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NURSE-TO-PHYSICIAN COMMUNICATIONS: **CONNECTING FOR SAFETY**

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Nurse-to-Physician Communications: Connecting for Safety

► By Diane W. Shannon, MD, MPH; and Leigh Ann Myers, RN, MSN



Ms. Jones, a 52-year old real estate agent, pulls into the hospital parking garage and after some delay, finds a free space. She hurries to the elevator, knowing that her 85-year old father, Mr. Kelley, is eager to get home after his three-day hospitalization for an exacerbation of chronic heart failure. She is also acutely aware of a walk-through scheduled with a client in two hours. She arrives at her father's room to find him dressed with his belongings packed. Greeting him she learns that his nurse is awaiting her arrival to review the discharge instructions.

Ms. Jones rings the nurses' station. The unit secretary notifies the nurse, who arrives a few minutes later. The nurse, Kathy Little, begins reviewing the discharge instructions. She is in the midst of reviewing Mr. Kelley's medications when the unit secretary pages her. She rushes out, explaining that she needs to get a discharge order from Mr. Kelley's physician, Dr. Greene, before he can leave.

Kathy returns several minutes later. Ms. Jones asks anxiously, "Is there a problem?" Kathy replies, "It turns out Dr. Greene is on vacation. The schedule was wrong. I have a call in to Dr. Gattley. I'm sure he'll call back soon."

Kathy completes the discharge instructions. The doctor has not yet replied 15 minutes later. "I'll page him again." Kathy says, leaving the room. Another twenty minutes pass. Mr. Kelley begins to become frustrated with the delay, loudly complaining to his

daughter and nearby staff. Ms. Jones is worried about the effect of the stress on him and concerned that the delay will require her to cancel her client appointment. She rings the call button. Kathy enters, apologizing for the delay. "Dr. Gattley didn't call back. The hospitalist on call will be here soon." "Please ask the doctor to hurry," implores Ms. Jones.

Twenty minutes later, Dr. Weston enters. Mr. Kelley complains to the physician about the delay. His daughter admonishes him to calm down. "You don't want to wind up back here again because of getting so upset." Ms. Jones asks about a discrepancy between the medication instructions from Dr. Weston and the list Kathy provided. Without comparing lists, the physician rebuffs her concerns with, "The nurse made a mistake. Use my list." Kathy's face reddens at the comment but she remains silent. Helping her father into the car 30 minutes later, Ms. Jones realizes that she cannot make her appointment on time and calls to cancel.

Ten days later, Mr. Kelley is re-admitted for a recurrence. In the ED, the admitting physician discovers that due to the inconsistency between staff instructions, Mr. Kelley failed to restart an oral diuretic.

Later, Ms. Jones writes a letter of complaint to the hospital CEO. The chief of staff investigates the incident. He learns that the unit secretary had referred to a paper-based call schedule that was outdated. Dr. Gattley failed to respond because another nurse on the unit had called about a different patient and he had called her back, not realizing that the two nurses were calling about different patients. Dr. Weston had failed to complete the prerequisite medication reconciliation process and thus overlooked the need to restart the diuretic the patient had taken prior to admission.

When asked about the incident, Kathy reports feeling frustrated at the time spent trying to contact physicians for discharge orders and the disrespectful manner of communication from Dr. Weston. The physicians describe their dissatisfaction with the inefficiency of the communication and discharge process. Ms. Jones describes her frustration about the added stress for her father and the medication error that subjected him to a second hospitalization. She is also upset that the delay tarnished her professional reputation with her client.

Health system reform has placed a significant focus on improved care coordination, which requires effective communication among

healthcare providers. Unfortunately, ineffective communication between providers is commonplace. A Toronto study of healthcare professionals in the OR found that 30 percent of "procedurally relevant exchanges" involved communication failures such as the absence of a key team member during the exchange or transfer of inaccurate information (Lingard, et al., 2004).

Disconnects in communication between healthcare providers have been clearly linked to adverse patient outcomes. A classic study of 13 ICUs across the country found that patients cared for by less collaborative nurses and physicians had a significantly higher mortality rate than those with providers who were more collaborative (Knaus, Draper, Wagner & Zimmerman, 1986).

In addition, research has shown that communication gaps and errors often underlie investigated events of patient harm. Of the 1,243 sentinel events reported to the Joint Commission in 2011, communication problems were the third most common contributing factor, identified in 60 percent of reported events (Joint Commission, n.d.).

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which were inefficiency, team tension, and delay (Lingard, et al., 2004).

Although some aspects of inter-provider communication have been identified and addressed, such as the need for standardized communication and improved teamwork skills in obstetrical settings and the OR, ineffective nurse-physician communication remains underappreciated and insufficiently addressed. A 2010 literature search on the topic of nurse-physician communication identified only 25 research studies in the acute-care setting published since 1992 (Manojlovich, 2010).

As a nurse and a physician who left clinical care to better understand and address the underlying deficiencies in the care system, we feel strongly that communication between nurses and physicians can and must be improved. We personally experienced the confusion of interfacing with healthcare professionals who had different perspectives, languages, and priorities. We witnessed multiple occasions in which simple misunderstandings or failures to communicate resulted in harm to patients or flared into tension between staff members. We experienced the frustration of communication processes that relied on the short-term memory of stressed individuals and were based on unreliable, antiquated systems for contact. We believe that poor nurse-physician communication has a substantial negative effect on patient safety, as well as the patient experience of care, nurse satisfaction, physician satisfaction, care quality, and non-clinical outcomes such as additional costs associated with unnecessary readmissions, duplicative testing, and other forms of waste and inefficiency.

In this article, we will review the underlying causes of ineffective nurse-physician communication and highlight currently available solutions. In this era of increasing pressure to improve efficiency and constrain cost escalations in healthcare, upholding patient safety will require more focused attention on an overlooked source of inefficiency and error: the routine communication between nurses and physicians, those frontline healthcare professionals who deliver care on a daily basis.

CAUSES OF THE COMMUNICATION DISCONNECT

Healthcare is by its very nature complicated, dynamic, and unpredictable. Patient needs often arise unexpectedly, requiring unplanned communication among busy healthcare pro-

viders. Professionals from a number of different disciplines frequently care for a patient at different times of day, sometimes at different locations, which limits the opportunities for face-to-face or other synchronous communication. In addition, several factors make effective communication between nurses and physicians particularly difficult to achieve.

Historic Tension and Hierarchy

The relationship between nurses and physicians has been characterized historically by hierarchy, power differential, and avoidance of open disagreement (Stein, 1967). Today, fundamental problems persist in many healthcare environments, including disruptive behavior by physicians, dismissive attitudes about nurses, and power and gender issues (Sirota 2007). Patient safety experts have pointed out the dangers that are associated with strict hierarchies in which individuals refrain from communicating concerns to those higher in the decision-making structure (Sexton, et al., 2000; Walton, 2006). As health reform pushes for greater accountability across the care continuum, healthcare providers will need to collaborate and function effectively on teams.

Divergent Views, Learned Communication Style, and Terminology

Professional education for nurses and physicians sets the stage for divergent views and perspectives. Nurses and physicians are trained to define well-being and its attainment differently (Arford, 2005). They are also taught to communicate very differently. Nurses are trained to relate information in narratives, whereas physicians are trained to provide the most concise, top-level communiqué possible. The fact that nurses and physicians are trained to communicate so differently can be a source of ongoing friction (Joint Commission, 2009).

In addition, nurses and physicians are trained under distinctly separate care models, which sometimes involve the use of different terminology to describe similar events. One of the key lessons learned by participants of the Idealized Design of Perinatal Care project convened by the Institute for Healthcare Improvement was that physicians and nurses used different criteria, developed by their respective professional organizations, to assess and describe fetal monitoring patterns (Cherouny, et al., 2005). An essential first step was developing a common language for describing the events.

Existing Inefficient Communication Processes

The existing infrastructure for communication between nurses and physicians is often inefficient, leading to reduced staff productivity, frustration, and reduced staff satisfaction. In many organizations, nurses are challenged to identify which physician to contact and the preferred means with which to do so. One of the most common barriers to communication with physicians cited by a sample of 375 nurses working in long-term care facilities in Connecticut was difficulty reaching physicians



and receiving call backs from them (Tjia et al., 2009). In the current system, nurses often must hunt for an on-call list, place a call, and wait for a call back. In the meantime, they may be called away from the nurses' station to attend to patient needs or other tasks. In addition, if a manual on-call list is used, the nurse may mistakenly contact a physician who is not currently responsible for coverage. If there is a significant delay or a failure to respond, he or she may escalate the problem to the nurse manager, who may intervene with a call to another physician or a department chair, but in the interim the patient experiences a delay in care—which may result in worsening of his or her clinical condition, staff frustration, and reduced productivity.

A study of communication between nurses and physicians in an urban hospital found that approximately 40 percent of the time that nurses spent communicating with physicians was “problematic time,” in which they searched for contact information or attempted, but failed, to communicate with the correct provider (Dingley, et al., 2008). Ultimately, these inefficient processes can hinder collegial and collaborative relationships between physicians and nurses.

SOLUTIONS TO BRING NURSES AND PHYSICIANS TOGETHER

We believe that a three-pronged strategy is needed to improve ineffective communication between nurses and physicians: culture change, use of structured communication tools, and supportive technology. No one of these interventions, no matter how successfully applied, is sufficient. All three must be effectively implemented to optimize nurse-physician communication and avoid communication gaps that can lead to patient harm.

Culture Change

The most fundamental intervention for improving nurse-physician communication is fostering an organizational culture that is patient-centric, safety-focused, and supportive of open communication and teamwork. Leaders play a crucial role in culture transformation by setting expectations, enabling and investing in specific structural supports, and modeling desired behaviors. As a means for improving nurse-physician communication, the Joint Commission recommends encouraging physicians to view patients as their primary customers and their role as partners in delivering the most effective and safe care (Joint Commission, 2009). Focusing on the patient can bring purpose and meaning to the work of all clinicians and help reinforce the natural synergy between the nurses' and physicians' roles (Bujak & Bartholomew, 2001).

Leaders can support open communication and teamwork through several interventions. An essential first step is ensuring that adequate policies are in place for addressing disruptive physician behavior, a significant barrier to effective communication. Second is flattening the hierarchy within the organization and fostering respect

among the various disciplines providing patient care. Regular teaching experiences provided by nurses for physicians and vice versa can help to personalize the nurse-physician relationship (Bujak & Bartholomew, 2011). In addition, specifically addressing the conflict between nurses and physicians can help prevent negative interpersonal dynamics (Joint Commission, 2009).

A third important intervention for open communication and teamwork is fostering the empowerment of nurses. By facilitating continuing education, participation on multidisciplinary committees, pursuit of specialty certification, and focused communication training, leaders can support nurses in communicating more confidently with physicians and other health professionals. Organizational leaders should consider pursuing Magnet® designation as a means for improving the work environment for nurses. Nurses who work in hospitals that have achieved Magnet designation report higher quality relationships with physicians than peers who work in hospitals without Magnet status (Schmalenberg & Kramer, 2009).

Finally, creating interdisciplinary patient care teams with a designated team manager sets the stage for teamwork and fosters improved communication. For example, an advanced practice nurse can serve as team manager; as such he or she is accountable for fostering timely communication between all care providers and the patient (Joint Commission, 2009).

Structured Communication Tools

Specific communication tools have proven successful at improving communication among care providers. Developed by the Department of Defense and the Agency for Healthcare Research and Quality, TeamSTEPPS is a teamwork training program that focuses on the development of four core competencies: leadership, situation monitoring, mutual support, and communication (Agency for Healthcare Research and Quality, n.d.; Joint Commission, 2009). Participants are trained to use several team-based communication tools, including SBAR (see below), call outs (communicating verbally to other staff important decisions so they can anticipate next steps), and huddles (a brief face-to-face communication between care providers in which information is exchanged and the care plan is clarified). The process has been applied successfully in many healthcare settings, including the obstetrics unit (Mann & Pratt, 2008; Pratt, et al., 2007).

SBAR (Situation, Background, Assessment, and Recommendation) is a structured communication tool that standardizes communication between health professionals (Institute for Healthcare Improvement, 2011). It can be especially effective when a nurse is contacting a physician with a concern about a change in patient status. By clearly spelling out his or her concerns, observations, interpretation, and recommendations, the nurse using SBAR provides the physician with a more complete picture of the clinical



situation than might be the case without the tool. In this way, the use of SBAR can prevent the scenario in which the physician underestimates the significance of a clinical finding conveyed via telephone.

Similarly, tools such as a daily goals worksheet can be helpful in bridging the communication gap between busy nurses and physicians. Use of this tool in the ICU was associated with a significantly improved understanding of patient care goals among both nurses and physicians—and shorter ICU stays (Narasimhan, et al., 2006).

Supportive Technology

Technology solutions are essential for supporting effective communication between nurses and physicians. Two types of solutions are available: tools that enable a particular aspect of communication and software-based communication platforms that coordinate and standardize clinical communication. We believe both types of solutions are essential for effective nurse-physician communication.

To communicate effectively, clinicians must have reliable, secure communication tools. Email, text messages, and notes in the electronic medical record (EMR) facilitate asynchronous communication between nurses and physicians. An advantage of asynchronous communication, or communication between individuals who are not present at the same time, is that it may reduce interruptions, which have been shown to increase medical errors (Westbrook, et al., 2010). To ensure compliance with Health Insurance Portability and Accountability Act (HIPAA) privacy regulations, these tools must be run on a secure network.

Other tools facilitate direct, synchronous communication between nurses and physicians. A wireless, voice-controlled communication system enables nurses to contact physicians or other staff located within the hospital while remaining at the bedside. Worn as a badge pinned to the uniform or lab coat, the device can also send secure text messages and mobilize care teams. Use of handheld phones also allows nurses to remain at the bedside with the added benefit of being able to place calls to individuals outside the hospital.

For truly effective, reliable communication between nurses and physicians, communication tools should be paired with a system-wide, software-based platform.

A comprehensive communication platform standardizes the processes that underlie clinical communication and addresses the flow issues inherent in contacting physicians, whose practice workflow, call schedule, and contact preferences often change on a daily basis.

A communication platform eliminates the need for nurses to remember physician-specific, frequently changing parameters every time they contact a physician. Instead, they call a single number and identify the physician they wish to contact by name or specialty. Using a rules-based algorithm, the platform initiates



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automated contact with the physician via the mode he or she has previously requested for that day and time. Return calls are automatically routed to the number designed by the caller.

The combination of a communication platform that standardizes contact through reliable processes and secure, effective communication tools streamlines communication. For example, pairing a communication platform with handheld or smart phones allows nurses to quickly contact physicians—and await return calls—without leaving the bedside.

CONCLUSION

The problem of ineffective nurse-physician communication is both common and complex. Multiple interrelated factors propagate the dynamic, which has clearly documented adverse effects on patient safety and other outcomes. Improving organizational culture, using structured communication tools, and linking a communication platform with secure, effective communication tools are critical for addressing the myriad communication gaps that thwart effective nurse-physician communication. We believe that all three solutions are necessary for true improvement.

To return to our vignette about Mr. Kelley, if the organizational culture at the hospital had been truly patient-centric and supportive of open communication among staff, the discharge process would have been designed with both Mr. Kelley and his daughter in mind, and staff would have been accountable for ensuring a smooth transition from the hospital. If an automated communication platform had been in place, and Kathy had a handheld phone, her call would have been automatically routed with a secure message to Dr. Gattley—all while Kathy remained at the bedside. If staff members were accustomed to using structured communication tools, perhaps Kathy would have approached Dr. Weston and voiced her concern about the discrepancy in medication lists at discharge. Given that these interventions are readily accessible today, we owe it to our patients to take the steps necessary to implement them and mitigate ineffective nurse-physician communication as a source of inefficiency and patient harm. ■

Diane Shannon developed an interest in understanding the larger forces at work in healthcare during her internship in internal medicine. Acutely aware of existing gaps in care processes, she pursued public health training to gain a broader picture of potential solutions. Leaving clinical practice to focus on system-level solutions, she has been a freelance writer specializing in performance improvement in healthcare for 13 years. She applies her passion for dramatic writing to this mission by creating stage plays, videos, and screenplays that focus on the patient experience of care. Shannon can be reached at dshannon@mdwriter.com.

Leigh Ann Myers first became interested in improving healthcare communication during her tenure as an ED nurse, where she experienced first-hand the frustrations—and patient safety effects—associated with ineffective communication between nurses and physicians. Later as a consultant in ED flow improvement, she documented the significant amount of time nurses spent trying to communicate with physicians. Eager to address at a systems level the inefficiencies she observed, she sojourned from the clinical arena to managing quality, safety, and patient experience collaboratives for a national alliance of health systems. She is currently vice president and chief clinical officer at PerfectServe, a healthcare communications technology company and can be reached at lmeyers@perfectserve.net.

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