RN’t You Curious?: What Nurses Want From Hospitalists

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Disclosures

- We have no relevant financial relationships to disclose.
Learning Objectives

1. Explore common communication pitfalls between hospitalists and nurses
2. Discuss ways to mitigate conflict and improve working relationships between nurses and hospitalists
3. Develop strategies to foster a culture of collaboration between hospitalists and nursing staff
The working relationship between physicians and nurses is subject to tension and conflict.

When nurses perceive lack of value or respect for their role, they face a barrier to the open communication that is needed to provide safe patient care.

Effective nurse-physician communication and collaboration contributes to both job satisfaction and higher quality of care.

- Ineffective communication linked with prolonged patient stays, patient harm from treatment delays and errors.

Tan et al., J Clin Nur March 2017
Survey Says...

- In order to get a better idea of the nursing perspective on nurse-physician interactions, we collected survey responses from 140 pediatric nurses from 4 hospitals.
- Before we tell you what they had to say, we want to see what you think.

Poll Question #1

How would you rate the overall quality of communication between nurses and doctors at your hospital?

1. Very poor
2. Poor
3. Acceptable
4. Good
5. Very good
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<tr>
<th>Rating</th>
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Source: https://api.event.com/polling/v1/api/polling/28f4b4

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**Poll Question #2**

Do nurses at your hospital feel respected by doctors?

1. Never  
2. Rarely  
3. Sometimes  
4. Often  
5. Always or almost always
The nurses surveyed were given a list of irritating doctor behaviors. Which of the following was ranked in the top 10?

A. Ordering very small decimal doses of medications
B. Not returning to talk to a family when promised
C. Giving tasks/orders without explaining the rationale
D. Interrupting the nurse’s admission questions
One specific hospitalist is condescending and downright rude to nurses all of the time. I have never seen this doctor lower his voice and not puff his chest out when he has to have a conversation with a nurse or resident who is ‘beneath’ him.

“[It helps] when doctors are friendly to the nurses, introduce themselves, remember our names, request our input on how we feel the patient is doing, when they are easily accessible. I hate when I page a doctor and they call back but sound like I am bothering them. I wouldn’t call if it wasn’t necessary.”
Small Group Discussion

- Working in groups of 3-4, come up with a list of the top 10 doctor behaviors that nurses find irritating

- Can be actions, omissions, attitudes, etc.
**Survey says...**

10. Getting frustrated or scolding the nurse for asking clarifying questions

9. Not understanding realistic timing of nursing tasks (e.g. expecting an order to be completed instantly, or multiple orders simultaneously)

8. Waking up a sleeping patient

**Survey says...**

7. Not returning to talk to a family when promised.

6. Being dismissive or oppositional when the nurses expresses concerns or asks questions

5. Not prescribing adequate symptomatic control (e.g. pain, nausea/vomiting)
Survey says...

4. Making promises to the family that can’t be fulfilled, when the nurse has to deal with the fallout (e.g. “Tommy will be able to sleep tonight without any interruptions”)

3. Not notifying the nurse of a change in the plan (including communicating with RN after changing orders)

2. Changing something in the room without notifying the nurse (e.g. turning off oxygen, turning off a beeping IV pump)

Survey says...

1. Not batching lab orders together, requiring a patient to be stuck multiple times
"I feel that everything on the list above is very important. Some of these items are less important in certain situations, but are things to be considered for improvement overall. It is very hard to give good care without being included/notified of the plan, however I rated the items higher that very directly affect the patient."

**Honorable mention:**
- Interruptions when nurses are giving report or caring for a different patient
- "Absent doctor" – not answering calls/texts, no face-to-face contact
- Night/covering team not managing the patient, deferring changes to daytime/primary team
- Telling a family something will happen soon (e.g. discharge) but then taking hours to make it happen
- Citing literature and statistics, air of grandiosity/superiority
- Expecting the nurse to communicate the change in plan with the family
Why the difference in perception?

- Different training backgrounds
  - **Physicians:** emphasis on independent decision-making
  - **Nurses:** trained to make decisions interdependently

- Different goals
  - **Physicians:** diagnose and treat disease, technical skill
  - **Nurses:** patient assessment, carrying out plan of care made with the team, role that is seen by the patient/family around the clock
    - “We are a vital part of the team, carrying out all the physical tasks.”
    - “There are times that a nurse can have 6-10 tasks that he or she is in the middle of, and as one person these tasks may take some time as they get done one at a time, maybe two at a time with some talent.”

Different Perspectives

- “Do you feel that the demands of your day are taken into account by the doctor?”
  - Average response 2.8 (< sometimes)

- “How often are you present on rounds for your patients?”
  - Average response 3.25 (sometimes)

- Many nurses commented on finding benefit in being present on rounds since it gives them a chance to hear the plan and be available for input
  - Yet some said that teaching/long discussions may take place prior to discussing the plan, and taking a large amount of time was not feasible for the nursing tasks they had to complete
A resounding theme from the survey was that nurses are seeking communication and respect
- Better communication from physicians
- To be asked for their input
- To be respected and valued as part of the team

Hospitalists don’t often introduce themselves, but many nurses feel that helps create a culture of collaboration

“Explaining and providing rationales for tests/procedures/tasks is really important because it helps educate us. We can in turn help educate the family if we have a good understanding of what’s going on.”

“[It’s great when the doctor makes] a phone call for an update if person-to-person contact was not made in the AM. Or asking if we need any clarification on orders that were put in (sometimes I like to take the opportunity to ask a few questions and learn). Having a better understanding of the plan and goals tremendously helps the family and allows me to prioritize tasks and my day.”
Based on evidence from a study of nurses’ perceptions regarding physician communication practices (Wanzer et al 2009), which of the following is NOT a characteristic of nurse-centered communication that improves nurse satisfaction when adopted by physicians?

A. Self-introduction  
B. Immediacy of response  
C. Humor  
D. Longer conversations

Wanzer et al, Health Commun 2009
Poll Question #5

Based on evidence from a recent review of nurse-physician communication (Tan et al 2017), which of the following statements is **false** regarding nurse-physician communication?

A. The use of smartphones for work communication has been shown to result in higher satisfaction ratings.
B. The electronic medical record (EMR) has been shown to improve nurse satisfaction with nurse-physician communication.
C. Mutual understanding of the professional role of nurses and physicians facilitates interprofessional communication.
D. Communication tools such as templates and worksheets have been shown to enhance nurse-physician communication.

Tan et al, J Clin Nursing 2017
“I would love if doctors approached the nurse before entering the room and asked if we have time to join on rounds for our patients. I often feel that I have to initiate being involved myself if I notice the team entering the room, or feel that I am intruding if I am doing something like giving a medication to the patient while they are rounding. **When included on rounds I feel patient care is improved because we are all on the same page; the patient, their families, the doctors and nurses.**”

“[I want] an atmosphere where nurses and doctors are on an even playing field, no inflated egos.”

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**Building Better Teams**

- A safe environment is built on teamwork and relationships
  - Collegiality, mutual respect, support

- Seeing various roles as part of the same multidisciplinary team helps to break down barriers to communication and foster a questioning environment
Small Group Discussion

- Get into small groups again of 3-4, but change up your group if needed to have folks from different hospitals represented
- Talk about your own roadblocks and pitfalls, helping each other brainstorm solutions
  - Examples of discussion topics
    - Difficulty having nurses present on rounds
    - Nurses seem afraid to ask questions/raise concerns
    - Nurses seem unprepared when asking questions
- After the small group discussion, we will ask groups to report out changes they think can be made in their own institution

Now what?

- We discussed a Top 10 list of things to **avoid**, but what about things to **pursue**?
- The following suggestions are based on nurses’ comments and input
1. Create rapport
   - Introduce yourself and learn nurses’ names
   - Say “thank you”
   - Pitch in to help when needed
     - (e.g. get that juice for the patient yourself!)

2. Invite nurses to rounds
   - Or try to check in with the nurse before going into the room
   - Ask their input, and respect their opinion

3. Clearly communicate the plan for the day

4. Update the nurse when the plan changes or when you need a timely response to your orders

5. Check in periodically with the nurses for questions or concerns

6. Update families often and don’t just expect the nurse to do it

7. Listen well and create an atmosphere of openness that allows everyone to express concerns professionally without feeling belittled
Now what?

8. Be present and available – many nurses requested more face-to-face conversations

9. Answer calls/texts/pages in a timely manner

10. Follow through on what you said you would do (e.g. early discharge, coming to talk to a family)

Quotes

“Probably biggest thing is communicating the plan for the day, and when changes are made, it’s nice to hear about it first, before orders are placed. Even little things like adding a new medication; the parents are almost always going to ask me what it’s for, it would be nice to know ahead of time.”

“[It’s great] when you feel like they listen to your concerns, when they ask if a task is realistic for nursing or for families, when they ask if nursing has any concerns.”
Culture Change

- Often change needs to come at an organizational level where nurses have support from leadership and can feel empowered to speak up for patient safety without fear of destructive conflict.

- We as hospitalists can lead by example.
  - “The senior doctors set the tone for relationships between physicians and nurses. When new physicians (and even medical students) see the attending being respectful towards nurses and including them in the plan of care, rounds, etc., this creates value for the nurse's role.”

Closing Thoughts

- Physicians may be unaware of how their behaviors disrupt their working relationship with nurses.

- This relationship can be improved by increasing communication (especially face-to-face), mutual understanding, and trust and respect.

- While addressing behavioral issues may be relevant, it is crucial to address system-level issues that create a “silo” mindset.

- Nurses find value in knowing that physicians are interested in what they want, so ask.
References

- “Relations Between Physicians and Nurses.” University of Missouri School of Medicine Center for Health Ethics. http://ethics.missouri.edu/relations.html