Perceptions of Effective and Ineffective Nurse–Physician Communication in Hospitals

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PROBLEM. Nurse–physician communication affects patient safety. Such communication has been well studied using a variety of survey and observational methods; however, missing from the literature is an investigation of what constitutes effective and ineffective interprofessional communication from the perspective of the professionals involved. The purpose of this study was to explore nurse and physician perceptions of effective and ineffective communication between the two professions.

METHODS. Using focus group methodology, we asked nurses and physicians with at least 5 years’ acute care hospital experience to reflect on effective and ineffective interprofessional communication and to provide examples. Three focus groups were held with 6 participants each (total sample 18). Sessions were audio recorded and transcribed verbatim. Transcripts were coded into categories of effective and ineffective communication.

FINDINGS. The following themes were found. For effective communication: 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 the unique role. For ineffective communication: making someone less than, dependence on electronic systems, and linguistic and cultural barriers.

CONCLUSION. These themes may be useful in designing learning activities to promote effective interprofessional communication.

Search terms: Interprofessional care, nurse–physician communication, safety

Introduction

Very little nursing or medical education addresses interprofessional communication, yet nurses and physicians are expected to deliver safe, high-quality health care as member of a team. Such care, particularly in hospitals, depends greatly on the ability of health professionals to communicate effectively and efficiently with each other (The Joint Commission, 2009; Lingard et al., 2006). The preeminence of communication is supported by data showing an association between poor communication and medical errors (Alvarez & Coiera, 2006; Gandhi, 2005; Gawande, Zinner, Studdert, & Brennan, 2003; Sutcliffe, Lewton, & Rosenthal, 2004) that result in significant patient mortality (Consumers Union, 2009; Kohn, Corrigan, & Donaldson, 2000). In fact, the Joint Commission reports that sentinel events can consistently be traced back to problems with communication (The Joint Commission, 2008).

Nurse–physician communication is particularly important, given the interdependence of the two professions and the primary role they play in safe, quality patient care. The well-entrenched hierarchical authority structure and sexism (even though women make up over one-third of the physician workforce) complicate nurse–physician communication. Unfortunately, disruptive communication occurs with alarming frequency in both nurses and physicians, and both sets of
professionals agree that such ways of communicating decrease patient safety (Rosenstein & O’Daniel, 2008).

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The extant literature is full of reports detailing the deleterious effects of poor interprofessional communication (mostly between nurses and physicians) (Bokhour, 2006; Burd et al., 2002; Dechairo-Marino, Jordan-Marsh, Traiger, & Saulo, 2001; Simpson, James, & Knox, 2006) and suggesting mechanisms to enhance interprofessional communication (Lyndon, 2006; McCallin, 2003; McKeon, Oswaks, & Cunningham, 2006). However, much of the research related to interprofessional communication, and patient safety has been narrow in scope and related to highly specific contexts (hand-offs, types of charting, rounds) (Varpio, Hall, Lingard, & Schryer, 2008). Although this has aided our understanding of how and when communication fails, what is missing from the literature is an investigation of what constitutes effective and ineffective interprofessional communication from the perspective of the professionals involved. Analyzing such perspectives may illuminate types of communication or communication strategies that could be taught and utilized to enhance interprofessional communication for increased patient safety. The purpose of this study was to explore nurse and physician perceptions of effective and ineffective communication between the two professions.

Methods

Focus group methodology was used. This qualitative research technique is useful in obtaining data about feelings and opinions of small groups of participants about a given problem, experience, or other phenomenon (Basche, 1987). Focus groups are designed to obtain participants’ perceptions regarding a defined area of interest in a permissive, nonthreatening environment (Krueger, 1994). The group interaction stimulates discussion that provides data and insights that do not occur with other data collection techniques (McDaniel & Bach, 1994). The study was approved by the university institutional review board.

Setting and Sample

The study was conducted at a large, urban university health science center in the United States. Participant inclusion criteria were registered nurses or physicians who had practiced in their clinical discipline for a minimum of 5 years in a hospital setting. This time-in-practice requirement was to ensure that participants had been exposed to a variety of communication styles and experienced significant successes and failures with various techniques. The assumption here is that at least 5 years of experience provided the insight needed to determine effective and ineffective interprofessional communication practices.

Three different focus group sessions were conducted. Each group consisted of six participants. One session included only nurses, another only physicians, and a third was mixed. The makeup of the groups was based on the assumption that nurses and physicians may have different ideas about what constitutes effective and ineffective interprofessional communication. As such, the single-discipline groups may offer insight into such phenomena because respondents may not feel the need for “political correctness” in front of their colleagues from the other discipline. Also, the combined group may reflect
“negotiated” ideas that result from the group dynamic of individuals from different professional perspectives. In sum, the different group compositions were meant to add to the richness and diversity of the data in order to gather the most comprehensive information regarding effective and ineffective interprofessional communication.

Procedure

We recruited participants for the focus groups through the university mass email distribution that reaches hundreds of practicing nurses and physicians. The email explained the purpose of the focus group and directed interested participants to contact a member of the investigative team. Individuals who met the eligibility criterion were invited to participate, and recruitment ceased after nine nurses and nine physicians accepted the invitation to participate.

Via email, prefocus group questionnaires were distributed to all participants to collect demographic and other descriptive information on the sample. In addition, the focus group guide that would be used during the actual focus group session was distributed so that participants could give forethought to the two scenarios. See Table 1 for the focus group guide.

Each of the three focus group sessions lasted 60 min and was facilitated by a different member of the investigative team (two doctorally prepared nurses and one physician) who were members of the university faculty. Facilitators were trained to follow a specific protocol that included introductory remarks, presentation of the two scenarios, and verification of information provided. While using different facilitators for each group introduced variance into the design, it also had the potential to enrich the data by bringing a different style and perspective to each group. Sessions were audio recorded for transcription to text. For participants’ convenience, all sessions took place at the noon hour in a hospital conference room, and lunch was served. Each participant received a $50 gift card to the university bookstore to compensate for their time and effort.

At the start of each focus group session, the facilitator gave a brief overview of the objectives and instructions regarding the process of the session. The facilitator proceeded to ask the open-ended questions previously distributed to participants. Clarification of responses was sought, and additional information was

Table 1. Focus Group Guide

| Instructions | We are asking that you reflect on your clinical experiences when participating. Our plan is that everyone will get an opportunity to speak. Our desire is to keep the proceedings flexible and informal. You should feel free to comment on others’ answers by agreeing, disagreeing, elaborating, providing additional examples, providing counter examples, etc. |
| Scenario 1 | Think of an actual clinical situation in which interprofessional communication (verbal and nonverbal) was key to the outcome of the situation. For example, situations that were on the edge of going well or poorly and communication tipped the outcome in a negative or positive direction. Briefly describe the situation. In what ways was communication critical to the outcome? Provide explicit examples. Provide as much detail of the types of communication or approaches to communication that work well or are problematic. |
| Scenario 2 | Think of two health professional colleagues (from your profession or another), one an exceptionally good interprofessional communicator and the other a poor interprofessional communicator. Do not name or identify these persons. What does each do consistently that makes him or her exceptionally good or poor at interprofessional communication? Provide explicit examples. |

Focus group guide was distributed to participants prior to the focus group session for reflection and used by the group facilitator to conduct the session.
requested as deemed necessary by the facilitator. The facilitator remained neutral and nonjudgmental throughout the session. The facilitator ended the sessions by summarizing the highlights of discussion and seeking verification from the participants (McDaniel & Bach, 1994).

Data Analysis

Audio recordings of the focus groups were transcribed verbatim. Two members of the investigative team (both of whom were present at all focus group sessions) read and reread the transcripts and developed individual preliminary thematic categories of effective and ineffective interprofessional communication. The two investigators developed a list of thematic categories along with supporting quotes for each theme. In order to be included, evidence of the theme had to occur across all focus groups and both investigators had to agree on the theme and its supporting evidence. The themes were reviewed and discussed at an investigator team meeting (four investigators) where themes were further refined and clarified.

Results

The characteristics of the sample are displayed in Table 2. Given that scheduling conflicts existed for many interested participants, multiple invitations to participate were declined.

Five themes were identified that characterized effective communication in the hospital setting, and three themes were identified that characterized ineffective communication. The themes are summarized in Table 3.

Table 2. Participant Characteristics

<table>
<thead>
<tr>
<th>Profession</th>
<th>Characteristic</th>
<th>Gender</th>
<th>Mean (SD) age</th>
<th>Mean (SD) years in practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td>Gender</td>
<td>9 females</td>
<td>46.72 (9.29) years</td>
<td>20.82 (10.47) years</td>
</tr>
<tr>
<td>Medicine</td>
<td>Gender</td>
<td>1 female, 8 males</td>
<td>39.88 (13.92) years</td>
<td>13 (11.7) years</td>
</tr>
</tbody>
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The total sample size was 18 with characteristics as indicated.

Table 3. Effective and Ineffective Interprofessional Communication Themes

<table>
<thead>
<tr>
<th>Effective communication</th>
<th>Clarity and precision of message that relies on verification</th>
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<td></td>
<td>Collaborative problem solving</td>
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<td>Calm and supportive demeanor under stress</td>
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<td>Maintenance of mutual respect</td>
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<td>Authentic understanding of the unique role</td>
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<td>Ineffective communication</td>
<td>Making someone less than (derision)</td>
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<td></td>
<td>Dependence on electronic systems</td>
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<td>Linguistic and cultural barriers</td>
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Results of thematic analysis of interprofessional focus groups.

Effective Communication

Clarity and precision of message that relies on verification. The most common theme expressed by participants was a need for straightforward unambiguous communication. For example, “I think you have got to be... clear, and time is of the essence” and “I think being clear and concise tells me what you want the first time.” Effective communication was enhanced when participants were confident that what was being heard or said was accurate. Accuracy seemed to rely on verification and confirmation. For example, “… the nurse or physician sort of reiterates the important points in the care plan especially in... ICU...” Also,
The most common theme expressed by participants was a need for straightforward unambiguous communication.

We usually try to discharge in the morning but with this particular patient we did not end up... putting in a [discharge] order until late afternoon because her tests were pending. But I was not sure if... the resident was communicating with the rest of the ancillary healthcare staff and head nurse, so I actually called in the afternoon, I had a gut feeling, and I called and I said hey, so is the patient going home? Yeah, yeah, yeah. The patient is going home. Fine. I did not follow up any more than that. I just assumed that it would happen. It turns out that the patient actually never went home and what happened was the nurse apparently did not know the patient was going home. The nursing staff did not know. They thought we had cancelled the discharge. I called the nursing supervisor and asked what do you think happened? What was the reason? I got a lot of discussion that occurred over what might have been such a simple thing as confirming with the nurses the patient is going home, not having to have the patient sleeping in a hotel hospital for the night. It ended up putting a lot of people into kind of a foul mood over the whole thing.

Collaborative problem solving. Participants felt that effective communication included coming together to problem solve as a team. For example,

There is so much information that they are providing and this is really helping and it became a new way of being and so beneficial and helped on both sides. Instead of seeing it as “us versus them.” It was the “we as a team.”

Also, “... teamwork is probably one of the greatest means of cutting down on mistakes and having a positive attitude.” This was accomplished by efforts to make sure that all were “on the same page” and that understanding was the same for all. For example, “We now have the same baseline so that... we are not grading things differently.” “So I think if we are on the same page... ineffectual communication will be minimized.” “... having the nurse or physician... understand the plan and be on the same page.” Also,

A nurse calls and says X has a fever and he does not have a Tylenol order and in fact what [she] does not need is a Tylenol order. What you need is a discussion examining why he has the fever. What she can identify that is wrong is the fever and what she is really saying is that he has changed, something is different. Let us look at this guy together but what you get is I need a Tylenol order and if the doctor then responds to that by saying... here is your Tylenol order then everybody has missed the whole thing.

Participants highly valued members of the other profession seeking them out for advice. There was consensus that patients benefited when both professions sought each other out for routine and complex decision making. For example,

... the best kinds of communications were the nurses who would sit down and say to me, “I want you to explain to me why you wrote these orders.” I remember very clearly somebody saying to me, “wait a minute, you have not been on this floor before. I do not know you.”

I think that what contributes to good communication is when a nurse says to me, “I do not like what I am seeing or I am seeing this. What do you think is happening? Why do you think this is going on?”

If the resident asks questions... they talk to us. They ask for our guidance. What do you think? They respect our opinion...
Calm and supportive demeanor under stress. A calm and supportive demeanor emerged as an integral part of effective communication for participants. This seemed particularly important in high-stress and emergency situations. Many participants mentioned the need for calm communication that included attention to a collegial tone and normal volume. For example, “And it looked like we knew we were not going to be able to have a positive outcome in this situation but the doctor was calm.” “I think sometimes even with the tone you know if there are cultural differences the urgency of a situation may be misunderstood.”

Participants also expressed that effective communication included showing support and appreciation. For example, “It is important to let the other staff know that they have indeed done what was expected of them and provide positive reinforcement.”

Maintenance of mutual respect. Effective communication was considered respectful. Respect for one another was tied to the establishment of a relationship. For example, “I think a good relationship between the communicator and the receiver.” “Good communication would be enhanced by that nurse having a good relationship with the physician.”

The theme also included the idea that trust was important to effective communication. Patients were served best when the members of the profession could rely on each other. For example,

When I was an intern I got taken aside by my attending . . . who said the nurses are afraid of you. How can they be afraid of me? Well you are sarcastic. Well that is my personality and he said something which is true and very important which is they are not here for your personality. They have to be able to talk to you about what they are seeing. If they are afraid that you are going to snap at them they will not be willing to tell you if they are not sure about something. The point of communication is that they will talk to you. It is not so that you can express your sense of humor and that was probably the most important thing anybody told me in supervision through my whole life.

We find because we know the same kids . . . if one of us says to the other . . . “does not this kid remind you of X?” and then we can figure out what it is that is bringing that to our minds and we usually come to the right place.

Authentic understanding of the unique professional role. An authentic understanding of what each professional uniquely provides in terms of patient care was seen as an important factor in effective communication. Nurses were particularly vocal about how lack of understanding of their unique professional role led to communication difficulties. For example, “I think one of the problems is that most doctors have no idea what nurses actually do and they think that what they are doing is carrying out orders and treatments and giving medications.” “I think that where I find the poorest communication is with physicians that don’t understand the role of the nurse.” “I think a lot of it is lack of insight into our role.”

An authentic understanding of what each professional uniquely provides in terms of patient care was seen as an important factor in effective communication. Nurses were particularly vocal about how lack of understanding of their unique professional role led to communication difficulties.
However, physicians also recognized that either they or their colleagues did not understand the full scope of professional nursing practice. They acknowledged that recognizing unique roles and clarifying who is doing what and why contributes to effective communication. For example, “The other thing that I have seen a positive outcome in is recognizing each other’s strengths and what you bring to the table.” “These are the things that I am going to be doing and this is my role and this is what you are supposed to do.”

Ineffective Communication

Making someone less than (derision). Participants clearly expressed that derision contributed to ineffective communication. Often this included humiliating colleagues and making them feel incompetent. For example, “I looked at the baby and obviously I did not know anything and I did not do anything and the next morning she said to me that the baby died because you did not call your senior soon enough.” “He said in the presence of the patient, ‘It is amazing on this floor; the nurses don’t know what they are doing.’”

These tactics resulted in making members of one profession feel less than their colleagues in the other profession. Bullying and intimidation were also commonly used tactics. For example, “It came across as panic and bullying and ‘do this’ and ‘do that’ instead of a team and let’s get together in one room. . . . [and say] This is what is going on.” “When he came back on the unit, he was very upset with her and told her that she can’t be paging him all the time for something that is not important.”

Dependence on electronic systems. Many times, participants credited communication problems with a dependence on electronic information systems that are supposed to support efficiency and enhance safety. One nurse commented,

... electronic medical record[s] ... put physicians in this sort of fantasy. I had expected things to happen because it was ... in the computer, but it goes a long way to have verbal communication and also follow up on the things that had happened.

Specific examples of reliance on electronic information systems were identified. A physician said,

I ordered it for earlier and did not tell the nurse I just sort of put it in the computer and assumed it would get done ... but I did not tell the nurse; I assumed that it would print up and she would get it . . . and about four or five hours later she asked me . . . “you wanted blood?”

Participants felt that electronic communication, in many instances, had taken the place of face-to-face dialogue. There was consensus that this was troublesome because it resulted in incomplete or fragmented communication that often failed to reach the sender in a timely manner. For example, “Computers do their part, e-mails, phone calls, but actually having people in the room in real time processing all of this is invaluable.”

Linguistic and cultural barriers. A final ineffective communication theme concerned miscommunication attributed to differences in language. Multiple participants mentioned poor communication with individuals for whom English was not their first language. In these instances, it appears as though the intended message was not received. For example,

I have noticed . . . there is a language barrier . . . their first language is not English and so communication . . . has been an issue at times . . . if there is a way . . . to make sure they are able to communicate in English with their physicians that would help even the same the other way around as well.

Or “...in the past... it is physicians or nurses having a language barrier.” “...that patient had a bad outcome based on that... the nurse did not
understand what the question was. . . English was not her first language.”

Participants also pointed out that differences in culture contributed to ineffective communication. For example, “. . . language barrier not only with words though. I think sometimes even with the tone. . . if there are cultural differences the urgency of a situation may be misunderstood so in that sense it is also . . . a barrier.” Or

. . . more than half of our nurses are Asian and I know we are generalized as submissive and subservient and then we also have a doctor group that is very diverse, too. They come from the Middle East and India. Sometimes I wonder with all the cultural diversity that is going on, a lack of training and lack of communication skills and you put that all together in a very stressful place like this, sometimes I wonder if that has a lot of bearing with how we deal with each other and that we are not understanding each other, not just work-wise and role-wise, but from where we came from and how we were raised. . . . The things that I see, sometimes, I stop and I say, “I wonder if he would have said that to her or to me if I were Caucasian.”

Discussion

This study explored perceptions of effective and ineffective interprofessional communication in hospitals from the perspective of practicing nurses and physicians. The majority of the extant literature on interprofessional communication is descriptive in nature and uses observational or survey methodology (Alvarez & Coiera, 2006). This study adds to the growing knowledge base related to interprofessional communication by using a qualitative focus group methodology whereby professionals offered rich descriptions of personal experiences with communication successes and problems.

Many of the themes validated previously supported evidence. The need for clear, precise communication that includes feedback mechanisms has been identified as contributing to safety in the military (Alonso et al., 2006) and the aviation industry (Helmreich, 2000). Likewise, recent guidelines for enhancing teamwork in health care recommend supporting precise and accurate communication through a closed-loop communication protocol, which means ensuring that information sent was received and interpreted correctly (Salas, Wilson, Murphy, King, & Salisbury, 2008).

Additionally, collaborative problem solving was seen as effective communication. This supports the vast amount of evidence that suggests interprofessional teamwork is an essential component of safe, quality care (Salas et al., 2008). In fact, the collective knowledge and situation awareness of members of an interprofessional team exemplified through shared problem solving is necessary for patient safety (Cook, Salas, Cannon-Bowers, & Stout, 2000; Salas et al.).

Our data suggest that such teamwork is highly prized by both nurses and physicians. Members of each profession expressed how patients benefited when team members came together to compare patient data and problem solve. This idea is supported by earlier work that suggests a link between nurse-physician collaboration and positive patient outcomes (Zwarenstein & Reeves, 2006).

Establishment of a relationship was seen as almost a precursor to effective communication. That is, participants had to feel comfortable with each other in order to communicate effectively. Relationships that were based on respect and trust were seen as the ones that most promoted quality care. In this respect, our participants felt that the ability to communicate effectively grew over time, noting that members of one profession had to “prove” themselves to members of the other and “earn” their respect. One method to develop deeper interprofessional relationships may be to implement more frequent and comprehensive interdisciplinary rounds whereby nurses and physicians really get to know each other and their respective perspectives (Chapman, 2009).
Nurses expressed frustration that physicians did not understand the independent nature of their practice or the scope of their practice. Nurses expressed their disappointment in being purveyors of tasks rather than professionals. This complicates communication in many ways. It would be difficult for communication to be perceived as respectful if it was not based on an authentic understanding of what one brings to the situation. In addition, true collaboration would not be possible if physicians did not understand what nurses could contribute to problem solving or clinical decision making. This profession-centric thinking is a construed and preferred view of the world that is most likely developed and reinforced through health profession education (Pecukonis, Doyle, & Bliss, 2008). Given that we educate health professions in silos, it is not surprising that they graduate and enter practice not understanding each other’s unique perspectives and unable to communicate effectively with each other. Developing and implementing high-quality interprofessional education pre- and post-licensure may enhance each profession’s understanding of the other.

In terms of ineffective communication, our data support the deleterious effect of derision on communication. Almost all participants could recall a time when they felt humiliated at the hands of a member of the other profession. This finding supports previous research that indicated that the majority of nurses and physicians have experienced or witnessed such disruptive behavior in members of both professions (Grenny, 2009; Rosenstein & O’Daniel, 2008). The type of disruptive behavior typified by derisive communication has been associated with errors, compromises in safety and quality, and patient mortality (Rosenstein & O’Daniel).

Some evidence supports that electronic communication mechanisms such as computerized order entry may enhance quality care and patient safety; however, such evidence is far from conclusive, with some data supporting our participants’ perception that errors may occur as a result of electronic communication (Eslami, de Keizer, & Abu-Hanna, 2008; Wolfstadt et al., 2008; Yu et al., 2009). Participants indicated that reliance on electronic communication was problematic. Most often, the problems occurred because the messages were not received. Participants felt that communication would be improved if electronic communication, especially that which is urgent, is followed up with verbal contact. Such a tactic is in line with the need for communication to be clear with mechanisms for verification.

We collected our data in a large urban medical center with a high percentage of nurses and physicians from countries outside the United States (Philippines, China, Middle Eastern countries, etc.). In every group, participants spoke about not being able to understand colleagues because of poor language skills or difficult accents. Furthermore, participants pointed to adverse patient outcomes because they were not understood, which they attributed to lack of language skill on behalf of the receiver. Others attributed communication problems not as much to language barriers but rather to cultural barriers, including attributing particular stereotypical traits to others based on ethnicity. While much work has been done related to the effect of language and culture on the provider–patient relationship, we found no research that investigated these phenomena in the context of interprofessional relationships.

Limitations

The study presents several limitations. While viewing the questionnaire prior to the focus group session enabled forethought and reflection, it may also have yielded scripted and socially desirable responses. Even though the use of multiple facilitators could have added to the richness of the data, it could also decrease reliability across groups. The sample size was small and most likely not representative of most institutions.

Conclusion

The results of this qualitative study are not meant to be generalized beyond the particular sample and

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setting. However, awareness of the themes could be a good starting point for encouraging nurses and physicians to reflect on their own contributions to effective and ineffective communication. Additionally, given that interprofessional education is a key strategy to improve quality care and patient safety, the themes could be used to design learning activities for nursing and medical students, including discussions, simulations, and role playing. Future research should attempt to verify these themes and evaluate strategies to increase effective interprofessional communication and decrease ineffective interprofessional communication.

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