurses work. Yet any success will be temporary unless all nursing concerns—including nurse–physician relations, staffing and scheduling difficulties, mandatory overtime, and less time spent with patients—are addressed continuously. ▼

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