

Inquiry into the Communication Process:
Nurses' Perceptions of Nurse/Physician Communication

by

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Abstract

As nursing has developed as a profession, the role of nurse-physician communication and how it relates to patient outcomes has been a focus of research. While poor patient outcomes have been identified as a result of ineffective nurse-physician communication, the factors leading to ineffective communication have not been identified. This qualitative research study was designed to identify the variables involved in effective and ineffective nurse-physician communication. The grounded theory method was applied to nine transcribed interviews of Master of Science nursing students. Three themes related to effective nurse-physician communication and two themes related to ineffective nurse-physician communication were identified during the study. These themes suggest areas for improvement in nurse-physician communication as well as areas where current practice should be continued and encouraged. An additional finding is that personal impacts of effective and/or ineffective communication had more significant consequences for participants than previous research has indicated. The results of this study indicate a need for further research into the process of nurse-physician communication.

Keywords: ineffective communication, effective communication, nurses and physicians, process, experiences

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CHAPTER ONE

Introduction

Patient outcomes suffer as a result of unsuccessful communication between nurses and physicians (Larson, 1999; Wolf, 2006). As nursing began establishing itself as a profession, the significance and process of effective communication were discussed and analyzed at length. Later, the often-tenuous nurse-physician relationship became a topic of research and evaluation, and researchers identified facilitators and significant obstacles to effective communication (Stein, 1967). Stein discussed the culture in which nurse-physician communication functions and concluded that the nurse-physician relationship includes prejudices and assumptions that inhibit any form of effective communication between physicians and nurses (1967).

Significance of the Problem

In 1986, a foundational research study designed to evaluate anticipated deaths and actual deaths within intensive care units revealed that patient outcomes improved with effective nurse-physician communication (Knaus, Draper, Wagner, & Zimmerman, 1986). One participating hospital had 69 predicted deaths reported with only 41 actual deaths while a similar hospital experienced 58% more actual deaths than originally predicted. The contributing factors of improved patient outcomes were staff communication and interdisciplinary coordination, not the unit's administrative design, specific medical treatment or association with a school of medicine (Knaus et al., 1986). In response to these findings, research was conducted to evaluate the efficacy of nurse-physician communication improvement programs, but inadequate evidence was found to support the programs' use (Zwarenstein, 2009).

Ineffective communication between medical team personnel has been found to be detrimental to patient care. Nurse-physician communication has been acknowledged as such a large risk factor in patient outcomes that the Joint Commission (TJC) has identified improved staff communication as a national safety goal. This goal was created in order to assure that accredited organizations were making every effort to assure improvement of nurse-physician communication (TJC, 2010).

Nurse-physician miscommunication has been shown to lead not only to inefficient patient care and poor patient outcomes, but also unhealthy work environments (Larson, 1999). Research also found that a key element in unhealthy work environments is the perception that ineffective communication is a barrier to providing best patient care (Manojlovich & DeCicco, 2007) and that unhealthy work environments can decrease job satisfaction and nurse retention rates (Manojlovich & Antonakos, 2008; Stone, Larson, Mooney-Kane, Smolowitz, Lin & Dick, 2006). In settings where members of the interdisciplinary team are not effectively communicating with one another, patient care may be negatively impacted, which in turn impacts patient outcomes (Wolf, 2006).

Problem Statement

Ineffective nurse-physician communication has been recognized as a large healthcare liability because it can contribute to poor patient outcomes (Wolf, 2006). Various studies have focused on registered nurses' (RNs) definitions of effective and ineffective nurse-physician communication and the various methods designed to improve nurse-physician communication (Robinson, Gorman, Slimmer, & Yudkowsky, 2010; Zwarenstein, 2009). However, few relevant studies have identified RNs' perceptions of

specific barriers to and facilitators of effective communication between nurses and physicians. This study is intended to address the information gap in the literature.

Purpose Statement

The purpose of this qualitative research study is to explore experienced RNs' perception of barriers to and facilitators of nurse-physician communication. Experienced RNs enrolled in a Master of Science in Nursing (MSN) program were asked to share their personal experiences with nurse-physician communication in multiple healthcare settings. This study will examine those experiences and analyze how RNs perceived them to affect nurse-physician communication.

CHAPTER TWO

Literature Review

Research has demonstrated a need for further evaluation of the factors that lead to impaired communication between nurses and physicians. Several studies have focused on assessing RNs' definitions of effective communication, their roles in interdisciplinary communication, and their satisfaction with communication. However, little research is available focusing on what RNs believe influences effective nurse-physician communication.

An extensive literature review was obtained using the CINAHL, Pub Med, SumSearch, TripDatabase, PsychInfo, and The Cochrane Collaboration and Science Center databases. Keywords searched were: *nurse/physician, relationships, patient outcomes, job satisfaction, communication, effective communication, ineffective communication, tools for communication, and communication education*. Search results were assigned into the following categories: current clinical practice guidelines to improve communication, definitions of effective communication, results of ineffective communication, and education as an intervention to improve communication.

Clinical Practice Guidelines to Improve Communication

One of the TJC's national patient safety goals, originally set in 2007, is improved communication among caregivers. The defined outcome of this goal is improved timely reporting of critical tests and critical results, which places the responsibility for appropriate and timely communication on each hospital and institution. However, TJC does not provide specific interventions to address this goal (TJC, 2010).

Effective Communication Defined

A qualitative study using a focus group of nine nurses and nine physicians found effective communication to have five common themes: clarity and precision of message that relies on verification, collaborative problem solving, calm and supportive demeanor under stress, maintenance of mutual respect, and authentic understanding of each team member's unique role (Robinson et al., 2010). Ineffective communication was found to have three common themes: making someone less than, dependence on electronic systems, and linguistic and cultural barriers. This study focused on perceptions of effective and ineffective communication and not on the distinct factors inhibiting effective communication. Identifying the exact factors of ineffective communication could provide a stronger foundation for the design of interventions intended to promote effective interdisciplinary communication.

Results of Ineffective Communication

Although multiple factors have been found to be the result of ineffective nurse-physician communication, two primary factors have been researched at length. RNs' reported job satisfaction level and patient outcomes are considered most affected by ineffective interdisciplinary communication.

Job satisfaction. Manojlovich and Antonakos (2008) report on a study that surveyed 866 RNs in 25 ICUs to determine their perceptions of and satisfaction with nurse-physician communication in their workplaces. Communication satisfaction was measured by evaluating RNs' understanding of nurse-physician communication and their opinions of communication openness, accuracy, and timeliness. Job satisfaction was assessed using a single question that rated participants' satisfaction with their current

jobs. Researchers found a positive weak correlation between communication satisfaction and job satisfaction was found ($r = .34, p < .001$; Manojlovich & Antonakos, 2008).

These findings suggest a lower level of satisfaction with nurse–physician communication that correlated with a lower level of job satisfaction.

Manojlovich and Antonakos's (2008) study provides statistically significant evidence that nurses who are dissatisfied with nurse–physician communication in turn experience decreased job satisfaction. The study does not provide evidence of causes of ineffective communication. Geographic limitations reduced the generalizability of this study.

Patient outcomes. Knaus et al. (1986) conducted a foundational study evaluating 5,030 patients of 13 intensive care units (ICUs). The researchers used an instrument to determine and score the severity of patients' illnesses and estimate a probability of death. Each of the 13 hospitals was required to provide information on staffing, organization, policies and procedures, educational affiliation, and extent of critical care personnel participation in patient care. Actual versus predicted death was found to be statistically decreased when the hospital maximized collaboration between members of the interdisciplinary ICU team. The death rate of Hospital 1 was 41% lower than originally predicted ($p < 0.001$), while Hospital 2 was found to have death rate 58% higher than originally predicted ($p < 0.01$; Knaus, et al., 1986). The researchers tallied the results of the two hospitals with the largest differences. This study provided a gateway to further research regarding interdisciplinary communication within the ICU and patient outcomes.

Manojlovich and DeCicco (2007) conducted a cross-sectional descriptive study of 866 RNs working in 25 separate ICUs to examine the relationship between nurses'

perceptions of their practice environment, nurse-physician communication, and selected patients' outcomes (Manojlovich, Antonakos, & Ronis, 2009). Data regarding ventilator-associated pneumonia, central line infections, and pressure ulcer prevalence was obtained from each of the ICUs. Nurses employed in those units were surveyed regarding their work environment and nurse-physician communication; they were asked about the components of magnet hospitals, empowerment in the workplace, interdisciplinary communication, and their perception of infection rates and overall patient outcomes.

Researchers' analysis of the 462 responses returned showed no statistically significant correlation with patient outcomes. One statistically significant finding demonstrated timeliness of communication had an inverse correlation with prevalence of pressure ulcers ($r = -0.38$, $p = .06$; Manojlovich et al., 2009). A correlation between perceptions of the frequency of misunderstood physician communication and increased ventilator associated pneumonia rates was also found ($r = -0.43$, $p = -0.3$). While some correlations were uncovered, the final findings were that specific aspects of nurse-physician communication were not directly related to adverse patient outcomes (Manojlovich et al., 2009).

This contradicts the findings of Knaus et al. (1986), and suggests that the relationship between communication, collaboration, and patient outcomes is difficult to assess. However, because the study was confined to one geographical location, application of its findings outside of southeastern Michigan is limited. Further, the study did not address predicted versus actual death but focused on adverse patient outcomes and provided inconclusive evidence to associate the relationship between workplace environment, nurse-physician communication, and patient outcomes (Manojlovich et al.,

2009). Despite its lack of conclusive findings, the study does bring awareness to areas in need of further research. Future studies focusing on a larger sample size pulled from multiple geographical locations could potentially uncover a statistically significant correlation between nurse-physician communication and patient outcomes.

One qualitative study using the grounded theory method evaluated nurse-to-patient care team communication to determine the types of communication perceived to improve collaboration and patient outcomes (Propp, Apker, Ford, Wallace, Serbenski, & Hofmeister, 2010). Of the 50 participants, 25 were staff RNs, 3 were clinical nurse specialists (CNS), 7 were physicians, 6 were personal care assistants (PCA), 4 were unit clerks, and 5 were unit coordinators/charge nurses.

Researchers found two main processes used by the nurse and team to facilitate communication: ensuring quality decisions and promoting team synergy. Ensuring quality decisions involved actively seeking information, processing information for physicians, individualizing communication with physicians, collaborating in decision making, building credibility with physicians and communicating diplomatically were present. Strategies identified as promoting team synergy included coordinating the patient-care team, mentoring team members, empowering lower-level team members, advocating on another's behalf, managing conflict constructively, listening actively to team members, fostering a positive climate, managing workplace stress, and pinch hitting for team members when needed (Propp et al., 2010). While this research adds to the literature on effective strategies to improve communication and collaboration, the knowledge gap about specific phenomena that inhibit effective nurse-physician communication remains.

Education as an Intervention to Improve Communication

A systematic review of five randomized controlled trials (RCTs) evaluated the outcomes of inter-professional communication intervention programs (Zwarenstein, 2009). Only RCTs with a focus on the collaboration between nurses and physicians were included in the review.

The first RCT involved 22 multidisciplinary teams from 5 acute care hospitals (Zwarenstein, 2009). The teams were randomized into an intervention group that participated with a control group in five facilitated meetings designed to prepare them for an audit. Quality of the study, which took place over six months, was noted as moderate. The findings of this study noted an increase in reports of improvement in provided care from the intervention group, with no changes noted from the control group.

The next RCT included patients and staff. Patients were randomly assigned to either an intervention unit that included daily interdisciplinary rounds or a control unit that carried out traditional rounds (Zwarenstein, 2009). The intervention unit's mean length of stay was 5.46 days while the control group's was 6.06 days ($p = 0.006$). This study quality was noted as moderate.

The third RCT looked at 15 experimental nursing homes, 18 control nursing homes, and the psychotropic drug prescription trend (Zwarenstein, 2009). The experimental homes had monthly-facilitated multidisciplinary rounds while the control homes did not. The number of drugs remained the same within the experimental homes (2.07% pre-intervention and 2.08% after intervention), but increased 7% in the control homes (2.06% pre-intervention to 2.20% after intervention; $p = 0.02$). Most significantly,

antidepressant drug prescriptions decreased by 59% ($p < 0.001$) in the experimental homes and by 34% ($p = 0.002$) in control homes. This study quality was noted as high.

The next RCT randomized patients on an inpatient telemetry unit (Zwarenstein, 2009) to an intervention medical team that conducted multi-disciplinary rounds or a control team that provided standard care. There was no change in length of stay between the intervention group (3.2 + 2.7 days) and the control group (3.2 + 3.2 days; $p = 0.090$). This study quality was noted as moderate.

The final RCT compared multidisciplinary rounds via audio conferencing or videoconferencing with a team that worked at two hospitals (Zwarenstein, 2009). There were more audio conferences held per patient (3.3 + 4.4) than videoconferences (1.9 + 1.3; $p = 0.04$). The video conference group had a decreased length of stay (6.0 + 4.5 days) compared to the audio conference group (10.2 + 12.3 days; $p = 0.03$).

Of these five studies, only one noted that patient length of stay was decreased with initiation of interventions to improve nurse-physician communication. Three studies found no statistical difference and one noted a decrease in psychotropic drug prescriptions. According to the literature, nurse-physician communication affects nurses' job satisfaction and patient outcomes; thus, identifying the barriers that limit communication between nurses and physicians can clear the way for implementation of appropriately-focused interventions to improve nurse-physician communication and the ensuing patient outcomes.

CHAPTER 3

Methods

A thorough literature review has shown nurse-physician communication to be a widely researched topic. Many of these studies have attempted to correlate perceptions of communication to nurse job satisfaction in addition to patient outcomes. The specific circumstances that define effective and ineffective communication have also been researched. With this information readily available to the nursing profession it becomes imperative to assess nurses' perceptions of what facilitates and inhibits effective nurse-physician communication. This knowledge will help healthcare organizations develop policies and procedures to encourage accurate flow of information between patient care providers.

Conceptual Framework

The conceptual framework utilized in this study is the grounded theory method developed by Glaser and Strauss and published in their 1967 book, *The Discovery of Grounded Theory* (Chen & Boore, 2009). The grounded theory method is a process of data collection in which no pre-determined theories are validated (Ghezeljeh & Emami, 2009). The grounded theory method analyzes data findings, codes themes and gathers and compares more data as needed (Ghezeljeh & Emami, 2009). As with any research, it is highly important in grounded theory to limit bias; thus, a review of the literature was completed before data collection and analysis were initiated (Moore, 2010; Walls, Parahoo, & Fleming, 2010). Use of the grounded theory method calls for the discovery of themes present within nurses' perceptions of influential factors to nurse-physician communication (Chen & Boore, 2009).

The first step in the grounded theory method is to identify the population and phenomena to be studied (Chen & Boore, 2009). The target population of this research study is RNs enrolled in an MSN program; the phenomenon examined is nurse-physician communication. Next, a focused literature review provided further understanding of nurse-physician communication but did not saturate or impose any perceptions that could influence the data collection and analysis (Ghezeljeh & Emami, 2009).

Taking a Glaserian approach to the grounded theory method employs immediate coding, comparison, and re-evaluation until the collected data shows consistent themes providing sufficient evidence of which factors influence nurse-physician communication (Chen & Boore, 2009). Once the literature review was finalized, it was described and disseminated with the data findings (Moore, 2010).

The purpose of this research study was to discover and analyze various themes present in nurses' perceptions of factors that influence nurse-physician communication. Identifying these factors allows researchers and healthcare professionals to design specific interventions to improve communication between caregivers and further potentially improve patient outcomes associated with miscommunication within the interdisciplinary team.

Design

The grounded theory method was chosen to explore and extract themes from the data because it ensures no bias is present in the disseminated data (Ghezeljeh & Emami, 2009). Interviews were conducted with RNs enrolled in a MSN program with at least two years of experience. Data were immediately coded, compared, and re-evaluated until consistent themes in nurses' perceptions of nurse-physician communication were

discovered. This is also known as saturation (Chen & Boore, 2009). Upon final analysis of the data collected an exhaustive literature review was conducted and those findings were compared to this study's findings (Walls, et al., 2010).

Setting and Sample

The study was conducted at Point Loma Nazarene University (PLNU) in southern California. Institute Review Board (IRB) approval from PLNU was requested and obtained prior to data collection. There were 9 participants in this study. The participant inclusion criteria were RNs enrolled in PLNU's Master of Science in Nursing (MSN) program with greater than two years of professional experience (Appendix G).

Instrument

The demographic data collection sheet used in this study is replicated in Appendix A. The researcher utilized a semi-structured interview format for data collection (Appendix B); specific questions asked varied based upon each participant's response.

Data Collection Procedures

Participants were informed about the research study via an invitation delivered to their Point Loma Nazarene University student e-mail addresses. An introductory letter was included with the invitation (see Appendix D). Upon showing interest in participation students were given an informed consent agreement (Appendix C) and asked to complete the demographic data collection tool.

Nine individual interviews were conducted lasting from 15-45 minutes. Interviews included the pre-formatted questions found in Appendix B, and any unclear responses were followed up with questions listed in the pre-formatted question form in order to assure adequate details were communicated during the interview process. This

process was repeated until responses were clarified appropriately. After completing the interviews participants were debriefed and allowed to ask any questions or express any concerns they had about the study or their participation (see Appendix E). Each interview was voice recorded and then transcribed verbatim. After the written transcript was triple checked against the voice recording, the latter was permanently deleted. Written transcripts had no personal data identifying any participant.

Data Analysis

Data analysis began upon initiation of interviews. The goal of the data analysis was to identify core factors that affect ineffective and effective nurse-physician communication (Speziale & Carpenter, 2007). Participant interviews were transcribed verbatim and constantly coded, analyzed and reviewed, and the constant comparative method used within the grounded theory method was employed to evaluate new data in light of data collected from previous questions or interviews. After each interview and before coding, the researcher observed a period of immersion or dwelling on the experience, evaluating and analyzing what was seen and heard.

The coding process was accomplished in three stages. In the first stage, level I or *substantive* coding, the generalized processes of nurse-physician communication were identified and all identifiable categories found within the data were coded. Based on these categories, further evidence to support level I coding was to be determined during level II coding, or *categorization*. The processes noted in level I coding were broken down into groups. These groups or categories of level II coding were determined as the level I codes were condensed. The codes were found to indicate a specific trend and multiple examples of this trend were identified. As level II codes were identified, level III codes were

discovered based upon further evaluation of the data relative to the factors of effective nurse-physician communication (Speziale & Carpenter, 2007). The grounded theory describes the goal of research as discovering why specific phenomena occurs as it does (Streubert Speziale, 2007). The purpose of this study was to discover specific barriers and facilitators of effective and ineffective communication in the nurse-physician relationship.

CHAPTER 4

Results

The goal of this research study was to answer three questions: What are the perceived factors that lead to effective nurse-physician communication? What are the perceived factors that lead to ineffective nurse-physician communication? What are the primary trends that are perceived to affect nurse-physician communication? Themes found to answer these questions were identified using the grounded theory method (Speziale & Carpenter, 2007).

Description of Sample

Nine participants – two males and seven females ages 25-53 years old – participated in the study. Their years of RN experience ranged from 2-30 years with a mean of 11 years. Two participants had obtained certification for their specialties.

Findings

Themes answering the three research questions were identified. One theme repeated within each interview was how intensely effective and ineffective communication between nurses and physicians affected each participant. The participants' visceral responses led to further investigation into the individual repercussions of effective and ineffective communication.

Effective Communication Themes

Three themes of facilitating effective nurse-physician were identified in this study. The first and most commonly identified theme was inclusion of RNs in the decision-making/problem-solving process. The second identified theme was development of mutual respect; the third was professional expansion.

Inclusion of RNs in the decision-making/problem-solving process. The most common theme articulated by participants was the need for registered nurses' assessment findings and observations to be included during patient care planning. One participant stated:

...I want to inform and be the eyes and ears for the physician and I want to help make a decision and give them my input... The good physicians get input from everyone and so when he comes in he should speak with the nurse, family... whomever is relevant to the patients' care.

Another participant described the success of nurse-physician communication with inclusion of the nurse as a part of the care team during an end-of-life situation:

We [physicians and nurse] came up with what we wanted to say [to the family] and everyone knew the actual options... the physician and myself and the rest of the team, we were all on the same page walking into the room and there was no sense of "What did the doctor say?" and "What should I do?" because we were very united on that front and it went really well with the family because I think they could really just sense that we were on the same page and we were looking out for the patient.

Participants expressed satisfaction with nurse-physician communication when they believed their evaluation of the patient and the patient's needs were heard and addressed by physicians. When RNs were involved in patient rounds, they also noted an overall increase in effective communication:

... I've had good communication with some doctors because they include the nurse in patient rounds...it makes you feel a part of the team when you are

working in that type of setting and then you feel comfortable asking questions or questioning orders and then it also fosters a better learning environment for the nurse and everybody else.

Participants felt that improved nurse-physician communication also increased patients' involvement in their own care:

The [doctor] will walk the patient over to my office and in front of the client, kind of summarize what they discussed... by him giving me these little details, I can springboard into what I can focus on with the patient... We call it a "warm hand-off" and it has been really effective in engaging a lot of our clients in this program that otherwise would not really care for it.

Another participant stated, *It...makes the patient care better because I do see the improvement of patient care with communication, because it gives me more information for my patient and that gives them [physicians] more information to do something for that patient.*

Development of mutual respect. Participants expressed the importance of developing mutual respect between nurses and physicians as a pathway towards effective communication:

They trusted me. They knew me... they knew what I was capable of and they saw whatever critical thinking I had. That was a big deal... they trusted my judgment while some of the other physicians... they don't know you and they're just like, "I don't know you; why would I trust what you're going to say?"

Another said, *They know you and you know them. We really know each other and how we work... we are really comfortable with each other.*

Participants also spoke to the importance of familiarity in nurse-physician communication:

...We have good relationships with our physicians, not only in times when we need them, but also when things are going well. We see them a lot, so familiarity is there... when it is time to page them... we aren't having second thoughts paging them about little things, like, "Did you mean to write this order and not this?"

One participant described an experience of developing rapport with the medical director and the benefit of effective communication in that situation:

He and I have worked together for almost ten years at this facility... he knows I have a lot of breadth and depth of experience. He knows my education, we have spent many hours over patient charts and EKGs, so he understands how I think and I know how he thinks. He will have me go down and take a look at the patient and tell him what is going on... that is, of course, the ideal.

Professional expansion. As participants recapped their educational journeys, an identified theme was that their enrollment in an MSN program expanded their ability to participate in effective nurse-physician communication even when the topic was not directly included within the curriculum:

I think that the MSN program builds you overall, person and spirit, and I think that being in the program now... I have learned a lot more. My brain has a little bit more confidence, knowledge, humility... more enlightenment on what I have yet to learn and what is out there. So, without actually teaching you how to communicate... with physicians, they do.

Another noted,

I am more and more reinforced in my thoughts. I feel that the nursing program is instilling that in us, to be more confident, to feel better about our profession. I think that for the first time in a really long, long time, I feel proud to be a nurse and I think this program has really infused that into my way of understanding where I am going with my career and I think that is bettering my relationship towards my practice and towards nurses and doctors.

Ineffective Communication Themes

Healthcare culture and nursing education were identified as the two themes involved in the process of ineffective nurse-physician communication. The theme of healthcare culture had several additional sub-themes further describing the processes leading to ineffective nurse-physician communication. Nursing education's current standard of curriculum was also identified as a component in ineffective nurse-physician communication.

Healthcare culture. RNs communicated several themes within healthcare culture that lead to ineffective nurse-physician communication. The most commonly expressed theme was a lack of time or regard for the nurses' opinion or observations. As one participant observed, *They just want to come in and see the patient and walk out and they don't care if they talk to you or not.* Another participant related:

I've gone up to one [physician and] said, "Hey, do you want me to go with these orders or these orders?" because he had written admit orders on top of the ER holding orders, and he said, "Nope, none of these, I want mine only." [He] wouldn't even listen to my concerns or anything like that... There were a couple of issues I thought were really important and he just completely wrote me off.

Lack of time and accessibility was also a prominent trend:

...They want to be contacted for everything, but at the same time they don't want to be called at unreasonable hours. They kind of want emergencies to occur during normal business hours when they're awake and not in surgery, but I don't think physicians realize how unavailable they can be sometimes. So, that's one of the things that definitely hinders communication... when you're trying to get in contact with a person that doesn't make themselves as accessible as they should.

One participant described a power struggle that encouraged ineffective communication between nurses and physicians:

...You call them and give them suggestions, but they don't want to do it, they want to do it their way. Or they call you and act like you don't know what you're talking about and they are the physician and you are the nurse.

Nursing education. When asked about their educational background, participants noted a lack of education within their BSN and MSN programs specifically designed to prepare or improve their communication skills with physicians. One said, *I don't remember ever even having a one day talk about communication in any of my classes,* and another agreed: *I don't remember that we had a lot of talk about physician communication.* There was also a noted lack of nurse-physician interaction during clinical hours:

I think when we did our clinical, we didn't really interact with the physicians that much; if we had any issues we had to tell the primary nurse, who contact[ed] the physicians for whatever care they needed. I don't remember anything about communication with providers.

Even with the professional expansion gained as a result of participating in an MSN program, participants still noted a lack of initial education on nurse-physician communication in the undergraduate setting:

I think the nurses ran a lot of interference for us as students and I think there just wasn't much physician interaction because we were so focused on "Make sure you do our assessment," and "Make sure you do the meds right," and "Make sure you write up your care plan perfectly." We were so much more focused on that.

Personal Impact of Communication

During interviews and again as the initial coding process began, the personal impact of effective and ineffective nurse-physician communication on each participant became increasingly evident. The theme of personal impact following ineffective communication was articulated when participants answered the question, "How do these trends affect your job satisfaction?" This question was asked twice, following the question "What specific trends do you see within the nurse-physician relationship that inhibits effective communication?" and again following the question "What specific trends do you see within the nurse-physician relationship that facilitates effective communication?"

Participants' extreme satisfaction experienced during effective communication versus their devastation and feelings of inadequacy during and following ineffective communication revealed a larger personal influence than expected. As this theme was manifested during the interviewing and coding process the identified trends experienced by participants were labeled under effective or ineffective communication.

Effective communication. When asked about their job satisfaction as it related to effective communication, all 9 participants expressed very high levels of satisfaction with their jobs. One said, *I love my job. Part of liking what you do is actually having this good communication and a relationship with the people you work with.*

This high level of job satisfaction was related back to how effective communication was perceived as allowing nurses to provide for their patients' needs:

I loved what I was doing. I felt like I was making a difference because I felt more autonomous in my care because I felt like I knew what the patient needed.

One participant described seeing improved patient outcomes following a system restructuring aimed at improving interdisciplinary communication: *...It is amazing. I get paid a lot less than a lot of my colleagues and peers... Seeing the improvements and benefits is amazing to me. It isn't something you can get monetarily.*

The most frequently reported job satisfaction experience resulting from effective communication was defined thus: *It is very high. Because then, we took care of the patient. It wasn't an "us versus them"; It was a "we" with the patient. It [was] all of us, doing the best for the patient.*

Ineffective communication. When asked about job satisfaction as a whole, participants expressed satisfaction with fulfilling their roles:

I'm advocating for my patient and I'm looking out for them and I'm going to do everything for that patient and I'm not afraid or intimidated.

The theme of adapting one's own practice to accommodate for a culture of ineffective communication was seen in multiple interviews:

Sometimes, I'm almost divided whether it's easier to bring the doctors in with me when talking with the family or if it's easier telling the doctor what I need before we go in or to let the doctor go in first and just deal with the aftermath.

Sometimes that's just easier.

Another participant discussed working in a teaching hospital:

If it's just a specific person... I was talking about attendings; you don't see them as much and so you can work with their interns and residents more and build a relationship with them and kind of get around that.

More often than other themes expressed regarding job satisfaction and ineffective communication, participants acknowledged a sense of personal devastation following ineffective communication. One participant admitted, *I felt like I didn't even want to come in to work.* Another said,

I started wondering, why am I even here? Why am I a nurse? Is there another job that I can go to? Maybe I should change hospitals, specialties? I questioned a lot of the reasons as [to] why I was there in the first place.

One participant expressed the difficulty of continuing to work with a physician following ineffective communication: *If they're going to negate you or make you feel like you don't know anything, then you just don't want to work with them and you want to avoid them.*

In addition to the personal impact, ineffective communication impacted participants' patients as well:

You are the one sitting bedside with the patient. Dealing with whatever stress it is causing them because the physician isn't calling back or you are scrambling to

find somebody else to take care of an urgent need for the patient when you shouldn't be...

The impact of ineffective communication, albeit devastating, was used as a catalyst for participants to improve professionally: *“It's like, OK, let me get my stuff together and my notes and prepare what I'm going to say. I would never not call a doctor just because I'm scared.”*

CHAPTER 5

Discussion

As the findings were coded and discovered another thorough literature review was completed. CINAHL, Pub Med, SumSearch, Trip Database, PsychInfo, The Cochrane Collaboration and Science Center databases were utilized. The keywords searched were *Nurse/Physician, effective communication, ineffective communication, nurses, and experience of communication*. The results of this literature review showed a continued gap in identifying what causes effective and ineffective communication. There was also no research found regarding the personal reactions of nurses who experienced effective and ineffective nurse-physician communication.

Interpretation of Results

For the nine participants of this research study, inclusion of RNs in the decision-making/problem-solving process, development of mutual respect, and professional expansion were identified as themes leading to effective nurse-physician communication. These findings corresponded with those of a recent qualitative study of nine nurses and nine physicians that used a focus group methodology to identify five effective communication themes: (a) clarity and precision of message that relies on verification, (b) collaborative problem solving, (c) calm and supportive demeanor under stress, (d) maintenance of mutual respect, and (e) authentic understanding of each team member's unique role (Robinson et al., 2010).

Healthcare culture and nursing education were perceived in this study to lead to ineffective nurse-physician communication. Robinson et al. (2010) found three themes of

ineffective communication: making someone less than, dependence on electronic systems, linguistics and culture.

This study focused on the perception of what makes communication effective or ineffective, not the distinct factors leading to effective or ineffective communication. By using the themes identified within this study and recognizing the personal impact effective and ineffective communication has on those involved, changes can be made within the medical community to assure effective communication in each nurse-physician interaction.

Implications for Nursing

With the identification of these themes, the nursing profession has an opportunity to develop and improve patient/caregiver communication and improve patient outcomes. These benefits are motivation to use the results of this study to advance current nursing standards and make changes in nursing practice, education, and administration to continue to improve upon nurse-physician communication.

Nursing practice. One opportunity to improve nursing practice identified in this study is in including RNs in the decision-making/problem-solving process and valuing nurses' roles in patient care planning. When the entire healthcare team recognizes the need to include RNs in the care planning process, a mutual respect will develop between healthcare team members, giving way to opportunities to change the current healthcare culture. In order to help improve nurse-physician communication, nurses must take ownership of their knowledge and education. This includes actively seeking out continuing education courses and, based upon participant responses about the experience of being in an MSN program, RNs may also need to prioritize the pursuit of graduate

education for its role in advancing knowledge about disease processes as well as in facilitating experience in effective communication.

Education. Nursing education has an opportunity to inspect undergraduate education and evaluate methods of improving nurse-physician communication. A majority of the nine participants could not recall ever communicating directly with a physician during their undergraduate education. Most were unable to recall even discussing methods of effective communication. Teaching undergraduate nursing students how to communicate effectively and equipping students with methods of communicating in difficult situations could enable them to be a catalyst in changing healthcare culture when they enter the professional arena.

Administration. Hospital administration can use the findings of this study to develop education for nursing staff. This education can focus on the factors that lead to effective and ineffective communication and give staff guidelines on communicating with physicians in stressful situations. With this knowledge practicing nurses from bedside RN to chief nursing officer can participate in improving communication and advancing the nursing profession.

Limitations

This study presented several limitations. The sample was limited to only nine participants who were enrolled in classes at Point Loma Nazarene University's MSN program in southern California. The sample size was likely not representative of all geographic locations and institutions.

Areas for Future Research

The results of this study suggest multiple opportunities for future study. A larger sample size is required to further identify the exact variables that result in ineffective and effective nurse-physician communication. With the findings displaying a larger personal impact following effective and ineffective communication than has been previously identified in the literature, an area for further research is the impact of nurse-physician communication on nurses' job satisfaction and retention rates. Additionally, research into the outcomes of communication curriculum in undergraduate nursing programs would aid in evaluation of education about nurse-physician communication.

Conclusion

Knowledge of how unsuccessful communication between nurses and physicians affects patient outcomes has provided a catalyst for research into the outcomes and process of ineffective and effective nurse-physician communication. However, there is a gap in the literature about specific variables that may result in effective or ineffective nurse-physician communication. In order to identify these variables, this study utilized grounded theory qualitative method to interview nine graduate nursing students about their nurse-physician communication experiences. Three themes present of effective communication and two themes of ineffective communication were identified. Additionally, the impact of effective and ineffective nurse-physician communication on nurses was found to be significant. This study suggests an opportunity for nursing practice, education, and administration to focus resources on improving nurse-physician communication and multiple areas where further research is necessary.

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Appendix A

Demographic Data Collection Tool

Code # _____

As with all answers to this survey, your responses will be kept confidential. Please circle the appropriate number or fill in the blank. Do not place your name on this form.

Are you male or female?

1: Male

2: Female

How old are you? _____

How long have you been an RN? _____

What is your highest level of degree earned?

1: Diploma/Associate's

2: Bachelor's

3: Master's

What is the current setting in which you work? _____

How long have you worked in your current setting? _____

Do you have specialty certification (i.e. CCRN, etc.)?

1: Yes

2: No

Appendix B

Interview Guideline Questions

What specific trends do you see within the nurse-physician relationship that inhibits effective communication? Examples?

How do these trends affect your job satisfaction?

How do these trends affect your perception of safe patient care?

How do these trends affect your perception of patient outcomes?

What specific trends do you see within the nurse-physician relationship that aids effective communication? Examples?

How do these trends affect your job satisfaction?

How do these trends affect your perception of safe patient care?

How do these trends affect your perception of patient outcomes?

How do you feel your MSN program helped you develop effective communication skills?

How do you feel your BSN program could have improved effective communication training?

How do you think you could improve communication between nurses – physicians?

Appendix C

Consent to Act as Research Subject

Sarah Joy Schleifer BSN, RN is conducting a research study to find out more about nurses' perception of nurse/physician communication. You have been asked to take part because you are a registered nurse enrolled in Point Loma Nazarene University's graduate nursing program.

The purpose of this study is to identify the following: the perceived factors that lead to effective nurse-physician communication, the perceived factors that lead to ineffective nurse-physician communication and the primary trends that are perceived to affect nurse-physician communication.

If you agree to be in this study, the following will happen to you: You will be asked to fill out a demographic data form that will provide information regarding your age, educational background, nursing experience and nursing expertise. You will then be asked to answer ten open-ended questions regarding your experience with nurse/physician communication. The interview will last approximately 45-60 minutes and will be digitally audio recorded. Throughout the interview you will be allowed to ask questions regarding the study and the purpose of the questions you are asked. Following completion of the interview you will be given the opportunity to voice any further questions or concerns about the study with no digital audio recording, if you so choose.

Upon completion of the interview and debriefing your involvement in the study will be complete.

Participation in this study may involve some minor risks or discomforts. These include: anxiety in regard to memories that are brought up following questions asked and an emotional response following the retelling of potentially difficult life experiences. This study may involve risks that are currently unforeseeable. However, if any new risks become known in the future, you will be informed of them.

There may or may not be any direct benefit to you from this experience. The investigator, however, may learn more about factors affecting nurse/physician communication. The alternative to participation in this study is to not participate. Participation in this research study is entirely voluntary. You may refuse to participate or withdraw at any time without fear of any repercussions.

Research records will be kept confidential to the extent allowed by law. You may withdraw from the study at any time without explanation.

If you decide that you no longer wish to continue in this study, you will be required to alert Sarah Joy Schleifer BSN, RN, the principal investigator, of your wishes to withdraw and she will destroy all data gathered from your participation.

You will receive a copy of this consent document to keep.

I agree to participate.

Subject's Signature

Date

Appendix D

Introductory E-mail to Potential Research Participants

Hello fellow PLNU graduate students,

My name is Sarah Joy Schleifer and as a part of my graduate thesis I am conducting a qualitative research study titled “Inquiry into the Communication Process: Nurses’ Perception of Nurse/Physician Communication.” The data collection will consist of 60-minute one on one interviews and I will offer a \$10.00 Starbucks gift-cards to those who participate. Participation is completely voluntary and there is no repercussion if you do not participate or if you withdraw from the study.

Please read the attached “Invitation Letter” and e-mail or call me if you are interested in participating or would like further information on the study. I greatly appreciate your time and consideration of this opportunity to assist in identifying the trends that affect nurse/physician communication.

Thank you all for your time,
Sarah Joy Schleifer BSN, RN

Appendix E

Introductory Letter to Potential Student Research Participants

Dear Student,

Sarah Joy Schleifer BSN, RN and MSN student is conducting a research study as a part of Point Loma Nazarene University's MSN program requirements for graduation. The purpose of this study is to evaluate the experiences of registered nurses with regard to nurse-physician communication. You have been asked to take part in this research study because you are an experienced nurse and graduate student in the School of Nursing at Point Loma Nazarene University (PLNU). There will be approximately 7-10 experienced nurse graduate students involved in this research project.

Participation in this study is completely voluntary and will not affect your status with the University in any way. If you consent to participate in this study, you will complete a brief demographic form and participate in a 60-minute interview where you will discuss your experiences surrounding effective and ineffective nurse-physician communication.

Participation in this study carries no risk for physical harm and minimal risk for emotional harm. Your individual responses to the demographic form and interview questions will be numerically coded in order to provide anonymity of your individual responses. To maintain the confidentiality of your individual responses, your demographic data and responses will be kept in a secure and locked area and will not be available to anyone not directly involved in this study's data collection or analysis. The audio recordings obtained during your interview will also be destroyed upon completion of the study. No personal identifying information will be reported during sharing of study findings.

I hope that you will be willing to participate in this study. Your consent to participate in the study is given when you sign the consent form and return it to the study investigator as well as participate in the 60-minute interview. If you have any questions or research-related problems, you may reach Sarah Joy Schleifer at 805-816-1474. If you have any questions about your rights as a participant in this study or to report research-related problems, you may contact the Institutional Review Board at Point Loma Nazarene University.

If you decline to participate, you do not need to do anything further.

Thank you for your time and consideration of this study.

Sarah Joy Schleifer BSN, RN

Appendix F

Interview Debriefing Guideline

1. The participants will be told that the primary point of this research project is to explore possible answers to the following questions:
 - a. What are the perceived factors that lead to effective nurse-physician communication?
 - b. What are the perceived factors that lead to ineffective nurse-physician communication?
 - c. What are the primary trends that are perceived to affect nurse-physician communication?
- d. The participants will be given an opportunity to ask any questions regarding the research project.
- e. The participants will be offered the opportunity to learn what the typical responses to the research questions have been.
- f. The participants will be given the opportunity to express their questions and concerns regarding the study.

Appendix G

PLNU IRB Expedited Review # 882



Saturday, May 28, 2011
 PI: Sarah Joy Schleifer
 Additional Investigators: N/A
 Faculty Advisor: Jeanne Maiden, Ph.D., RN
 Title: Inquiry into the communication process: Nurses' perception of nurse/physician communication

The research proposal was reviewed and verified as an expedited review under category 7 and has been approved in accordance with PLNU's IRB and federal requirements pertaining to human subjects protections within the Federal Law 45 CFR 46.101 b. Your project will be subject to approval for one year from the May 28, 2011 date of approval. After completion of your study or by May 28, 2012, you must submit a summary of your project or a request for continuation to the IRB. If any changes to your study are planned or you require additional time to complete your project, please notify the IRB chair.

For questions related to this correspondence, please contact the IRB Chair, Ross A. Oakes Mueller, Ph.D., at the contact information below. To access the IRB to request a review for a modification or renewal of your protocol, or to access relevant policies and guidelines related to the involvement of human subjects in research, please visit the PLNU IRB web site.

Best wishes on your study,


 Ross A. Oakes Mueller, Ph.D.
 Associate Professor
 Department of Psychology
 IRB Chair

Point Loma Nazarene University
 3900 Lomaland Dr.
 San Diego, CA 92106
 619.849.2905
 RossOakesMueller@pointloma.edu

Research Project Number:

POINT LOMA NAZARENE UNIVERSITY
Institutional Review Board (IRB)



PROPOSAL COVER SHEET

To be completed for all *research*, defined in 45 CFR 46.102, involving *human subjects*, defined in 45 CFR 46.102, and conducted at Point Loma Nazarene University, by or under the direction of any employee, agent or student of this institution, including research conducted at or in cooperation with another entity. Click *Regulations* at <http://www.hhs.gov/ohrp>.

1. Title of Research: Inquiry into the Communication Process: Nurses' Perception of Nurse/Physician Communication

2a. Principal Investigator (PI): Sarah Joy Schleifer
 (If student, please circle one: Undergraduate, Masters)
 If not affiliated with PLNU, please explain.

2b. Additional Investigators: N/A

2c. Faculty Advisor (if applicable): Jeanne Maiden PhD, RN

2d. PLNU Sponsor (if PI is not PLNU employee or agent): N/A

3. Review Category

Exempt (Complete Section A) by category (See 46.101 on above website.)

Expedited (Complete Section B) by category 7 (See 46.110 on above website.)

Full (Complete Section C)

4. Anticipated Date on which Data Collection will begin: July 1st, 2011

5. If this is a funded project, please name funding source(s).

N/A

6. If this proposed research has been, or will be reviewed by an Institutional Review Board (IRB) elsewhere please name the IRB(s). If applicable, attach a copy of each IRB's recommendations and dated approval.

You must submit this form, all supporting documents and a description of the proposed research, as specified in Section A (for Exempt research), Section B (for Expedited Review) or Section C (for Full Review) *in paper format*. Prior to submission, all proposals require that you read the Guidelines to Professors and require signatures below as necessary.

Researcher (signature), Department	Date
<u>Sarah Joy Schleifer</u>	<u>5/24/2011</u>
Researcher (printed)	Phone or email
<u>Jeanne Maiden</u>	<u>sschleif@pointloma.edu</u>
Faculty Advisor or PLNU Sponsor	Phone or email
(except if P.I. is current PLNU faculty)	<u>jeannemaiden@pointloma.ed</u>

Proposals that are incomplete or lacking signatures will be returned.