

# A qualitative study on the relationship between doctors and nurses offering primary health at KwaNobuhle (Uitenhage)

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**Keywords:** Doctor-nurse relationship, primary health care, public-private interface

## Abstract

### Background

Primary health care, which was the domain of the nursing profession, was popularised by the introduction of free health services by the South African legislature. In addition, the district health system was developed with the aim of keeping people healthy by creating small management systems adapted to cater for local needs. These measures increased public access to healthcare centres, leading to an increased workload at primary health level. The government, being a large organisation, relies on groups that include doctors and nurses to accomplish its goals, and the effectiveness of these groups plays a major role in determining the effectiveness of the overall organization. "The nurse has an ethical responsibility in the interest of the welfare of her patient to be a loyal and competent colleague to the doctor. The nurse and the doctor must be able to rely on each other. Mutual respect is vital." Nurses have dependent, independent and interdependent roles in their interaction with doctors, and both professions should embrace the Patient's Rights Charter, which requires a good standard of practice and care of patients. International journals have published numerous letters citing doctor-nurse disagreements in their interactions. Historically, the doctor-nurse relationship is an unequal one characterised by the dominance of the doctor, with nurses assuming a position of lower status and dependence on physicians. One qualitative study showed that nurses perceive the quality of communication with doctors as being poor. Lack of teamwork in the relationship resulted from different expectations and a confusion of roles. Both professions have however demonstrated a willingness to promote teamwork in hospitals. A journal review on interventions to promote collaboration between nurses and doctors showed positive gains once collaboration was embraced.

### Method

This was a descriptive qualitative study in which the experiences of Kwa-Nobuhle general practitioners and professional nurses were explored. An equal number of nurses and doctors (five each) were purposefully selected, for the free-attitude interviews used for data collection. All interviews were analysed using the thematic analysis method. Themes were integrated into a single model.

### Results

Majority of respondents experienced a relatively good relationship. The positive factors were balanced by negative experiences by almost all respondents. The positives were personal growth, efficiency at work, opportunity for education and learning at the primary healthcare level. The negatives were doctors' inconsistent clinic visits, role confusion (with doctors being confused with policymakers), dominance of the doctor in the relationship, and lack of doctor-nurse forums for communication, with subsequent suspicion and tension. The impact of the conflicts was neutralised by the track record of the relationship and the behaviour of the participants towards each other.

### Conclusion

This study showed congruence with other studies, where the doctor-nurse relationship was influenced by a power differential, collaboration, role confusion, impact of the respondents' competence, the significance of recognising the nurses' hierarchy and continuity of the care they provide at the primary health level.

Maximum variation, strict admission criteria and data validation through a member check addressed issues of bias in this study. The exploration of relationships is a sensitive issue and a different methodology may produce different results. The environment where this research was conducted may differ from others, leading to discrepancies in findings. Future research could further focus on team building and the essential elements to sustain the doctor-nurse-patient team.

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## Introduction

Primary health care, which was the domain of the nursing profession, was popularised by the introduction of free health services by the South African legislature.<sup>1</sup> In addition, the district health system was developed with the aim of keeping people healthy by creating small management systems adapted to cater for local needs.<sup>2</sup> These measures increased public access to healthcare centres, leading to an increased workload at primary health level.<sup>3</sup> The government, being a large organisation, relies on groups that include doctors and nurses to accomplish its goals, and the effectiveness of these groups plays a major role in determining the effectiveness of the overall organization.<sup>4</sup> "The nurse has an ethical responsibility in the interest of the welfare of her patient to be a loyal and competent colleague to the doctor. The nurse and the doctor must be able to rely on each other. Mutual respect is vital."<sup>5</sup> Nurses have dependent, independent and interdependent roles in their interaction with doctors,<sup>5</sup> and both professions should embrace the Patient's Rights Charter, which requires a good standard of practice and care of patients.<sup>6</sup> International journals have published numerous

letters citing doctor-nurse disagreements in their interactions.<sup>7</sup> Historically, the doctor-nurse relationship is an unequal one characterised by the dominance of the doctor, with nurses assuming a position of lower status and dependence on physicians.<sup>8</sup> One qualitative study showed that nurses perceive the quality of communication with doctors as being poor.<sup>9</sup> Lack of teamwork in the relationship resulted from different expectations and a confusion of roles.<sup>10</sup> Both professions have however demonstrated a willingness to promote teamwork in hospitals.<sup>11</sup> A journal review on interventions to promote collaboration between nurses and doctors showed positive gains once collaboration was embraced.<sup>12</sup>

## Methods

This was a descriptive qualitative study using the free attitude interview technique for data collection. The study population was drawn from the general practitioners visiting Kwa-Nobuhle clinics and belonging to an Independent Practitioner's Association (IPA), as well as the professional nurses rendering healthcare services in Kwa-Nobuhle clinics. Five subjects were selected from each group and their experiences of the relationship

between doctors and nurses at primary health level in Kwa-Nobuhle were recorded on audio and videotape. The exploratory research question was: "How have you experienced the relationship between doctors and nurses at primary health level in Kwa-Nobuhle?" The interviews were transcribed verbatim, followed by the manual identification of themes using 'colour coding' for individual interviews and a cut-and-paste method for the integration of themes.<sup>13,14</sup> Respondent validation involved taking the interpreted data to the respondents for their comments. Purposeful sampling, whilst ensuring the selection of information-rich subjects,<sup>15</sup> also achieved maximum variation by age, occupation and work experience so as to have proper representation of the range of experiences (see Table I).

The chief researcher's prior knowledge of the participants' work habits assisted with the identification of extreme or deviant cases and intensity sampling.<sup>14</sup> Two of the five selected nurses worked for Uitenhage Municipality, whilst three were Uitenhage Provincial Hospital employees. One nurse in a senior position was selected from each body. Three doctors were selected from institutions other than the Medical

**Table 1:** Demographic characteristics of respondents

*	Gender	Age	Marital status	Total experience	PHC experience	Position in IPA/ clinic	#
Interview							Institution
1	Male	38	D	9 years	6 years	Executive	Medunsa
2	Male	44	M	20 years	5 years	Member	Natal
3	Female	39	M	10 years	10 years	RN	
4	Female	45	S	16 years	16 years	SPN	
5	Female	59	D	19 years	6 years	RN	
6	Female	48	M	14 years	6 years	SPN	
7	Female	44	M	9 years	5 years	RN	
8	Male	45	M	18 years	14 years	Member	Medunsa
9	Male	53	M	12 years	7 years	Executive	WITS
10	Male	39	D	8 years	5 years	Member	UCT

University of Southern Africa, and the overt discontent of a doctor with the voluntary clinic duties led to his inclusion in the study. The inclusion criterion was continuous contact for a minimum of three years between a professional nurse and an IPA doctor serving at the clinics. Ethical approval for this research project was granted by the Research, Ethics and Publications Committee of the Medical University of Southern Africa. The Senior Medical Superintendent of Uitenhage Provincial Hospital and the Chief Director of Health Services for Uitenhage Municipality granted permission to interview their employees.

**Results**

The majority of the respondents reported a satisfactory relationship between doctors and nurses. This was based on the personal experiences of these interactions by the respondents. Only one respondent expressed outright dissatisfaction with this relationship. The themes that emerged were:

**1. Influence of previous experiences**

q **Previous experience**  
 Experience in a different work setting besides a hospital influenced one respondent’s approach to the doctor-nurse relationship at primary health level. Two experienced doctors compared the hospital environment with primary health care and

concluded that “there was not much interaction between nurses and doctors” in hospitals, resulting in less understanding between these two professions. One doctor further indicated an unbalanced doctor-nurse interaction in hospitals and a resistance by nurses to doctor dominance, saying that “in hospital you (doctor) would send a nurse on an errand and she would do it because she had to do it and you insist. I do not experience problems when I request assistance from a nurse at primary health level.”

**2. Positive attributes**

q **Communication**  
 Elements of communication ranged from the use of the same language to effective interaction. A doctor and a nurse stated that a common practitioner-patient language obviates the need for interpreting, thus leading to more efficiency at the primary health level. Communication further led to better doctor-nurse collaboration, as shown by one nurse, who stated that “we are never without a doctor and we don’t know what is happening”.

q **Favourable attitudes**

This was described as the behaviour of a fellow worker that encourages partnership and teamwork.

o **Partnership**

Different expectations emerged from the participants. One doctor expressed appreciation for the free interaction with nurses, which was felt should not be confined to work

environment, whilst another viewed the nurses’ enthusiasm and willingness to cooperate with doctors as building partnership. The doctor-nurse interaction was further viewed by a doctor as a barrier breaker: “We know their frustrations, we meet in town, we talk, we are actually becoming colleagues, that’s what I feel personally it (the interaction) has achieved.”

o **Teamwork**

One doctor was particularly passionate about the existence of teamwork in primary health care. His vast experience in a hospital environment led him to conclude that the competency of nurses in primary health care ensures cooperation and teamwork with the doctors. A nurse felt that there was a positive regard for one another from teamwork: “During resuscitation there is usually no fights like ... ‘you sister you don’t know how to ... and you doctor you didn’t say...’ in other words we work as a team.”

**3. Negative attributes**

q **Inconsistency**

Two nurses in senior positions freely expressed the inconsistencies of the doctor during clinic visits as generating conflict. Their concerns were mostly about the impact of this on staff morale and the inconveniences caused to the patients. This is illustrated by the remark made by a nurse that “patients wait for hours on end, only to hear

that the doctor would not be able to help them, it is so frustrating and inconveniencing to both the nursing staff and the patients... it is quite unprofessional, ... it is quite annoying!" Another nurse stated: "You are never sure whether the doctor will come or not and they don't tell us."

#### q **Cooperation**

A doctor, openly critical of the level of cooperation between the nurses and the doctors, felt that nurses were using doctors for the alleviation of their workload rather than for their expertise. Another doctor viewed nurses as being uncooperative and said that they "(drag) their feet or refused to be sent on errands by a doctor". A senior nurse explained poor cooperation as a doctor creating more work for nurses instead of trying to ease workload: "He will order bloods ... and whilst he is busy with his own work he expects the sister to take bloods for him. They do not appreciate the workload that is there."

#### q **Tensions**

Tensions emanated from:

##### o Patients

A nurse stated that "patients direct their frustrations at us (nurses) and we are limited, there is nothing we can do." This statement is partly as a result of certain actions by some doctors, but some blame was apportioned to the patients, who want to bypass the nurses and be seen by a doctor: "Even if you want to give the doctor fifteen or ten patients, they jump in and go to the doctor".

##### o Body language

This refers mostly to the attitude and approach of one's counterpart to his or her work, as explained by a doctor's statement: "The nurses are pleasant and enthusiastic all the time." Another doctor qualified this by saying that "there is no dragging of feet or doing something grudgingly." An outright view on body language comes from one nurse, who stated "Just the appearance, the facial expression of

a doctor says a lot...."

##### o Workload

The workload at the primary health level was either viewed as conflict generating or an area for much sought-after collaboration. A disgruntled doctor described the workload as a crisis: "There is absolutely no way that two doctors can see that load, absolutely no way!" A nurse, on the other hand, blamed the patients: "They are coming for the sake that there is a doctor that day. So, they will flock to the clinic that day." A different view from a senior nurse was that "doctors do not appreciate the workload that is there" when they create work for the nurses by giving them many orders. A similar point is made by another senior nurse, who complained that "doctors leave the clinics for hospital and they leave behind lots of patients in queues."

#### q **Domination/Role confusion**

Doctors assumed leadership roles in the relationship and got offended by the nurses' suggestions on patient care. One nurse said, "It is as if you are challenging his own experience." A doctor demonstrated this attitude by stating that "there comes a time when you have to draw the lines and put your foot down and say; 'this cannot go like this, it must go like this'... you have to be easy but you must be firm." Another doctor expressed concern that the nurses confused the role of doctors at primary health level with that of the authorities. The consequences were the disappointments that arose when they realised that even doctors were powerless in effecting changes at primary health level. The same view is shared by another doctor, who stated that the nurses were disappointed with the failure of doctors to adopt the advocacy role as per their expectations: "Sisters would like us to be their mouthpiece, thinking that we should actually voice their sentiments, especially when

there is a problem involving the superintendent."

## **4. Benefits accrued**

### q **Mutual respect**

The majority of the respondents hinted at mutual respect as a single achievement in the doctor-nurse relationship, as illustrated by the following quotations:

"The competence level of the nurses has bridged the gap such that we work as a team." [Doctor]

"If you suggest something about the patient they are willing to take your ideas." [Nurse]

"What is important about our relationship with nurses is that if you treat them right, they will treat you right." [Doctor]

"I think some of the nurses are so highly trained, they know all that we know." [Doctor]

"Some of the doctors are willing to take their time and explain a condition, and if you suggest something about the patient they are willing to take your ideas." [Nurse]

The doctor-nurse interaction also brought about introspection by the participants, as shown by the following comments:

"We are quick to put blame on nurses; we do not look at ourselves first and our faults." [Doctor]

"Nurses' hierarchy is very important in the sense that for us as doctors it is always important to speak first to the most senior person." [Doctor]

### q **Learning**

A doctor remarked that the doctor-nurse relationship brought about a reciprocal learning experience, where "nurses learn by referring patients to the doctors and we learn a lot from them." To emphasise the significance of learning at the primary health level, one doctor stated that "if the relationship is right, the nurse will be very interested in what you are saying and be very receptive, in as much as



you can approach them on an issue.”

**5. Desires**

**q Clinic reorganisation**

Most respondents expressed a wish to see improved interactions between the two professions, with communication regarded as the single most significant factor. Both the doctors and the nurses expressed a need for a forum where all stakeholders could play a meaningful role. The following sentiments elucidate the need for changes at the primary health level:

“I believe there should be constant communication between the medical superintendent, the doctors and our pharmacy department.” [Doctor]

“There should be much more interaction between doctors and nurses in order to trash out any problem around treatment, or some form of feedback about the performance of the clinic.” [Senior nurse]

There were diverse and sometimes opposing views on how to bring about improvements at the primary health level. One senior nurse viewed the presence of doctors at the primary health level as essential for the realisation of an efficient primary health care: “We would like to keep away primary health patients from hospital so that the hospital could be able to deal with emergencies and trauma cases.” A doctor who felt that “the protocols can be structured such that nurses can prescribe, then we move the doctors to tertiary level” opposed this view.

**Discussion**

The district health model and the public-private interface have resulted in an increasing number of doctors in primary health care. Whereas the role of a doctor is clear-cut in hospital situations, this is not so at the primary health level. Without quantifying the experiences of the respondents, it

inductively emerged that the doctor-nurse relationship in primary health care in Kwa-Nobuhle is built on a track record of cooperation and collaboration. There are strengths and weaknesses that influence the final outcome, as pointed out by the respondents with most of their experience in the hospital environment. These respondents found the primary health level favourable for a better doctor-nurse relationship. The results of this study support the findings of Aquilino et al., which show that previous experience and interdependency with nurse practitioners lead to a favourable attitude towards nurse practitioners.<sup>16</sup>

In almost all doctor-nurse conflicts, communication seemed to be the missing component. Such conflicts range from doctor inconsistency in clinic attendance and a lack of doctor-nurse cooperation, to confusion about the participants’ roles at the primary health level. The conflicts were balanced by the benefits that arose as a result of healthy communication. Among these benefits was positive regard for one another, which led to better collaboration and a reciprocal learning experience. The impression

created can be summarised in Figure 1.

Other components of a healthy doctor-nurse relationship that were cited were introspection, recognition of the nurse’s hierarchy by the doctors, and patient participation in care. This was viewed as the provision of support that will lead to job satisfaction and patient-centred care. When all these factors are brought together, they should form balanced care, as demonstrated in Figure 2.

The respondents acknowledged the increased utilisation of healthcare centres, but there were divergent views on the potential of this for doctor-nurse conflicts. Almost all the respondents viewed communication as a means of addressing workload problems, with patient education being offered as another solution. This study emphasises the significance of teamwork, which is defined by the World Health Organization as coordinated action, carried out by two individuals jointly, concurrently or sequentially.<sup>17</sup> The multidisciplinary team approach has lately become even more significant as a result of challenges brought by the HIV/AIDS pandemic.

Maximum variation, strict

**Figure 1**

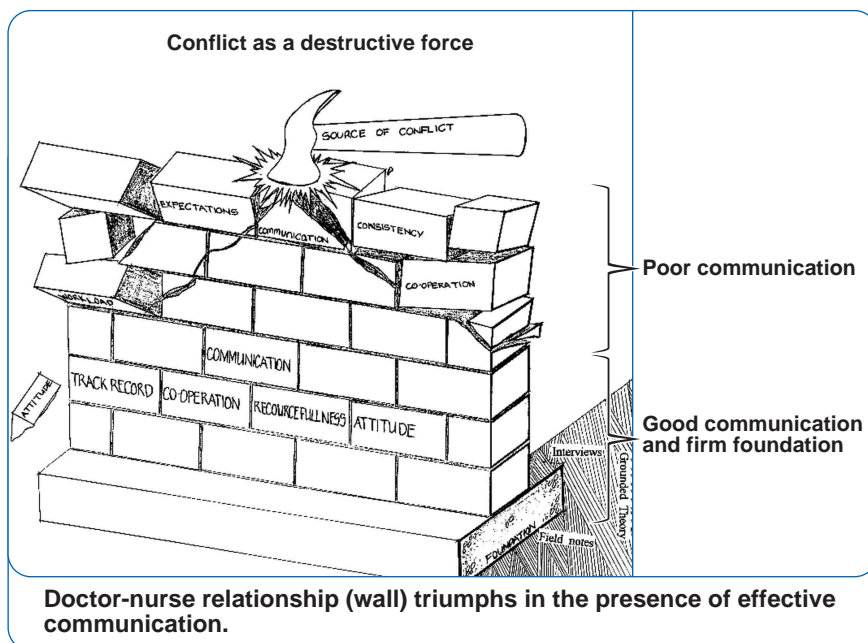
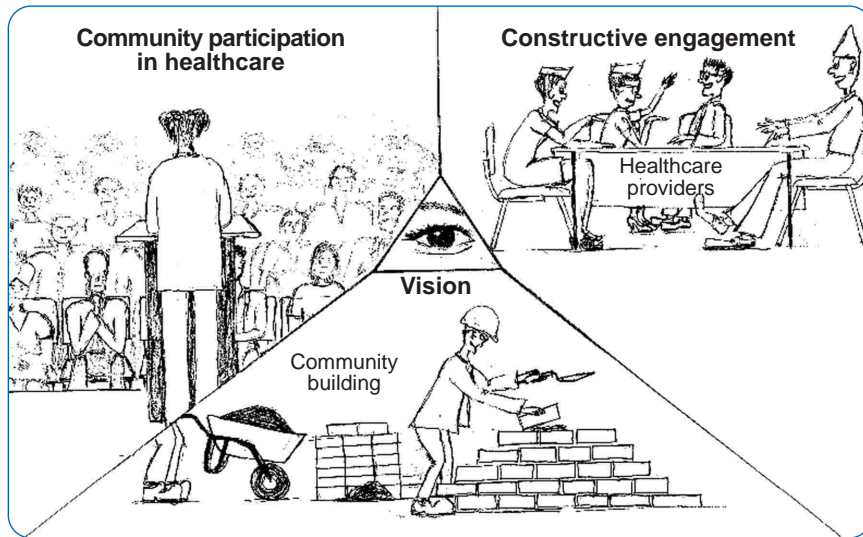


Figure 2



admission criteria and data validation through a member check addressed issues of bias in this study. The exploration of relationships is a sensitive issue and a different methodology may produce different results. The environment where this research was conducted may differ from others, leading to discrepancies in findings. Future research could further focus on team building and the essential elements to sustain the doctor-nurse-patient team.

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### References

1. South African Health Review. Chapter 14 "Free health care: policies; Part 3, Priorities of the Ministries of Health; 1995.
2. South African Health Review. Chapter 17 "District Health Systems developed; Part 3,

3. Priorities of the Ministries of Health; 1995 (last updated 19/05/2000).
3. Wilkinson D, Sach ME, Abdool Karim SS. Examination of attendance patterns before and after introduction of South Africa's policy of free health care for children aged 6 years and pregnant women. *British Medical Journal* 1997;5(11): 440-1.
4. Forsyth DR. Group dynamics. 3rd ed. Belmont, Calif. : Wadsworth; 1998.
5. Searle C. Professional practice: a South African nursing perspective. Durban: Butterworth; 1987.
6. Radcliff M. Reviews: Doctors and nurses: new game, same results. *British Medical Journal* 2000; April:1085-7.
7. Department of Health. Directorate: Quality Assurance. Patient's Rights Charter; 1999.
8. Keddy B, Gillis MJ, Jacobs P, Burton H, Rogers M. The doctor-nurse relationship: an historical perspective. 1986;11(6):745-53.
9. Anderson FD, Malony JP, Oliver DL, Brown DL, Hardy MA. Nurse-physician communication: perceptions of nurses at an army medical center. *Military Medicine Journal* 1996;161(7):411-415.
10. Sweet SJ, Norman JJ. The nurse-doctor relationship: a selective literature review. *Journal of Advanced Nursing* 1995;22(1):165-170.
11. Bukonda NK. Nurses and physicians valuation of and willingness to promote teamwork. *Nursing Administration Q* 1996;21(1):42-59.
12. Zwarenstein M, Bryant W. Interventions to promote collaboration between nurses and doctors. *Cochrane Database System Review* 2000;2:CD000072.
13. Creswell JW. Research design: qualitative and quantitative approaches. London: Sage; 1994.
14. Pope C, Ziebland S, Mays N. Qualitative research in health care: analyzing qualitative data. *British Medical Journal* 2000;320:114-6.
15. Patton MQ. Qualitative evaluation and research methods. 2nd ed. Newbury Park, CA: Sage; 1990.
16. Aquilino ML, Damiano PC, Willard JC, Momany ET, Levy BT. Primary care physician perceptions of the nurse practitioners in the 1990s. *Archives of Family Medicine* 1999; 8(3):224- 7.
17. Dennill K, King L, Swanepoel T. Aspects of primary health care – community health care in Southern Africa. 2nd ed. Cape Town : Oxford University Press; 1999.