Collaboration Between Physicians and Nurses: Essential to Patient Safety

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Managing the complexity of modern health care delivery takes all of the resources and patience that leaders and caregivers can muster. In an environment already laden with risk, it is vital that all caregivers stay focused and that distractions are kept to a minimum. Collaboration between physicians and nurses is a fundamental element of a patient safety and risk management program. The ability of physicians and nurses to work together as a unified team is essential to improved outcomes, error and risk reduction, and optimum care.

Even though technology is designed to improve efficiency, a great deal of effort must go into collaboration: communication of even simple orders may become problematically complex, delay of a single procedure can lead to frustration and fault-finding, misunderstandings and miscommunications can all too easily create tensions among the team. When tensions and frustrations do build, then the environment becomes even more risky and is ripe for error. Mistakes occur, communication is compromised, trust erodes. In every care setting—hospital, clinic, or office—patients become more prone to error and risk if the team taking care of them is not working together as a collaborative unit.

Changing Roles of Physicians and Nurses

The years have brought changes to both the medical and nursing professions that have the potential to compromise collaboration and teamwork if not acknowledged and understood. For example, with the advent of clinical record technology, communication between caregivers is now much more likely to be electronic or telephonic rather than face-to-face. Orders are written, updated, and changed on-line perhaps without any verbal communication. Nurses who were formerly dependent on the attending physician for the particular pieces of a patient's history that aided in planning their care must now depend on a computer. Conversely, where the nurse had always been the round-the-clock source of patient information for physicians, it is now more likely that the physician consults the electronic record. To some, this technology transition has been painless; to others it has been difficult and burdensome. Even though technology was never meant to be a substitute for personal communication, there is no doubt that it has had an affect on the day-to-day physician-nurse interactions.

Likewise, images of a solo attending physician and a nurse at the patient's bedside are fading. The team has grown and become highly specialized. The attending is now joined in caring for a patient by the critical care intensivist, the hospitalist, a physician's assistant, and perhaps residents in training. Nurses now need to collaborate with providers in many roles with different training, expertise, and focus. Fielding inquiries from such a variety of caregivers can sometimes make it unclear who is in charge.

Each profession, medicine and nursing, is experiencing unique pressures. Financial concerns, office and business management, and payer reimbursement bear down on the daily lives of practicing physicians. More and more, those who pay for health care are influencing decisions about care and length of stay. Office technology, coding, and third-party billing requirements are increasing in complexity—taking physicians' time away from their patients. Add to this the growing shortage of primary care physicians and the stage is set for frustration to spill over into interactions with nurses and other caregivers.

The nursing profession is under a different, but equal, set of pressures. A severe and prolonged drop in nursing school enrollment and graduating nurses created severe vacancy rates. Hospitals were forced to create new roles: patient care technicians and nurse extenders helped to fill the gap; permanent nursing positions were substituted with temps and per diem staff. Where the nurses once knew every physician on staff, and vice versa, that is no longer the norm. When many of the faces that physicians see in their own health care facility are unfamiliar, trusting relationships become more difficult to establish.

Leadership: Setting the Tone and Expectations

How do we lead to mitigate the risks these changes present? How do we create an environment that encourages and fosters collaboration and decreases the opportunity for tension, mistrust, and disrespect? There is no order one can give or magic wand one can wave to say that nurses and physicians must collaborate, but there are a number of building blocks that can be used to solidify nurse-physician collaboration that are worthy of review.

"It starts at the top" is certainly true when it comes to creating an environment that fosters collaboration and is focused on the patient. Organizational leaders—trustees, clinical chairs, and senior management—must all commit to a mission that prioritizes an organizational climate for collaborative care. Regularly communicating this message is vital, but backing it up with consistency is equally important. The actions and interactions of the most senior physician and nurse leaders will be carefully watched. Do they respect one another? Do *they* collaborate and work as a team? If senior leaders do not themselves embrace this kind of teamwork, then one can hardly expect the message of collaboration to be heard or heeded.

But it is not enough for only those leaders "at the top" to be committed to this goal. Champions must be developed at all levels of the organization and in all clinical departments. Each clinical chief and chair, along with each managing supervisor and department director, must follow suit and embrace the goal of creating a collaborative environment within his or her own sphere of practice. They must model it and provide opportunities for nurses and physicians to work together. It is their responsibility to identify people, problems, or barriers that are creating tension or otherwise making collaboration difficult. These may be systems or process issues, service problems, or ornery and difficult clinicians that need the attention and intervention of senior leaders. Everyone is accountable to foster collaboration and teamwork that contributes to better patient care. These expectations must be clearly written and consistently communicated.

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Providing Resources and Opportunities

Do physicians and nurses have what they need to do their work? A lack of resources—material, human, or technical—increases the chances for frustration, discontent, and error. Functioning, up-to-date equipment, supportive information technology, and a well-trained, motivated workforce are essential to support nurses and physicians. Equally important is the workplace environment that values the contributions of physicians and nurses, and regularly looks for opportunities to recognize and celebrate the achievements of both groups.

Does your organization provide opportunities for nurses and physicians to lead and plan together, to further foster collaboration? Are nurses and physicians regularly given time to discuss cases, oversee quality, and set policy? Are physicians and nurses present and leading organizational committees that recommend organizational change, choose equipment and other capital purchases, and strategically plan? Finally, do nurses and physicians have opportunities to learn together, understand each others' challenges, and celebrate mutual success? These structural and cultural component parts are not expensive, speak volumes about the investment in physician and nursing staff, and provide enormous opportunities for nurse-physician collaboration.

Nurses and Physicians as CEOs

A clinical nursing background is a great foundation for being a health care CEO. Through my years as a practicing nurse, I developed a deep appreciation for the unique roles physicians and nurses have in patient care. Nursing is a physically and mentally challenging profession with round-the-clock accountability—and it requires a great deal of clinical education, patience, and compassion. In my leadership role, I find myself regularly referencing these clinical fundamentals.

My physician CEO colleagues share similar sentiments about their clinical background and experiences. Understanding the rigors of a medical education coupled with the overwhelming accountability for the patient's care is difficult to appreciate unless you have been in practice. Of course, it would be naïve to think that one's clinical background is all that is required to be a CEO. However, having the clinical perspective and witnessing the day-to-day interdependence of physicians and nurses certainly makes a difference in fostering organizational expectations and culture.

The nurse-physician partnership is a powerful one that has enormous capacity to serve the patient and the public. Fostering collaboration at the bedside as well as in the board room is an important part of a risk management program, creating a safer environment, and delivering patient-centered care. ■