Communicating for Better Care: Improving nurse–physician communication.

Marina Burke MSN, RN  AJN, American Journal of Nursing
Jeremy Boal MD    December 2004
Ruth Mitchell MSN, RN    Volume 104 Number 12
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Abstract

OVERVIEW: Effective nurse–physician communication is essential to care, especially that of older adults, who often have comorbidities that can lead to frequent moves between care settings. This article examines the current state of nurse–physician communication and presents suggestions on how to improve it, including developing relationships, defining communication strategies, and packaging information for clarity.

A nurse’s messages left on a physician’s answering machine receive no reply. A physician angrily tells a nurse that he isn’t responsible for a patient, even though he was the admitting physician. A nurse can’t read a physician’s order, but not wanting to bother her, she doesn’t call the physician for clarification. A physician refuses to hear a nurse’s opinion, even though it’s apparent that the nurse clearly knows the subject. At the heart of each of these circumstances—and many more like them—is poor communication.

Deficient communication among providers creates the conditions for acrimony, frustration, and distrust that can lead to inferior care and a greater risk of error. As dramatist Bertolt Brecht wrote, “Society cannot share a common communication system so long as it is split into warring factions.” In health care, nowhere is this split more evident than in communication between nurses and physicians. But can this change? Can the two factions unite?

Clearly, nurses and physicians have a common goal: to provide care. And many of these patients are at least 65 years old, a population Mezey and Scholder have referred to as “hospitals’ ‘core business.’” Older adults have more diagnoses, take more medications, have higher degrees of functional and cognitive impairment, and are more likely to report their health status as “poor” than are younger patients. Older patients are also hospitalized more frequently, which creates greater opportunity for loss of critical information as patients move from one setting to another.

Better communication among providers can be a tremendous boon to older patients and their families; thus, improved nurse–physician communication is not only a remedy for diminished job satisfaction, it’s also an elixir for improving care.

NURSE–PHYSICIAN COMMUNICATION: IN THE LITERATURE

Several studies have examined nurses’ and physicians’ perceptions of the quality of their interactions. In one, designed to “assess communication and collaboration,” researchers surveyed 67 primary care providers affiliated with Brigham and Women’s Hospital in Boston and 820 home care clinicians (nurses and physical therapists) affiliated with eight regional agencies. Forty-seven percent of primary care providers and 74% of home care clinicians reported satisfaction with
communication between the two groups. Yet fewer than half of all primary care providers reported reading home care certification forms carefully before signing them, and only 38% of them reported ease of reaching home care clinicians as “very good” or “excellent.” Thirty-one percent of home care clinicians rated the ease of reaching primary care providers as “fair” or “poor.” And only 18% of home care clinicians reported having “clearly defined parameters . . . regarding appropriate reasons” for calling the primary care providers. Most reported that having clear parameters would likely decrease the number of calls they made.

In a study of communication among ICU clinicians, Baggs and colleagues examined the association between nurse–physician collaboration and patient outcomes. Negative outcomes were defined as death or ICU readmission. Three hospital ICUs were compared—a medical ICU, a surgical ICU, and a combined medical–surgical ICU. At the time of patient discharge from one of these units, ICU physicians and nurses filled out questionnaires examining their perceptions of how much collaboration was necessary to decide whether to transfer the patient. In one of the three settings, the medical ICU, nurses’ reports that collaboration took place were associated with improved patient outcomes, even after controlling for disease severity. This was n’t the case for the other two settings. Physicians’ reports that there was collaboration were not associated with improved outcomes at any of the three sites; the authors surmise that “nurses’ reports may be a more sensitive indicator.” At least one study failed to show an association between patient outcomes and how nurses perceived nurse–physician collaboration.

In a survey of 320 nurses and physicians in eight nonsurgical ICUs in Texas, Thomas and colleagues found considerable discrepancies in the two groups’ perceptions of the quality of “interprofessional communication.” While 73% of physicians reported that the quality of collaboration was high or very high, only 33% of nurses responded in kind. Compared with physicians, nurses were more likely to report that disagreements weren’t resolved appropriately, that their input was poorly received, and that they found it difficult to assert themselves.

Studies have also noted the harmful consequences of poor communication on job satisfaction and retention among nurses. In one large-scale survey conducted by Rosenstein (see “Nurse–Physician Relationships: Impact on Nurse Satisfaction and Retention,” AJN, June 2002), 1,200 responses were received from employees of 84 hospitals or medical groups in the VHA West Coast network of health care systems. Participants included nurses, physicians, hospital executives, and other employees. The survey exposed a troubling discrepancy between nurses’ and physicians’ views of the professional atmosphere at their facilities. For example, on a 10-point scale, in which 10 represented the highest score, the nurses’ mean rating of the overall atmosphere of nurse–physician relationships was 6.74, while to physicians it was 7.52—a statistically significant difference. In addition, the nurses’ mean rating of a physician’s value and respect for nurses’ input and collaboration was 5.83, while the physicians was 7.26. Finally, when asked about physicians’ awareness of the importance of nurse–physician relationships on nurse satisfaction, nurses and physicians also disagreed, giving ratings of
4.71 and 6.18, respectively. In fact, 30% of respondents reported knowing at least one nurse who left the hospital as a result of “disruptive physician behavior.”

**IMPROVING RN–PHYSICIAN COMMUNICATION**

We offer the following suggestions for improving communication and collaboration, thus fostering better care. We have based them on the above data, a series of focus groups with physicians and nurses conducted in our home-based primary care program (see “A Perfect Union,” page 46), and our experience in working with a variety of teams caring for elderly patients (including those in outpatient practices, inpatient medical and geriatric units, and home care).

It’s important to note that there are many problems related to communication and collaboration that can only be fixed with broad changes in systems, such as improvements in electronic medical records and changes in reimbursement structures that support team-based care. (For example, the Program for All-Inclusive Care of the Elderly—which provides acute and chronic care to older adults who’re eligible for nursing home placement but would prefer to remain at home—receives a lump sum payment from Medicare and Medicaid for each patient. The dollars are pooled in order to provide all needed services, which include, but are not limited to, physician care, skilled nursing services, home attendant services, adult day health care, physical therapy, and subspecialist care.) Nevertheless, it’s clear that there are many steps that nurses can take that will have a positive impact. These guidelines can be applied to a variety of settings.

**Work at developing relationships.**

A personal connection can enhance working conditions and help to prevent the acrimony that can develop as a result of on-the-job misunderstandings. Don’t be afraid to use humor in your communications as you develop relationships based upon mutual respect. While not every strategy will work in every situation, the following are worth considering.

*Assume that you and the physician are on the same team* and that you have the same broad goals for the patients. And don’t be passive. Don’t wait for the physician to ask you questions or give you orders. This could result in the miscommunication of important information. For example, if you can’t read a prescription, call the physician for clarification. Nobody benefits if the nurse refuses to assert herself under such conditions.

*Recognize that you are equal to the physician* when it comes to caring for your patient. Address the physician as a colleague. Be friendly and professional upon your initial contact, but don’t assume that the physician knows how nurse staffing is organized—make clear your title and your relationship to the patient. For example, explain that you are the primary nurse or the wound care consultant.

*Arrange a meeting with a physician you usually speak with over the phone.* Suggest, for example, stopping by her office or accompanying a patient to an appointment. A face-to-face meeting can be especially important when there is a risk of conflict between the physician and the nurse. For example, when a patient’s condition...
isn’t improving as expected, or a patient gives contradictory information to the physician and the nurse, resist the temptation to blame the physician; instead, seek a mutual solution in person.

*Report good news about the patient*, such as a wound that is healing well, an insomnia treatment that’s working, or a favorable response to a change in drug regimen. Don’t assume the physician wants to hear only the bad news.

*Be prepared for conflict.*
Interpersonal friction will at times mar even the most successful collaborations. And the inevitably complicated needs of patients and families will at times place extra strain on the nurse–physician relationship. When this happens, patience and understanding can ease tensions, as will a willingness to refocus attention on the patient’s interests. For example, when a physician doesn’t want to return a call from a patient who has been hostile, simply validating the physician’s feelings can help to keep things moving in the right direction. Adverse clinical outcomes, poor communication with patients, or patients who don’t adhere to treatment regimens can cause some physicians to feel they’ve failed.

*Define communication strategies.*
The best defense against miscommunication is discussing communication strategies long before a crisis develops.

*Discuss preferred methods of communication,* such as fax, telephone, voice mail, e-mail, pager, or mobile phone. Is e-mail an option for either of you? Would the physician prefer noncritical information—such as routine requests for home care certification or normal blood pressure and blood glucose readings—faxed to the office?

*Ask for specific parameters* around contacting the physician about an urgent matter. For example, agreeing on specific blood pressure measurements, pulse or temperature readings, or lung sounds will enable you to limit unnecessary calls. A clear idea of the physician’s specific concerns for a patient will make it easier to place future findings in context.

*Know what you want to find out or report.*
When calling or meeting with a physician, plan ahead. For example, if you suspect a patient with dementia might have a urinary tract infection, organize the elements of your argument that support this diagnosis, including variances from baseline measurements of relevant variables, before discussing the situation with the physician.

*Agree upon an approach to family members.* Does the physician already have a good rapport with the patient and family? Will one of you be the chief communicator with a particular family member? Expect these roles to change over time.

Package information so that the clinical situation is likely to be understood.
There is growing evidence showing that physicians’ clinical decisions are affected by outside feedback. For example, feedback regarding polypharmacy in elderly patients has
been shown to positively affect prescribing patterns; this suggests that if nurses provide specific feedback they may help to improve patient care. Yet it can be difficult to provide a concise summary of a patient’s condition, especially with older adults who tend to have particularly complex health issues. A patient may have congestive heart failure, diabetes, and arthritis. A patient may take 11 medications each day and suffer from frequent falls. It’s the nurse’s ability to discern which are the most appropriate details to share with the physician, which ones will most directly affect the physician’s ability to make the best clinical decisions.

Report clinically essential information and explain your findings in the appropriate context.

Don’t assume the physician wants to hear only an outline. For example, is the patient’s blood pressure within the range of other recent readings? Has there been a dietary or medication change since the last visit that might explain a change in blood pressure? Or perhaps the most important aspect of the patient’s condition is mood. Is he isolated because of immobility or depressed because of the recent loss of a family member? It’s important to consider psychosocial aspects; one study found that older adults with depression had an almost 70% higher mortality rate after 18 months than those without depressive symptoms.

Describe pertinent environmental and economic factors that may help to explain the patient’s condition.

For example, a home care nurse, the physician’s “eyes and ears” in the home, might note poor lighting in the home of a patient with a history of unexplained falls. Unsafe environments are a common cause of falls and other injuries in older adults. One study of 1,000 community-dwelling older adults found two or more home hazards in almost 60% of participants’ bathrooms. Also, an ambulatory care nurse might discover that a patient hasn’t been taking his medications as prescribed because he’s on a limited income and can’t afford them. Unless the nurse brings such issues to the physician’s attention, they may not be addressed adequately.

Turn a conversation into an opportunity to collaborate.

For example, when presenting information about a patient with a deteriorating wound, you might say, “I have some ideas about why the patient’s wound isn’t healing, and I’d like your opinion.” Don’t miss the opportunity to go over other important parts of the care plan. Asking “Have you had a chance to order the orthopedic consultation?” may provide a necessary reminder to the physician.

DIALING FOR DOLLARS

Physicians caring for Medicare patients who are receiving skilled care in the home can bill for care plan oversight. In order to do so, they must spend 30 minutes or more in a calendar month performing Medicare-approved oversight tasks—for example, discussing the plan of care with home health care nurses, reviewing the results of laboratory tests performed between visits, or reviewing consultants’ reports. Many physicians are unaware of this option. For more information about care plan oversight billing, go to www.graphicmail.com/rwcode/default.asp?Section=11156.
TIPS FOR NURSES BY HEALTH CARE SETTING 📚

Hospital 📚
Inform the physician if the patient doesn’t receive any visitors or if he frequently appears more confused at a specific time of day. And don’t assume the physician is aware of all relevant clinical data—for example, that recent laboratory work was done.

Nursing home 📚
Inform the physician of anything that might indicate that the resident is ready to consider or change an advance directive. For example, if he mentions that he wishes not to be connected to a ventilator if he stops breathing, inform the doctor. The time may be right for the physician to consider a formal discussion about advance directives with the patient and family.

Ambulatory care 📚
Inform the physician if clinical changes appear in a patient after there has been a change in the caregiver who accompanies the patient to the clinic. For example, if a patient presents with unexpected weight loss after a new aide has taken over his care, it’s important for the physician to be made aware of this.

Home care 📚
Consider inviting the physician on a home visit to assess the patient, meet the family, or to clarify the goals of care with the family and patient. Most physicians rarely, if ever, make home visits and may feel uncomfortable in that setting. In the meantime, tell her about all the interventions possible in the home care setting—for example, digital wound pictures, infusion services, in-home blood drawing, or advanced telemonitoring.

LET'S TALK 📚
Two conversations, one foot in the mouth—which example would you follow?

RN: Hi. I’m at Cara Moore’s house. They said you wanted to be called?

MD: Who are you? Are you from the nursing agency?

RN: That’s right. She seems to be doing fine. We’re going to set her up for weekly visits.

MD: Let me tell you a little about her.

RN: I’m just the intake nurse. Somebody else will be following her.

MD: She just got out of the hospital, where she was treated for pneumonia. What’s her respiratory status?

RN: I haven’t examined her yet, but she looks okay; she’s calm.

MD: Okay. Well, I guess you could make sure that she isn’t also being fed by mouth.
RN: All right.

MD: Goodbye.

RN: Hello, Dr. Marcus. I’m Lynn Harris, the nurse from the agency, and I’m at the home of Cara Moore on my first visit. You made a referral to us because she recently came home from the hospital after an episode of pneumonia. Can you tell me a little about Ms. Moore and how her family cares for her and what your concerns are over the next few weeks?

MD: Ms. Moore has severe weakness and difficulty swallowing because of multiple sclerosis and a feeding tube, so she requires 24-hour care. Her daughter has continued to try to feed her by mouth — I think that’s why she aspirated and ended up in the hospital.

RN: Her daughter tells me that the feeding tube is working fine and that her mother has received all the appropriate medications. She tells me that she has not been giving her mother anything by mouth, because they told her at the hospital that this is what caused the pneumonia. She feels disappointed but is scared that her mom will become sick again. Today, Ms. Moore appears somewhat sleepy, with a blood pressure of 110/70, pulse of 94, temperature of 98.6, and a respiratory rate of 24. I heard dry rales at the lung bases but good air movement. Are these findings typical for her?

MD: She almost always has some dry basilar rales, as you picked up, but she was not tachypneic at baseline. I’m a little concerned that the pneumonia hasn’t completely resolved or that the daughter may still be feeding her by mouth.

RN: I see. Do you think restarting her albuterol by nebulizer could help her breathe again? I can plan to visit twice weekly to monitor her respiration, pulse, and lungs. I will also let you know over the next few weeks whether I think the daughter is feeding her mother by mouth. Does that sound okay?

MD: I agree with a trial of nebulizer treatments, but counsel the daughter only to give them twice a day at the maximum. I think twice a week is a good visit frequency.

RN: How do you like to be reached?

Camera On Call

Videoconferencing between nursing home residents and off-site clinicians.

Late one night, 91-year-old Eliza Jo Lockhart complains of a pain in her eye to her nurse at the nursing home. Noting redness, the nurse arranges for the physician to be notified at home. As he accesses the videoconferencing system from his home office, the nurse positions a portable video workstation at Ms. Lockhart’s bedside. Five minutes after receiving the phone call, the physician is speaking directly with Ms. Lockhart, communicating over secure Internet channels. As she describes her symptoms, he remotely controls the camera at her bedside, closely inspecting her eye. Following
evaluation, he concludes that conservative care is appropriate and follow-up can be arranged in the morning.

**Videoconferencing** between nursing home residents and off-site clinicians offers opportunities for greater access to clinicians, reduced costs, greater speed and efficiency, and improved quality of care. A research team at the Regenstrief Institute and Indiana University in Indianapolis has assembled a portable, wireless, Internet-based videoconferencing system—the first to be studied for use in the nursing home, through a contract (N01-LM-9-3542) with the National Library of Medicine.

Using mostly commercially available components, we built a rolling cart for a nursing home that was equipped with a remotely controllable digital video camera, lamp, personal computer, lightweight display, battery, speakerphone, and videoconferencing software. The total cost of the unit was $6,085. We also equipped the homes of seven physicians who worked with the nursing home with Internet service and videoconferencing workstations.

Although a wide variety of videoconferencing systems are commercially available, ours was far less expensive than others, which often cost $50,000 or more, not including monthly service fees. A commercial product comparable to ours costs $36,000 per year in service fees alone; we paid an annual service fee of only about $1,200 for high-speed Internet service. Our system also included components not usually needed but were included for research purposes, such as hardware and software to record and archive the video sessions.

We studied two applications of this videoconferencing system. The first was acute, nighttime medical problems; the second was routine, daytime encounters.

While analysis of the daytime application is still under way, both clinicians and residents were satisfied with videoconferencing in the nighttime study. For example, when asked, “How would you rate tonight’s communication with the doctor?” nurses in 66% of encounters and residents in 48% of encounters responded either “very good” or “excellent.”

In the nighttime study, clinicians had the opportunity to conduct videoconferencing with nearly any resident who had an acute medical problem. (We initially excluded residents with end-stage renal disease, those with expected stays of less than 72 hours, and those who could not speak intelligible English. These criteria were later liberalized, to be more inclusive.) However, it was interesting to note that while most medical problems didn’t require videoconferencing (for example, calls for routine hyperglycemia), the physicians stated that making medical decisions was easier when videoconferencing was used to assess changes in mental status, abnormal laboratory values, and falls. We are currently assessing whether the video encounters were associated with decreases in diagnostic testing and referrals to EDs. Clinicians using the system required about 90 minutes of
training; in an ideal world, using the system would be as intuitive using a telephone and far less time would be required. The nursing home residents were surprisingly accepting of the equipment and processes. They needed no special training, and many smiled at and interacted easily with the “talking heads” on the monitor, later expressing unsolicited appreciation for the chance to speak with their primary care clinician.

Of course, it remains to be seen whether videoconferencing will ultimately be a substitute for certain physical examinations or other medical care in the nursing home. Certainly the greater computerization of nursing homes would make it easier to incorporate new technologies. But perhaps most important in developing these technological capabilities is continued attention to the clinician–resident relationship. An analysis of clinician–resident interactions observed in videoconferencing sessions is currently under way. Residents should not suffer for the sake of their clinicians’ convenience. Clinicians will require special training to alert them to the unintended compromises that videoconferencing may create.—Michael Weiner, MD, MPH, Indiana University School of Medicine, Gunther Schadow, MD, PhD, Regenstrief Institute, Inc., and Clement McDonald, MD, Regenstrief Institute, Inc. To ask about developing a videoconferencing system in a nursing home, contact Michael Weiner at mw@cogit.net.

A Perfect Union
Making nurse–physician communication work.

It would have been a lucky place for a child to skin a knee. In an outdoor restaurant overlooking New York City’s Hudson River, physicians and nurse practitioners from the Mount Sinai Visiting Doctors Program were sharing after-work burgers, salads, and drinks with the nurses from the Visiting Nurse Service of New York City. It was early evening, the workday was over, and the mood was decidedly relaxed.

“We stayed for hours,” recalls Ruth Mitchell, MSN, RN, the manager of a team with the Visiting Nurse Service, which is affiliated with the Mount Sinai Visiting Doctors Program of New York. “We talked about everything—from work issues to personal stories.”

And that was the point. The two groups had recently begun working together, and team leaders had decided on a new tactic: promote camaraderie by letting the nurses, physicians, and nurse practitioners get to know each other outside of work. Even having the home care nurses meet the other clinicians was a significant event in a professional arena in which that rarely occurs. Since that evening in 2002, teamwork has been bolstered, protocols have been established on how and when to contact each other, and joint patient visits have been made for particularly complex cases.

Peter Gliatto, MD, who joined the Visiting Doctors in 2003, calls the relationship he has with the visiting nurses “vastly different” from other nurse–physician relationships he’s had. “It’s very collaborative,” he says. “The cases can be very complicated and there’s a lot of shared decision making.” The two groups still have regular meetings—some off-site social outings and some shared in-service programs. Most recently, some met on a
weekend, when a nurse practitioner from the Visiting Doctors married the office manager of the Visiting Nurses.– *Lisa Santandrea, senior editor*

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