Communication: A Dynamic Between Nurses and Physicians

The status of health care is a leading topic for discussion in the United States today. Importantly, consumers demand quality health care; therefore, health care professionals need to provide high-quality, safe, effective health care while lowering cost. One main component to delivering this service successfully is effective communication. Communication prevents costly errors, streamlines patient care to prevent delays, and demonstrates a united front among members of the health care team (Schmalenberg & Kramer, 2009). While nurses and physicians as key members of the health care team facilitate quality care, many studies show breakdown in nurse-physician communication remains a concern. According to The Joint Commission (Woods, 2006), nearly 60% of medical errors are a direct result of communication breakdown.

Background

The education and clinical placement received by physicians and nurses during prelicensure training contrast greatly and have been an influential element in communication breakdown between the two professions (Dixon, Larison, & Zabari, 2006). During the pre-licensure stages for the two professions, emphasis is placed on their individual roles in patient care. The lack of co-educational experiences involving the two professions possibly leads to a lack of understanding of what each profession contributes to the interdisciplinary team, and complicates communication between nurses and physicians. Robinson, Gorman, Slimmer, and Yudkowsky (2010) noted nurses believe physicians do not view them as professionals but simply "purveyors of tasks" (p. 214). Nurses attribute this belief to their perception that physicians are not always knowledgeable of nurses' scope of practice and the autonomy nurses have earned. According to Dixon and co-authors (2006), physicians express frustration with nurses' communication style, describing it as "disorganization of information, illogical flow of content, lack of preparation to answer questions, inclusion of extraneous or irrelevant information, and delay in getting to the point" (p. 377). Clearly, each professional group perceives the other to be the primary culprit in communication breakdown.

Research indicates physicians must inform themselves of the scope of practice and knowledge nurses can contribute to patient care. Likewise, nurses must understand the unique problem-solving process used by physicians and provide information in a timely, accurate manner (Tschannen et al., 2011). Nurses should be assertive in advocating for patient needs so physicians clearly understand the primary issues in order to take appropriate action to correct patient concerns or problems (McCaffery et al., 2011).

Barriers

In addition to each profession's potential perceptions of the other, multiple barriers exist that hinder nurse-physician communication. A continuous flow of interruptions and multiple patient handoffs affect the ability of nurses and physicians to connect effectively, and establish a trusting and collegial relationship (Tschannen et al., 2011). Time is also a major factor in communication breakdown. Because nurses and physicians can be independently busy, finding time to communicate properly becomes a pressing issue (Burns, 2011). Work environments characterized by high patient acuity and staffing shortages create additional stress and thus contribute to communication breakdown. Even sex disparity among health care team members can create a barrier to effective communication (Fernandez, Tran, Johnson, & Jones, 2010). Males tend to prefer clear, quick, fact-based communication, while females prefer a more in-depth discussion style that attempts to understand the reason for occurrences (McCaffrey et al., 2011).

Advances in technology implemented to increase quality and efficiency have a part in communication breakdown as well. Communication modalities, such as text pagers, patient inbox messaging, and electronic ordering systems, can contribute to increased errors. Use of these methods may misrepresent the urgency or the tone of the communication received; due to equipment malfunction, a message may not be received at all. According to Robinson and colleagues (2010), nurses and physicians express a desire to follow up on urgent orders or electronic messages with some form of verbal contact.

Evidence-Based Practice Solutions

Many strategies have been developed to address nurse-physician communication breakdown. Implementation of unit-based care teams places physicians and nurses
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close to each other, increasing opportunities for improved communication (Gordon et al., 2011). Mandatory bedside rounds also have been shown to promote effective communication, creating greater satisfaction for the patient and members of the health care team. Increased satisfaction occurs because physicians, nurses, and patients participating in bedside rounds receive the same information to accomplish their tasks and meet patient care goals (Burns, 2011). Including patients and their families in bedside rounds provides opportunity for direct dialogue that reduces the occurrence of miscommunication regarding the plan of care and allows patients to become active members of the health care team. If the plan of care is not understood by all team members, cohesive care is not accomplished and the opportunity to achieve patient care goals can be missed (O’Leary et al., 2010).

Utilization of the SBAR tool has gained popularity in health care. Provision of the situation (S), background (B), assessment (A), and recommendations (R) has proven to be effective in nurse-physician communication. “Communicating in the SBAR format allows each discipline to give and receive vital information in a way that satisfies varying communication styles and needs” (Dixon et al., 2006, p. 380). Less common solutions include implementation of a formal resident orientation to the patient care unit (Quisling, 2009). Research has found pairing a new resident on the unit with a nurse for a designated amount of time “clarified to the physician nurses’ unique contribution to healthcare and underscored the importance of collaboration” (Booth, 2010, p. 8). Furthermore, nurses perceived physicians were more informed about the nursing role and felt a higher level of comfort communicating with physicians when this method was applied. Improvement in the coordination of care is apparent when a trusting relationship is present (Quisling, 2009).

Author’s Clinical Experience

The author works as a registered nurse on a medical respiratory unit in a large teaching hospital in the midwestern United States. During a unit council meeting in 2011, many nurses on the unit expressed a desire to improve communication with the physicians by the next year. Use of the SBAR tool had been implemented prior to the unit council meeting was expected among caregivers hospital wide. This tool has helped communication, especially during hand-off between patient care units and during acute situations that require intervention. However, nurses on the author’s unit recognized the need for more strategies to improve communication in addition to the SBAR tool.

Bedside rounds have been implemented with a medicine service assigned to the author’s unit, with a prompt card used to guide discussion of critical elements of patient care, such as pain, mobility, safety, fluid reconciliation, and discharge plans. When physicians from the medicine service arrive at a patient’s room, they page the primary RN to attend bedside rounds. The assigned nurse is identified with a picture posted near the patient’s door, and his or her pager number is provided on the door card. While this method worked initially, it now is utilized inconsistently. Barriers to effective use of this model include the availability of nurses and high patient acuity, in which some patient needs may take priority over bedside rounds. In addition, frequent change occurs in physician residents who staff the medicine service, and new residents are unfamiliar with the unit processes.

The solution to ineffective communication on the unit is implementing the process of mandatory multidisciplinary bedside rounds. Patients and staff members alike will experience improved satisfaction because the same communication is shared among all team members at the same time, with time allowed for clarification and feedback. According to Burns (2011), mandatory bedside rounds reduce errors and lead to more efficient patient care. This process also allows patients to witness effective communication among health care team members, contributing to a feeling of confidence in the care they receive and greater satisfaction with their hospital experience. A strategy must be identified to facilitate nurses’ consistent involvement in the mandatory bedside rounds.

Currently, the unit is implementing a new process to facilitate effective communication. At every shift change, the unit secretary prints the patient list with the RN assigned and provides it to the primary pulmonary service (a physician-staffed service stationed on the unit). Instructions for finding text pager numbers for individual nurses also are posted in the workroom for members of the pulmonary service. This process facilitates effective communication by providing physicians with nurses’ contact information for each shift, creating an easy method to relay concerns or changes to the plan of care for the day. To date, this process has been received well but only a post-intervention evaluation will determine its effectiveness in improving nurse-physician communication.

Conclusion

Communication between nurses and physicians can affect patient care outcomes. Many challenges remain to effective communication among caregivers. Members of the health care community need to investigate these challenges and implement solutions that fit particular work areas and requirements. More research is needed to evaluate potential solutions and successful options. All caregivers have a responsibility to improve communication as a vital component of professional practice.

REFERENCES


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