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Research Article

THE PERCEPTIONS OF NURSES AND PHYSICIANS ABOUT THEIR PROFESSIONAL RELATIONSHIP WITH EACH OTHER

***Abolfazl Farhadi, Fariba Nik Pey, Shabnam Shafiee, Sadegh Farhadi and Alef Nik Pey**
Department of Nursing, Shirvan Branch, Islamic Azad University, Shirvan, Iran
**Author for Correspondence*

ABSTRACT
Nursing is a profession that establishes various cultural and social communications in the context of work environment. The purpose of this study was to the exploration of nurses and physicians experiences regarding their professional relationship with each other. This study is a qualitative research using phenomenology method eighteen semi-structured interviews were carried out with 9 nurses and 9 physicians. They described their experiences related to professional communication. The interviews were recorded and transcribed and the data were then analyzed using the Colizzii analysis method. Several themes emerged from the data showing the nurses and physicians experiences regarding their professional relationship with each other. In this paper, two major themes of hierarchy and trust is implied. The findings revealed that hierarchy and trust are two important themes in the relationship between doctors and nurses should be considered.

Keywords: *Professional Communication, Nurses, Physicians, Phenomenology*

INTRODUCTION
Webster's Dictionary defines communication as "the imparting or interchange of thoughts, opinions, or information by speech, writing, or signs." It is important to consider that communication is not just verbal in form. One study states that 93 percent of communication is more affected by body language, attitude, and tone, leaving only 7 percent of the meaning and intent based on the actual words said (Allesandra, 1996). Whereas the spoken words contain the crucial content, their meaning can be influenced by the style of delivery, which includes the way speakers stand, speak, and look at a person (JCAHO, 2005). Collaboration in health care is defined as health care professionals assuming complementary roles and cooperatively working together, sharing responsibility for problem-solving and making decisions to formulate and carry out plans for patient care (Fagin, 1992; Baggs, 1998). Collaboration between physicians, nurses, and other health care professionals increases team member's awareness of each other's type of knowledge and skills, leading to continued improvement in decision making (Christensen and Larson, 1993). In today's health care system, delivery processes involve numerous interfaces and patient handoffs among multiple health care practitioners with varying levels of educational and occupational training. During the course of a 4-day hospital stay, a patient may interact with 50 different employees, including physicians, nurses, technicians, and others. Effective clinical practice thus involves many instances where critical information must be accurately communicated. Team collaboration is essential. When health care professionals are not communicating effectively, patient safety is at risk for several reasons: lack of critical information, misinterpretation of information, unclear orders over the telephone, and overlooked changes in status (JCAHO, 2005). Lack of communication creates situations where medical errors can occur. These errors have the potential to cause severe injury or unexpected patient death. Medical errors, especially those caused by a failure to communicate, are a pervasive problem in today's health care organizations.
According to the Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations, JCHAO), if medical errors appeared on the National Center for Health Statistic's list of the top 10 causes of death in the United States, they would rank number 5 ahead of accidents, diabetes, and Alzheimer's disease, as well as AIDS, breast cancer, and gunshot wounds (JCAHO, 2005). The 1999 Institute of Medicine (IOM) report, *To* Err Is Human: Building a Safer Health System, revealed that between 44,000 and 98,000 people die every year in U.S. hospitals because of medical errors (IOM,

2000). Even more disturbing, communication failures are the leading root cause of the sentinel events reported to the Joint Commission from 1995 to 2004. More specifically, the Joint Commission cites communication failures as the leading root cause for medication errors, delays in treatment, and wrong-site surgeries, as well as the second most frequently cited root cause for operative and postoperative events and fatal falls (JCAHO, 2005). Traditional medical education emphasizes the importance of error-free practice, utilizing intense peer pressure to achieve perfection during both diagnosis and treatment. Errors are therefore perceived normatively as an expression of failure. This atmosphere creates an environment that precludes the fair, open discussion of mistakes required if organizational learning is to take place. In the early 1990s, Donald Berwick wrote about patients needing an open communication system instead of experiencing adverse events stemming from communication failures (Berwick, 1992).

Effective teams are characterized by trust, respect, and collaboration. Deming (Deming, 1982) is one of the greatest proponents of teamwork. Teamwork, he believes, is endemic to a system in which all employees are working for the good of a goal, who have a common aim and who work together to achieve that aim. When considering a teamwork model in health care, an interdisciplinary approach should be applied.

Unlike a multidisciplinary approach, in which each team member is responsible only for the activities related to his or her own discipline and formulates separate goals for the patient, an interdisciplinary approach coalesces a joint effort on behalf of the patient with a common goal from all disciplines involved in the care plan. The pooling of specialized services leads to integrated interventions. The plan of care takes into accounts the multiple assessments and treatment regimens, and it packages these services to create an individualized care program that best addresses the needs of the patient. The patient finds that communication is easier with the cohesive team, rather than with numerous professionals who do not know what others are doing to manage the patient (Schmitt, 1982).

It is important to point out that fostering a team collaboration environment may have hurdles to overcome: additional time; perceived loss of autonomy; lack of confidence or trust in decisions of others; clashing perceptions; territorialism and lack of awareness of one provider of the education, knowledge, and skills held by colleagues from other disciplines and professions (Catlett and Halper, 1992). However, most of these hurdles can be overcome with an open attitude and feelings of mutual respect and trust (Flin *et al.*, 2003). Trust has been characterized as a multi-dimensional concept primarily consisting of a cognitive element (grounded on rational and instrumental judgments) and an affective dimension (grounded on relationships and affective bonds generated through interaction, empathy and identification with others) (Gilson, 2003). Trust appears to be necessary where there is uncertainty and a level of risk, be it high, moderate or low, and this element of risk appears to be derived from an individual's uncertainty regarding the motives, intentions and future actions of another on whom the individual is dependent. In the context of health care the evidence suggests the concept seems to embrace confidence in competence (skill and knowledge), as well as whether the trustee is working in the best interests of the trustor (Mishra, 1996). The latter tends to cover honesty, confidentiality and caring, and showing respect whereas the former may include both technical and social/communication skills. Trust relationships are therefore characterized by one party, the trustor, having positive expectations regarding both the competence of the other party, the trustee, and that they will work in their best interests (Hall *et al.*, 2001).

Unfortunately, many health care workers are used to poor communication and teamwork, as a result of a culture of low expectations that has developed in many health care settings. This culture, in which health care workers have come to expect faulty and incomplete exchange of information, leads to errors because even conscientious professionals tend to ignore potential red flags and clinical discrepancies. They view these warning signals as indicators of routine repetitions of poor communication rather than unusual, worrisome indicators (Chassin and Becher, 2002).

Although poor communication can lead to tragic consequences, a review of the literature also shows that effective communication can lead to the following positive outcomes: improved information flow, more effective interventions, improved safety, enhanced employee morale, increased patient and family satisfaction, and decreased lengths of stay (Knaus *et al.*, 1986). Fuss and colleague (Fuss *et al.*, 1998) and

Gittell and others (Gittell *et al.,* 200) show that implementing systems to facilitate team communication can substantially improve quality.

Effective communication among staff encourages effective teamwork and promotes continuity and clarity within the patient care team. At its best, good communication encourages collaboration, fosters teamwork, and helps prevent errors (Ronda *et al.,* 2008). A review of the organizational communication literature shows that a common barrier to effective communication and collaboration is hierarchies (Dansereau and Markham, 1987).

Sutcliff and colleague's research (Sutcliffe *et al.,* 2004) concurs that communication failures in the medical setting arise from vertical hierarchical differences, concerns with upward influence, role conflict, and ambiguity and struggles with interpersonal power and conflict. Communication is likely to be distorted or withheld in situations where there are hierarchical differences between two communicators, particularly when one person is concerned about appearing incompetent, does not want to offend the other, or perceives that the other is not open to communication.

The importance of collaboration between nurses and physicians has been noted by many researchers. It has been shown that collaboration between nurses and physicians increases not only the satisfaction of nurses but also that of physicians. Moreover, some studies suggest that effective nurse–physician collaboration is positively related to the quality of medical care, as reflected in low death rates in intensive care units. Accordingly, intervention programs or certain changes in nursing systems have been proposed to improve nurse–physician communication and collaboration.

Vazirani *et al.,* (2005) report that introducing a nurse practitioner in to each medical team, appointing a hospitalist medical director, and institutionalizing daily multidisciplinary rounds resulted in better collaboration and communication between physicians and nurses as measured by physician's reports (Kyoko *et al.,* 2008).

In health care environments characterized by a hierarchical culture, physicians are at the top of that hierarchy. Consequently, they may feel that the environment is collaborative and that communication is open while nurses and other direct care staff perceive communication problems. Hierarchy differences can come into play and diminish the collaborative interactions necessary to ensure that the proper treatments are delivered appropriately.

When hierarchy differences exist, people on the lower end of the hierarchy tend to be uncomfortable speaking up about problems or concerns. Intimidating behavior by individuals at the top of a hierarchy can hinder communication and give the impression that the individual is unapproachable (Weick, 2002).

In spite of the importance of nurse–physician collaboration, nurse–physician relationships have historically been depicted as hierarchical, with nurses subordinated to physicians. Although some researchers have noted that the quality of nurse–physician relationships has improved in recent decades, there remain many barriers that hinder effective nurse–physician collaboration.

The physician's response pattern showed that physicians feel a greater level of hesitation communicating the potential error with a physician senior to them than with a physician junior to them. Similarly, the nurses showed a greater level of hesitation communicating the potential error with a nurse senior to them. Therefore, both physicians and nurses reported that seniority-based hierarchy affected how comfortable they would be communicating potentially dangerous errors with other staff members. More relevant to the present study, the vignette study revealed that nurses tend to experience a greater level of hesitation when the staff member apparently administering an overdose was described as a physician rather than as a nurse (Kyoko *et al.,* 2002).

Staff who witness poor performance in their peers may be hesitant to speak up because of fear of retaliation or the impression that speaking up will not do any good. Relationships between the individuals providing patient care can have a powerful influence on how and even if important information is communicated.

Research has shown that delays in patient care and recurring problems from unresolved disputes are often the by-product of physician-nurse disagreement (Prescott and Bowen, 1985).

MATERIALS AND METHODS

Methods

Study Design

This study is a qualitative research using phenomenology method eighteen semi-structured interviews were carried out with 9 nurses and 9 physicians. They described their experiences related to professional communication. The interviews were recorded and transcribed and the data were then analyzed using the Colizzii analysis method.

The use of the interview format allowed for the exploration of individual experiences with nurse-physician communication among nurses with varied levels of experience, language skills and demographic characteristics.

Study Population

Our target population was nurses and physicians with at least 5 years experience. . Nurses were eligible for participation if they provided more than 120 hours of direct patient care per month as reported by the facilitie's director of nursing. Physicians were eligible for participation if they provided more than 50 hours per month in the hospital.

Data Collection

Semi-Structured Interviews—Respondents to the questionnaire were asked if they were interested in participating in a semi-structured interview. Of those who expressed interest, we invited a subset to participate in interviews.

Our final sample included 18 (9 nurses and 9 physicians selectively sampled). All participants completed informed consent procedures and had their interview tape recorded and transcribed for analysis. A typical interview lasted about 30-60minutes.

During the interview, a trained interviewer asked the following questions:

"1 - Nature of (literally) is the professional association of nurses and doctors together how?

2 - What factors affecting the relationship between nurses and doctors?"

Data Analysis

Author reviewed all 18 transcripts and proposed a framework for extracting major themes related to nurse-physician communication. Each investigator then read at least3 transcripts and compared the themes in those transcripts with the proposed framework. All the authors met to discuss and revise the framework.

This process continued iteratively until all authors agreed that all themes and dimensions regarding nurse-physician communication had been identified, and that the framework provided a reasonable depiction of the process of communication and factors affecting nurse-physician communication as stated or implied by participants. Finally, each transcript was re-read by 2 authors, who coded comments using the revised framework. Authors also identified exemplary comments and confirmed that the final framework accommodated each important comment related to nurse-physician communication.

The study was reviewed and approved by Board of the school of nursing, Ahwaz Jundishapur University of Medical Sciences.

RESULTS AND DISCUSSION

Results

Nurses and doctors offered numerous examples of difficult nurse-physician communication encounters during the interviews. Thematic analysis of nurse's comments revealed many themes characterizing difficult encounters including: patience, independence / dependence, interaction / non-interaction, the relationship between upstream / under , instrumental relationship , scapegoat , being professional / non-professional , observance / non- Observance with respects, interference / non- interference , responsibility / an responsibility, trust / distrust , personal expectations, hierarchy , disruptive behavior, ethnicity, differences in schedules and professional routines, varying levels of preparation, differences in accountability, complexity of care. In this paper, we expand on two major themes including *hierarchy and trust*.

Hierarchy

Every team needs a manager's job. In the treatment team, physician is the team manager and the physician's expertise and more responsibility he has given more authority as well". "I think the relationship between doctors and nurses have a hierarchy .We cannot let the doctor do anything for the patient".

Trust between Nurses and Physicians

Many doctors do not trust us and think of all the nurses do not have enough education. When a nurse knows a doctor and the doctor knows the nurse and they trust each other, that's the best communication there is going to be. When it's a strange nurse or strange doctors… then I think that's your major barrier to communication."

Conclusion

A review of the organizational communication literature shows that a common barrier to effective communication and collaboration is hierarchies (Knaus *et al.,* 1986). Sutcliff and colleague's research (Gittell *et al.,* 2000) concurs that communication failures in the medical setting arise from vertical hierarchical differences, concerns with upward influence, role conflict, and ambiguity and struggles with interpersonal power and conflict. Communication is likely to be distorted or withheld in situations where there are hierarchical differences between two communicators, particularly when one person is concerned about appearing incompetent, does not want to offend the other, or perceives that the other is not open to communication.

In health care environments characterized by a hierarchical culture, physicians are at the top of that hierarchy. Consequently, they may feel that the environment is collaborative and that communication is open while nurses and other direct care staff perceive communication problems. Hierarchy differences can come into play and diminish the collaborative interactions necessary to ensure that the proper treatments are delivered appropriately. When hierarchy differences exist, people on the lower end of the hierarchy tend to be uncomfortable speaking up about problems or concerns. Intimidating behavior by individuals at the top of a hierarchy can hinder communication and give the impression that the individual is unapproachable (Dansereau and Markham, 1987).

Staff who witness poor performance in their peers may be hesitant to speak up because of fear of retaliation or the impression that speaking up will not do any good. Relationships between the individuals providing patient care can have a powerful influence on how and even if important information is communicated (Knaus *et al.,* 1986).

Within health care, there have been and will continue to be many approaches to professional communication. Unfortunately, the body of evidence is very limited, and the research findings to support professional communication and the relationship with patient safety and quality are not available at this time. There were limited studies that tested specific interventions aimed at changing nurse-physician communication, and there is some evidence that focusing on a doctor-nurse communication may have a positive effect. Health care organizations and providers will be challenged as they seek to improve the effectiveness of professional communication, given all the subtleties of the nurse-physician relationships (Knaus *et al.,* 1986).

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