Nursing Health Services Research Unit

a collaborative project of the University of Toronto Faculty of Nursing and McMaster University School of Nursing

Our mission is to develop, conduct and disseminate research that focuses on:

- design
- management
- utilization
- outcomes
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…of nursing.

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funded by the
Ontario Ministry of Health & Long-Term Care
2004-2009

www.nhsru.com

This research has been generously funded by a grant from the Government of Ontario. The views expressed do not necessarily reflect those of the Government of Ontario.

Ontario

OUTCOMES AND ISSUES ASSOCIATED WITH NURSE-PHYSICIAN COLLABORATION

NURSE-PHYSICIAN COLLABORATION: FACT SHEET II OF IV

This fact sheet (II of IV) presents selected content from a report entitled *Nurse-Physician Relationships – Solutions and Recommendations for Change*. The full report is available on line at www.nhsru.com.

COLLABORATION WITHIN HEALTHCARE

Collaboration is "an essential element of quality healthcare" (Coeling & Cukr, 2000, p. 63), and is associated with several positive outcomes for patients, nurses, physicians, and healthcare organizations. However, there is evidence that it is still not commonplace within the majority of healthcare organizations (Coeling & Cukr, 2000; Barrere & Ellis, 2002).

While nurses and physicians share a similar opinion of the importance of communication within the hospital, they have different views on their respective group's contributions to the process (Larson et al., 1998). The growing body of literature suggests that these different perceptions of collaborative interactions hinder future efforts to investigate their significance (Corser, 1998; Baggs, 1997; Larson et al., 1998).

OUTCOMES ASSOCIATED WITH COLLABORATION

A variety of positive outcomes for patients, nurses, physicians, and healthcare organizations have been identified in association with inter-disciplinary collaboration. Selected examples include:

I. Patient outcomes

- Improved satisfaction (Baggs & Ryan, 1990; McEwan, 1994; Liedtka & Whitten, 1998)
- Improved care or outcomes (Aiken, 2001; Dechairo-Marino et al., 2001; Baggs et al., 1999; Estabrooks et al., 2005; Laschinger et al., 2001; Laschinger, Almost, & Tuer-Hodes, 2003)
- Decreased risk-adjusted length of stay (Shortell et al., 1994; Baggs, Ryan, & Phelps, 1992; Aiken, 2001; Lassen et al., 1997)
- Reduced medication errors (Sim & Joyner, 2002; Lassen et al., 1997)

II. Nursing outcomes

- Improved job satisfaction (Baggs & Ryan, 1990; Baggs & Brooks, 1994; Baggs et al., 1992; Taylor, 1996)
- Decreased job associated stress (Baggs & Ryan, 1990)
- Lower nurse turnover rates (O'Brien Pallas et al., 2004; Laschinger et al., 2001; Laschinger, Almost, & Tuer-Hodes, 2003)
- Improved communication amongst caregivers (Liedtka & Whitten, 1998; Miccolo & Spanier, 1993; Lassen et al., 1997)
- Improved efficiency (Aiken, 2001)

III. Physician outcomes

- Improved job satisfaction (Miccolo & Spanier, 1993)
- Improved communication amongst caregivers (Liedtka & Whitten, 1998; Miccolo & Spanier, 1993; Lassen et al., 1997)
- Decreased job associated stress (Miccolo & Spanier, 1993)
- Improved understanding of the nursing role (Liedtka & Whitten, 1998)
- Improved efficiency (Aiken, 2001)

IV. Organizational outcomes

- Decreased costs (Liedtka & Whitten, 1998; Lassen et al., 1997)
- Improved efficiency of healthcare workers (Aiken, 2001)

Positive nurse-physician relationships set the standard for healthy workplaces within healthcare organizations and facilitate the attainment of these favourable outcomes.

BARRIERS TO COLLABORATION

One of the problems associated with research on the topic of collaboration is the "myriad of incomplete, contradictory, or borrowed definitions of collaboration that had been used"(Corser, 1998, p. 327). Barriers are reported to occur due to:

- Role misunderstanding;
- Real and perceived differentials in power (Corser, 2000), position, and respect; and
- Varying perceptions of decision-making input and autonomy (Baggs et al., 1997; Pike, 1991; Knaus et al., 1986).

Patients are also becoming more knowledgeable about their health conditions and possible treatments, which has led to requests for more information from the healthcare professionals treating them (Williamson, 2003). This greater involvement of consumers in their healthcare decisions demands increased inter-disciplinary communication in order to provide the necessary information (Fox, 2000).

A communications audit in the United Kingdom (Fox, 2000) set out to determine the factors which affect internal communication between nurses and physicians. The results identified 5 key inter-related factors:

1. **Awareness** - of protocols and regulations relating to communication. This was not commonplace amongst nurses or physicians.
2. **Experience** – of inter-disciplinary communication. Senior staff members were more proficient at communicating than less experienced staff.
3. **Interaction** - between the two disciplines. This was more difficult between the disciplines as opposed to within them.
4. **Profession** – an understanding of each discipline's role within healthcare. This was absent and had a negative effect on communication.
5. **Environment** – the work environment. This could have a significant effect on communication, however it was likely that communication affected the environment to a greater extent.

Additionally, Rosenstein (2002) conducted a survey targeting nurses, physicians, and healthcare executives in a large network of hospitals to assess the atmosphere and significance of nurse-physician relationships. The survey also looked at disruptive physician behaviour and how this may impact on nurses' satisfaction and retention. The majority of respondents reported some degree of disruptive physician behaviour in their institutions, and both physicians and nurses agreed that it influences the attitudes of nurses as well as other staff members towards patient care, inhibits teamwork, and affects the outcomes of patient care.

This review of the literature provides some insight into both the outcomes and the issues associated with nurse-physician relationships.

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December 2005

References available upon request