Indian Journal of Fundamental and Applied Life Sciences ISSN: 2231– 6345 (Online)
An Open Access, Online International Journal Available at www.cibtech.org/sp.ed/jls/2014/03/jls.htm
2014 Vol. 4 (S3), pp. 844-849/Farhadi et al.
Research Article

THE ROLE OF PREPAREDNESS AND SHARING RESPONSIBILITY IN PROFESSIONAL RELATIONSHIP BETWEEN NURSES AND PHYSICIANS

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

ABSTRACT
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. The purpose of this study was to determine the role of preparedness in professional relationship between nurses and physicians. 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 physician's experiences regarding their professional relationship with each other**.** In this paper, two major themes of preparedness and sharing responsibility are 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
Over the years, there have been repeated cries and admonitions for improving nurse-physician communication and questioning why it is so difficult to achieve (Miller, 2001; Kappeli, 1995). Some research has shown that the lack of interpersonal and communication skills of physicians and nurses is associated with errors, inefficiencies in the delivery of care and frustration (Helmreich and Schaefer, 2002). There is evidence, though conflicting, that links better collaboration with better patient outcomes, specifically reduced medication errors (Arford, 2005; Croskerry *et al.*, 2004), reduced risk of inpatient mortality (Baggs *et al.*, 1991; Estabrooks *et al.*, 2005), improved patient satisfaction, 99 and some support for efficiency measures such as shorter hospital length of stay (Zwarenstein and Bryant, 2000; Shortell *et al.*, 1994; Zimmerman *et al.*, 1991, 1993). However, several major reviews and studies found no relationship between nurse-physician collaboration and patient outcomes such as mortality or self-reported health status (Zwarenstein and Bryant, 2000; Zimmerman *et al.*, 1991, 1993). Physician satisfaction is generally not related to perceived increased collaboration; most frequently the evidence links perceived increased collaboration with nurse satisfaction (Van and Cukr, 2000; Boyle and Kochinda, 2004).
Additionally, nurses and physicians view the level of collaboration very differently, with nurses typically perceiving less collaboration and poorer communication than physicians (Kaissi *et al.*, 2003; Baggs *et al.*, 1997). So, even though the descriptive evidence for improved patient outcomes and improved hospital efficiency is conflicting, it does not clearly negate the premise that better communication and collaboration could have an impact on patient outcomes (Ronda *et al.*, 2008). 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 and Schmitt, 1988). 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). 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 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. 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). Effective teams are characterized by trust, respect and collaboration.

Deming 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. Respectful atmosphere, shared responsibility for team success and appropriate balance of member participation for the task at hand are components of successful teamwork.

A study determined that improved teamwork and communication are described by health care workers as among the most important factors in improving clinical effectiveness and job satisfaction (Flin *et al.*, 2003). In a study the largest percentage of comments regarding respects and uses the expertise of nurses, social workers and other non-physician team members came from other health care workers and physicians. They described the need for physicians to respect and work well with all members of the team in order to provide high quality care. A healthcare worker noted that physicians must be ". . . willing to recognize the years of expertise we team members have amongst us and the collective experiences of the group, and tapping into those as a resource for their patient." Health care workers described how involving all members of the team can tap into important sources of information not immediately available to the physician's interactions (JCAHO, 2005).

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 (JCAHO, 2005; Knaus *et al.*, 1986).

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. The fact that most health professionals have at least one characteristic in common, a personal desire to learn, and that they have at least one shared value, to meet the needs of their patients or clients, is a good place to start.

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 (Sutcliffe *et al.*, 2004). Varying levels of preparation one of the common Barriers to interprofessional communication and collaboration (Ronda *et al.*, 2008).

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 variedlevels 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 facilities' 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 DICSUSSION

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 privacy, Interference / non- Interference , responsibility / an responsibility, trust / distrust , personal expectations, hierarchy , disruptive behavior, ethnicity, differences in schedules and professional routines, *preparedness*, sharing responsibility, differences in accountability, complexity of care. In this paper, we expand on two major themes including *preparedness* and sharing responsibility.

***Preparedness*—** "I think if you are calling a physician you should be prepared at least with immediate information. They shouldn't have to wait while you call them back with a set of vitals or something like

that…. I think that's a failing on the nurse's side of things." "A nurse could have all information and must be prepared." "In other words, we should be more prepared." "If you are a expert nurse, surely the doctor kept bragged .because our nurses are not considerable 6scientific, doctors are finding themselves in a higher position." "Scientific gaps between doctors and nurses, is cause of the disrespectation of doctors to nurses." sharing responsibility —"When a doctor, see the nurse good information about patient, trust him."

"Doctors dose not involve us in decision making for the patient." "Treat is teamwork. In this team, doctors and nurses and other sectors such as ... must have worked together." "The relationship between doctors and nurses is a two-way relationship." "I think the relationship between doctor and nurse is an emotional and a friendly working relationship".

Conclusion

It is important for health care organizations to assess possible setups for poor communication and be diligent about offering programs and outlets to help foster team collaboration. 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. 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 (Catlett and Halper, 1992).

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. 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 (Ronda *et al.,* 2008). In a study the largest percentage of comments regarding respects and uses the expertise of nurses, social workers and other non-physician team members came from other health care workers and physicians. They described the need for physicians to respect and work well with all members of the team in order to provide high quality care. A healthcare worker noted that physicians must be ". . . willing to recognize the years of expertise we team members have amongst us and the collective experiences of the group, and tapping into those as a resource for their patient." Health care workers described how involving all members of the team can tap into important sources of information not immediately available to the physician (JCAHO, 2005). Varying levels of preparation one of the common Barriers to interprofessional communication and collaboration (Ronda *et al.,* 2008).

Effective teams are characterized by trust, respect, and collaboration. Deming 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. 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. However, most of these hurdles can be overcome with an open attitude and feelings of mutual respect and trust. A study determined that improved teamwork and communication are described by health care workers as among the most important factors in improving clinical effectiveness and job satisfaction (Flin *et al.,* 2003). 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.

REFERENCES

Arford PH (2005). Nurse-physician communication: an organizational accountability. *Nursing Economics* **23** 72–7. 55. [PubMed]

Baggs JG, Schmitt MH and Mushlin AI *et al.*, (1999). Association between nurse-physician collaboration and patient outcomes in three intensive care units [see comments], *Critical Care Medicine* **27** 1991–8. [PubMed]

Baggs JG, Schmitt MH and Mushlin AI *et al.*, (1997). Nurse-physician collaboration and satisfaction with the decision-making process in three critical care units. *American Journal of Critical Care* **6** 393–9. [PubMed]

Baggs JG and Schmitt MH (1988). Collaboration between nurses and physicians. *Image: Journal of Nursing Scholarship* **20** 145–9. [PubMed]

Boyle DK and Kochinda C (2004). Enhancing collaborative communication of nurse and physician leadership in two intensive care units. *Journal of Nursing Administration* **34** 60–70. [PubMed]

Catlett C and Halper A (1992). Team approaches: working together to improve quality. In: *Quality Improvement Digest*, edited by Frattalie C (Rockville, MD: American Speech-Language-Hearing Association) 1.

Chassin MR and Becher EC (2002). The wrong patient. *Annals of Internal Medicine* **136**(11) 26–33. [PubMed]

Christensen C and Larson JR (1993). Collaborative medical decision making. *Medical Decision Making* **13** 339–46. [PubMed]

Croskerry P, Shapiro M and Campbell S *et al.*, (2004). Profiles in patient safety: medication errors in the emergency department. *Academic Emergency Medicine* **11** 289–99. [PubMed]

Estabrooks CA, Midodzi WK and Cummings GG *et al.*, (2005). The impact of hospital nursing characteristics on 30-day mortality. *Journal of Nursing Research* **54** 74–84. [PubMed]

Fagin CM (1992). Collaboration between nurses and physicians: no longer a choice. *Nursing and Health Care* **13**(7) 354–62.

Flin R, Fletcher G and McGeorge P *et al.*, (2003). Anaesthetist's attitudes to teamwork and safety. *Anaesthesia* **58**(3) 233–42. [PubMed]

Helmreich RL and Schaefer H (2002). Team performance in the operating room. In: *Human Errors in Medicine*, edited by Bogner MS (Hillsdale, NJ: Lawrence Erlbaum) 225–54.

Joint Commission on Accreditation of Healthcare Organizations (2005). The Joint Commission guide to improving staff communication. Oakbrook Terrace, IL: Joint Commission Resources.

Kaissi A, Johnson T and Kirschbaum MS (2003). Measuring teamwork and patient safety attitudes of high-risk areas. *Nursing Economics* **21** 211–8. 207. [PubMed]

Kappeli S (1995). Interprofessional cooperation: why is partnership so difficult? *Patient Education and Counseling Journal* **26** 251–6. [PubMed]

Knaus WA, Draper EA and Wagner DP *et al.*, (1986). An evaluation of outcome from intensive care in major medical centers. *Annals of Internal Medicine* **104** 410–8. [PubMed]

Miller PA (2001). Nurse-physician collaboration in an intensive care unit. *American Journal of Critical Care* **10** 341–50. [PubMed]

Ronda G Hughes (2008). Rockville, Agency for Healthcare Research and Quality (US). Patient Safety and Quality an Evidence-Based Handbook for Nurses, Publication No: 08-0043.

Schmitt MH (1982). Working together in health care teams. In: *Life Cycle Group Work in Nursing*, edited by Janosik EH, Phipps LB (Monterey, CA: Wadsworth Health Sciences Division) 179–98.
Shortell SM, Zimmerman JE and Rousseau DM *et al.*, (1994). The performance of intensive care units: does good management make a difference? *Medical Care* **32** 508–25. [PubMed]
Sutcliffe K, Lewton E and Rosenthal M (2004). Communication failures: an insidious contributor to medical mishaps. *Academic Medicine* **79** 186–194. [PubMed]
Van Ess Coeling H and Cukr PL (2000). Communication styles that promote perceptions of collaboration, quality, and nurse satisfaction. *Journal of Nursing Care Quality* **14** 63–74. [PubMed]
Zimmerman JE, Knaus WA and Draper EA *et al.*, (1991). Organizational correlates with ICU efficiency and effectiveness. *Critical Care Medicine* **19**(supplement) S35.
Zimmerman JE, Shortell SM and Rousseau DM *et al.*, (1993). Improving intensive care: observations based on organizational case studies in nine intensive care units: a prospective, multicenter study [see comments], *Critical Care Medicine* **21** 1443–51. [PubMed]
Zwarenstein M and Bryant W (2000). Interventions to promote collaboration between nurses and doctors. *Cochrane Database of Systematic Reviews* CD000072. [PubMed]