Negotiating transformational leadership: A key to effective collaboration

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Abstract

Transformational leadership is important because it provides not only direction but it also creates opportunities for professional development. This qualitative investigation explored how medical doctors, in order to be transformative, should negotiate with advanced practice nurses while working in collaboration with them. The results first suggest that medical doctors and advanced practice nurses should negotiate appropriate levels of supervision in their working relationship commensurate with the education and experience that the advanced practice nurses bring to the practice. Second, mentoring should be a reciprocal communication process between medical doctors and advanced practice nurses, where thoughtful feedback facilitates appropriate adjustments in respective communication and time management styles. Third, educating necessitates mutual learning, with each party acknowledging the possibility of learning from the other and being sensitive to the value of what the other contributes to the working relationship. The authors conclude that effective leadership involves negotiating along these dimensions, which will contribute to effective team-building.

Key words health-care teams, interdisciplinary teams, leadership effectiveness, team-building, transformational leadership.

INTRODUCTION

Medical doctors (MDs) often assume supervisory leadership roles while collaborating with advanced practice nurses (APNs) on interdisciplinary health-care teams in skilled nursing and long-term care facilities. Such physician involvement is mandated in all but six of the states in the USA and is required in the state of Illinois, where this investigation was conducted (Buppert, 2006). Scholars have explored what constitutes a health-care team, the advantages and disadvantages of collaboration, and the dimensions of effective and ineffective team leadership (Stapleton, 1998; Hallas et al., 2004; Rosen & Callaly, 2005; Kvarnstrom & Cedersund, 2006; Stanley, 2006; Taylor, 2007) Furthermore, scholars have acknowledged the value of transformational leadership: a model suggesting that effective leadership entails partnering with one’s colleagues and creating opportunities for professional development (Kotter, 1990; Kerfoot, 2006). The objective of this qualitative investigation is to examine where MDs, if they are to be transformative, should negotiate with APNs in order to increase the likelihood of effective collaboration.

LITERATURE REVIEW

Buchanan (1996) defines collaborative practice as an interdependent association of health-care personnel, including nurses, physicians, and other allied health-care workers, all committed to the common goal of providing patient care. Sebas (1994: 48) argues that physicians and nurses collaborate, but “...within the framework of their respective professional scopes of practice”. In terms of advantages, Martin (2006a) discusses the flexibility with which interdisciplinary teams cross organizational, professional, and geographic boundaries. Campbell et al. (1990) believe that collaboration provides opportunities to bridge the professional gap between medical and nursing care, while Stoller et al. (2004) argue that highly structured teams provide medical personnel with opportunities to model non-hierarchical behavior. In addition, Wilgeng (2004) argues that medical teams provide opportunities to improve knowledge, competency, and skill through the collaborative process and impact favorably on staff morale. Perhaps most importantly, Rosen and Callaly (2005) acknowledge that teams provide a broader and more comprehensive view of the patient’s problem: a holistic approach that can be better informed and of a higher quality than more individualized assessments.

In terms of challenges to teamwork, Stapleton (1998) argues that the health-care system is hierarchical, with traditional roles being continually reinforced. Scholars note the patterns of subordination between MDs and nursing practitioners (NPs) as being influenced by cultural patterns of male
dominance (Lamb, 1991; Harris & Redshaw, 1994). Campbell et al. (1990) argue that nursing education emphasizes the importance of “psychosocial” influences on the patient, in comparison to medical education, which emphasizes somatic (biomedical) tasks, including physical diagnosis and treatment. Medical doctors can be insensitive to this distinction. Furthermore, MDs do not have a clear understanding of the NP’s role, while NPs have a broader understanding of the education that MDs receive (Martin et al., 2005). Thus, collaboration becomes challenging for NPs. Kvarnstrom and Cedersund (2006) argue that nurses must guard against having their expertise suppressed, as well as falling into dysfunctional patterns of conformity influenced by dated expectations.

Scholars also have examined the kind of leadership needed to ensure effective team functioning. Kotter, as cited in Stanley (2006), describes the transactional leader as one who subordinates and controls, while the transformational leader sets direction and creates opportunities for the professional development of individual health-care team members. Wilgeng (2004) argues that the transactional leader is often self-centered, leading via directives and mandates, while the more transformational leader is an inclusive motivator, proactively solving problems that promote team effectiveness. Kerfoot (2006) describes this contrast in leadership styles as the difference between “telling and directing” and “partnering”. Kerfoot argues further that partnering between healthcare team leaders and team members is facilitated via the effective sharing of information, one-on-one coaching, and mentoring. The notion of partnering is hardly new, as the distributed leadership perspective has long advocated that leadership practice is not something done to followers or the actions of one individual but, rather, it is the interactions that occur among the leader and followers that are critical to leadership effectiveness (Spillane, 2005). Finally, scholars concur that overall team effectiveness is influenced by transformational leadership (DiMichele & Gaffney, 2005; Kvarnstrom & Cedersund, 2006).

Researchers thus acknowledge that interdisciplinary teams pairing MDs and APNs are commonly used in the delivery of health care. They offer analytical insight not only pertaining to their advantages and disadvantages but also regarding the importance of transformational leadership within team contexts. What remains unclear, however, are the actual areas where the “partnering”, as suggested by Kerfoot (2006), should occur. Research has failed to reveal a qualitative “field-based” perspective that suggests both specifically and strategically where MDs who are assuming supervisory leadership roles in health-care teams should negotiate with APNs in order to increase the effectiveness of their collaboration. Hence, determining where such negotiation should occur will be the purpose of this investigation.

METHODOLOGY

Participants

The participants for this investigation were members of a collaborative health-care team located in a large Midwestern suburban area and serving patients at 40 nursing homes. The team consisted of five physicians and eight APNs, ranging in age from 29–51 years. Four of the MDs practiced internal medicine and one was a family practitioner. Four of the MDs had subspecialty training in geriatrics. The APNs included five APNs specializing in family practice (two of whom had training in geriatrics), two APNs specializing in adult medicine, and one clinical specialist who was also trained in geriatrics. We selected the participants from a collaborative health-care team in order to create a purposive sample that included MDs who interacted regularly and assumed a leadership role with anywhere between one and four APNs while meeting the needs of patients at several nursing homes. We adhered to established ethical guidelines in our research and this investigation was approved by the Institutional Review Board at DePaul University, Chicago, USA.

Procedures

We conducted semistructured interviews with five MDs and eight APNs. The in-depth interviews were ~ 60–90 min in length. The interview protocol consisted of open-ended questions. For example, the MDs and APNs were asked to describe the areas of agreement and disagreement that typified their working relationships with one another. The researchers asked the participants how they would describe their working relationships, the terms that best characterized their partners’ preferred decision-making approach, the problems encountered in attempting to work together, and suggestions for improved understanding within their team relationships. The interviewers questioned what the APNs sought from the MDs in order to enhance the working relationship and, in turn, what the MDs sought from the APNs to do the same. The relative strengths and weaknesses of their association also was examined, along with how each addressed the deficiencies they experienced in their working relationship with the other. The interview protocol elicited detailed accounts of the MD/APN day-to-day working association.

Data analysis

In analyzing the interview data, we followed established qualitative procedures (Glaser & Strauss, 1967; Berg, 1998; Strauss & Corbin, 1998; Lindlof & Taylor, 2002). First, the interviews were tape-recorded and transcribed. Second, we used a process called “open coding”. During this process, the interviewee comments are first tagged with conceptual labels and then grouped according to similarity of the theme. Then, “constant comparisons” are made between and among the categories to ensure discreetness of content (Strauss & Corbin, 1998). The analysis of the data suggested that the MDs and APNs should negotiate in three areas, including supervision, mentoring, and education.

RESULTS

Supervision

First, the MDs acknowledged the absence of understanding that typified their working relationships with NPs. Second,
the MDs often assumed a “transactional” stance in describing their leadership roles. Third, the NPs described their need for greater autonomy and less supervision within the context of their paired associations with MDs on the health-care team.

One MD mentioned, in reference to an APN assuming a role on a health-care team:

It is a big transition, made more difficult because a lot of people don’t understand what an advanced practice nurse does and what their scope of practice is. They are practicing alongside doctors who don’t understand the role and what might be needed as collaborators.

A second MD stated:

I don’t know how much medical knowledge they [the APNs] have compared to us and it also depends upon your experience.

A third MD mentioned:

They [APNs] are working alongside nurses who [think] you’re just a nurse.

The APNs also sensed the absence of understanding that was present in the relationship. One APN asserted:

... The MDs aren’t exactly sure what an APN is capable of doing. A new physician really needs to understand the role of an APN and the potential scope of that role, and that isn’t always clear.

A second APN indicated, in reference to the MD with whom she was paired:

She’s a very experienced physician who really didn’t know what the heck I was doing there... She didn’t understand what my role was.

An absence of understanding existed between the MDs and APNs on this health-care team.

The MDs emphasized the “control” that each needed to assert within the team context. One MD asserted:

I am in charge, but we are a team...”

A second MD asserted:

It’s true, they’re a nurse practitioner, but they’re still responsible to us.

A third MD mentioned:

They work under me, and under my license...

Finally, an MD asserted:

I think, in general, the doctor drives that relationship [the MD/APN relationship]. The doctor says, “Well, I’m doing this, you help me in this way” in so many words.

Although it is true that there are legal parameters governing the collaboration between an MD and APN, the APNs on this team clearly felt “overly supervised” and desired greater autonomy. One APN stated:

... Physicians must understand the independence that is a part of the nurse practitioner role.

A second APN indicated that the MDs needed to recognize that:

... A nurse practitioner should be able to practice independently and know when to call when they need some help.

In describing the supervision she received from her MD partner, an APN said:

There’s nothing wrong with going behind [an MD verifying the results of an APN’s physical examination of a patient] and actually seeing the patient yourself...but, you don’t have to reinvent the wheel then... So, on the one end, the APN then starts to say, “Oh, what am I doing here?”

Finally, an APN suggested that MDs should not view the relationship as one of:

...delegation, but instead view the relationship as a partnership.

These data not only suggest that MDs need a clearer understanding of the education and training that APNs receive, but that MDs need to engage in dialogue with APNs, geared toward creating an accurate perception of the APNs’ education, experience, and current clinical skill levels. Such interaction could influence the MDs’ willingness to share more responsibility for patient care and facilitate the identification of areas where APNs, because of their advanced training, might assume more leadership and initiative within the team itself. For example, APNs will often independently make patient visits, conduct routine assessments, adjust treatment plans, and write certain orders, but they must work interdependently to understand the treatment care plan authorized by the physician with whom they are paired. Negotiation could facilitate the identification of other areas where APNs could take independent action. However, within the context of this investigation, state licensure in Illinois, as well as the collaborative agreement of the health-care institution itself, governs the assignment of certain responsibilities. Hence, any negotiation of responsibilities would have to be consistent with the regulations operative at given practice sites and geographic locations.

**Mentoring**

Sometimes referred to as coaching, mentoring is often associated with on-the-job learning needs that can be addressed by way of “partnering” among co-workers (Hall & Mirvis, 1995). The employee might have the knowledge and experience needed for a particular position, but mentoring could facilitate a more effective application of that knowledge, enrichment of a particular skill set or even appropriate performance adaptations. The data suggests that both the MDs and APNs believed that such needs existed within the context of their day-to-day association. When asked for suggestions that would create improved understanding within their working relationships with the APNs, the MDs offered specific suggestions in the areas of oral and written communication and time management.
First, consider oral communication. One MD acknowledged that the APNs needed to communicate:

...in a more succinct and factual [manner],...medical, physiological facts of the case, offering evidence-based descriptions of patients’ symptoms, paring it down to prioritizing the information they give: time is precious.

In describing his communication with an APN, a second MD indicated:

...They go on and on at length, often including superfluous information.

Another MD suggested that APNs should:

...cut to the chase...what information is most important so that [when] the information [is] handed off to the next person, they know what to do in following the medical plan.

Another physician pointed out that an entire office visit usually took 15 min and he could not take 10 of the 15 min to listen to his NP describe a case.

Comments pertaining to written communication suggested similar themes. One MD described a discharge summary in the following manner:

The nursing documentation is very wordy, pages and pages. Discharge summaries need to be distilled down.

These data suggest that MDs desire more efficient and factual communication from the APNs whom they supervise.

Similarly, in describing the interactions that their APNs have with facility personnel, the MDs expressed a need for APNs to manage their time more efficiently. One MD indicated that his APN, when approached for assistance at a nursing home, often dropped everything to accommodate an immediate request, even when it was not the most efficient use of her time. Another MD mentioned that, because APNs are capable of performing routine nursing tasks, they will step in when asked and assume some of those responsibilities while at a nurses home, rather than delegating the work efficiently and remaining focused on more important patient issues. As one MD commented:

Because they [APNs] are able to do some of the nursing things, they go do it themselves. They need to give the nurses directions so they can get what the APN needs and get back to them, so they can make the higher level decisions.

The APNs acknowledged that physicians often communicated with them in an irritated or impatient manner, provided insufficient information during problem-solving, and failed to listen critically during conversations that took place between them. One MD acknowledged the difficulty she had keeping her temper in check while communicating with her APN:

I know how much my nurse practitioner handles the load, but if I expect her to do a history and physical and something which I told her in the application which she cannot, I don’t listen to her and I throw my tantrum...I have to work on that.

An APN described a telephone conversation and, in referring to the MD with whom she was paired, she stated:

She basically kind of screamed at me. “Give him the Lovenox. That’s what you need to give him! And I’m like, “Well, it’s not in the PDR [Physician’s Desk Reference], I’m not finding that it’s indicated”. She said, “Give him the Lovenox at 1 mg per kg every 12 hours!” The physician then hung up the telephone on the APN.

In terms of providing sufficient explanatory information, an APN indicated that she wished the MD with whom she was paired would:

Give me your reasoning and not just bark at me the order that what it’s going to be and that’s how it’s going to be.

Another APN acknowledged that some MDs simply “lectured” the APNs while providing information and such a communication style turned her off. Similarly, an APN asserted, in describing her conversations with MDs:

Some of them, there’s a give and take, and there are others who have really low interest in speaking with me at all and no interest in my input.

Finally, an APN stated:

Some [MDs] just won’t even talk to the nurse practitioner and, you know, tell them what’s going on. Others expect them to do everything and just kind of pick up and, you know, that they’re just there to do all of the work.

Second, the APNs suggested that the MDs needed to work on their critical listening skills while communicating with team members. One APN commented:

One of the things would be getting her to listen to me as opposed to just saying, “No, it’s this way”. getting her to listen to my rationale and try to understand where I am coming from.

A second APN commented:

MDs must be willing to listen, examine APN notes, explain differences, and make changes.

Another APN commented:

If I say, “This person needs to go out [to the hospital]” and that needs to be done, I mean, it is frustrating a little bit sometimes to not have that trust, in a sense.

These data suggest that the MDs want the NPs to work more efficiently and to provide specific, factual communication, prioritized in terms of importance. Similarly, the NPs want to be really heard and addressed in an appropriate tone while simultaneously being provided the information they need to understand the decisions the MD makes. The MDs and APNs identified areas where each could potentially provide the other with some valuable mentoring, rather than the more limited transactional approach of one party, the MD, determining where the other needs to be mentored.

**Education**

Campbell et al. (1990) argue that, although they are sensitive to the needs of their patients, physicians view their primary
responsibility to be the diagnosis and treatment of disease processes (a biomedical orientation) while the nursing tradition places more emphasis on the patient’s life situation and experience (a psychosocial orientation). Furthermore, Campbell et al. argue that, although the treatment of the disease should be at the forefront, there is a need for contextual care that incorporates both philosophical orientations. The analysis of the data suggests that both the MDs and APNs recognized the need for an educational dimension in their day-to-day association. However, while some MDs recognized the value of both philosophical orientations and believed that they could benefit from the expertise that the APNs had to offer, other MDs offered a narrower view of what collegial education should consist. The APNs not only attached value to the notion of learning and acquiring knowledge but also appreciated those physicians who clearly demonstrated sensitivity to the nursing perspective. One MD commented:

We can both learn from each other. The physician often has a more in-depth background in some of the complex medical issues and takes the leadership in that. With the nursing background, the APN has some additional quality issues that they are trained to focus on that physicians tend not to focus on.

A second MD commented:

The APN will spend more time talking and more time listening to small talk, social issues important to patients and family. Physicians think this stuff is silly . . . physicians often think this isn’t useful information because it is not medical.

In acknowledging the importance of the psychosocial dimension, an MD asserted:

We see the medical treatment, but there is so much for them [the patients] to take in their day-to-day life, but if they’re worried about the personal things in their life and if they are being taken care of . . . the APNs help the patient settle personal issues, they can then focus on difficult medical decisions.

Finally, an MD mentioned:

I should know some things a little better . . . at least, by virtue of training, but some of the APNs that I have worked with have years of experience more than myself and I look to them for the answers to questions. Medicine is both education and experience.

Other MD comments suggested a narrower and more “transactional” approach to collegial education. One MD asserted:

We need to discuss what the holes are in their [the APNs’] education and how we might collaborate to fill some of those holes.

A second MD indicated:

Collegial education has to do with just straightforward clinical matters. Examine the neuron electric system in this way or this finding means this, not that, or it means something, not nothing, or use this medication in this way; those sorts of things.

A third MD argued that the APNs needed instruction in evidence-based medicine and how to follow a particular line of reasoning as it would pertain to a particular diagnosis. The MD indicated that, from her perspective, such reasoning constituted a critical gap in the knowledge that the APNs possessed.

In acknowledging her supervising physician’s sensitivity to the nursing perspective, one APN stated:

I mean, she really knows how to manage these patients . . . she respects me okay. She respects me and she respects me for what I can bring to the care of the patients. It means she includes the nursing component, okay? It’s not just the doing of the medical tasks, she sees it much broader.

Another APN described her previous supervisor in the following manner:

There’s actually one physician who’s at another center now who I don’t have any correspondence with as far as patient care, but she’s a wonderful resource. So, I can call her up and say, “I’ve got this going on, what do you think?” and it’s not that I wouldn’t go to the doctor I’m currently working with, but she has a knack with really just looking at the whole situation, and often there are family issues or other sorts of things, and she’s a very good resource.

In contrast, a third APN stated:

The nurse practitioners make rounds in a different way than physicians do because the orientation to the work is a different one. I mean, it’s coming from a nursing orientation, not a medical orientation. The nurse practitioners tend to look at things and pay a lot of attention to psychosocial stuff that the physician may gloss over.

These data suggest that there are MDs on the team who are sensitive to the importance of the psychosocial dimension, as well as those who are not. Similarly, there are MDs who see value in the nursing perspective and view the APN as a resource from whom they can learn, while others view collegial education in a transactional manner, where one party would determine what the other needs to know and how best to meet that particular need. The MDs and APNs must communicate in order to determine how each might “educate” the other.

Some of the MDs offered suggestions that described how collegial education, as a reciprocal process, might be integrated into a team dynamic. One MD discussed the value of identifying “teachable moments” throughout the workday or week. She stated:

Learning is better if it’s based around a case, a current case, or you can go back to a case that you may have already had, going back over it calmly . . . how things might have been handled differently or thinking about
how well things were handled, you can think in advance of what some of the teaching points are and you can do [so] calmly, so you are not pointing fingers. What can we take from this case to the next case?

She further indicated that the APNs also could be proactive in suggesting particular cases for discussion.

Another MD discussed the value of reviewing charts together as a basis for providing both guidance and feedback within the context of their professional pairing. She went on to suggest that a certain percentage of charts could be randomly pulled for discussion purposes, with the names removed in compliance with the Health Insurance Portability and Accountability Act (1996) guidelines. The discussions could focus on factors, including:

- legibility, accuracy, patient history and past history, medications – including dosage, name, route, and frequency – allergies, advance directives, patient assessment, actual examination, diseases present, and plan of care.

In particular, the MDs and APNs could discuss the danger of having either inadequate or inaccurate information charted about any one of the dimensions listed. Finally, as the construction of patient charts is a collaborative process, she indicated that both the MDs and NPs could participate in a “scoring” of the effectiveness of the charts along such dimensions and subsequently use their scorings as the basis of developmental discussion. Strategies such as these could provide opportunities for team members to not only engage in meaningful dialogue, but to do so while recognizing the value of the professional experience each brings to the discussion and displaying sensitivity to the differences in educational orientation.

CONCLUSION

We have identified three areas where MDs should display transformational leadership and negotiate with their APNs in order to facilitate more constructive collaboration: supervision, mentoring, and education.

Our data suggest that MDs often do not understand the APN’s role. The APNs often feel over-supervised and unable to assume autonomous actions that are commensurate with their knowledge, background, and experience. Medical doctors, who do not fully understand the APN’s role, often display transactional leadership tendencies: emphasizing their need to exert control within the team context. Hence, opportunities for MDs and APNs to share information pertaining to their educational background and work experience should be created. Such dialogue could influence the MDs’ willingness to allow NPs to assume more initiative and, perhaps, even to share certain leadership functions within the team context.

The MDs believe that the APNs need to write and speak in a more economical manner, prioritizing important facts and time more efficiently while working with nurses at different sites. Meanwhile, the APNs believe that the MDs should communicate without impatience or even anger, provide the APNs with sufficient information to understand patient decision-making, and to listen critically while communicating with them. For effective mentoring to occur, both parties need to acknowledge the potential value of receiving feedback geared toward enriching their respective communication or time management skills.

The analysis of the data in this investigation suggests that there are MDs who value the psychosocial dimension that the APNs bring to collaborative practice and MDs who seem less aware of its importance. Furthermore, some MDs define collegial education primarily from a biomedical perspective, while others openly acknowledge the value of the expertise and experience that their NPs bring to practice, even recognizing how they might learn from them. These data suggest that APNs appreciate working with MDs who value the nursing perspective and that they become frustrated by those MDs who seem less or completely unaware of its importance. One might argue that, for teams to provide the holistic and better-informed approach to providing quality care that Campbell et al. (1990) recommend, that collegial education, like mentoring, must be perceived as a reciprocal process and that MDs and APNs must acknowledge, through dialogue, what their respective learning needs are and how such needs might be systematically addressed within the context of their day-to-day association.

Recall Spillane’s (2005) argument that leadership is not something done to followers but, rather, it is the interactions that occur among the leader and followers that are critical to leadership effectiveness. By negotiating appropriate levels of supervision and by providing APNs with opportunities to assume initiatives commensurate with their training, education, and experience, by accepting mentoring as a reciprocal communication process from which both parties could benefit, and by acknowledging that all members of health-care teams have learning needs and could potentially learn from each other, MDs will not only be displaying transformational leadership, but they also will be engaged in effective team-building.

This qualitative investigation focused on the internal dynamics of one interdisciplinary health-care team. Although logically limited in generalizability, these findings may not only be used as an impetus for interdisciplinary discussions of leadership within the context of collaboration, they may also have heuristic value, motivating scholars to continue identifying strategies that could potentially enrich the MD/APN professional association, allowing each to benefit from and experience the strengths that the other brings to collaborative practice.

REFERENCES


