Improving the physician–nurse relationship

In her article "Ethics and the physician–nurse relationship" (*Can Med Assoc J* 1983; 129: 290, 292, 293) Jane Wilson examines the moral dilemma faced by nurses who must carry out ethical decisions made by physicians. As she points out, the issue of resuscitation is a clear example of this dilemma.

The publication of guidelines for "Do not resuscitate" orders by Rabkin and colleagues[1] helped bring the issue into the open. Subsequently an editorial in *Supervisor Nurse*[2] referring to these guidelines provoked a flurry of letters in the August 1979 issue of that journal from nurses whose observations are similar to those of Ms. Wilson.

In studying this issue on several medical wards I found that nurses were often not involved in the decision-making process; occasionally they were not even informed that a decision had been reached. In addition, physicians did not evaluate the appropriateness of resuscitation for all critically ill patients. As a result, nurses were required to assess these patients in the physician's absence and make important ethical decisions.

Nurses generally dealt with this lack of communication in one of three ways:

- Aggressively pursuing the physician until he or she reached a decision.
- Resorting to "slow codes" (e.g., "Walk, don't run, to the phone")[2] if they believed that resuscitation was not appropriate but they had not received instructions from the attending physician.
- Resuscitating all patients unless told otherwise by a physician.

I also noted that patients sometimes confide in nurses rather than in physicians. A terminally ill patient may tell his nurse that he wants only palliative care, yet the physician, unaware of the patient's wishes, may continue to treat aggressively. In these situations the nurse can be a valuable source of information to the physician, helping him or her approach the patient about the latter's fears and misunderstandings.

The adoption by hospitals of a resuscitation policy can play a useful role in narrowing the gap in communication. First, the requirement that physicians write "Do not resuscitate" orders would help ensure that nurses are at least informed of the decision. More important, guidelines would encourage physicians to discuss the ethical implications of resuscitation with colleagues (including nurses) and with patients and their families. The experience at McMaster University Medical Centre[3] indicates that communication among health professionals and discussion of prognosis with patients and their families probably improved after the adoption of a resuscitation policy.

Guidelines will not ensure that all doctors will open up on this issue, but their adoption would represent a step in the right direction towards better physician–nurse and physician–patient communication.

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When is a patient's use of primary care services unwarranted?

The article by Dr. Christel A. Woodward and colleagues in the Oct. 15 issue of the Journal (1983; 129:. 822–827) could have been taken directly from my patient records over the past several years. As I read the article I found myself adding patients' names to the encounter descriptions.

I do not feel that my opting out of the Ontario Health Insurance Plan has made any difference to the frequency of unwarranted visits to my office. If the physician is opted in, the patient's visit is free, so who cares? If the physician is opted out, the patient often feels that he or she is paying for the service, so why should the physician complain?

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Does the Victorian Order of Nurses have a future?

It was most refreshing to read in the article by Jane Wilson that the national director for Canada of the Victorian Order of Nurses (VON), Miss Ada McEwen, "sees the transfer of visiting nursing to government administration simply as part of the normal evolution of VON services" (*Can Med Assoc J* 1983; 129: 625–626). What a pity that this message, which I have always understood to be part of the VON operating philosophy, has not reached the Calgary branch.

The home care program in Calgary was started by the VON in 1970 after 11 years of lobbying with the government. In 1978, provincial regulations were promulgated for all home care programs in Alberta, and provincial government funding was extended. Existing home care programs were transferred to local health units in 1976. Thus, the Calgary home care program was transferred from the stewardship of the VON to the administration of the Calgary Local Board of Health. Since that time it has grown rapidly and flourished. This transfer was not inappropriate since the home care program is much more than a nursing program. However, nursing services for the home care program were contracted out, largely to the VON. In the past 5 years the VON has allowed itself to become 95% dependent upon this program for income and in doing so has forfeited funding by the United Way and similar organizations, largely because the home care program pays full fees for each nursing visit.

Recently, following an independent study that suggested significant cost savings in home care if nursing services were provided in house, the inevitable struggle began, as Ms. Wilson points out. The VON became threatened by takeover, although not, in this case, from a government agency. There has been no evidence of innovation or of an attempt to identify the gaps in the health care of this community, but rather a vitriolic and destructive attack on the efficiency of the home care program and the integrity of some of its employees. This seems inconsistent with the policy expressed by Miss McEwen.

CMAJ *tries to publish as wide a selection of letters to the editor as possible. We can accept more letters and publish them more promptly if they are short and convenient to edit. We ask that letters be no longer than two typescript pages (450 words) and be typed double-spaced with wide margins, like a manuscript.*

I take particular exception to the implication that the VON is running a palliative care program for the dying and their families in Calgary. This program is a cooperative effort between the Calgary home care program and the Tom Baker Cancer Centre that was started in 1980 with considerable encouragement and support from the staff of the cancer centre. The VON was invited to provide a team of specially trained nurses for the palliative care program. Although the VON was receptive to the idea of being involved in the program, it was initially reluctant to designate a specific group of nurses for this purpose. Eventually it agreed. Under the direction of the home care program the initial phase of the palliative care program has been a great success owing to the efforts of all the caregivers and support staff involved. The VON nurses deserve their share of praise; however, this is a community program run by the Calgary home care program with support from medical oncologists, psychosocial workers, bereavement counsellors, clergy and volunteers in addition to the nursing service. Financial support comes from the home care program, the Tom Baker Cancer Centre and a private foundation, which also provide considerable psychosocial support and in-service training for VON staff, for which the VON pays nothing. It is thus inappropriate for the VON to repeatedly refer to the palliative care program as a VON-sponsored program when it is not.

One can only applaud Miss McEwen's approach to the current national plight in which the VON finds itself. It is unfortunate that her message is not being received by her own staff.

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Health economics

The view expressed by Dr. Denys K. Ford in his "Personal View" in the Aug. 1, 1983 issue of *CMAJ* (129: 286–287) is shared by me and by many other Canadians. His article should be reprinted and mailed to every elected provincial and federal politician and should be published intact in every newspaper in the country. It is time that we become proactive instead of reactive in our efforts to educate the public. Dr. Ford's article could go a long way in achieving that goal. Congratulations for publishing it.

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