

The Doctor-Nurse Game

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THE relationship between the doctor and the nurse is a very special one. There are few professions where the degree of mutual respect and cooperation between co-workers is as intense as that between the doctor and nurse. Superficially, the stereotype of this relationship has been dramatized in many novels and television serials. When, however, it is observed carefully in an interactional framework, the relationship takes on a new dimension and has a special quality which fits a game model. The underlying attitudes which demand that this game be played are unfortunate. These attitudes create serious obstacles in the path of meaningful communications between physicians and nonmedical professional groups.

The physician traditionally and appropriately has total responsibility for making the decisions regarding the management of his patients' treatment. To guide his decisions he considers data gleaned from several sources. He acquires a complete medical history, performs a thorough physical examination, interprets laboratory findings, and at times, obtains recommendations from physician-consultants. Another important factor in his decision-making are the recommendations he receives from the nurse. The interaction between doctor and nurse through which these recommendations are communicated and received is unique and interesting.

The Game

One rarely hears a nurse say, "Doctor I would recommend that you order a retention enema for Mrs. Brown." A physician, upon hearing a recommendation of that nature, would gape in amazement at the effrontery of the nurse. The nurse, upon hearing the statement, would look over her shoulder to see who said it, hardly believing the words actually came from her own mouth. Nevertheless, if one observes closely, nurses make recommendations of more import every hour and physicians willingly and respectfully consider them. If the nurse

is to make a suggestion without appearing insolent and the doctor is to seriously consider that suggestion, their interaction must not violate the rules of the game.

Object of the Game.—The object of the game is as follows: the nurse is to be bold, have initiative, and be responsible for making significant recommendations, while at the same time she must appear passive. This must be done in such a manner so as to make her recommendations appear to be initiated by the physician.

Both participants must be acutely sensitive to each other's nonverbal and cryptic verbal communications. A slight lowering of the head, a minor shifting of position in the chair, or a seemingly nonrelevant comment concerning an event which occurred eight months ago must be interpreted as a powerful message. The game requires the nimbleness of a high wire acrobat, and if either participant slips the game can be shattered; the penalties for frequent failure are apt to be severe.

Rules of the Game.—The cardinal rule of the game is that open disagreement between the players must be avoided at all costs. Thus, the nurse must communicate her recommendations without appearing to be making a recommendation statement. The physician, in requesting a recommendation from a nurse, must do so without appearing to be asking for it. Utilization of this technique keeps anyone from committing themselves to a position before a sub rosa agreement on that position has already been established. In that way open disagreement is avoided. The greater the significance of the recommendation, the more subtly the game must be played.

To convey a subtle example of the game with all its nuances would require the talents of a literary artist. Lacking these talents, let me give you the following example which is unsubtle, but happens frequently. The medical resident on hospital call is awakened by telephone at 1 AM because a patient on a ward, not his own, has not been able to fall asleep. Dr. Jones answers the telephone and the dialogue goes like this:

This is Dr. Jones.

(An open and direct communication.)

Dr. Jones, this is Miss Smith on 2 W—Mrs. Brown, who learned today of her father's death, is unable to fall asleep.

(This message has two levels. Openly, it de-

Submitted for publication Dec 13, 1966.

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Reprint requests to University of Kentucky, Lexington, Ky (Dr. Stein).

scribes a set of circumstances, a woman who is unable to sleep and who that morning received word of her father's death. Less openly, but just as directly, it is a diagnostic and recommendation statement: i.e. Mrs. Brown is unable to sleep because of her grief, and she should be given a sedative. Dr. Jones, accepting the diagnostic statement and replying to the recommendation statement, answers.)

What sleeping medication has been helpful to Mrs. Brown in the past?

(Dr. Jones, not knowing the patient, is asking for a recommendation from the nurse, who does know the patient, about what sleeping medication should be prescribed. Note, however, his question does not appear to be asking her for a recommendation. Miss Smith replies.)

Pentobarbital mg 100 was quite effective night before last.

(A disguised recommendation statement. Dr. Jones replies with a note of authority in his voice.)

Pentobarbital mg 100 before bedtime as needed for sleep, got it?

(Miss Smith ends the conversation with the tone of a grateful supplicant.)

Yes I have, and thank you very much doctor.

The above is an example of a successfully played doctor-nurse game. The nurse made appropriate recommendations which were accepted by the physician and were helpful to the patient. The game was successful because the cardinal rule was not violated. The nurse was able to make her recommendation without appearing to, and the physician was able to ask for recommendations without conspicuously asking for them.

The Scoring System.—Inherent in any game are penalties and rewards for the players. In game theory, the doctor-nurse game fits the nonzero sum game model. It is not like chess, where the players compete with each other and whatever one player loses the other wins. Rather, it is the kind of game in which the rewards and punishments are shared by both players. If they play the game successfully they both win rewards, and if they are unskilled and the game is played badly, they both suffer the penalty.

The most obvious reward from the well-played game is a doctor-nurse team that operates efficiently. The physician is able to utilize the nurse as a valuable consultant, and the nurse gains self-esteem and professional satisfaction from her job. The less obvious rewards are no less important. A successful game creates a doctor-nurse alliance; through this alliance the physician gains the respect and admiration of the nursing service. He can be confident that his nursing staff will smooth the path for get-

ting his work done. His charts will be organized and waiting for him when he arrives, the ruffled feathers of patients and relatives will have been smoothed down, his pet routines will be happily followed, and he will be helped in a thousand and one other ways.

The doctor-nurse alliance sheds its light on the nurse as well. She gains a reputation for being a "damn good nurse." She is respected by everyone and appropriately enjoys her position. When physicians discuss the nursing staff it would not be unusual for her name to be mentioned with respect and admiration. Their esteem for a good nurse is no less than their esteem for a good doctor.

The penalties for a game failure, on the other hand, can be severe. The physician who is an unskilled gamesman and fails to recognize the nurses' subtle recommendation messages is tolerated as a "clod." If, however, he interprets these messages as insolence and strongly indicates he does not wish to tolerate suggestions from nurses, he creates a rocky path for his travels. The old truism "If the nurse is your ally you've got it made, and if she has it in for you, be prepared for misery," takes on life-sized proportions. He receives three times as many phone calls after midnight than his colleagues. Nurses will not accept his telephone orders because "telephone orders are against the rules." Somehow, this rule gets suspended for the skilled players. Soon he becomes like Joe Bfstplk in the "Li'l Abner" comic strip. No matter where he goes, a black cloud constantly hovers over his head.

The unskilled gamesman nurse also pays heavily. The nurse who does not view her role as that of a consultant, and therefore does not attempt to communicate recommendations, is perceived as a dullard and is mercifully allowed to fade into the woodwork.

The nurse who does see herself as a consultant but refuses to follow the rules of the game in making her recommendations, has hell to pay. The outspoken nurse is labeled a "bitch" by the surgeon. The psychiatrist describes her as unconsciously suffering from penis envy and her behavior is the acting out of her hostility towards men. Loosely translated, the psychiatrist is saying she is a bitch. The employment of the unbright outspoken nurse is soon terminated. The outspoken bright nurse whose recommendations are worthwhile remains employed. She is, however, constantly reminded in a hundred ways that she is not loved.

Genesis of the Game

To understand how the game evolved, we must comprehend the nature of the doctors' and nurses' training which shaped the attitudes necessary for the game.

Medical Student Training.—The medical student in his freshman year studies as if possessed. In the anatomy class he learns every groove and prominence on the bones of the skeleton as if life depended on it. As a matter of fact, he literally believes just that. He not infrequently says, "I've got to learn it exactly, a life may depend on me knowing that." A consequence of this attitude, which is carefully nurtured throughout medical school, is the development of a phobia: the overdetermined fear of making a mistake. The development of this fear is quite understandable. The burden the physician must carry is at times almost unbearable. He feels responsible in a very personal way for the lives of his patients. When a man dies leaving young children and a widow, the doctor carries some of her grief and despair inside himself; and when a child dies, some of him dies too. He sees himself as a warrior against death and disease. When he loses a battle, through no fault of his own, he nevertheless feels pangs of guilt, and he relentlessly searches himself to see if there might have been a way to alter the outcome. For the physician a mistake leading to a serious consequence is intolerable, and any mistake reminds him of his vulnerability. There is little wonder that he becomes phobic. The classical way in which phobias are managed is to avoid the source of the fear. Since it is impossible to avoid making some mistakes in an active practice of medicine, a substitute defensive maneuver is employed. The physician develops the belief that he is omnipotent and omniscient, and therefore incapable of making mistakes. This belief allows the phobic physician to actively engage in his practice rather than avoid it. The fear of committing an error in a critical field like medicine is unavoidable and appropriately realistic. The physician, however, must learn to live with the fear rather than handle it defensively through a posture of omnipotence. This defense markedly interferes with his interpersonal professional relationships.)

Physicians, of course, deny feelings of omnipotence. The evidence, however, renders their denials to whispers in the wind. The slightest mistake inflicts a large narcissistic wound.

Depending on his underlying personality structure the physician may obsess for days about it, quickly rationalize it away, or deny it. The guilt produced is usually exaggerated and the incident is handled defensively. The ways in which physicians enhance and support each other's defenses when an error is made could be the topic of another paper. The feelings of omnipotence become generalized to other areas of his life. A report of the Federal Aviation Agency (FAA), as quoted in *Time Magazine* (Aug 5, 1966), states that in 1964 and 1965 physicians had a fatal-accident rate four times as high as the average for all other private pilots. Major causes of the high death rate were risk-taking attitudes and judgments. Almost all of the accidents occurred on pleasure trips, and were therefore not necessary risks to get to a patient needing emergency care. The trouble, suggested an FAA official, is that too many doctors fly with "the feeling that they are omnipotent." Thus, the extremes to which the physician may go in preserving his self-concept of omnipotence may threaten his own life. This overdetermined preservation of omnipotence is indicative of its brittleness and its underlying foundation of fear of failure.

The physician finds himself trapped in a paradox. He fervently wants to give his patient the best possible medical care, and being open to the nurses' recommendations helps him accomplish this. On the other hand, accepting advice from nonphysicians is highly threatening to his omnipotence. The solution for the paradox is to receive sub rosa recommendations and make them appear to be initiated by himself. In short, he must learn to play the doctor-nurse game.

Some physicians never learn to play the game. Most learn in their internship, and a perceptive few learn during their clerkships in medical school. Medical students frequently complain that the nursing staff treats them as if they had just completed a junior Red Cross first-aid class instead of two years of intensive medical training. Interviewing nurses in a training hospital sheds considerable light on this phenomenon. In their words they said,

A few students just seem to be with it, they are able to understand what you are trying to tell them, and they are a pleasure to work with; most, however, pretend to know everything and refuse to listen to anything we have to say and I guess we do give them a rough time. In essence, they are saying that those students who quickly learn the game are re-

warded, and those that do not are punished.

Most physicians learn to play the game after they have weathered a few experiences like the one described below. On the first day of his internship, the physician and nurse were making rounds. They stopped at the bed of a 52-year-old woman who, after complimenting the young doctor on his appearance, complained to him of her problem with constipation. After several minutes of listening to her detailed description of peculiar diets, family home remedies, and special exercises that have helped her constipation in the past, the nurse politely interrupted the patient. She told her the doctor would take care of the problem and that he had to move on because there were other patients waiting to see him. The young doctor gave the nurse a stern look, turned toward the patient, and kindly told her he would order an enema for her that very afternoon. As they left the bedside, the nurse told him the patient has had a normal bowel movement every day for the past week and that in the 23 days the patient has been in the hospital she had never once passed up an opportunity to complain of her constipation. She quickly added that if the doctor wanted to order an enema, the patient would certainly receive one. After hearing this report the intern's mouth fell open and the wheels began turning in his head. He remembered the nurses comment to the patient that, "the doctor had to move on," and it occurred to him that perhaps she was really giving him a message. This experience and a few more like it, and the young doctor learns to listen for the subtle recommendations the nurses make.

Nursing Student Training.—Unlike the medical student, who usually learns to play the game after he finishes medical school, the nursing student begins to learn it early in her training. Throughout her education she is trained to play the doctor-nurse game.

Student nurses are taught how to relate to physicians. They are told he has infinitely more knowledge than they, and thus he should be shown the utmost respect. In addition, it was not many years ago when nurses were instructed to stand whenever a physician entered a room. When he would come in for a conference the nurse was expected to offer him her chair, and when both entered a room the nurse would open the door for him and allow him to enter first. Although these practices are no longer rigidly adhered to, the premise upon which they were based is still promulgated. One nurse

described that premise as, "He's God almighty and your job is to wait on him."

To inculcate subservience and inhibit deviancy, nursing schools, for the most part, are tightly run, disciplined institutions. Certainly there is great variation among nursing schools, and there is little question that the trend is toward giving students more autonomy. However, in too many schools this trend has not gone far enough, and the climate remains restrictive. The student's schedule is firmly controlled and there is very little free time. Classroom hours, study hours, meal time, and bedtime with lights out are rigidly enforced. In some schools meaningless chores are assigned, such as cleaning bed springs with cotton applicators. The relationship between student and instructor continues this military flavor. Often their relationship is more like that between recruit and drill sergeant than between student and teacher. Open dialogue is inhibited by attitudes of strict black and white, with few, if any, shades of gray. Straying from the rigidly outlined path is sure to result in disciplinary action.

The inevitable result of these practices is to instill in the student nurse a fear of independent action. This inhibition of independent action is most marked when relating to physicians. One of the students' greatest fears is making a blunder while assisting a physician and being publicly ridiculed by him. This is really more a reflection of the nature of their training than the prevalence of abusive physicians. The fear of being humiliated for a blunder while assisting in a procedure is generalized to the fear of humiliation for making any independent act in relating to a physician, especially the act of making a direct recommendation. Every nurse interviewed felt that making a suggestion to a physician was equivalent to insulting and belittling him. It was tantamount to questioning his medical knowledge and insinuating he did not know his business. In light of her image of the physician as an omniscient and punitive figure, the questioning of his knowledge would be unthinkable.

The student, however, is also given messages quite contrary to the ones described above. She is continually told that she is an invaluable aid to the physician in the treatment of the patient. She is told that she must help him in every way possible, and she is imbued with a strong sense of responsibility for the care of her patient. Thus she, like the physician, is caught in a paradox.

The first set of messages implies that the physician is omniscient and that any recommendation she might make would be insulting to him and leave her open to ridicule. The second set of messages implies that she is an important asset to him, has much to contribute, and is duty-bound to make those contributions. Thus, when her good sense tells her a recommendation would be helpful to him she is not allowed to communicate it directly, nor is she allowed not to communicate it. The way out of the bind is to use the doctor-nurse game and communicate the recommendation without appearing to do so.

Forces Preserving the Game

Upon observing the indirect interactional system which is the heart of the doctor-nurse game, one must ask the question, "Why does this inefficient mode of communication continue to exist?" The forces mitigating against change are powerful.

Rewards and Punishments.—The doctor-nurse game has a powerful, innate self-perpetuating force—its system of rewards and punishments. One potent method of shaping behavior is to reward one set of behavioral patterns and to punish patterns which deviate from it. As described earlier, the rewards given for a well-played game and the punishments meted out to unskilled players are impressive. This system alone would be sufficient to keep the game flourishing. The game, however, has additional forces.

The Strength of the Set.—It is well recognized that sets are hard to break. A powerful attitudinal set is the nurse's perception that making a suggestion to a physician is equivalent to insulting and belittling him. An example of where attempts are regularly made to break this set is seen on psychiatric treatment wards operating on a therapeutic community model. This model requires open and direct communication between members of the team. Psychiatrists working in these settings expend a great deal of energy in urging for and rewarding openness before direct patterns of communication become established. The rigidity of the resistance to break this set is impressive. If the physician himself is a prisoner of the set and therefore does not actively try to destroy it, change is near impossible.

The Need for Leadership.—Lack of leadership and structure in any organization produces anxiety in its members. As the importance of the organization's mission increases, the demand by its members for lead-

ership commensurately increases. In our culture human life is near the top of our hierarchy of values, and organizations which deal with human lives, such as law and medicine, are very rigidly structured. Certainly some of this is necessary for the systematic management of the task. The excessive degree of rigidity, however, is demanded by its members for their own psychic comfort rather than for its utility in efficiently carrying out its mission. The game lends support to this thesis. Indirect communication is an inefficient mode of transmitting information. However, it effectively supports and protects a rigid organizational structure with the physician in clear authority. Maintaining an omnipotent leader provides the other members with a great sense of security.

Sexual Roles.—Another influence perpetuating the doctor-nurse game is the sexual identity of the players. Doctors are predominately men and nurses are almost exclusively women. There are elements of the game which reinforce the stereotyped roles of male dominance and female passivity. Some nursing instructors explicitly tell their students that their femininity is an important asset to be used when relating to physicians.

Comment

The doctor and nurse have a shared history and thus have been able to work out their game so that it operates more efficiently than one would expect in an indirect system. Major difficulty arises, however, when the physician works closely with other disciplines which are not normally considered part of the medical sphere. With expanding medical horizons encompassing cooperation with sociologists, engineers, anthropologists, computer analysts etc, continued expectation of a doctor-nurselike interaction by the physician is disastrous. The sociologist, for example, is not willing to play that kind of game. When his direct communications are rebuffed the relationship breaks down.

The major disadvantage of a doctor-nurselike game is its inhibitory effect on open dialogue which is stifling and anti-intellectual. The game is basically a transactional neurosis, and both professions would enhance themselves by taking steps to change the attitudes which breed the game.

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