Evidence Search Strategies: A review of the research evidence from open years and 2005-2010 was conducted via electronic databases (PubMed, PubMed Central, Medline, Ovid, Cochrane Library, ProQuest, PsycNet, Health Business Fulltext Elite, and Yahoo) using the search terms of “nurse-physician,” “RN-MD”, “nurse-MD,” “communication,” “acute care,” and “ambulatory care,” either alone, mixed, or in combination. Inclusion criteria were nurse-physician communication, nurse-physician team, various patient outcomes, and various healthcare settings. Exclusion criteria were nurse-physician measures other than communication, and teams other than nurse-physician. The database search yielded 5214 hits and 27 articles were selected as relevant for inclusion. 5 other articles were located via contextual links and a Yahoo web-based search, for a total of 32 articles. After careful examination, 4 articles were eliminated, as they did not answer the clinical question or targeted inappropriate populations and/or healthcare settings. The remaining 28 articles pertained to the clinical area of inquiry and were reviewed in detail. The strength of the research evidence evaluated for this integrative review ranges from insufficient to fair, with the majority of the evidence as insufficient. There was difficulty in discriminating between the concept of communication and the concept of collaboration.

- **Barriers (2,3,5,7,13,14,15,21,22,23,24,27)**
  - Abusive/Disruptive Behavior (21,27)
    - Literature describes verbal abuse of RN by MDs, disruptive MD behavior, and advice of how RNs can cope with abuse and “handle” MDs (21,27)
    - Excuses for harsh criticism of RNs by MDs may be a coping mechanism by RNs who cannot leave the abusive situation (27)
    - Power overrides effective communication, with potential for conflict and verbal abuse, in hierarchal environments (27)
  - Fear (2,23): Nurses avoid crucial conversations due to fear of
    - Independent action (23)
    - Appearing inadequate or incompetent (5)
    - Need to demonstrate competence in front of other healthcare professionals (5)
    - Being publicly humiliated in front of other healthcare professions (5,23)
    - Questioning MD knowledge (23)
    - Retribution (2)
    - Retaliation (unfair assignment or schedule; refusing to help; refusing a vacation) (2)
    - Isolated or excluded from the group (2)
    - Gossiped or talked about (2)
    - Being wrong (2)
    - No time (2)
    - Upsetting the status quo (rocking the boat) (2)
    - Why bother? Nothing will change; it’s no use (2)
  - Silence (2,5,22)
    - Speech and silence interact and shape each other (5)
    - Silent cultures never change (2)
    - Silence may be defensive or strategic (5)
    - Silence may be influenced by larger institutional and structural power dynamics, as well as by immediate situational context (5)
RN-MD Communication
An Integrative Review of the Evidence – July 2010

- Social historical, cultural, institutional factors reproduced on a daily basis (5)
- Silences reflect individual behaviors, as well as predispositions or internalized factors resulting from broader institutionalized power relations (5)
  - Because of their central role in patient safety and advocacy, nurses are often the subject denoted in questions about why no one spoke up (5)
  - Silence of the surgeon could be interpreted as reflection of resistance to institutional protocols (pause) or assertion of traditional power structure (5)
  - New nurses may not be confident in speaking up when concerned (22)
  - Effect collegial teams do not permit silence to shroud the human pathways of interaction between team members (2)
  - 3 Types of Silences: (5)
    - Absence of Communication (5)
      - Fear of exposing a lack of knowledge (5)
      - Not sharing information others did not possess (5)
      - Not providing follow-up communication (5)
    - Not responding to queries or requests (5)
      - May relate to not hearing the request or mental preoccupation (5)
      - Surgeons concentrating, with nurse interpreting silence as deliberate (5)
      - Nurses’ frustration non-responses may inhibit future communication (5)
    - Speaking quietly or hesitantly (5)
      - Symptom of traditional view of silence as a passive or quiescent stance (5)
      - Social practice in which a nurse who speaks and acts assertively risks losing legitimacy (5)
      - Nurses often use question repetition, rather than increasing speech volume (5)
      - Quiet nurse volume contrasted to louder surgeon volume (5)
      - Nurses perceived as “agitated” if they did speak more loudly (5)
    - Trust (22)
      - Lack of MD trust may be a factor in inhibiting RN-MD communication (22)
    - Avoidance (2,3,22,27)
      - RNs most common method of dealing with confrontation is avoidance (2)
      - Nurses avoid crucial conversations due to fear (2)
      - Weak responses, lack of action, and avoidance behaviors keep nurses in a subordinate role (3)
      - RNs keep conversations to a minimum to avoid orders for interventions they would prefer not to implement (22)
      - RNs accept cultural norms by discursive strategies (changing the subject) to meet nursing goals while minimizing RN MD tension (27)
    - Nurse Perceived Communication Barriers (7,13,14,15,24)
      - There is a discrepancy between nurses and MDs perceptions in communication (24)
      - Lack of MD openness to communication (7,24)
• MD refusing to clarify order or underlying rationales for management decisions (24)
  ▪ Logistical challenges (finding a quiet place to call MD) (7,24)
  ▪ Lack of professionalism (7,24)
  ▪ Language barriers (7,24)
  ▪ Hurried by MDs (7)
  ▪ Inability to reach MDs promptly (7,24)
  ▪ Disrespect by MDs (7)
  ▪ Lack of MD responsiveness (24)
  ▪ Did not call back (24)
  ▪ Unable to be reached (24)
  ▪ Delayed callbacks by MD contributes to lack of information by nurse (don’t have chart, etc) (24)
  ▪ MD providing incomplete orders (24)
  ▪ MDs perceived by nurses as reluctant to communicate may not be actively avoiding communication, but rather not actively seeking communication (14)
  ▪ Perceive MDs as being angry that the patient issue was not taken care of during business hours (24)
  ▪ Staff may view SBAR format as yet another barrier or as additional work (13)
  • Behavioral/Emotional Traits (14)
    ▪ Behavioral Traits: MD reluctance to communicate with RNs (14)
    ▪ Emotional Traits: MD emotional difficulties (14)
    ▪ MD behavioral traits are easier to change than MD emotional traits (14)
      • RN communication with MD who have difficult emotional traits was less likely to improve, even after a long period of co-working experience (14)
      • RNs hesitate to initiate communication with “moody” and “quick tempered” MDs (14)
      • RNs found it difficult to communicate with MDs who see RNs lower in hierarch or express contempt for RNs (14)
      • RNs report it easy to communicate with MDs who are emotionally composed, even in urgent situations (14)

➢ Communication Tools (2,3,4,12,13,15,18,20,22)
  • Use the DESC Communication Model for organizing thoughts and feelings (2)
    ▪ D: Describe behavior (2)
    ▪ E: Explain the effect of the behavior (2)
    ▪ S: State the desired outcome (2)
    ▪ C: Consequence - Say what happens if the behavior continues (2)
  • The 5 step STICCC process can improve communication and avoid failure via back and forth iterative dialogue between communicators (12)
    ▪ Leads to sense-making between communication because it requires feedback (12)
    ▪ Situation: Here is what I think we face (12)
    ▪ Task: Here is what I think we should do (12)
    ▪ Intent: Here’s why (12)
    ▪ Concern: Here is what we should keep our eyes on (12)
RN-MD Communication
An Integrative Review of the Evidence – July 2010

- Calibrate: Now talk to me; tell me if you don’t understand, cannot do it, or see something I do not (12)
  - Use Situation, Background, Assessment, Recommendation (SBAR) tool to provide a framework for communication between healthcare team members (3,13)
    - Concrete approach for framing any conversation, especially a critical one that requires immediate attention and action (13)
    - Levels the communication playing field (13)
    - Can be used any time a situational briefing should occur or any time there is an expected change the care process (13)
    - Documents and formalizes RN-MD communication processes (13)
    - Minimizes errors, miscommunication, and communication breakdowns (3,13)
    - Nurse must know the answers to the SBAR questions before contacting the MD (13)
      - Nurses must be fully prepared to answer the MDs questions and recommend treatments (13)
    - Place a prompt on telephone in MD lounge to ask RNs for assessment and/or recommendations (4)
      - Not all MDs welcome suggestions from RNs (22)
  - No significant differences were found between pre and post training mean anxiety and skill scores for nurses trained in the use of the SBAR tool when calling MDs (20)
  - Use of a simple goals worksheet has the potential to improve communication between nurses and MDs (15)
    - Template can be modified and applied to various healthcare settings and acute care units (15)
  - Placing RN and MD pictures on the wall is an effective way to assist people in getting to know each other (18)

- Communication strategies (1,3,14,18,21,22,24)
  - There is insufficient empirical evidence to recommend any specific communication strategy or technology device to improve doctor-nurse communication (21)
    - As of 2005, there are no RCTs that investigated RN-MD communication interventions that had a patient outcome as a measure of interest (21)
    - Few, if any methods or devices have been empirically tested (21)
    - Body of evidence is limited; research findings are not available to support professional communication and its relationship with patient safety and quality (21)
    - Mixed or weak evidence to support using some techniques cited in the literature (21)
  - Some evidence that focusing on a MD-RN communication may have a positive effect (21)
  - Careful consideration and evaluation is needed to ensure that efforts to improve RN-MD communication problems do not lead to the implementation of ineffective strategies (21)
  - An RN-MD Communication Intervention Program should involve a method of effectively affecting MD emotional traits (14)
  - An Appreciative Inquiry approach can provide hope for a skeptic staff (18)
Strategies to Eliminate Unnecessary Phone Calls (24)
- Bundle phone call to prevent redundancy (24)
- Address issues when the MD is in the facility (24)
- Triage call to the next business day if possible (24)

Suggestions For Improved Professional Communication (21)
- Evaluate various strategies for MD-RN communication using important organizational outcomes that are measurable outcomes (21)
  - Use a strategy that meets the needs and culture of the organization (21)
- Select a strategy, focus training, and provide organizational support and sufficient resources toward improving MD-RN communication (21)
- Slowly implement the change using sufficient resources and sufficient time
- Do not implement multiple changes simultaneously (21)
- Persist in that strategy for an extended period of time (21)
- Critically and rigorously evaluate the strategy using patient outcomes and worker satisfaction (21)
  - Be willing to publicly eliminate the strategy if it does not improve outcomes (21)

Strategies To Create An Organizational Context fostering goal-directed, open, dynamic, patient-centered communication include (1):
- Unit-based advance practice nurses to manage interdisciplinary teams (1)
- Development of nurses to enhance competency that is required to empower autonomy (1)
- Policies and procedures to equalize power dynamics (1)
- Nurse to nurse coalitions to increase the centrality of non-productive RN-MD conflict (1)
- Daily behaviors reflective of equal valuing of all professionals’ contributions to patient care (1)

Opportunities for Communication Improvement: (3)
- Garner administrative support (3)
- Create a zero-tolerance policy for MD abuse and unacceptable behavior (3)
- Provide assertiveness training (3)
- Use names as a powerful equalizer (3)
- Take advantage of formalized collaborative models (3)
- Build community (3)

Strategies for RN-MD Communication: (1,3,22)
- Understand role differences (3)
- Education to raise knowledge levels (3)
- Use RN-MD teams to perform a root cause analysis for unplanned outcomes (3)
- Ask for what you want (3)
- Communicate using the SBAR tool to prevent communication breakdowns (3)
- Frame MD communications from a medical cultural context (1)
- Insist MDs call nurses by their names (3)
- MDs should encourage new RNs to communicate findings even when they are not completely sure of the implications to avoid jeopardizing patient safety (22)
- Nurses need to be prepared for telephone calls (3)
- Rounding by both MDs and RNs (3)
- Remind coworkers they are all on the same team (3)
### RN-MD Communication

An Integrative Review of the Evidence – July 2010

- Advocate for the patient (3)
- Take personal responsibility; take conversations off the floor (3)
- Connect with coworkers and form a community (3)
- Acknowledge positive behavior and relationships (3)

  **Nurse Managers/Leadership Communication Strategies:** (3)
  - Create a shared vision (3)
  - Develop strong relationships with your physician counterparts (3)
  - Set the standard for RN-MD communication (3)
  - Role model effective confrontation (3)
  - Insist MDs call staff by name (3)
  - Organize joint educational events (3)
  - Organize social events as networking opportunities (3)
  - Elevate nursing by presenting papers on clinical issues (3)
  - Present these papers at least monthly at department meeting (3)
  - Invent creative strategies to nurture partnerships (3)

#### Doctor-Nurse Game, 1967 (22,23)

- Hierarchical system conditions can force RNs to revert to the “physician-nurse” game to achieve what they believe is in the patient’s best interest (22)
- MD-RN relationship takes on a new dimension and fits a game model via an interactional framework (23)
  - The Doctor Nurse Game is a transactional neurosis (23)
  - Major disadvantage of the game is its inhibitory effect on open dialogue which is stifling and anti-intellectual (23)
- **Object of the Game** (23)
  - Nurse: Be bold, have initiative, and be responsible for making significant recommendations while also appearing passive; done as to make recommendations appear to be initiated by MD (23)
  - Physician: Requests a recommendation from the RN without appearing to be asking for it (23)
- **Rules of the Game:** Open disagreement between players must be avoided at all costs (23)
  - Do not commit to a position before a sub rosa agreement on that position has already been established (23)
  - Greater the significance of the recommendation, more subtly game is played (23)
- **Game Scoring System:** Nonzero sum game model. Rewards & punishments are shared (23)
- **Rewards:** MD-RN team that operates efficiently (23)
  - Doctor-nurse alliance (23)
  - Some informal RN-MD rules may be suspended for skilled players (23)
  - MD utilizes RN as a valuable consultant (23)
  - MD gains respect and admiration of RNs (23)
  - MD confident that nursing staff will smooth the path for getting MD work done (23)
  - “If the nurse is your ally, you’ve got it made” (23)
RN-MD Communication
An Integrative Review of the Evidence – July 2010

- RN gains self esteem and professional satisfaction (23)
- RN gains a reputation as being a “damn good nurse” (23)
- MD esteem for a good nurse is no less than their esteem for a good MD (23)
  - Penalties/Punishments: Unskilled players playing the game badly share in penalties (23)
    - MD labeled as a “clod” (23)
    - “If the nurse has it in for you, be prepared for misery” (23)
    - Some informal RN-MD rules are not suspended for unskilled players (23)
    - RNs not viewing role as a consultant and does not communicate recommendations is perceived as a dullard (23)
    - Outspoken RNs labeled as a “bitch” and may soon be terminated (23)
  - Game Genesis: Medical Student & Nursing Student Training (23)
  - Forces Preserving the Game (23)
    - Rewards & Punishments
    - Strength of the Set (23)
      - If MD is a prisoner of the set and does not actively try to destroy it, change is near impossible (23)
      - RN perception that making a suggestion to MD is insulting and belittle to MD (23)
    - Sexual Roles: Stereotyped roles of male dominance and female passivity (23)

Education/Training (10,13,14,21,23,25,27)
  - RN-MD relationships could benefit from interprofessional training in which RN and MDs exchange opinions about communication barriers (14)
  - No patient outcomes change with implementation of inter-professional education versus single-discipline education (21)
  - Collaborative RN-MD communication curricula should:
    - Focus on communication behaviors that foster productive and collaborative relationships (25)
    - Combine joint education for RN and MD (27)
    - Illustrate the effects of positive communication on teamwork and patient outcomes (27)
  - Nurse (13,23,28)
    - Nurses can be the least educated members of any healthcare team (13)
      - The nursing profession should consider strengthening nursing education and clearly delineating nurses’ role and competencies (28)
    - “Expecting a nurse with a 2 year degree to communicate effectively and collaborate with a MD who has a doctorate is unrealistic” (13)
    - RNs learn to play the doctor-nurse game throughout education and training (23)
  - Physician (10)
    - MDs learn to communicate in a way that is satisfying to RNs as they go through training (trial and error method) (10)
Modes of Communication (3,14,16)
- Behaviors (See Barriers)
- Face to Face (14,16)
  - RNs hesitate to initiate communication with MDs who appear to be busy or irritated (14)
  - More 60% of communication between RNs and MDs takes place face to face (16)
- Silence (See Barriers)
- Telephone (3,14,16)
  - Nurses need to be prepared for telephone calls (3)
  - Nurses did not like to contact MDs by phone (14)
  - Approximately 1/3 of RN-MD communication takes place via the telephone (16)
- Written (16)
  - The medical record is not an effective communication tool (16)
  - MDs may not routinely read nurses notes (16)
  - MD notes often written late in the day (16)

Nursing Implications (5,19,22,28)
- Power (5,22)
  - Silence may be used as a means of exerting power or resisting power (5)
  - Silences may be a form of expression used by nurses as a space to accomplish personal objectives, achieve goals, and communicate (5)
  - RNs use modified communication tactics to nudge MD in the “right” direction or get the response they desired (22)
- Work of Nurses (19,28)
  - The work of the nurse is different than the work of the MD (19)
  - Nurses must find a way to explain what they actually do and make their contributions visible (28)

Organizational Leadership (2,13,26)
- Healthcare leaders must teach assertive communication and confrontation skills in the workplace (2)
- With proper implementation and ongoing staff education of SBAR, healthcare agencies can establish a reputation for providing clear, consistent, and direct communication (13)
- Without administration buy-in and support, the system-wide changes necessary for successful SBAR implementation may not occur and impede success and/or sustaining of process changes (13)
- Healthcare professionals should use a communication style that invites the patient’s perspective, including a precise assessment of what exactly an individual patient want to know at a given moment (26)

Organizational Culture (1,2,6,7,13,16)
- Culture kills the best of strategies (1)
- 3 powerful forces impede communication in healthcare: Time pressures, knowledge, and culture (2)
Neither checklists nor procedures nor process improvement will work in the absence of meaningful, collegial relationships in which every team member feels comfortable in communicating what they see, feel, and know at all times (2)

Poor communication and hierarchical communication patterns historically contribute to poor RN-MD relationships (6)

Strong communication is needed for a culture that promotes teamwork and open discourse, consistent and ongoing education & training, and clear policies & procedures (7)

The transition to SBAR may require a complete change in the organization’s culture related to communication (13)

Incomplete exchange of information between team members is common in healthcare settings and often become the norm as a “culture of low expectations” with regard to communication practices (16)

Perspectives of Organizational Behaviors (1):

1. Structural Perspective: Communication is a rational, goal-directed process focused on transmitting facts (1)
   - Focus is evaluation (1)

2. Human Resource Perspective: Communication is an open, sharing, collaborative process resulting in commitment to action (1)
   - Built around theories of human needs and motivation such as Maslow, with a focus on development (1)
   - Participative decision making is essential to improving RN-MD communication (1)

3. Political Perspective: Communication is an exercise in power dynamics and conflict resolution (1)
   - Organizational behavior is a function of competition for scarce resources (money, status, control, influence) (1)
   - RN-MD communication can be conflictive to the point of dysfunctional (1)

4. Culture Perspective: Communication is symbolic of the organization’s beliefs and reflective of the values of the organization’s executive management (1)
   - Professions are also unique cultures which socialize members into unique communication patterns that are foreign to cultural outsiders (1)

Outcomes (1,2,3,7,8,10,11,12,21,25,27)

- Patient Outcomes (1,2,3,7,8,10,11,12,21,27)
  - Patient Safety (1,2,3,7,8,10,12,21,27)
    - Even though evidence is conflicting, it does not clearly negate the premise that communication & collaboration could have an impact on patient outcomes (21)
      - The lack of empirical research does not mean that there is not enough evidence to prove the correlation between effective RN MD communication and positive patient outcomes (27)
      - Research has shown lack of interpersonal and communication skills of MD and RNs is associated with errors, inefficiencies in care delivery, and frustration (21)
Sound nurse-physician communication is a cornerstone of safe, efficient, and effective high-quality patient care (1,7).

The Joint Commission emphasizes that the timeliness of communication must increase for patient safety issues (2,10).

Patient safety can only be enhanced when bad experiences are shared, probed, understood and procedures changed (2).

Major improvements in patient safety mean MDs must step away from old hierarchical medical model and be an effective leader in building meaningful, collegial relationships (2).

The failure of MD and nurses to work together, to share decision making and to communicate is unethical, as such behavior (3):

- Does not focus on patient needs (3)
- Has a negative impact on keeping patients safe from unnecessary harm (3)

Nursing perceptions of communication between ICU nurses and MDs taken as a whole were not related to adverse outcomes (12).

Verbal abuse in the OR setting has the potential to impact patient care and safety (27).

### Medication Errors (11)

- As ICU RN perceptions of MD communication improved, ICU RN perceptions of med errors decreased (11)

### Mortality (8,21)

- Excellent communication and interactions between nursing and MDs results in significantly lower deaths (8)
- After communication training, team development meetings, or weekly rounds (21):
  - No difference in patient mortality rates (21)
  - Conflicting LOS results (21)

### Pressure Ulcers (12)

- Timely RN consultation with MDs may help in preventing PU (12)

### SBAR (21)

- SBAR studies at 4 KP sites met short term organizational “communication initiative” expectations, but did not report long term measures (21)
- KP QI study of various groups training in SBAR, assertion checklists, and briefings resulted in reduced wrong site surgery incidences (21)

### VAP (12)

- The greater the variance in ICU nurses’ perceptions of understanding communication with MDs, the greater are the VAP rates (12)

### Nurse-Sensitive Outcomes (1,3,9,10,21,25)

- Nurse Job Satisfaction (9,21,25)

  - Work environment affected nursing job satisfaction in part through nurses’ perceptions of the effectiveness of their communications with MDs (9)
  - Structural empowerment, nursing practice environment, and RN-MD communication were independent predictors of nurse job satisfaction (9)
Staff satisfaction increased after communication training, team development meetings, or weekly rounds (21)

KP QI study of various groups training in SBAR, assertion checklists, and briefings resulted in improved staff satisfaction (21)

Interventions aimed at improving effective communication improved staff work satisfaction (21)

There is a strong relationship between MD use of Nurse Centered Communication behaviors (clarity, humor, immediacy, listening, and empathy) and nurses’ reports of job satisfaction (25)

Nurse Centered Communication model was significant, with humor, work environment, meaningfulness of work, and stress serving as significant predictors of nurse job satisfaction (25)

### Nurse Communication Satisfaction (10,25)

Some factors associated with nurse communication satisfaction are immutable (race), other may be amendable to intervention (working with various levels of MDs) (10)

ICU Nurses are more satisfied with understanding, open, and accurate communications, especially with attending-level MDs (10)

ICU RN years of experience was inversely associated with communication satisfaction (10)

RN satisfaction with communication varied by ICU type (10)

ICU RNs’ satisfaction with MD communication may deteriorate as communication difficulties persist over time (10)

There is a strong relationship between MD use of Nurse Centered Communication behaviors (clarity, humor, immediacy, listening, and empathy) and nurses’ reports of satisfaction with MD communication/relationship (25)

### Nurse Retention (1,21,27)

Improved RN/MD communication can decrease nurse turnover rates and nurse burnout (1)

- Verbal abuse is linked to staff shortages/absenteeism and difficulty in recruiting RNs (27)

KP QI study of various groups training in SBAR, assertion checklists, and briefings resulted in decreased nurse turnover (21)

### Miscellaneous (3,21,25,27)

There was no relationship between the frequency of reported Nurse Centered Communication behaviors and the length of nurse-MD conversation (25)

Poor relationships, poor communication, and compromised cooperation between physicians and nurses have a negative impact on keeping nurses in a profession that often demeans and devalues nurses (3)

Verbal abuse is linked to staff shortages (absenteeism), difficulty in recruiting RNs, with ultimate effects seen on OR schedules, overtime, and level of nursing expertise (27)

6 month training session of Collaborative Communication Intervention reported (21)

- Increased in perceived MD-RN communication skills (21)
RN-MD Communication
An Integrative Review of the Evidence – July 2010

- Increased nurse leadership skills (21)
- Increased problem solving (21)
- Decrease in nurse stress (21)
- Interventions aimed at improving effective RN-MD communication: (21)
  - Increased RN perception of opportunities (21)
  - Decreased information overload (21)
  - No change in nurse perception of RN-MD collaboration (21)
- MD-Sensitive Outcomes (21)
  - Training was effective in improving MD attitudes, beliefs, & communication ability (21)
  - Interventions aimed at improving effective RN-MD communication improved MDs perception of RN-MD collaboration (conflicts with views of RNs) (21)

- Physician Implications (1,2,3,19)
  - Power (1,2,3)
    - Competition for status and power (MD as captain of the ship), different values and beliefs (care vs. cure) (1)
    - If MDs believe they have total accountability, they will demand total autonomy in patient decision-making (2)
    - MD often use an aloof business-like stance to maintain the dominant position (3)
  - Work of MDs (19)
    - The work of the MD is different than the work of the nurse (19)

- Professional Enculturation (2,3,5,14,27,28)
  - Nurse Worldview (2,5,27)
    - Nurses report seeing themselves as “keepers of the peace” who role is to maintain a calm environment for MDs such as surgeons to focus on their work (5)
    - Nurses’ use of discursive strategies, passive-aggressive communication style, and deflective patterns is partially a result of gender related leadership (2,5,27)
  - Physician Worldview (2,3,14,27,28)
    - MDs are trained to lead in an hierarchical medical model system (2)
    - RNs found it difficult to communicate with MDs who see RNs lower in hierarchy (14)
    - Exclusionary and inclusionary concepts of othering within hierarchal systems by MDs result in domination and subordination of RNs (27)
    - MDs are expected to have all the answers, thus setting high expectations for this profession (3)
    - Medical Resident’s descriptions of their attitude toward nurses are consistent with nurses’ frequent complaints that MDs (28)
      - See nurses as implements and tools (28)
      - “We decide, you carry it out” approach (28)

- Practice Settings (2,5,10,11,16,17,22,24,26)
  - Geography (17)
Localization of physicians to specific units increased the frequency of Nurse-Physician communication, but did not create a shared understanding amongst team members (17)

- Operative/Surgical (2,5)
  - OR processes of power produce silence and constrained communication (5)
  - OR Nurses often feel constrained in their ability to communicate with MDs (5)
  - Silence and quiet may reflect an OR team having an experienced, familiar, and comfortable working relationship (5)
  - Time pressures drive and cause distracting communication, distractions fragment and fracture teamwork and the surgical team’s ability to stay focused and supportive of each other (2)
  - Take time to discuss issues outside the OR; track outcomes and discuss outliers (2)
  - MDs and nurses must be aware of communication nuances & complexities in order to interpret the multiple modalities and strategies of communication in the OR (5)
  - Nurses have less positive perceptions of the effectiveness of their communication compared with surgeons (5)
  - Many instances in which nurses have difficulty in obtaining MD responses or actions are related to brief events occurring in domains of nursing responsibility (surgical pause, instrument count, maintaining sterility) (5)
  - Loud surgeon speech may co-create quieter OR nurse speech (5)

- Labor and Delivery (22)
  - RN and MDs shared a common goal of healthy mother and baby (22)
  - Interdisciplinary communication and teamwork could be improved to promote a safer care environment during labor and birth (22)
  - Experienced RNS were comfortable managing labor and communicating with MD on an “as needed” basis, provided they felt mother and baby were doing well (22)
  - RNs and MDs believe that minimal communication is desired during normal labor if mother and baby doing well (22)
    - Conversations of less than 2 to 4 minutes during routine labor is considered normal by both disciplines (22)

- Long Term Care (24)
  - A combination of nurse and physician behaviors contributes to ineffective communication in the LTC setting (24)

- Medical/Surgical (26)
  - If ward rounds serve as the central marketplace of information, nurses’ knowledge is under represented (26)
  - Typical ward round is a dyadic interaction between patient and MD, with only minor contributions from nurses (26)

- Critical Care (10,11)
  - RN satisfaction with communication varied by ICU type (10)
  - ICU RNs preferred communicating with attending-level MDs than 1st yr residents (10)
Providing ICU RNs with more information, support, resources, and opportunities at work can improve communication with MDs (11)

Improving or enhancing the characteristics of the ICU practice environment also will enhance RN-MD communication (11)

RN-MD Communication (2,3,6,7,8,13,14,16,18,21,25,26,27,28)
  - Neither checklists nor procedures nor process improvement will work in the absence of meaningful, collegial relationships in which every team member feels comfortable in communicating what they see, feel, and know at all times (2)
  - Poor communication and hierarchical communication patterns historically contribute to poor RN-MD relationships (6)
  - Nurses and physicians often do not reliably communicate with one another and communication often suboptimal when it does occur (16)
  - Effective communication is essential for interdisciplinary collaboration and is described as (6)
    - Frequent, timely, understandable, accurate, and satisfying (6)
  - Effective communication is characterized by (2,6)
    - Discussion with contributions by all parties (2,6)
    - Active listening & Questioning (6)
    - Openness (6)
    - Willingness to consider other ideas and ask for opinions (6)
    - Free flow of information among participants who are able to speak out (2,6)
    - Nonhierarchical (6)
  - RN-MD Partnership (2,3,8,13,16,18,27)
    - Successful communication sets up a partnership between the RN and MD (18)
    - Awareness and reflection on discourses of resistance via RN-MD communication perspectives are the first steps towards the crucial transformation of health care delivery (27)
    - All team members should reciprocal responsibilities to be receptive, communicative and trusting (2)
    - Disagreements become clearer when the focus of the conversation is on high quality, safe care for the patient, rather than RN or MD roles (3,13,27)
      - Patients expected nurse and MD to discuss plan of care on a daily basis (16)
      - Disagreements tend to disappear when the debate shifts to the welfare of the patient (13)
    - Strong RN-MD communication is seen in respectful MD and RN interactions (8)
  - Nurses (14,16,21,26)
    - Nurses identify can MD 71% of the time (16)
    - Nurses perceive less collaboration and poorer communication than MDs (21)
    - Nurses are typically less satisfied than MDs with communication & interaction patterns (21)
    - Nurses need for their opinions to be heard by MDs (21)
    - RNs find it difficult to communicate with some but not all physicians (14)
      - Easy to initiate communication with MD who usually initiated communication with RNs (14)
RN-MD Communication
An Integrative Review of the Evidence – July 2010

- Hard to initiate communication with MD who tend not to provide explanation when making orders (14)
  - Nurses do not contribute substantially to the content of what is said during ward rounds (26)
  - If ward rounds serve as the central marketplace of information, nurses’ knowledge is under represented (26)
  - Typical ward round is a dyadic interaction between patient and MD, with only minor contributions from nurses (26)
    - Physicians (14,16,25,28)
      - MDs can identify nurses 36% of the time (16)
      - MDs can increase nurses’ satisfaction with communication by concentrating on being immediate and listening effectively (25)
      - MDs should be regularly evaluated by nurses on the extent to which their instructions and communications about patients are clear and concise (25)
      - Medical residents emphasize successful communication is contingent upon the nurse, the situation, and the type of information communicated (28)
        - Nurse: competent, or incompetent (28)
        - Competence: able or unable to communicate important information (28)
        - Situation: acute or nonacute (28)
        - Information communicated: factual or subjective (28)
    - The residents believe that despite these instances of poor communication and problematic relationships, nurses pose no significant threat to patient care, as the nurses’ role is to simply follow MD orders (28)
    - A RN-MD co-working experience can improve initially difficult RN-MD communication only when the communication difficulty is caused by MD’s behavioral traits, rather than emotional traits (moody, quick-tempered) (14)

➢ Technology Impact (19)
  - Communication problems after implementation of unintegrated CPOE systems restrict RN-MD synchronization, coordination, and RN-MD work integration (19)
  - The inability of RNs to take verbal orders changes previous informal methods of facilitating medication workflow and order communication with MDs (19)
  - To compensate for technology-induced workflow problems, nurses and MDs use extra effort to develop many informal communication interactions, ad hoc rules, and informal communication practices (work-a-rounds), which has considerable potential for nurses and MDs to make medication errors (19)
  - Healthcare professions will develop compensatory reactions to repair workflow breakdowns and facilitate the work process and communication (19)

➢ Timeliness and Preparation of Communication (10,12,18,24)
  - Timeliness of communication was not associated with communication satisfaction for nurses (10)
  - As timeliness of communication increased, prevalence of PU decreased (positive trend only, not statistically significant) (12)
  - Communication with MDs is more successful when the RN is ready with the right information about the patient for the MD (18)
Inadequate nurse preparedness may be the result of, or exacerbated by, MD behavior such as delayed response to phone calls and MD interruptions (24).

Reliance on synchronous communication (immediate contact with another person) can push the limits of human memory in an interrupt-driven environment (24).

- Contributes to suboptimal nurse preparedness, as the nurse less likely to have information on hand (24).
- Delayed callbacks by MD contributes to lack of information by nurse (don’t have chart, etc) (24).
- Delay between preparation and delivery of a patient assessment can interfere with the ultimate quality of the information being communicated (24).

**Future Research** (2,9,10,12,15,16,17,20,21,22,25,26,27)

- Design longitudinal studies to determine whether the influences of RN-MD Communication hold over time and with different patient populations (9).
- Design studies with large samples to examine the significant influences of RN-MD communication on patient outcomes such as hospital-acquired pressure ulcers, and nurse-physician-sensitive outcomes such as nurse and physician satisfaction (10, 12).
- Further research is needed to optimize RN-MD Communication in order to develop a shared mental model of patient care and assess its impact on early recognition and intervention of potentially hazardous patient situations, as well as the quality of patient care (12,16,17,21,22,27).
- Determine whether the quality of patient care is related to a well-balanced exchange of information to which nurses, physicians, and patient contribute their specific knowledge (25,26).
- Further research is needed regarding RN-MD Communication that addresses (27): a) Superficial nature of communication (27); b) Cultural factors underlying verbal exchanges (27).
- Further testing of SBAR and other communication processes, methods, and tools (2,12,15,20).
Purpose/intended Audience

Because we want everyone in our communities to have the healthiest lives possible, we are making our evidence reviews available to the communities we serve to help Californians and others lead healthier lives.

Integrative reviews and evidence summaries are provided as a community service for reference purposes only, and must be used only as specified in this disclaimer. These documents are intended for use by clinicians. If you are not a clinician and are reading these documents, you should understand that the information presented is intended and designed for use by those with experience and training in managing healthcare conditions. If you have questions about them, you should seek assistance from your clinician. The information contained in the evidence reviews is not intended to constitute the practice of medicine or nursing, including telemedicine or advice nursing.

Limitations On Use

These documents have been developed to assist clinicians by providing an analytical framework for the effective evaluation and treatment of selected common problems encountered in patients. These documents are not intended to establish a protocol for all patients with a particular condition. While evidence reviews provide one approach to evaluating a problem, clinical conditions may vary significantly from individual to individual. Therefore, clinicians must exercise independent professional judgment and make decisions based upon the situation presented.

Kaiser Permanente's documents were created using an evidence-based process; however, the strength of the evidence supporting these documents differs. Because there may be differing yet reasonable interpretations of the same evidence, it is likely that more than one viewpoint on any given healthcare condition exists. Many reviews will include a range of recommendations consistent with the existing state of the evidence.

All of the Kaiser Permanente integrative reviews and evidence summaries were developed from published research and non-research evidence and do not necessarily represent the views of all clinicians in Kaiser Permanente. These documents may also include recommendations that differ from certain federal or state health care mandates.

Intellectual Property Rights

Unless stated otherwise, all of these materials are protected by copyright and should not be reproduced or altered without express written permission from Kaiser Permanente. Permission is granted to view and use these documents on single personal computers for private use within your hospital or hospital system. No portion of these materials in any form may be distributed, licensed, sold or otherwise transferred to others.

The organizations within Kaiser Permanente retain all worldwide rights, title and interest in and to the documents provided (including, but not limited to, ownership of all copyrights and other intellectual property rights therein), as well as all rights, title and interest in and to their trademarks, service marks and trade names worldwide, including any goodwill associated therewith.
No Endorsement or Promotional Use

Any reference in these documents to a specific commercial product, process, or service by trade name, trademark, or manufacturer, does not constitute or imply an endorsement or recommendation by Kaiser Permanente. The views and opinions expressed in these documents may not be used for any advertising, promotional, or product endorsement purposes.

Disclaimer of All Warranties and Liabilities

Finally, although Kaiser Permanente believes that all of the information provided in its documents is accurate, specific recommendations derive from combining the best available evidence. Although we have sought to ensure that the documents accurately and fully reflect our view of the appropriate combination of evidence at the time of initial publication, we cannot anticipate changes and take no responsibility or assume any legal liability for the continued currency of the information or for the manner in which any person who references them may apply them to any particular patient. Kaiser Permanente does not assume any legal liability or responsibility for the completeness, clinical efficacy or value of any apparatus, product, or process described or referenced in the documents. We make no warranties regarding errors or omissions and assume no responsibility or liability for loss or damage resulting from the use of these documents.