UNDERSTANDING INTERDISCIPLINARY COMMUNICATION AND COLLABORATION AMONG PHYSICIANS, NURSES, AND UNLICENSED ASSISTIVE PERSONNEL

by

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UNDERSTANDING INTERDISCIPLINARY COMMUNICATION AND COLLABORATION AMONG PHYSICIANS, NURSES, AND UNLICENSED ASSISTIVE PERSONNEL

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ABSTRACT

The negative impact of medical errors on patient safety poses a major problem for health care providers. Since physicians, nurses, and unlicensed assistive personnel (UAPs) each provide a portion of patient care, coordination of the various treatments and interventions provided is critical to prevent errors and fragmentation of care. The significance of this qualitative phenomenology study is that it can provide information to enhance interdisciplinary communication and collaboration among physicians, nurses and UAPs, thereby positively impacting patient care outcomes. Semi-structured face-to-face, privately held individual interviews were conducted to determine how physicians, nurses and UAPs view their roles and each other’s role in patient care. Health care leaders can use the information from the study as a foundation for enhancing coordination of patient care. Study results suggest that physicians, nurses and UAPs must recognize and respect each other’s contributions to patient care and members of each discipline should be included in patient care decisions.
DEDICATION

I dedicate my academic journey to my mom, Mamie Taylor, and dad, Coyt Walter (C. W.) Taylor, Sr. (both deceased). Education was important to both of my parents, but especially to my dad who did not finish high school. He was a little disappointed at first when I chose to be a nurse instead of a doctor, but always believed in me and came around to understanding that nursing was my calling.

My mom and her mom, Lucille Rowland (Nana), were my role models. Nana was the kind of person that would give you the shirt off her back if she thought you needed it more than her. Mom was a nurse who constantly went above and beyond the call of duty for her patients and always placed her family and friends’ needs above her own.

My sons, Michael T and Ares were also supportive. They knew not to disturb me when I was in the “dungeon” (our nickname for the studio) where I did my schoolwork. Ares helped me learn how to use the NVivo program. I also dedicate this to my other family members and friends who understood why I could not spend time with them. They would say, “We’re proud of you, Gwen.”

I owe a special thanks to my husband, Michael (Mike), who supported me throughout my educational journey. I could not have finished without Mike, my partner, my love and soul mate. Mike admitted he wanted to spend more time with me (walks, movies, etc.), but he said it was more important to him that I finish my dissertation journey. His love boosted my spirits and his encouragement kept me going when I wanted to give up. He kept me focused as we lost my dad, Mike’s mom, Etta (L’Bay), my mom, Grandma Cora, Auntie Margaret, my sister, Corlette (Coco) Taylor, and Mike’s sister, Erma.
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Chapter 1

Introduction

As patients are increasingly hospitalized with complex health issues, it is essential that physicians, nurses and unlicensed assistive personnel (UAPs) work together to meet health needs. Working together is not easy however; collaboration and cooperation in health care is complicated and challenging. In the hospital setting, collaboration refers to how physicians, nurses and UAPs interact concerning clinical decisions (Stein-Parbury & Liachenko, 2007). Robust collaboration and efficient communication among physicians, nurses, and other health care providers have been associated with improved patient outcomes, such as decreased hospital lengths of stay and reduced mortality rates (Siegele, 2009). Poor interdisciplinary communication and collaboration leads to negative consequences such as medical mistakes and poor quality service, and jeopardizes patient safety (Aston, Bullôt, Galway & Crisp, 2005).

The connection between interdisciplinary communication and collaboration and patient care outcomes highlights the importance of examining the phenomena among direct patient care providers like physicians, nurses, and unlicensed assistive personnel (UAPs). Chapter 1 presents background information and an overview of the problem as it relates to gaining insight into interdisciplinary communication among physicians, nurses, and UAPs. The research question, study design, and conceptual framework for the study are also presented. The last sections of the chapter include definitions, assumptions, limitations, and delimitations.
Background

Patients expect and often demand to receive safe, quality care in the hospital, and health care providers have a responsibility to protect patients by developing systems that promote prudent care (White, 2002). Annual reports by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) have consistently identified inadequate communication between health care providers as a root cause of adverse patient outcomes (Siegele, 2009). In response to the high incidence of medical errors, JCAHO established national safety goals, one of which is improving communication among health care providers; it is the number-two goal, behind improving patient identification (Beyea, 2006; Catalano & Fickenscher, 2008).

Tensions, misunderstandings, and conflicts among health care providers can interfere with effective interdisciplinary communication and collaboration. Conflict can be described as differences of opinions and interests among health care providers (Nelson, King, & Brodine, 2008). Conflict may arise from differences in opinion about patient care or from the longstanding perception of hierarchy of physician dominance and nurse subservience (Nelson et al., 2008). Poor physician-nurse communication and collaboration, and lack of shared ownership and shared responsibility for patient care pose barriers to patient safety (Buckley, Laursen, & Otarola, 2009). Poor nurse-nurse communication and collaboration can also create a barrier to safe patient care. A significant number of nurses report poor or fair interactions with their peers (Dougherty & Larson, 2010).

Conflicts may arise as nurses delegate tasks to unlicensed assistive personnel (UAPs). As nurses take on more responsibilities, they must relinquish some of their
duties to UAPs (Spilsbury & Meyer, 2004). According to the American Nurses Association (ANA), UAPs assist registered nurses (RNs) by performing delegated activities under RN supervision, which can include direct and indirect patient care (Kleinman & Saccomano, 2006). One crucial element of delegation is communication and teambuilding between registered nurses and UAPs (Kleinman & Saccomano, 2006).

Cready, Yeatts, Gosdin, and Potts (2008) presented thought provoking points about teamwork. Empowered teams consist of interdisciplinary members with various job titles and responsibilities. Team members make decisions about their own jobs and make recommendations to other team members. Studies indicate that empowered teams have a positive perception of the importance and meaning of their work, and feel competent to fulfill their responsibilities (Cready et al., 2008). The culture within an organization can affect employee performance and research indicates that poor relationships among health care providers can significantly affect patient care outcomes (Hader, 2005). An organizational culture must contain norms and values that help the organization adapt to a changing environment (Marion, 2005). In a toxic culture, there is a dictatorial, authoritative structure that fosters a sense of instability, distrust and fear (Sopow, 2006). Such a dysfunctional culture results in organizational relationships that leave little room for sharing or listening (Sopow, 2006).

Some hospitals have a toxic hierarchical organizational culture, which fosters an atmosphere of mistrust and hostility among workers, particularly among physicians, nurses and UAPs. In these hospitals, physicians write orders and tend dictate to nurses and nurses tend to do the same to UAPs; there is very little interaction among the groups. Providing quality healthcare requires an organizational culture that promotes
collaboration (Al-Assaff, Bumpus, Carter & Dixon, 2003). A negative work environment has been identified as a contributing factor to undesirable patient safety outcomes (Lin & Liang, 2007).

Collaboration is important to break down barriers and build a good working environment. Collaboration that allows health care providers to resolve their differences is likely to create a positive work environment (Nelson et al., 2008). Interdisciplinary collaboration can be effective when the professionals involved have a clear understanding of each other’s roles (O’Toole & Kirkpatrick, 2007). While the number of studies reporting the effect of working relationships and team dynamics on patient outcomes is relatively small, several studies have indicated the benefits of cohesive teamwork on patient outcomes (Rosenstein & O’Daniel, 2005). Maximizing nurse-physician collaboration and creating satisfying work roles can potentially improve patient care (Lindeke & Sieckert, 2005). Respondents to a 1997 national patient safety survey conducted by the American Medical Association’s (AMA) National Patient Safety Foundation (NPSF) identified carelessness on the part of overworked, hurried, and stressed health providers as the main reason for errors (Quigley, 2003).

Poor communication and collaboration among health care providers can increase medical errors, and place patient safety in jeopardy. Mraayan and Huber (2003) suggested that the incidence of medical errors could be reduced with a better understanding of the causes of patient injury and systems that promote patient health and safety. Researchers found that an interdisciplinary team-based work environment fosters safer patient care by improving communication, interdependence, and information
sharing among team members, thereby decreasing inadvertent and unintentional errors (Clark, 2009).

**Problem Statement**

The general problem is the negative impact of medical errors on patient safety. Medical errors are a major cause of death in the United States (Olden & McCaughrin, 2007). Nearly 100,000 patients die annually due to medical errors (Ross, 2008; Wakefield, 2002). White (2002) noted that increased research and public focus on the negative impact of medical errors, combined with increased demand for health care services, and increased accountability present challenges to the delivery of safe patient care. Inter-professional communication and collaboration is important to developing a culture of patient safety (Scherer & Fitzpatrick, 2008).

This qualitative, phenomenological study examined the specific problem of insufficient collaboration and poor communication among physicians, nurses, and UAPs, which jeopardizes patient safety. Conflict and misunderstanding among interdisciplinary health care providers can cause unintentional patient harm (Lin & Liang, 2007). The National Joint Practice Commission formed in 1971, and supported by the American Nurses Association and the American Medical Association, recognized the detrimental effects of nurse-physician conflict on patient care (Schmalenberg & Kramer, 2009). Nurse-nurse and nurse-UAP conflict can also contribute to negative patient care outcomes.

**Purpose Statement**

The purpose of this qualitative, phenomenological study was to explore how physicians, nurses and UAPs describe their individual functions and their roles as
providers of safe patient care. The proposed study also aimed to explore how members of each discipline view the functions and roles of members of the other disciplines. The anticipated outcome of the proposed study was a greater understanding of interdisciplinary communication and collaboration among physicians, nurses and UAPs to enhance patient safety. A qualitative interview process, utilizing open-ended questions (see Appendix G) and semi-structured dialogue was used for the study. Qualitative research methods involve collecting data from interviews or observation to explore and gain understanding of social phenomena from the subjects’ perspectives, in their own environments (Malterud, 2001). The population for the study consisted of a purposeful sample of male and female physicians, nurses, and UAPs of varying ages working at St. Luke’s-Roosevelt Hospital in New York City, NY. To ensure a comprehensive representation of the hospital, study participants included physicians (interns, residents and attending physicians), nurses and UAPs from medical-surgical units and specialty areas, such as the emergency department, critical care and psychiatry that worked at least one year at the hospital.

**Significance**

With increasing regulatory and public demands, increasing workloads, and decreasing resources, collaboration and cooperation among health care providers is essential to safely meeting patient care needs. Since physicians, nurses, and UAPs each provide portions of patient care, coordination of the various treatments and interventions provided is critical. Lack of cooperation and collaboration hampers efficiency and quality goals (Hofmarcher, Oxley & Rusticelli, 2007). Studies indicate that a cohesive team with an integrative work process decreases fragmentation of care (Anthony, Casey, Chau, &
Brennan, 2000). Collaboration requires bringing various perspectives into the decision-making process. Differences in perspectives can affect understanding in clinical situations (Stein-Parbury & Liaschenko, 2007). A person’s perceptions of truth can be obscured by his or her system of beliefs, assumptions, values, and contexts (Cunningham & Cordeiro, 2006).

Many issues can affect communication. Contributing factors may include individual communication style differences, gender, perspectives, education, previous experiences, culture, stress, fatigue, established hierarchies, and social structures (Manning, 2006). Breakdowns in communication or misunderstandings between physicians and nurses or among nurses themselves can lead to errors or omissions in patient care and can cause serious patient injury or death (Hader, 2005). Communication failure can delay diagnosis, create confusion regarding a patient’s plan of care, and cause unnecessary repeated tests (Sutker, 2008). Sutker (2008) reported that a recent survey of physicians listed poor communication among physicians, nurses, and other professionals as one of the top four obstacles to patient safety. The significance of the study is that it can provide information to enhance interdisciplinary communication and collaboration among physicians, nurses and UAPs, thereby positively impacting patient care outcomes.

**Significance of Study to Leadership**

Hospital leaders may use the findings of the study to facilitate the development and maintenance of an effective patient safety culture, which requires leadership at many levels (Callahan & Ruchlin, 2003). The members of a cross-disciplinary committee of hospital department heads may utilize an understanding of the various viewpoints and perspectives of patient care to design effective in-house training programs. Effective
leaders understand that no sustainable change can occur without understanding that all practitioners have their own beliefs about what constitutes good practice and safe patient care (Wagner et al., 2006).

Responsible leadership recognizes the need to acknowledge and embrace diversity in the workplace and in the decision making process. According to Pless (2007), responsible leadership requires understanding diverse stakeholders and motivating and promoting a shared sense of meaning, purpose, and commitment. Effective leadership involves merging knowledge, practice, politics, ethics, traditions and new visions, as well as identifying motives emotions, attitudes, abilities, intentions, preferences and relationships that complicate practice (Cunningham & Cordeiro, 2006). Enacting effective leadership can facilitate high levels of collaboration, trust and respect, and stimulate improvements in teamwork, quality and safety (Greenfield, 2007). Leaders create familiarity and flatten the hierarchy, making people feel more comfortable about raising concerns (Pfrimmer, 2009). Through collaboration, patient care solutions that reflect the combined wisdom of health care team members can be created (Tschannen, 2004). An understanding of collaborative processes in health care teams can provide a theoretical basis for health care education and training (Patel, Cytryn, Shortliffe, & Safran, 2000).

Nature of the Study

The goal of the study was to discover ways to enhance interdisciplinary communication and collaboration, thereby promoting the development of a patient safety culture. The study used qualitative research methods to understand perceptions of physicians, nurses and UAPs on professional roles in safe patient care; perceptions of
personal roles as well as the roles of other professionals were also assessed. A qualitative research method provides a useful approach for investigating the meanings, interpretations, social norms, and perceptions that impact behavior (Hansen, 2006). The information can then be used to develop strategies that are individualized to the participants and their unique situations (Goering, Boydell, & Pignatiello, 2008).

Quantitative research methods represent human experiences in numerical terms, usually through experimental designs testing existing hypotheses (Hansen, 2006). Quantitative researchers try to determine the cause of events and to predict similar events in the future (Merriam, 2009). Quantitative investigators distance themselves from the subjects and systematically describe facts and characteristics of a phenomenon or the relationships between phenomena (Merriam, 2009; Neuman, 2003). Qualitative researchers, on the other hand, are not necessarily interested in the cause and effect of phenomena; they seek to understand an event from the subject’s perspective of its meaning (Merriam, 2009). A qualitative research method was therefore appropriate for gaining an understanding of physician, nurse and UAP perspectives on their roles as providers of safe patient care.

Health care professionals provide care to diverse populations with various perspectives and experiences. Nursing, for instance, focuses on an individual’s health experiences and on helping people optimize their health. The American Nurses Association defined nursing as “the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations” (American Nurses Association, 2011, para. 1).
The phenomenological research design is well suited to nursing research. Phenomenology allows researchers to explore perceptions and experiences to discover meanings from a subject’s point of view (deMarrais & Lapan, 2004). In order to diagnose and treat human responses, nursing promotes sensitivity, cultural competence, and holistic care. Sensitivity is closely linked to perception and feeling, which, in turn, are linked to appreciation, empathy, and understanding (Sayers & de Vries, 2008). Cultural sensitivity and cultural competence requires acquisition of knowledge of other cultural ways and identifying patterns in order to individualize patient care (Maier-Lorentz, 2008).

The value and strength of phenomenology lies in challenging assumptions about the world or a phenomenon. Phenomenological research is a specific subset of qualitative research that focuses on analyzing people’s life experiences (Koivisto, Janjonen, & Väisänen, 2002). Over the last 20 years, the phenomenological approach gained prevalence in nursing research because it is considered highly appropriate for examining the human experience (Wimpenny & Gass, 2000). Phenomenology encourages researchers to look beneath the surface of a phenomenon, and to be sensitive and open to new insights. Thus, a phenomenology researcher explores a phenomenon from a subject’s point of view, or as a subject experiences it.

Physicians, nurses and UAPs all have their own subculture within the health care system; they have different histories and forms of education that foster different professional identities, values, perspectives and skills (Stein-Parbury & Liaschenko, 2007). A patient safety culture that recognizes the importance of communication and collaboration depends on the perceptions, attitudes, knowledge and skills of health care
providers (Scherer & Fitzpatrick, 2008). Researchers assert that culture and socialization are determinants of effective collaboration, along with factors such as interpersonal trust, respect, and open communication (Stein-Parbury & Liaschenko, 2007).

While the expertise of physicians, nurses, and UAPs as individual practitioners are important to safe patient care, good interdisciplinary relationships are also important to high quality patient care. However, different perspectives and priorities among the disciplines may present a barrier to collaboration that prevents them from capitalizing on their interdependence (Siegele, 2009). The interdependence of physicians, nurses and UAPs supported the case for a qualitative phenomenological study aimed at understanding communication and collaboration among these health care providers.

Individuals experience life differently thereby creating varied perspectives about their existence in the world. Phenomenological researchers are interested in how a phenomenon is lived (Giorgi, 2008). Phenomenology attends to the meaning conferring presence in and to the life-world (Garza, 2007). Meaning is reflected in the focus on the interaction between people and their perceptual environments and the world of experiences in which people meaningfully live together (Garza, 2007). Kleiman (2004) described lived experiences as those that disclose the vital, pre-reflective awareness an individual has about the events in which the individual participated.

Phenomenological inquiry requires that biases and preconceived notions about the phenomenon under study be recognized and acknowledged. Phenomenology is a direct exploration and account of an event as mindfully experienced, without preconceptions or presuppositions; central invariant structures or essences of the everyday experience are examined (Maly & Krupa, 2007). The term essence refers to the concepts that provide
common insight into the phenomenon under investigation (Maly & Krupa, 2007). A phenomenologist investigates phenomena from the participant’s perspective, using the participant’s own words and expressions of the experience (Giorgi, 2006). Based on the nature of the study, the following research question was explored.

**Research Question**

The research question guiding the study focused on understanding the barriers to effective interdisciplinary communication and collaboration among physicians, nurses and UAPs. The qualitative researcher engaged in prolonged interaction with study participants using interviews and observations to gain a true understanding of their individual and collective life experiences (Broussard, 2006). Phenomenological researchers seek to discover the “lived meanings expressed in the data that are psychologically relevant and then through eidetic intuition, raise them to a typical, general level and then comprehend the lived experience on the basis of its essential components” (Giorgi, 2008, p. 43). The central research question for the exploratory study was broad enough to allow uncontrolled descriptions and permit patterns and themes to emerge. The central research question was: How do physicians, nurses and UAPs perceive each other’s role in patient care and interdisciplinary communication and collaboration?

**Theoretical Framework**

The Schutzian lifeworld phenomenological orchestra study reported by Valerie Malhotra (1981) provided a model for the study. The orchestra study illustrates how an orchestra’s final symphony performance is made up of more than the sum of its parts or orchestra members. While members may have a shared stock-of-knowledge, they also
have individual experiences or stocks-of-knowledge and view a phenomenon from slightly different angles or perspectives (Malhotra, 1981). The musicians in the orchestra hear certain parts of the music being played, but do not hear the entire piece while they are playing (Malhotra, 1981). The purpose of the symphony study was to gain better understanding of how the various perspectives come together to produce a comprehensive musical performance.

In most orchestras, a conductor leads the group. The conductor directly oversees the musicians, decides what, how and when the music is played (Seifter, 2001). The conductor model for the orchestra fosters a hierarchical approach to the musical performance. In this type of orchestra, there is little room for the opinions and suggestions of the musicians and such input is rarely solicited (Seifter, 2001). The traditional orchestra model presents a barrier for interdisciplinary communication and collaboration in the hospital.

According to Malhotra (1981), a conductor is not an absolutely essential component of an orchestra. A conductor-less orchestra system is a collaborative leadership model that invites every member to participate in decisions (Khodyakov, 2007; Seifter, 2001). The conductor-less orchestra system demonstrates a willingness to change and promotes open communication (Khodyakov, 2007). The model encourages all members to give their best performance (Khodyakov, 2007; Seifter, 2001).

The study sought to understand physician, nurse, and UAP perceptions of interdisciplinary communication and collaboration to facilitate safe patient care. Physicians, nurses and UAPs sit in various positions in the health care orchestra when performing the musical score (patient-centered care). Each health care provider sees
patient care from a slightly different perspective. Each orchestra member brings to bear his or her own stock-of-knowledge about the score that affects how he or she approaches or interprets the composer’s (patient) musical score (Malhotra, 1981). In some hospitals, there is a disconnection between the various orchestra members’ (physician, nurses and UAPs) interpretations of the music (patient care). The objective of the qualitative phenomenological study was to increase understanding of how to influence the various health care providers to deliver more collaborative care.

Malhotra (1981) discussed creating a “we-relationship,” a form of cooperation and collaboration.

It is based on face-to-face interaction where participants are immediately aware of each other…They hear the music produced by the other and intermittently communicate verbally and nonverbally…Mutual ‘tuning in’ occurs…Each player must not only be conscious of his or her own part, but also of the parts of the other musicians. (Malhotra, 1981, p. 105)

In the hospital, safe patient care is the musical score and the main focus of the orchestra of health care providers. In a successful orchestra performance, the musicians (physicians, nurses and UAPs) engage in a joint interpretive project based on their individual and collective stock-of-knowledge (Malhotra, 1981). A successful performance depends upon the expression of relatively independent and distinct efforts in a collaborative whole (Bartolovich, 2007). The musicians must be perceptive to each other and coach each other, playing the notes as the composer (patient) wrote them, in order to produce a cohesive performance (Bartolovich, 2007; Malhotra, 1981).
Discourse theory and team building theory support the metaphoric orchestra model. Musicians (physicians, nurses and UAPs) must effectively communicate with each other in order to function as a cohesive health care team. Discourse is a reciprocal process of sharing contrasting ideas (Friman, 2010). Interdisciplinary practitioners synthesize disciplinary knowledge in new ways to create unified knowledge (Friman, 2010). Retchin (2008) suggested that collaborative interprofessional care models combine complimentary skills from health care providers with markedly different training, aptitude, and certification. Effective collaborative models can be influenced by interaction and the structure of a health care team (Retchin, 2008). Hardy, Lawrence and Grant (2005) argued that effective collaboration emerges from a process in which conversations produce discursive resources that create a collective identity and then translate that identity into collaboration. Research consistently recommends the investment of time and resources toward team building, development of flexible organizational structures, effective communication and shared control by all health care professionals to yield positive care outcomes (Bélanger & Rodriquez, 2008). Discourse can enable physicians, nurses and UAPs to find common ground to build a cohesive orchestra (team) and efficiently perform the music of patient care.

**Definitions**

Some terms and phrases included in the study may generate various interpretations. For the purpose of the study, critical terms and phrases are defined below.

**Collaboration:** Collaboration is the process in which health care providers with different knowledge and skills interact to synergistically and constructively influence patient care (Nelson et al., 2008; Ross, 2008; Vazirani, Hays, Shapiro, & Cowan, 2005).
Collaboration involves “direct and open communication, respect for different perspectives, and mutual responsibility for problem solving” (Stein-Parbury & Liaschenko, 2007, p. 471).

Nurse: The term nurse refers to a registered nurse (RN). A person must graduate from an accredited nursing program and pass the National Counsel for State Boards of Nursing Licensing Examination for registered nurses (NCLEX-RN) (New York State Education Department, 2006).

Patient safety: Patient safety is a term adopted by the federal government’s Agency for Health Care Research and Policy, which refers to protecting patients from unintentional harm or adverse medical events (Weinberg, 2002).

Physician: A physician is a person who has completed a program of medical education, received the doctor of medicine (MD) or equivalent degree, and is licensed to practice medicine. A physician diagnoses, treats, operates, or prescribes for any human disease, pain, injury, deformity, or physical condition (New York State Education Department, 2011).

Unlicensed Assistive Personnel: Unlicensed assistive personnel (UAPs) are unlicensed individuals, regardless of title, trained to assist registered nurses with delegated patient/client care activities (Kleinman & Saccomano, 2006; Newhouse, Steinhauser, & Berk, 2007). UAP titles include, but are not limited to nursing assistant, certified nursing attendant, patient care assistant, health care assistant, support associate and patient care technician (Reid, 2004).
Assumptions

An assumption is a theory or belief that acts as a starting point for developing other theories or theoretical statements (Neuman, 2003). A vital assumption in the study was that physicians, nurses and UAPs in the hospital have negative perceptions about each others’ contributions to safe patient care that interfere with effective communication and collaboration. Physicians, nurses and UAPs barely speak to or listen to each other. Patients might provide different information to each member of the team. For instance, a patient might tell the UAP about the regular parties he attends, where he gets “wasted” in conversation during hygienic care, but not mention it to the physician or nurse, for whatever reason (even though they asked him about drinking). Another assumption was that physicians, nurses and UAPs could work collaboratively to provide patient care. Other assumptions were that enough physicians, nurses, and UAPs can be recruited to participate in the study and that participants will provide open and honest contributions.

Scope

The research question, participants, data collection and evaluation guided the study. The methodology was designed to explore the various perceptions of physicians, nurses and UAPs towards interdisciplinary communication and collaboration. The scope of the study was limited because physicians, nurses and UAPs were solicited for participation at only one major metropolitan hospital center.

Limitations

It was expected that limitations to the study might include recruiting enough participants for the study, gaining full honest cooperation from participants, and time constraints. Phenomenological researchers must be concerned about a participant’s ability
to reflect, focus, intuit and describe. Purposeful sampling was used for the proposed study, so care was taken to choose participants who were willing to challenge their taken-for-granted assumptions and understandings (McNamara, 2007).

Another potential problem for the study was familiarity with subjects. Pre-established relationships with study participants could have positively or negatively affected participation. To minimize potential negative effects of familiarity, the researcher ensured that knowing the participants did not interfere with identifying the participants’ experiences (Roberts, 2007). This will be discussed further in the Methods section.

**Delimitations**

A delimitation of the study included the focus on the central phenomenon, physician, nurse and UAP perceptions of interdisciplinary communication and collaboration. Another delimitation of the study could be the exclusion of health care providers other than physicians, nurses and UAPs; licensed practical nurses were not included because of their limited numbers in the hospital setting of the study. Drawing participants from only one hospital site and using specific selection criteria also perpetuate delimitation.

**Summary**

Increasing reports of negative patient outcomes (including death) underscore the importance of collaboration among health care providers to safely meet patients’ needs. Interdisciplinary communication and collaboration are important for coordinating patient care and developing a patient safety culture in the hospital (Scherer & Fitzpatrick, 2008). Safe patient care involves implementing practices associated with the best possible
outcomes and avoiding actions associated with poor outcomes (Clarke, 2006). Interdisciplinary collaboration is essential to delivering cohesive patient care (Nelson et al., 2008; Newhouse, 2008), and breakdowns in communication can prompt devastating effects on patient outcomes (Hader, 2005; Sutker, 2008). Building a safer health care environment demands researching and the developing of systems to continually monitor, evaluate and improve mechanisms to prevent errors (Al-Assaff et al., 2003). Understanding of physician, nurse and UAP perceptions of interdisciplinary communication and collaboration is an important step toward supporting patient safety efforts.

In Chapter 1, the rationale for exploring the perceptions of physicians, nurses and UAPs in order to investigate interdisciplinary communication and collaboration was provided. A qualitative phenomenological method utilizing a semi-structured interview approach also was described. The plan to analyze data for patterns and themes that characterize participants’ experiences was briefly explained. The Schutzian lifeworld phenomenological orchestra study (Malhotra, 1981) was presented as the theoretical model for the study. The significant terms, assumptions, limitations, and delimitations for the study were described.

Chapter 2 provides a comprehensive review of the literature as a foundation for the study. The discussion begins with a historical overview of interdisciplinary communication and collaboration among physicians, nurses and UAPs. Individual findings and conclusions from the literature are also presented and summarized.
Chapter 2

Literature Review

This qualitative, phenomenological research study aimed to explore the perceptions of physicians, nurses and unlicensed assistive personnel (UAPs) in order to understand interdisciplinary communication and collaboration. Interdisciplinary communication and collaboration is important to providing safe patient care and depends on the interactions of health care providers with highly diverse cultural, ethnic, educational and medical backgrounds (Pfrimmer, 2009). According to Resnick and Bonner (2003), “collaboration integrates the individual perspectives and expertise of various team members on behalf of providing quality patient care” (p. 444). Breakdowns in communication cause a vast majority of adverse patient outcomes (Pfrimmer, 2009); thus, strategic communication is critical to building successful collaboration and meeting common goals for patient care (Siegele, 2009).

Interdisciplinary communication among physicians, nurses, and unlicensed assistive personnel is essential to promoting continuity of patient care. The Institute of Medicine (IOM) report *To Err is Human* noted that the American health care system is highly fragmented and often wastes resources by duplicating efforts, causes gaps in care, and fails to build on the strengths of all health care providers (Weinberg, 2002). The IOM recommended implementing systems for reporting, aggregating, and analyzing medical errors, and using the analyses to drive improvement in the health care system (Clarke, 2006). Building a safer health care system requires research, development and implementation of systems to reduce errors, thereby creating a culture that is dedicated to the highest standards of patient safety (Al-Assaff et al., 2003).
Literature Searched

A literature search was conducted for the study. Major databases reviewed included EBSCOhost, ProQuest, Journals@Ovid, Questia, Thompson Gale PowerSearch, JSTOR, Medscape and Medline. Key words used included combinations of the following words or phrases: interdisciplinary communication, collaboration, teamwork, physician-nurse relationship, physician-physician relationship, nurse-nurse relationship, unlicensed assistive personnel (UAP), nursing assistant, nursing attendant, certified nursing attendant, health care assistant, patient safety, and quality of care.

The research question described in Chapter 1 provided a guide for the literature review. The following review begins with a discussion of the historical relationships among physicians, nurses and UAPs. An overview of the current literature pertaining to physician, nurse and UAP relationships, and interdisciplinary communication and collaboration is presented. Chapter 2 concludes with a summary of the current findings concerning interdisciplinary communication and collaboration among physicians, nurses and UAPs.

Historical Overview

Historically, the physician-nurse relationship was hierarchical in nature. The physician was seen as superior to the nurse. The physician-nurse relationship was clear, physicians had the knowledge, and the nurses were good, but not necessarily very knowledgeable (Radcliffe, 2000). A traditional part of the physician-nurse relationship consisted of nurses complying with physicians’ orders (de Raeve, 1993). Davies, Salvage, and Smith (1999) associated the physician-nurse-patient relationship to a family in which the physician was the husband (head of household), wise, firm, yet kindly. The
nurse was the wife who stayed in the background, dutifully keeping order among the servants and perpetually watchful of her husband’s needs. The patient was the respectful and obedient child that was slightly in awe of the father.

Stein’s (1968) groundbreaking work described the physician-nurse relationship as the doctor-nurse game. Submissive female nurses, who were supposedly responsible for patient services, surreptitiously guided the clinical decisions of dominant male physicians, who were responsible for diagnosing, operating and prescribing for patients (Reeves, Nelson, & Zwarenstein, 2008). According to Stein, nurses knew not to directly confront physicians with treatment recommendations. Nurses made subtle suggestions, and being careful not to appear insolent, persuaded the doctors to seriously consider their ideas. In a well-played game, the physicians and nurses efficiently operated as a team.

Over the years, some elements of the doctor-nurse game changed, while others remained the same. In 1990, Stein (as cited in Radcliffe, 2000) found that nurses tired of their subservient image and began to seek and value a professional image. The change was partly due to social transformations in society in which a power balance between the genders and changes in the professions, particularly the increase in the number of female physicians, began (Reeves et al., 2008). A nurse’s role in health care meant more than being a good woman; it was about being a well-educated, independent, and skilled practitioner (Radcliffe, 2000). The historically negotiated territory of doctor-nurse relations and the pillars of professional autonomy and responsibility impede the transition from professionally anchored care to collaborative care (Reeves et al., 2008).

A power struggle also impacted the nurse-UAP relationship. The UAP role was often stigmatized and stereotyped as “unqualified” or “untrained” (Stokes & Warden,
Health care organizations often envisioned UAPs as cheap labor whose duties frequently overlapped with those of registered nurses (Thornley, 2000). In addition, ambiguous or nonexistent UAP training assessment and monitoring guidelines caused confusion about how to appropriately delegate to them, fueling conflict among nurses and UAPs (Quallich, 2005; Stokes & Warden, 2004).

More Recent Findings

Patient Safety

All health care practitioners have a responsibility to protect patient safety. Maintaining an environment in which all health professionals can practice safely, competently and ethically is a critical goal in health care (Storch & Kenny, 2007). The IOM Committee on Quality of Health Care in America’s report To Err is Human: Building a Safer Health System spawned the idea that medical errors and resultant patient injuries may be a systemic problem, rather than simply the result of individual mistakes (Basanta, 2003; Olden, & McCaughrin, 2007; Ross, 2008; Schutz, Counte, & Meurer, 2007). The IOM report included several specific recommendations ranging from legislative and regulatory initiatives to creating organizational cultures that encourage recognition and learning from errors (Basanta, 2003; Messmer, 2008; Quigley, 2003; Wakefield, 2002). Patient safety requires open communication among health care providers, patients, and the community, learning from mistakes, and a flexible health care culture that can rebound from crises (American Society for Healthcare Risk Management, 2006). Patient safety means doing the right things in the right way for the right patient at the right time (Clarke, 2006).
Health care organizations institute various initiatives in an effort to improve patient safety with inconsistent success. Schutz and colleagues (2007) investigated patient safety improvement initiatives within a conceptual framework that builds on organizational ergonomics and emphasizes structural influences on patient safety. Effective design of work systems considers the interaction of the external environment, the technical subsystem, the internal environment, and the employee subsystem (Schutz et al., 2007). The study supported the development of a patient safety culture encompassing individual perceptions of safety, and recognizing that different work units (health care professions) may assume different levels of safety based on their work, interactions, or working conditions. The interactions among physicians, nurses and UAPs affect a hospital’s patient safety climate and must continually be examined to maximize patient safety.

**Organizational Culture**

Organizational culture can influence patient safety. Culture is a set of group beliefs, customs, language, norms, and values that are passed along by communication, interaction and imitation (Mannahan, 2010). Organizational culture plays a central role in the health care work environment by shaping the environmental incentives and experiences that prompt organization members to act; it influences attitudes such as motivation and commitment, and influences quality of work (Gifford, Zammuto, Goodman, & Hill, 2002). Organizational culture provides the framework for guiding behaviors, interaction, and organizational function (Casida, 2008). The organization provides the context in which physicians, nurses and UAPs interact and communicate (Arford, 2005). A negative organizational culture could negatively affect organizational
function. Strong negative emotions can cause people to adopt defensive behaviors such as withdrawal, dissociation, competition and politicking, which then contribute to communication problems, apathy, fatigue, error rates and decreased productivity (Hornstein & deGuerre, 2006).

According to Malloy and colleagues (2009), the perceptions of health care organizational culture may vary dramatically based on the hierarchy within the organization, as well as the professional discipline. Understanding and aligning the individual group cultures of physicians, nurses and UAPs is essential in order to provide appropriate and consistent patient care. Scholars noted that conflicting cultures lead to misunderstanding, under-appreciation of work roles and responsibilities, and inconsistent decision-making (Malloy et al., 2009).

Adopting a patient safety oriented organizational culture is gaining popularity in health care. Protecting patient safety is a team effort and every health care team member plays a significant role (Clancy, Farquhar, & Sharp, 2005). Casida (2008) presented the Denison Organizational Culture Model, which includes four organizational culture traits: adaptability, involvement, consistency, and mission. When these four cultural traits are positively aligned, the organizational culture supports positive interaction among organization members and promotes patient safety. An ineffective patient safety culture can cause unintentional harm. Clarke (2006) stated that in order to prevent this unintentional patient harm, health care providers must be aware of the nature of the problems in the health care system, make systemic changes, and monitor their effects. Using a medical sociological approach, Infante (2006) analyzed barriers to problem solving derived from the connection between patient safety and interprofessional care and
suggested a systems approach to handling medical errors to help facilitate
interprofessional communication. Similarly, Olden and McCaughrin (2007) built on
Daft’s organizational theory to develop an organizational design for reducing medical
errors. According to Daft (as cited in Olden & McCaughrin, 2007), examining the various
parts of an organization, how those parts interact, and how the interactions affect
organizational performance and patient outcomes is important to developing an
environment that supports patient safety.

A patient safety culture is also a critical factor in the operating room. Physicians,
nurses and UAPs, such as operating room (OR) technicians must act in concert to safely
perform surgery. Scherer and Fitzpatrick (2008) conducted a survey to examine and
compare the perceptions of nurses and physicians in the perioperative area toward a
hospital safety culture. The study reported significant differences between nurse and
physician perceptions of patient safety; however, the study was limited in scope and the
types of questions used to gather data provided no insight into identifying or
understanding their perceptions (Scherer & Fitzpatrick, 2008). Clancy and colleagues
(2005) advocated developing a safety culture that focuses on analyzing how and why
problems occur in an environment of mutual trust and respect.

Hughes and Lapane (2006) conducted a cross-sectional study of nurse and nursing
attendant perceptions of the patient safety culture in nursing homes. The study domains
included overall safety perceptions, teamwork within departments, communication
openness, feedback and communication about errors, non-punitive responses to errors,
organizational learning, management expectations, and actions promoting safety. The
study noted a difference in nurse and nursing attendant perceptions of patient safety in the
nursing home. However, the study focused on the differences in perceptions of the treatment or reporting of errors, rather than on perceptions of what patient safety means to nurses and nursing attendants. While reporting errors is important, building a true patient safety culture requires that nurses and UAPs develop a common understanding of what patient safety means.

Cultural competence among physicians, nurses and UAPs can also influence patient care. Mannahan (2010) suggested that because medicine and nursing are often referred to as unique cultures, exploring and achieving cultural competence provides nurse leaders with new perspectives that can be used to improve relationships with physician colleagues, thereby positively impacting patient safety. Physicians, nurses and UAPs value the patient’s wellbeing, but the professional beliefs regarding how that wellbeing is achieved differs (Arford, 2005). Physicians treat disease based on what they physically hear, see, or count, while nurses view disease as a life experience (Arford, 2005). Physicians and nurses are trained in cultural competence related to the diverse patient populations they serve; therefore the concept of cultural competence can be used to gain a better understanding among the two groups.

Campinha-Bacote’s Model of Cultural Competence in Health Care Delivery provided a framework for expanding the application of cultural competence to the physician-nurse cultural context (Mannahan, 2010). The acronym ASKED illustrates the major constructs of the Campinha-Bacote model: awareness, skills, knowledge, encounters, and desire. Physicians and nurses must become aware of their own biases toward each other, be able to conduct a cultural assessment, have knowledge about the worldviews of each other’s culture, seek out face-to-face encounters or interaction with
each other’s culture, and have the desire to become culturally competent with each other. Cultural incompetence among physicians and nurses can lead to misunderstanding and conflict.

Working conditions can either enhance or inhibit patient care. Lin and Liang (2007) used historical research to examine the many issues impacting the nursing work environment. Research supported the belief that improving the interrelated concerns of the nursing work environment and nursing status would improve patient safety. Extensive research on health care work environment and workplace empowerment indicated a link between nurses’ working conditions and patient care outcomes (Manojlovich & DeCicco, 2007). Aberdeen (2004) suggested that poor workplace practices and attitudes could seriously impair the development of a personal care assistant’s competence.

The concept of a healthy work environment or organizational culture is gaining appeal in health care. Professional organizations and state and national authorities are increasingly challenging health care organizations and providers to improve work environments as a means of promoting patient safety (Kramer & Schalenberg, 2008). A healthy work environment is defined as “a work setting in which policies, procedures, and systems are designed so that employees are able to meet organizational objectives and achieve personal satisfaction in their work” (Shirey, 2006, p. 258) while providing safe, healing, humane, and respectful patient care environments. The six standards for a healthy work environment established by the American Association of Critical Care Nurses (AACN) include skilled communication, true collaboration, effective decision-making, appropriate staffing, meaningful recognition, and authentic leadership (Green, McArdle, & Robichaux, 2009; Shirey, 2006).
Maintaining healthy work environment standards supported the need for the study. Green and colleagues (2009) purported that promoting caring, self-knowledge, and self-care are necessary for emotional maturity, healthy relationships and empathy, and for promoting a healthy work environment. In a healthy work environment, health care interdisciplinary team members must recognize and appreciate each other’s contributions and work collaboratively to promote quality patient care (Green, 2009). Work environments that allow ineffective interpersonal relationships among health care workers and/or do not support educational efforts to change behaviors perpetuate intolerable working conditions that threaten patient safety (McCaffrey et al., 2010).

Manojlovich and DeCicco (2007) used a non-experimental, descriptive design to examine the relationships between nurse perceptions of their practice environments, nurse-physician communication and three patient outcomes sensitive to nursing care in the intensive care unit: ventilator associated pneumonia (VAP), catheter-associated sepsis, and medication errors. Results suggested a relationship between work environment factors and communication with physicians. The study also noted a significant relationship between catheter-related sepsis, medication errors, and the workplace environment scale, which indicated an inverse relationship between nurse perceptions of communication with physicians and all outcome variables. The study findings suggested there is a poor alignment between nurse and physician perceptions of communication.

**Communication**

Communication is crucial in health care. Arford (2005) stated that providing the best patient care must begin with clear and appropriate communication, and true
collaboration is impossible without it. Health care providers must be able to effectively share patient care information. Interprofessional communication can positively or negatively affect the vital partnership between health care providers and patients (Weeks, 2004). The Joint Commission for Accreditation of Healthcare Organizations (JCAHO) recognized the importance of communication in patient safety by setting a national standard to improve the effectiveness of communication among health care providers (Manojlovich & Antonakos, 2008). Communication is the mechanism that allows members of each health care discipline to influence each other and form caring networks (Yeo, 2006). Vital patient-related communication includes forming and implementing patient care plans, transitions of care and emergent situations, which require clear and concise exchanges of patient information (Manning, 2006). Communication breakdowns were identified as the root cause for approximately 70% of the sentinel/adverse events reported to the Joint Commission (Twedell, Donahue, Smith, Dykes, & Fitzpatrick, 2010). Various oversight agencies hold health care organizations accountable for adverse patient care outcomes resulting from ineffective nurse-physician communication (Arford, 2005).

Interdisciplinary communication is important to achieve desirable patient outcomes and fewer medical errors (Coeling & Cukr, 2000; Mcaffrey et al., 2010). Skilled communication focuses on critical elements needed for successful information sharing, including self-awareness, inquiry and dialogue, conflict management, negotiation, advocacy, and listening (McCaffrey et al., 2010). Inadequate communication among health care providers creates an environment that cultivates hostility, frustration, and distrust, which can lead to inferior patient care (Burke, Boal, & Mitchell, 2004). The
study aimed to identify specific behaviors that facilitate communication and can help physicians, nurses and UAPs develop specific skills to enhance collaboration.

Perceptions of effective communication differ somewhat in health care facilities other than the hospital. Volkman and Hillemeier (2008) surveyed school nurses to examine communication with community physicians and its relationship to school nurse satisfaction. The researchers suggested that leadership perceptions might contribute to the confidence of school nurses in their capabilities, and influence their communication with community physicians. Also, nurses’ experience with the system and with students may assist school nurses in communicating with physicians because the nurses have important background information on students. The study used data from a previous survey of Pennsylvania school nurses as a basis for research questions. The study examined school nurse perceptions of the effectiveness of their communication with community physicians. Study results indicated that 76% of school nurses reported very effective or effective communication with physicians (Volkman & Hillemeier, 2008). Most of the communication between school nurses and physicians was written, which may have affected the results.

Hospitals tried many strategies to overcome barriers to effective communication with limited success. Narasimhan, Eisen, Mahoney, Acerra, and Rosen (2006) instituted a quality improvement initiative aimed at improving communication in the medical intensive care unit (ICU) at Beth Israel Hospital Center in New York City concerning patients’ daily care plans. The initiative sought to determine whether using a daily goals worksheet (partially designed by physicians and nurses) would enhance communication among health care team members, patients, and their family members. Physician and
nurse perceptions of communication were surveyed before starting the initiative, and again at six and nine months after it began. A questionnaire was given to all of the interns, residents, attending physicians, and all ICU staff nurses. Both physicians and nurses reported improved communication with each other. Interestingly, willingness to continue to use the daily goals worksheet changed in opposite directions. Nurses initially resisted the worksheet, and physicians supported the idea. After the nine-month trial period, nurses wanted to continue using the daily worksheet, while physician interest waned. The study, which explored perceptions of interdisciplinary communication, can add new insight into why physicians and nurses distinguish things differently.

Using various communication styles showed promise for improving interdisciplinary communication. Coeling and Cukr (2000) conducted a study using Norton’s Theory of Communicator Styles as a framework to identify the effect of the dominant, contentious, and attentive communication styles on nurse perceptions of collaboration, quality of care, and satisfaction with the interaction. According to Coeling and Cukr (2000), these three styles were selected because previous studies indicated their importance in nurse-physician communication. The aim of the study was to establish if using or not using Norton’s three communicator styles was associated with actions nurses describe as collaborative (rather than non-collaborative), thereby improving the quality of patient care and/or increasing nurse satisfaction. Findings indicated that using an attentive style instead of a contentious or dominant style yielded significantly higher perceptions of collaboration, improved care, and increased nurse satisfaction (Coeling & Cukr, 2000). The study was limited to nurses entering advanced practice as opposed to regular staff registered nurses and did not include UAPs, which supported the need for further
investigation into physician, nurse and UAP perceptions of effective communication.

Weeks (2004) conducted a critical discourse analysis of physician-nurse communication. Discourse analysis examines verbal or written communication to determine the underlying meaning behind what is actually said or written (McCloskey, 2008). According to Weeks, the common theme that arises in empirical research is that although it is recognized that nurse-physician communication impacts patient care, communication patterns are not always effective and are sometimes destructive, thereby indicating a need for further research. Furthermore, the focus on the negative aspects of nurse-physician relationships dominate the discourse, thereby reducing the potential for the development of truly new approaches that lead to understanding and enhancing nurse-physician communication (Weeks, 2004).

Cultural factors can influence communication. Factors such as role conflicts, status differences, and education differences, and goal conflicts influence nurse-physician communication (Weeks, 2004). The fact that physicians and nurses run in different social circles lessens the chance of similar communication patterns and mutual understanding. Weeks (2004) suggested that gender and education might play a role in interdisciplinary communication. Women’s communication patterns are expected to be complaisant, while male communication is assertive; furthermore, assertive women are often unfavorably labeled. Different educational backgrounds may also cause goal conflict when determining priorities in patient care. Interestingly, Weeks (2004) pointed out that the virtual absence of physicians’ voices in nursing research might present an underlying discourse regarding physician interest in and concern about this issue (Weeks, 2004). A study that includes physician perceptions can add to the understanding of the issue.
Manojlovich (2005) used the nursing role effectiveness model (NREM) as a framework to study the relationship of the hospital work environment and nursing characteristics to nurse job satisfaction. The NREM is a conceptual model of the effects of nurse characteristics and work environments on nurse perceptions of the effectiveness of RN-MD communication and job satisfaction (Manojlovich, 2005). The study used only a few aspects of the NREM and a non-experimental survey design to explain how the work environment affects nurse perceptions of RN-MD communication and job satisfaction. The study findings indicated a connection between work environment, communication, and nurse job satisfaction; advantageous environments positively influenced nurse perceptions of communication with physicians and job satisfaction.

Manojlovich and Antonakos (2008) used a non-experimental, descriptive design to investigate nurses’ satisfaction with communication in the intensive care unit. The researchers asserted that the hierarchical boundary that often separates nurses from physicians could inhibit communication. In addition, nurses may be more dissatisfied with their attempts to communicate with physicians than vice versa. The purpose of the study was to determine if certain aspects of communication could be linked to nurse satisfaction with communication. The study found that openness and understanding were strongly associated with communication satisfaction; timeliness was moderately associated with communication satisfaction; and accuracy was relatively weakly associated with communication satisfaction (Manojlovich & Antonakos, 2008). Further examination of physician, nurse and UAP perceptions will add insight into why communication satisfaction differs.
Green and Thomas (2008) implemented a project aimed at improving nurse-physician communication. Survey data indicated that, according to physicians, the pertinent patient information required for successful nurse-physician collaboration were “antecedents to changes in patient status, documentation of changes in patient status, nursing interventions performed in response to changes in patients’ status, documentation of physician notification, and outcomes of interventions” (Green & Thomas, 2008, p. 226). The project provided some insight into what physicians expect from nurse-physician communication, but did not present how nurses or UAPs would interpret those expectations. Nurses and UAPs might not respond well to physician expectations, therefore further exploration was needed.

Brown and colleagues (2010) piloted an intervention to improve nurse competency for communicating depression-related information to physicians. The piloted intervention consisted of a two-hour classroom-based skills building course administered by a nurse educator and a geriatric psychiatrist. The course included a lecture on major depression and barriers and strategies for conveying depression-related information to physicians. The theory of diffusion of innovation provided the framework for the intervention and participants had the opportunity to observe and practice communicating pertinent information (Brown et al., 2010). The study suggested that nursing educational preparation was not significantly associated with certainty for communicating depression-related information at baseline. Also, communication did not improve after the training. This study, which included a physician researcher, provided no insight into whether training is an effective method for improving nurse-physician communication. In addition, the study did not include UAPs. Therefore, further research was needed.
Physician, Nurse, and Unlicensed Assistive Personnel Relationships

The physician-nurse relationship has changed somewhat over the years. While physicians and nurses continue to play the doctor-nurse game, as described by Stein (1968), the rules for nurses have changed. Physicians continue to embrace a hierarchical model of dictating orders that nurses complete, however, nurses currently consider themselves as equal health care providers obligated to make decisions and take responsibility for patient care (Weinberg, Miner, & Rivlin, 2009). Gould and Fontenla (2006) found that nurses highly value social interaction, respect for the profession and autonomy.

Weinberg and colleagues (2009) presented a qualitative study of the physician-nurse relationship from the perspective of medical and surgical residents. The study used the theory of relational coordination, which states that work is successfully achieved with high-quality relationships and communication among workers. Study results indicated that physician perceptions of nurse experience, education, and abilities to discern pertinent facts about patients affected the views of residents on physician-nurse collaboration (Weinberg et al., 2009). Since physician perceptions affect communication with nurses, it followed that there was a need for deeper understanding of those perceptions.

UAP-nurse relationships are also important. Seago (2000) conducted a survey of nurses and UAPs in five tertiary care hospitals, which measured self-reported thinking and behavioral styles in the workplace. The study sought to discover if there is a relationship between hospital position and the organizational culture inventory (OCI) thinking and behavioral styles. The study supported further investigation to gain
understanding of physician, nurse and UAP perceptions of their roles in safe patient care. The humanistic-helpful, affiliative, approval, conventional, and dependent thinking and behavioral styles reflect a concern for people. The oppositional, power, competitive, competence, and achievement thinking and behavioral styles reflect a concern for tasks. The self-actualization thinking and behavioral style reflects a concern for one’s own goals and the avoidance thinking and behavioral style reflects self-blame and guilt (Seago, 2000). Results of the regression analysis indicated that position was a predictor of a number of thinking and behavioral styles. Interestingly, UAPs scored higher on the dependent and oppositional thinking and behavioral styles than registered nurses. Seago (2000) suggested that the results of the study be interpreted cautiously and at the aggregate level only. This study supported further research into why nurses and UAPs thoughts and behavioral styles differ.

**Collaboration/Teamwork**

Researchers recognize the importance of teamwork/collaboration among health care providers to prevent fragmentation and ensure continuity of patient care. Working as a team, clinicians can address many of the conditions that perpetuate errors (Beyea, 2006). Research identified fragmentation of care as a contributing factor to medical mistakes (Retchin, 2008; Weinberg, 2002). Collaborative health care is a process in which health care professionals jointly provide patient-centered care (Thiele & Barraclough, 2007), thereby preventing fragmentation. Interprofessional collaboration allows health care providers to build an understanding that reflects independent and shared decision-making that increases the effectiveness of comprehensive health care delivery (Thiele & Barraclough, 2007).
The orchestra model incorporated into this study offered a foundation for building interprofessional relationships. The effectiveness of a team may be dependent on member perceptions of the team structure and conditions under which the team is formed (Anthony et al., 2000). Rodger, Mickan, Mauinac, and Woodyatt (2005) suggested that a professional group’s perception of how they should work with other professions impacts their interpretation of collaboration. According to Stupak and Stupak (2006, building successful teams requires reciprocal responsibility, giving and receiving feedback, open and interactive communications, respect and compassion, collaborative decision-making, focus, and strategic inclusion. Successful collaborative interaction involves nonhierarchical power sharing among individuals who are considered as collegial equals (Taylor, 2009).

Collaboration requires networking, leadership and vision (Boswell & Cannon, 2005). Networking strengthens collaborative efforts by enabling a person to identify and access multiple resources to build a team to accomplish desired goals, and a shared vision implies that all team members believe in the mission/goals of the group (Boswell & Cannon, 2005). Lack of a shared definition of collaboration presents a barrier to working together (Gardner, 2005). Other barriers to collaboration may include lack of time for teambuilding, confused roles, effects of professional socialization, and power and status differentials (Reeves & Lewin, 2004).

Perceptions of teamwork/collaboration vary among health care providers. Studies indicate that physicians and nurses have different perspectives on three types of information used to make patient care decisions: case knowledge, patient knowledge, and person knowledge (Stein-Parbury & Liaschenko, 2007). Case knowledge refers to
scientific information such as anatomy and physiology and disease processes; patient knowledge refers to a particular patient’s experience; and person knowledge refers to the patient as a person with a history/biography. Thomson (2007) conducted a study at Wake Forest University Baptist Medical Center to determine if there were differences in physician and nurse attitudes toward nurse-physician collaboration in the medical-surgical patient care setting. Thomson cited several multicultural studies motivating the research. One study compared U.S., Israeli, Italian and Mexican nurse and physician attitudes regarding nurse-physician collaboration (Thomson, 2007). The study findings suggested that nurses, regardless of cultural background, desired collaborative nurse-physician relationships more than physicians. Thomson (2007) also noted a Russian study, in which third-year medical students were encouraged to take nursing jobs prior to completing their medical educations. While the idea spawned from a need to ease the nursing shortage, it created a generation of physicians who were more knowledgeable of the nurse’s role in patient care and improved the nurse-physician communication gap. This study supported the need for further investigation into why nurses desire collaboration more than physicians. It also supported the need for better understandings of patient care delivery roles.

Schmalenberg and Kramer (2009) synthesized findings from six research studies pertaining to nurse perceptions of nurse-physician relationships. Nurses identified five types of nurse-physician relationships: collegial, collaborative, student-teacher, friendly stranger, and hostile/adversarial. Collegial relationships are characterized by equal trust, power, and respect (Schmalenberg & Kramer, 2009). Collegial relationships among physicians, nurses and UAPs could present a first step in developing collaborative
relationships. Collaborative relationships are distinguished by mutual instead of equal trust, power, respect, and cooperation. Mutual trust, power, respect and cooperation are often elusive concepts in the hospital. “Nurses freely say that the physicians and nurses listen to one another, but the ‘doctor is still on top’” (Schmalenberg & Kramer, 2009, p. 77). In the student-teacher relationship, either the physician or the nurse acts as a teacher. The friendly stranger relationship involves a cordial but formal exchange of information. Hostile/adversarial relationships involve anger, verbal abuse, and real or implied threats. In excellent hospitals, collegial and collaborative climates were dominant in medical units (Schmalenberg & Kramer, 2009). The nurse-physician structure-identification study suggested that clinical nurse-physician relationships might be improved by ensuring: patients’ best interests are the highest priority (i.e., creation of a patient safety culture); constructive conflict resolution is practiced; interactive interdisciplinary patient rounds occur; and competent performance and self-confidence are exhibited (Schmalenberg & Kramer, 2009).

The relationship between nurse practitioners (NPs) and physicians is similar to that of registered nurses. Evidence shows that NPs and physicians understand collaboration from different viewpoints. Running, Hoffman, and Mercer (2008) conducted a replication study to update findings on physician willingness to work with nurse practitioners. Physicians were asked to rate specific incentives for forming associations with NPs to determine if physician perceptions of NPs have changed. Also, the study sought to determine the factors that influence physician perceptions of collaboration with NPs. Increased accessibility to health care, improved quality of care, physician satisfaction, and economic benefits were the incentives investigated (Running
et al., 2008). The new study results were similar to the original study, which suggested that despite the increased responsibility and clinical competence of NPs, behaviors associated with the traditional relationships between nurses and physicians continued to exist and negatively influenced collaboration.

Clarin (2007) reviewed the literature to identify common barriers to effective nurse practitioner (NP) and physician (MD) collaboration and determine strategies to overcome those barriers in order to promote successful collaboration. Barriers to successful collaboration between NPs and MDs include lack of MD knowledge of the NP role and scope of practice, poor MD attitudes toward NPs, lack of respect for NPs, and poor communication between MDs and NPs. Research supported the need for physicians to be oriented to the concept of collaboration and to the NP role and scope of practice. The research also suggested using collaboration models, like the orchestra model in the current study, to differentiate NP responsibilities from MD responsibilities. Clarin (2007) noted that a weakness in the review was that the studies were conducted by NPs and many studies involved small samples. Therefore, additional study was needed from the physician perspective.

The lack of understanding of the UAP role poses a barrier to effective nurse-UAP collaboration. State Boards of Nursing recognize UAPs as nonprofessional or paraprofessional workers, frequently trained in workplace settings, who assist registered nurses (RNs) in providing patient care (Aberdeen, 2004; Kleinman & Saccomano, 2006). UAPs view their role as being similar to that of the RN and display a positive concern for their patients (Potter & Grant, 2004). A qualitative study in the United Kingdom (UK) examined nursing care assistant (NCA) perceptions of their role in health care. Studies
suggested that NCAs view themselves as facilitators in the communication between registered nurses (RNs) and patients (Workman, 1996; McLaughlin et al., 2000). NCAs also believed that by assuming routine tasks such as bathing and ambulation, they provided time for RN therapeutic patient care activities, and did not see many differences between their role and that of RNs in patient care (McLaughlin et al., 2000; Workman, 1996). Research in the United States indicated that hospital acute care nurses had a different perception. Nurses were not satisfied with UAPs’ level of training, skills, and ability to perform delegated tasks, communicate pertinent information, or provide more time for professional nursing activities (McLaughlin et al., 2000).

UAPs spend a significant amount of time with patients, providing hygienic care and support. Research indicates that nursing aides provide 21% of total patient care nursing hours (Howe, 2008). Nurses depend heavily on nursing care assistants to help with growing patient health care needs (Chapman & Law, 2009). However, it is difficult to find information about the UAP role in teamwork or interdisciplinary collaboration (Thornley, 2000). Thornley (2000) partly attributed the difficulty to the many titles associated with this group of health care providers, including generic support worker, clinical support worker, healthcare support worker, care team assistant, nursing assistant, ward assistant, theatre assistant, community care worker, home carer, scientific helper, doctors’ assistant, and bed-maker. Thornley also noted that a lack of understanding related to the role and training of these health care workers compounds the problem. Issues concerning these workers centered on whether they engage in “nursing” or direct patient care and clinical duties, or solely “ancillary” duties (Thornley, 2000).
Similarities in some of the patient care responsibilities for nurses and UAPs can cause confusion and threaten interdisciplinary collaboration. Anthony and colleagues (2000) explored the similarities in the perceptions of RNs and UAPs towards collaboration. Perceptions of the nurses’ role and collaboration with physicians were two areas investigated. While the study noted that there were no significant differences between RN and UAP perceptions of how physicians valued and collaborated with nurses, the study provided no indication of what those perceptions were or how they affected patient care. Also, the study did not discuss the nurse or UAP perceptions of collaboration with each other.

Potter and Grant (2004) reviewed and summarized studies that examined the characteristics of RN and UAP working relationships and the patient care practices that influence those relationships. It is important to understand how RN and UAP working relationships influence patient care and devise strategies to positively affect patient outcomes. Studies indicated that many nurses find it challenging to effectively communicate with UAPs, foster teamwork, and appropriately delegate responsibilities (Potter & Grant, 2004). Nurses have a responsibility to delegate patient care activities based on the specific UAP abilities and the intricacy of the activity, but many nurses are uncertain about what, how and when to delegate (Kido, 2001; Kleinman & Saccomano, 2006). Other concerns included educational background, the level of training in the healthcare institution, and an underlying mistrust between RNs and UAPs. Also, assigning UAPs to work with multiple RNs within a shift presented a barrier to developing good collaborative relationships. Research suggested that good RN-UAP collaborative relationships included taking initiative, communicating well, appreciating
each other’s contributions, and demonstrating a willingness to help each other with tasks (Potter & Grant, 2004). UAPs show initiative when they are easily accessible and anticipate patient care needs, and good communication is reciprocal. Respect develops as RNs and UAPs share the work and acknowledge each other’s contributions to patient care (Potter & Grant, 2004). The study suggested that further study was needed to gain better understanding of how RNs and UAPs can work together better in the interest of safe patient care.

Reflective practice could present a viable approach for improving interdisciplinary relationships and collaboration. Ross, King, and Firth (2005) introduced a technique to encourage health and social practitioners to reflect upon interprofessional relationships and practice. Phenomenological interview methods were adapted to design an exercise that allowed practitioners to reflect on and describe their experiences of a daily collaborative working event, and to consider ways to improve their working relationships.

The Ross et al. (2005) study had two stages. In the first stage, participants were asked to reflect on a work related occurrence, and then write the names (initials) or job titles of involved parties on arrow-shaped cards. The cards were then placed on a large sheet of paper in whatever pattern the participants felt described their working relationships. The facilitator insured that participants understood the procedure without prompting or coaxing. Once the participant completed organizing the cards, the cards were traced onto the paper forming a permanent record. Then participants were asked to describe their situation and explain the position of the cards.
The second stage of the Ross et al. (2005) study, involved the *Salmon Line* technique to help participants focus on how change might be achieved. The facilitator and participant selected a bipolar construct, such as friendly-unfriendly or good communication-bad communication. The choice of construct was often drawn from important themes that emerged from the discussion of the visual layout. A dimensional line was drawn on the back of the paper between the two poles of the chosen construct and each participant was asked to place the arrow-shaped cards along the line in relation to others and to provide reasons for the card placement, their ideal positions, and how they might improve their relationships. A case study of a nurse in the United Kingdom was presented to illustrate the reflective technique, which helped participants understand the procedure. The study found that despite being in constant contact with physicians in their practice, the nurses felt they had less of a teamwork relationship with the physicians than with other nurses. The nurses felt a lack of closeness and a lack of recognition and respect for their expertise. The study provided valuable insight into nurse perceptions of collaborative practice, but neglected the physician and UAP perspective.

Reader, Flin, Mearns, and Cuthbertson (2007) examined perceptions of collaboration among physicians and nurses in intensive care units (ICUs) in the UK. The aim of the study was to determine if a shared perception of interdisciplinary communication existed. Findings indicated that physicians perceived a higher level of communication and collaboration than nurses. Also, senior physicians reported a higher level of communication among physicians than junior physicians, with 88% of senior physicians and 53% of physician trainees reporting very positive perceptions. Further study was needed to explore why physicians might perceive a higher degree of
collaboration than nurses and UAPs and how those perceptions affect their professional relationship.

Siegel, Young, Mitchell and Shannon (2008) investigated the organizational, managerial, and nurse-level factors associated with the nurse supervisory roles over UAPs in nursing homes. The study used a qualitative, ethnographic approach that included interviews, observations, and a review of organizational documents. The investigators purposely limited the study to three nursing homes with fewer deficiencies than state and national averages, with the assumption that the sample would share the most basic levels of organizational systems needed to support the minimum standards of care. Results indicated that organizational support for the nurse supervisory roles varied across sites. Nurses described their supervisory roles as providing oversight and monitoring for UAP work. Managers reported that they expected ongoing, informal nurse-UAP communication and formal shift reports. Nurse job descriptions identified general descriptions for nurse reports to UAPs, but there were inconsistencies between job descriptions and observed practices. Managers acknowledged the need for supervisory education for nurses, but the education provided was limited. Studying perceptions among physicians, nurses and UAPs can better inform training efforts.

The aviation industry’s concept of crew resource management (CRM) provided a foundation for the idea of using simulation to improve teamwork. Aviation developed CRM to reduce critical judgment errors by training crewmembers to avoid or mitigate the consequences of errors by making better choices and making better use of each other’s talents (Gordon, 2006). Simulation has been used successfully to train flight crews to handle crisis situations. Applying these concepts to the health care setting, Messmer
(2008) studied the level of nurse-physician collaboration during simulation training. Messmer reasoned that simulation might be instrumental in improving patient outcomes during critical situations by teaching interdisciplinary teams to effectively work together. Simulation in health care increases learning and retention, improves overall performance and communication skills, and enhances teamwork while reducing patient safety risks (Messmer, 2008). The study noted that during the scenarios, physicians discussed decisions among themselves, and nurses behaved similarly. However, a team concept evolved by the end of the three scenarios. There were high levels of group cohesion and collaboration and satisfaction with patient care decisions; UAPs were not included in the Messmer study.

Weinberg (2002) discussed the need to change decision-making in healthcare from a clinician-run (usually the physician) system to a shared system of decision-making. Weinberg suggested that new methods of conflict resolution are needed to address patient safety issues. Evidence suggests that conflict between nurses and physicians continues to persist (O’Brien, Martin, Heyworht, & Meyer, 2009). However, some progress in nurse-physician relationships has been noted in some high acuity specialty areas, such as operating rooms, and intensive care units. Buback (2004) purported that physician-nurse relationships in the operating room could be improved with assertiveness training aimed at conflict resolution and communication skills. While these studies concentrate on the physician-nurse relationship, conflict among nurses and UAPs might also be improved with training.
Conflict Among Team Members

Physicians pledge their lives to the service of humanity, to practice with conscience and dignity, and to place the health of the patient above all else (Selvakone, 2009). In nursing, caring is the central theme through which nurses show moral character, respect and appreciation for patients and physician colleagues (Cook & Cullen, 2003; Hudacek, 2008; Kahn, 2005). Storch and Kenny (2007) asserted that the inability of physicians and nurses to work collaboratively represented an ethical failure and suggested that nurses and physicians develop a vision of shared moral work.

Physicians’ moral work focuses on clinical, scientific and ethical competence aimed at curing and healing. Nurses’ moral work focuses on the health experience of the person through treatment or other interventions, with attention to the “lived experience” of the individual and family in caring for them physically, emotionally and spiritually (Storch & Kenny, 2007, p. 485).

Shared moral work develops from a shared understanding and respect for the contributions of each health care profession. Storch and Kenny proposed that physicians and nurses develop a forum within the health care setting in which they communicate about their work environment and their experiences in working together for the patients’ benefit, and identify factors that constrain or facilitate collaborative practice. Once a trusting environment is established, a commitment to better understanding each other’s worlds may be obtained, further supporting improved patient care.

Lack of respect for one another can cause conflict among physicians, nurses and UAPs, which presents a barrier to teamwork and collaboration. According to Longo (2010), disruptive behavior and conflict among health care providers is an ongoing,
basically accepted aspect of health care that threatens the safety and wellbeing of patients and health care providers. Disruptive behavior was defined as “any inappropriate behavior, confrontation, or conflict, ranging from verbal abuse to physical and sexual harassment” (Rosenstein & O’Daniel, 2005, p. 19). The IOM identified dysfunctional relationships among nurses, physicians, and other healthcare providers as one source of potential medical errors (Saxton, Hines, & Enriquez, 2009). Similarly, the Joint Commission noted the negative impact of disruptive behavior on patient safety (Longo, 2010). A literature review by Saxton and colleagues (2009) revealed that 94% of respondents in studies of disruptive behavior reported a link between disruptive behavior and poor patient outcomes. Condescending language, disrespect, and failure to return phone calls were the disruptive behaviors identified most often as barriers to effective patient care (Burke et al., 2004; Saxton et al., 2009). Information from a phenomenological study of physician, nurse and UAP experiences can be used to find ways to mitigate behaviors that interfere with collaboration.

Attention is often focused on physicians when it comes to disruptive behavior (Longo, 2010). However, every health care provider has a responsibility to resolve problems that can compromise patient safety (Beyea, 2006; Longo, 2010). Rosenstein and O’Daniel (2005) examined physician and nurse perceptions of the impact of disruptive behavior on both the nurse-physician relationship, and patient care. The study provided evidence of disruptive behavior in both physicians and nurses. Disruptive behavior and conflict negatively affected physician and nurse frustration, concentration, information transfer, communication and interdisciplinary work relationships (Rosenstein & O’Daniel, 2005). The researchers recommended further studies aimed at finding
strategies to reduce disruptive behavior among physicians and nurses. The current study included UAPs as well, which will add another dimension to safe patient care.

Other studies also attempted to document the effects of negative relationships. Morrison and Nolan (2007) sought to uncover the causes and consequences of negative relationships through a qualitative analysis. The study explored participants’ feelings about negative relationships, or interactions characterized by frequent concealment, manipulation, conflict, disrespect, disagreement and/or animosity. While the study was not specific to the health care environment, it offered some potential reasons for negative relationships in the general workplace that may be useful in the health care work environment. Many participants stated that negative relationships affected communication, and when people were reluctant to talk with one another, mistakes were made. Increasing understanding among physicians, nurses and UAPs can provide a foundation for building better relationships, thereby positively affecting patient care.

One form of disruptive behavior, bullying is gaining attention in health care, among nurses, in particular. According to Johnson and Rea (2009), 37% of participants in their study on workplace bullying identified fellow nurses as the offenders. Dellasega (2009) wrote an article discussing nurses’ stories of bullying by other nurses. Bullying involves repeated attempts to cause actual or perceived physical or emotional harm or injury, usually perpetrated by a person that has some sort of hierarchical power over another person (Longo, 2010). Horizontal or lateral violence are forms of aggression towards someone with similar authority. Vertical violence is directed toward an actual or perceived subordinate, such as physician to nurse, or nurse to nursing assistant or technician (Buback, 2004). Relational aggression is a type of bullying in which
psychological and social behaviors cause harm (Dellasega, 2009; Johnson & Rea, 2009). The harmful effects of relational aggression may include excessive anger, anxiety, depression, loneliness, delinquency, and even suicide or homicide (Dellasega, 2009). Dellasega (2009) noted that there is limited information available on the subject of bullying among nurses in the United States; however more research is inevitable due to the Joint Commission’s requirement that health care institutions have processes in place to address intimidating and disruptive behavior in the workplace. A study examining physician, nurse and UAP perceptions of interdisciplinary communication and collaboration can better inform efforts to comply with the Joint Commission requirement.

Woelfle and McCaffrey (2007) reviewed five research studies to search for evidence of horizontal violence among nurses. If evidence existed, the second aim was to learn how lateral violence affected patient care. Horizontal violence is the “demeaning and downgrading of others through unkind words and cruel acts that gradually undermine confidence and self esteem” (Woelfle & McCaffrey, 2007, p. 123). The authors suggested that policies be put in place to protect and hold staff accountable for lateral violence, and that more studies be conducted in order to understand the nature and extent of aggression among nurses. Nurses cannot deliver compassionate, safe patient care if they are bombarded by an atmosphere of negativity and fear. Repeated verbal abuse may undermine a person’s self-esteem and decrease morale and confidence to provide quality work (Buback, 2004).

Feelings of oppression and misery might cloud a nurse’s judgment, causing them to engage in behaviors that keep others from performing at their best. Dunn (2003) proposed that sabotage is a form of horizontal violence and that oppressed groups feel
powerless to face their oppressors and turn anger and hostility inward, resulting in self-
destructive aggression and criticism within the group. Sabotage is an example of
misplaced aggression. Behaviors involved include discouraging, scapegoating,
backstabbing, complaining, and other forms of destructive communication. Dunn (2003)
conducted a correlational study aimed at determining if there is a relationship between
self-perceptions of the degree of sabotage in a workplace and the degree of job
satisfaction among perioperative nurses. The results indicated that the most frequent
methods of sabotage included being expected to do another person’s work, being
reprimanded in front of others, and not being acknowledged for one’s own work. This
study indicated a need for deeper exploration into nurses’ feelings about themselves.

Bullying among nurses is not isolated to the United States. Hutchinson, Vickers, Wilkes, and Jackson (2009) reported the results of the qualitative stage of a national
sequential mixed method study of bullying among Australian nurses. The authors
concluded that more research is needed to understand the enabling or motivating factors
behind bullying behavior. The study framed bullying as a corrupt behavior in an effort to
enlighten organizations about the seriousness of the problem. Hutchinson and colleagues
(2009) suggested that corruption is a form of behavior, which involves the “individual or
institutional misuse of public resources or entrusted power, for private power, profit, or
political gain, through conduct that deviates from rules” (p. 215).

Hutchinson and colleagues (2009) used semi-structured interviews to explore
nurses’ experiences of being bullied, their beliefs and perceptions about bullying, and
why it happened. The study noted five key aspects of bullying as organizational
corruption: silence and censorship (the institutional backdrop), networks of predatory
alliances, corrupting legitimate routines and processes, reward and promotion, and protection from detection. Silence and censorship involves institutional secrecy and cover up, which allows corrupt conduct to thrive; networks of predatory alliances refers to the nature of established informal organizational systems engaged in corrupt conduct; corrupting legitimate routines and processes refers to correct routines that are changed for personal gain; reward and promotion describes the way networks advance the careers of individuals within the alliances; and protection from detection refers to how members of alliances protect each other. For instance, respondents discussed a work environment in which the official position was to routinely deny that misconduct or adverse events occurred, in order to preserve the organization’s public image, thereby supporting corrupt behavior.

Using qualitative interviews, Silén, Tang, Wadensten, and Ahlström (2008) examined Swedish nurses’ experiences of workplace stress and the occurrence of ethical dilemmas in a neurological setting. Nurses in the study reported that although they supported each other in the workplace, they felt morally distressed because they could not influence their working situations. Routines, political decisions, and economic factors hindered them from providing patient care as they saw fit (Silén et al., 2008). In addition, nurses felt they were unappreciated and not respected as professionals by physicians. Conflicts among nurses and nursing assistants arose because nursing assistants wanted nurses to help with basic care, but the nurses had other medical tasks to perform. Kalisch (2009) compared RN and UAP perceptions of missed care and assessed how they explained underlying teamwork issues. Results of Kalisch’s study noted a lack of teamwork and communication among RNs and UAPs. Disagreements with colleagues
were distressing and negatively affected communication and cooperation (Silén et al., 2008).

The UAP occupation is highly stressful and nursing attendants often feel unappreciated and undervalued as members of the health care team. Few jobs are more physically and emotionally draining than that of a nursing attendant (Beck, Doan, & Cody, 2002). Nursing attendants perform most of the physically demanding aspects of nursing care, such as feeding, bathing, ambulating, toileting, and transporting (Marshall, 2006). Research found that nursing attendants have little or no control over their practices despite studies showing that including nursing attendants in the decision making process would positively impact patient safety. Excluding nursing attendants from shift reports, interdepartmental meetings, and patient care conferences discourages cooperative communication (Beck et al., 2002).

The issue of delegation contributes to the conflict among nurses and nursing assistants. Appropriate delegation plays an important role in job satisfaction and patient safety (Newhouse et al., 2007). Many nurses are not sure what and how to delegate appropriately. It is important that nurses understand the difference between delegating and dumping work to UAPs (Cohen, 2004). Often nurses express concern that delegation takes too much time, demonstrates lack of loyalty to their profession, or gives the impression of laziness (Quaillich, 2005). These perceptions create an environment in which the nurses are consistently overburdened, and cultivate conflict between nurses and UAPs. Good delegation is motivated by doing what is best for the patient; it is not a mechanism for offloading tasks nurses do not want to perform (Cohen, 2004). Howe (2008) found that educational programs aimed at empowering UAPs contributed to
improved patient outcomes. Nurses in England believe that UAPs should be regulated, trained and then held individually accountable for their practice (Alcorn & Topping, 2009). Recognizing UAPs as valued members of the health care team enhances motivation to provide quality patient care.

**Conclusions**

Consistent themes emerged in the literature review. Diverse perspectives on health care roles often cause conflict among team members, which affects their ability to perform well. Barriers and distractions in the healthcare environment make it difficult to make timely and efficient patient care decisions (Potter & Grant, 2004). Communication should be tailored to the needs of the audience (Luck & Rose, 2007), and research indicates that solutions to communication issues between nurses and physicians might arise from different sources for each group (Manojlovich & Antonakos, 2008). Physicians view collaboration as an activity involving work with their medical colleagues, while other health care providers see collaboration as an interprofessional activity (Reeves & Lewin, 2004). Sometimes, physicians perceive nurses’ desires for increased autonomy and improved communication as possible encroachment on physician territory (Weeks, 2004). Similarly, as UAP roles take on more nursing responsibilities, many nurses perceive it as a threat to the RN role (Spilsbury & Meyer, 2004). According to the literature, the relationship and conflict between physicians and nurses is similar to that between nurses and UAPs. Nurses feel that physicians do not listen to them, and UAPs feel the same way about nurses (Kalisch, 2009).

While the review revealed an abundance of research on physician-nurse relationships, much of the research was conducted in special hospital care units such as
ICUs or operating rooms. Physicians and nurses in these areas report higher levels of collaboration than regular patient care areas. Likewise, physicians report a perception that general medical unit nurses know less about illness and patient care than ICU nurses, which negatively affects collaborative efforts (Thomson, 2007). The literature review revealed very little research conducted on regular medical units or in the hospital as a whole. Adams and Bonds (2003) held that it is important to examine the wards, and that staff interactions, work organization, and work environment at this level are important for the provision of patient care resulting in positive outcomes.

Research on UAPs has been primarily limited to nursing homes. Very little information was found on nurse-UAP relationships. The existing literature focuses mainly on nurse supervisory roles over UAPs. No information was found on physician-UAP relationships or on the interactions and perceptions of the three groups as members of a health care team. Spilsbury and Meyer (2004) noted that studies do not adequately address the UAP role, particularly from the UAP perspective. Further, most literature on these interdisciplinary interactions is greater than five years old. Thus this literature review revealed a gap in the research pertaining to collaboration and communication among physicians, nurses and UAPs as a health care team providing safe patient care. The current study addresses the identified gaps in the research knowledge and updates the initial studies with more current practical findings.

**Summary**

The literature review supports the use of the Shutzian lifeworld phenomenological orchestra study reported by Malhotra (1981) as a model for the current study. In an orchestra, the conductor successfully blends the different musician perspectives into a
cohesive musical performance. In order to provide safe patient care, physicians, nurses, and UAPs must blend their varied perspectives through successful collaboration. Successful collaboration is defined as health care providers sharing responsibility and decision-making for devising and implementing patient care plans (Thomson, 2007). Systems that support interdisciplinary collaboration have been found to positively impact patient care outcomes (Kramer & Schalenburg, 2008). Likewise, conflict and misunderstanding among health care providers can jeopardize patient safety. Successful alignment of health care requires communication that encompasses ongoing efforts to inform and enlist key individuals and build coalitions (Callahan & Ruchin, 2003).

The literature review revealed that the research question in the current study could be best answered using a qualitative phenomenological approach. The research method and design for this qualitative, phenomenological study is discussed in Chapter 3. The research question, design appropriateness, strategies for data collection, and method for data analysis are also discussed. In addition, Chapter 3 addresses concerns about validity and reliability.
Chapter 3

Research Methods

The purpose of the current qualitative, phenomenological study was to explore how physicians, nurses and UAPs describe their individual functions and their roles as providers of safe patient care. The study also aimed to explore how members of each discipline view the functions and roles of members of the other disciplines. The anticipated outcome of the study was a greater understanding of interdisciplinary communication and collaboration among physicians, nurses and UAPs. The study was based on the belief that understanding perceptions among these health care providers can be used to enhance patient safety. A qualitative interview process, utilizing open-ended questions (see Appendix G) and semi-structured dialogue was used for the study.

Effective communication and collaboration among physicians, nurses and UAPs is essential for safe patient care. The interconnectedness between health care stakeholders and the interface of collaborative efforts affect the success of clinical processes (Dietrich et al., 2010). Interdisciplinary collaboration produces a supportive environment that reinforces worth and importance among staff and facilitates interprofessional cohesiveness, improved productivity, and improved patient outcomes (Negley, Ness, Fee-Schroeder, Kokal, & Voll, 2009). A discussion of the research method, research design and data collection tools for the study are presented in Chapter 3.

Research Method

Quantitative and qualitative methods were considered for the study. Qualitative methods are typically used for exploratory studies, while quantitative methods are typically used for testing arguments (Hohenthal, 2006). Quantitative research emphasizes
measuring variables and testing hypotheses that are linked to general causal explanations (Neuman, 2003). Quantitative research methods are appropriate for collecting information related to numbers, and comparing and/or determining relationships between known variables. The current study did not seek to measure causal relationships, test a specific line of reasoning, or to quantify physician, nurse and UAP perceptions; it sought to discover and understand those perceptions. Therefore, quantitative methods were not appropriate.

The study’s purpose corresponds with the qualitative research method, which evolved from behavioral and social sciences as a means of understanding the holistic nature of human beings (Burns & Grove, 2005). Qualitative research methods are appropriate for inquiry related to behaviors, understandings, actions and experiences, and measured through detailed written descriptions and explanations of the study phenomena (Hansen, 2006; Malterud, 2001). Qualitative research can generate insight into perceptions, values, desires, and preferences in a subjects’ language (Goering et al., 2008), and was therefore appropriate for the study.

Qualitative methods such as grounded theory, ethnography, and phenomenology were considered for the study. Grounded theory is an inductive method that aims to generate a theory by gathering data about a phenomenon, identifying the key elements and then categorizing the relationships between those elements (Elliot & Jordan, 2010; Walls, Parahoo, & Fleming, 2010). Grounded theory was not appropriate for the current study because the researcher did not seek to develop a theory. Ethnography is a methodology associated with exploratory inductive research that enables researchers to provide insightful descriptions, test established social and cultural theories or develop
new theories and is often used to study the cultures within health care organizations (Barton, 2008). Ethnography involves learning from a group of people about their cultural experiences and communication patterns (Rubin, Balaji, & Barcikowski, 2009). Ethnography, which entails the immersion of the researcher in the community under study, over an extended period of time, might have been useful in the study (Roberts, 2007; Salkind, 2003). However, immersion is used in ethnography to gather enough information on the culture to design research questions, formulate hypotheses or identify constructs (Salkind, 2003). The researcher is a long-term member of the hospital’s nursing staff, therefore gathering initial cultural information to guide the research design had already occurred.

Phenomenology was best suited for the study, which sought to gain understanding of physician, nurse, and UAP feelings about health care communication and collaboration because it was compatible with studying affective and emotional human experiences (Merriam, 2009). Phenomenology is appropriate for developing a deeper understanding of the existential features of human experiences and is widely used in qualitative research aimed at showing phenomena in new ways (Butler & McGonigal-Kenney, 2010). Phenomenology studies the meaning of an event or issue from the perspective of those involved with the issue being researched in an effort to understand subjective life-world (Drew, 2001) or lived experiences and “the background concerns, habits, practices, relational qualities, and skills in actual situations that make up human being and human worlds” (Chan, Brykczyinski, Malone, & Benner, 2010, p. XIX).
Research Design Appropriateness

Phenomenology was most appropriate for the study, which sought to gain understanding of physician, nurse, and UAP feelings about health care communication and collaboration because it is compatible with studying affective and emotional human experiences (Merriam, 2009). Phenomenology is appropriate for developing a deeper understanding of the existential features of human experiences and is widely used in qualitative research aimed at showing phenomena in new ways (Butler & McGonigal-Kenney, 2010). Phenomenology studies the meaning of an event or issue from the perspective of those involved with the issue being researched in an effort to understand subjective life-world (Drew, 2001) or lived experiences and “the background concerns, habits, practices, relational qualities, and skills in actual situations that make up human being and human worlds” (Chan, Brykczenski, Malone, & Benner, 2010, p. XIX).

The Schutzian lifeworld phenomenological orchestra study described by Valarie Malhotra (1981) and the conductorless orchestra (Bartolovich, 2007; Khodyakov, 2007) provided a metaphoric model for the study. The metaphor illustrates how the different perspectives of orchestra members (physicians, nurses and UAPs) come together to create a cohesive final performance. The individual orchestra members’ may share a stock-of-knowledge; however individual experiences and perspectives of the music (patient care) differ. Stock-of-knowledge refers to social guidelines of appropriate behavior that enable individuals to think of the world as containing “types” or categories of things (Porter, 2005). People “act, experience and learn from their everyday lives; their experiences accumulate into stock-of-knowledge for them to interpret the outside world; and the
stock-of-knowledge is gained through a process of socialization” (Yu & Kwan, 2008, p. 35).

Safe patient care is the composer’s (patient) musical score produced by an orchestra of health care providers in the hospital. Physicians, nurses and UAPs apply their individual and collective stock of knowledge and experiences to patient care delivery. Through collaboration, skilled communication, and a respectful work environment, partnerships can develop that promote optimal patient care (successful performance of the musical score) (Dietrich et al., 2010).

**Research Question**

The research question guiding the qualitative study evolved from the evidence that lack of understanding among physicians, nurses and UAPs leads to poor interdisciplinary communication and collaboration, which negatively impacts patient care outcomes. Qualitative research is highly descriptive, and is based on participants’ own words (Merriam, 2009). The research question for the exploratory study was broad enough to allow unrestrained descriptions and permit patterns and themes to emerge. The central research question for the current phenomenological inquiry was: How do physicians, nurses and UAPs perceive their role in patient care and interdisciplinary communication and collaboration?

**Population**

Qualitative phenomenological research explores participants’ experiences from their perspective. Phenomenology assumes that individuals make sense of their lived experiences according to personal significance, which implies that practical and instinctive understanding is more meaningful than abstract conceptualization (Standing,
2009). Phenomenology interprets and describes human experience to understand the central nature of that experience (Tan, Wilson, & Olver, 2009). The study sought to explore the perceptions of physicians, nurses, and UAPs within the hospital setting.

The population for the qualitative phenomenological inquiry consisted of a purposive sample of willing physicians (interns, residents and attending physicians), and nurses and UAPs with at least one year of work experience at St. Luke’s-Roosevelt Hospital. Written authorization was obtained to use the hospital premises for the study. In addition, union leaders were informed of the study and their support for member involvement was obtained. Approval for the study was obtained first from the University Of Phoenix (UOP) School Of Advanced Studies Academic Review Board and Instructional Review Board, and then from the St. Luke’s-Roosevelt Hospital’s (SLRH) Institutional Review Board.

**Sampling**

A purposive non-probability, criterion-based, convenience sample was used for the study. Purposive sampling uses expert judgment in selecting participants with a specific purpose in mind (Neuman, 2003). Non-probability sampling is the method of choice in qualitative research since statistical generalization is not the primary goal (Merriam, 2009). In criterion-based sampling, the investigator determines a list of essential attributes for participants that directly reflects the purpose of the study and guides the identification of information-rich sources. Specific characteristics for participation included: male and female physicians, nurses and UAPs of varying ages and ethnicities; physicians involved in direct patient care, regardless of title (intern, resident, attending) or specialty; nurses employed at least one year; and UAPs employed at least
one year. All participants will be at least 18 years old. Convenience sampling is based on location, and availability of respondents (Merriam, 2009). Purposive, non-probability, convenience criterion-based sampling was appropriate because the study was conducted in one metropolitan hospital with a specific group of expert participants.

Hundreds of physicians, nurses and UAPs work at the hospital. A hospital-wide invitation (Appendix A) was sent to prospective participants using the hospital email system’s Global Notification feature. An invitation was posted on the hospital’s internal intranet home page, and flyers (Appendix B) were posted on patient care units, in an attempt to recruit a minimum of 30 participants representing an equal number of physicians, nurses and UAPs. An average sample size of 20 to 50 participants is adequate for qualitative studies (Mason, 2010). The final sample size was determined by the number of responses to the invitation to participate and on how quickly data saturation occurred during the interview process. Saturation generally refers to reaching a point where further data collection (conducting additional interviews) becomes counter-productive and new information does not necessarily add substantively to the overall story (Mason, 2010). Qualitative researchers rarely determine sample size in advance; cases are selected gradually (Neuman, 2003). An adequate number of participants must be recruited to answer the research questions (Merriam, 2009).

**Informed Consent**

Informed consent (Appendix C) was obtained from participants. Informed consent is a fundamental ethical principle in research. The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research identified three ethical principles for research: respect for persons, beneficence and justice (Burns &
Grove, 2005). The principles were developed to protect research subjects from abuse. After introductions and initial icebreaking pleasantries, a detailed explanation of the study’s purpose was provided to potential participants. The discussion included background information, and potential risks and benefits of participation. Informed consent is a research subject’s or participant’s voluntary authorization, with full understanding of the risks involved with investigative procedures; it is a contract between the researcher and participant (Amarasekera & Lander, 2008). Potential participants were encouraged to ask questions and express concerns. Participants were informed that their involvement in the study was strictly voluntary and that they could withdraw from the study at any time without any type of penalty. Participants could withdraw from the study before, during or after data collection verbally or in writing. Researcher contact information was included in the informed consent. In addition, all procedures involved in the study were openly discussed including the need to sign consent, the interview process, tape-recording, maintaining privacy and confidentiality, analyzing and reporting study results. Informed consent was a matter of fully disclosing the procedures of the study before requesting permission to proceed (Cooper & Schindler, 2003). Following the discussion, participants received a written copy of the consent, which included all of the information discussed. Participants were also allowed to ask any lingering questions. Interviews were scheduled after respondents agreed to participate at the time and place of his or her convenience.

Researchers should discuss the study’s benefits, while being careful to neither overstate the benefits nor understate the potential harm (Cooper & Schindler, 2003). Participants must be aware of any potential harm as a result of their involvement in the
study; and they cannot be coerced (Neuman, 2003). A direct benefit of study participation was a light snack or lunch and beverages provided during interviews. Potential indirect benefits of study participation were assisting in the potential improvement of understanding interdisciplinary communication and collaboration, and enhancing patient safety. The study did not pose any predictable harm to participants. However, the fear of reprisals might have been a real or perceived stressor for participants. Participants might have feared that their working relationships could be compromised if colleagues learned of their true feelings. Researchers should pay attention to the human factors, issues and behaviors that influence individual values, attitudes and reactions that affect communication and information transfer (Rosenstein, 2009). Fear of reprisal was mitigated by making every effort to maintain confidentiality and by making participants as comfortable as possible. The interviews were conducted privately in a location of the individual participant’s choice. Also, while the hospital’s in-house website was used to announce and invite participation; only the researcher knew who actually participated or which participant made which statement. Participants were aware of measures to maintain confidentiality prior to the interview (see Appendix C).

Confidentiality

Confidentiality is crucial to the proposed study. Participants must feel comfortable to reveal true experiences and honest insights. Confidentiality is a core aspect of informed consent (Amarasekera & Lander, 2008). Participants’ right to privacy and anonymity are protected only when the participants’ identity cannot be linked to data (Whiting, 2008). An attribute coding method was used to protect confidentiality. Attribute coding is a notation of basic descriptive information such as participant
characteristics or demographics (Saldaña, 2009). No names or identifying information were used in any notes or reports. Fictional names were randomly selected from a list of Jane Doe (female) and John Doe (male) numbered from one to fifteen and assigned to each participant (i.e. MD John or Jane Doe 1). Randomly chosen colors describe units. The researcher kept a code log of assigned names and unit color. The code log, personal information, history and experiences were kept in a database on a private password protected laptop computer. The laptop computer, tape-recorder and any handwritten notes were secured in a locked file cabinet.

Only the researcher had access to the computer and information throughout the study. A hospital research mentor was only involved in an advisory capacity. The hospital mentor did not have access to participant information. The hospital research mentor signed a nondisclosure agreement (Appendix D). The hospital research mentor was not present during interviews. The researcher transcribed and analyzed data privately. Researchers protect participant confidentiality by obtaining signed nondisclosure documents, restricting access to participant information, disclosing respondent information only with written consent, restricting access to data instruments that identify the participant and nondisclosure of data subsets (Cooper & Schindler, 2003). Upon completion of the study, data was transferred to a non-rewritable data storage disc. Once the data was transferred to the disc, all data stored on the laptop was immediately and securely erased. Data will be kept for five years and then the data storage disc and tape recordings will be destroyed and all written notes will be shredded.
Geographic Location

The geographic location for the study was St. Luke’s Hospital located at 1111 Amsterdam, NY, NY 10025. In 1979, St. Luke’s Hospital and Roosevelt Hospital merged to form St. Luke’s-Roosevelt Hospital Center (Continuum Health Partners, 2010). The St. Luke’s Hospital (SLH) site is located in Upper Manhattan, and the Roosevelt Hospital site is located in midtown Manhattan. SLH has 541 beds; it is currently a full service community and tertiary care center and serves a diverse population (Continuum Health Partners, 2010).

Data Collection

The researcher personally conducted data collection for this phenomenological study, which proceeded slowly and ultimately surpassed the initial approval deadline. Data collection was paused until new approvals were obtained. Data consisted of the words participants used to describe their perceptions and experiences. Participants were expected to speak freely and honestly. Data collection consisted of qualitative semi-structured interviews. The phenomenological interview is the primary method used to uncover the essence or basic underlying structure of the meaning of an experience (Merriam, 2009).

Study participants chose the time and place of the interviews to maximize participant comfort and facilitate intimate conversation. Low-key open-ended interviews encourage participants to engage in conversation to discuss concerns and meanings that are important to them (Rubin & Rubin, 2005). During the conversation, the responsive interviewer recognizes that the interviewee (conversational partner) has a distinct set of experiences and areas of expertise (Rubin & Rubin, 2005). To stimulate in-depth
conversation, the interviewer used probes such as “tell me more about that” and “you mentioned…can you expand?” Researchers create new questions as the conversation progresses to tap into participants’ distinct knowledge and cultivate the conversational relationship, which will take participants’ responses in new directions (Donalek, 2005).

The researcher met with participants and conducted individual in-depth interviews using an interview guide (see Appendix G). The interview sessions lasted from 40 to 60 minutes. Interviews were held in a convenient location of the participant’s choice. A natural setting encourages participants to openly share experiences (Neuman, 2003). Phenomenological interviews aim to elicit pre-reflective responses from participants. The pre-reflective awareness is the natural attitude, which refers to the person’s innate world-directed perspective or point of view when that person intends things, situations and facts (Kleiman, 2004; Sokolowski, 2000). In-depth personal interviews elicit stories, thoughts and feelings about the study phenomenon and are consistent with an intimate focus on one person’s experience, thereby providing a context for understanding the meaning behind the person’s behaviors (Dilley, 2004; Smith, et al., 2009).

The qualitative interview began with general conversation to gain trust and help participants to relax and speak freely, and used open-ended questions to provide focus. Interviewing requires special attention to creating situations that support ways to gain trust and facilitate dialog (Neuman, 2003). Qualitative researchers conduct intimate in-depth interviews using open, direct, verbal questions to elicit detailed narratives (Whiting, 2008). Phenomenological research relies heavily on in-depth interviews because interviewing is considered one of the most reliable sources of information about the meanings people confer to their experiences from their own perspectives (Darlington
Semi-structured interviews allow individualized expression of ideas and feelings about the world (Merriam, 2009). The interviews focused on the perspective and experiences of the research participant (Neuman, 2003) and the issues under investigation guided the largest portion of the semi-structured interview process (Merriam, 2009).

The interviewer played a dynamic role in the interview process. An interview is a social construct created between the interviewer and interviewee. Interviewing requires social, physical, mental and communication skills, as well as, the skill of comprehension, the complex aptitude and competence of reflection and representation, which are ultimately only learned through trial and error (Coar & Sim, 2006; Dilley, 2004). A researcher’s lack of interview skills can influence the type of information obtained in a phenomenological interview. In addition, most researchers acknowledge that interviewers harbor personal biases that can influence data collection, but those biases can be offset if the researcher employs checks and balances (Luck & Rose, 2007; Rubin & Rubin, 2005; Whitley & Crawford, 2005). Self-examination and self-knowledge achieved through performance of the epoche in which the researcher abstains from making suppositions, remove clutter from the researcher’s mind, allowing him or her listen with genuine curiosity, be open to new ideas and see an object as it truly appears (Moustakas, 1994).

Reduction and control of bias, which recognize researcher fallibility, are important in a phenomenological study (Pogenpoel & Van der Linde, 2001). The investigator remained mindful of the study’s purpose, strove to curb her, personal biases about physician, nurse and UAP interactions and kept an open mind. The investigator listened intently to participant expressions and feelings, and refrained from injecting
personal opinions or reactions about interviewee responses. Through the process of phenomenological reduction, which requires researchers to bracket or withhold prior knowledge of the study phenomenon and to maintain an attentive openness to the descriptions provided, participants’ meanings were identified without the researcher embracing her own assumptions (Kleiman, 2004; Koivisto et al., 2002). In qualitative research, “interaction bias is an issue whether the behaviors studied are answers to questions in a probing interview, open discussion, casual conversation in a setting of naturalistic inquiry, or solicited responses on a self-administered questionnaire” (Miyazaki & Taylor, 2008, p. 781). Acknowledging personal values, principles, prejudices or interests helps a researcher to avoid bias and be open to new experiences and perspectives.

The interviewer-respondent interaction is a complex phenomenon. Both parties bring biases, predispositions, attitudes, and physical characteristics that affect the interaction and the data elicited. A skilled interviewer accounts for these factors in order to evaluate the data being obtained. Taking a stance that is nonjudgmental, sensitive, and respectful of the respondent is a beginning point in the process (Merriam, 2009, p.109).

The researcher audio tape-recorded the interviews with participants’ express permission, using a tape recorder to the ensure accuracy of data collection. The tapes were carefully transcribed and analyzed for emerging themes to gain understanding of participant perceptions. Tape-recording guarantees that a permanent record is preserved for analysis (Merriam, 2009; Whiting, 2008), and is commonly used and recommended (Hansen, 2006). Transcriptions of the taped interviews allow a researcher to discover
phrases and perceptions that were missed during the initial interview (Whiting, 2008). It is difficult to write everything being said during an interview while remaining attentive and responsive to interactions (Whiting, 2008); therefore the researcher used note taking in conjunction with the tape recordings. Note-taking is not recommended as the primary method of data collection because the investigator cannot be certain of what is important enough to write down at the onset of a study (Merriam, 2009). Note taking was used as an adjunct to tape recording. The researcher used notes to record participant’s initial reactions, record the researcher’s reactions to what the participant said, or to pace the interview (Merriam, 2009).

**Participation**

Participant recruitment was more difficult than the researcher anticipated. Nurses readily volunteered for study participation and recruitment proceeded smoothly and quickly. However, physician and UAP recruitment proceeded more slowly. Emails sent to potential participants on the hospital’s internal system and posted flyers yielded insufficient responses. Only two physicians responded to the initial email invitation and three UAPs responded to the flyers. Stimulating interest and commitment of adequate numbers of participants is essential to the integrity and validity of any research project (Hooven, Walsh, Willgerodt, & Salazar, 2011). To stimulate participation, the researcher placed two additional advertisements on the hospital’s intranet and newsletter, placed invitations in physicians’ mailboxes, and spoke more frequently at physician grand rounds conferences. The researcher also approached the interns and residents and UAP union delegates to gain support for the study. Strategically placing information and

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speaking with key leaders is an acceptable approach to help increase visibility and stimulate interest in a research project (Chesney, 2006; Hayes, 2006).

**Instrumentation**

Instruments are the tools used to collect data. The researcher used an interview guide (see Appendix G) specifically designed to address the research question: What are the lived experiences of physicians, nurses and UAPs in relation to interdisciplinary communication and collaboration? The interview guide incorporated open-ended, mirror, and summary questions, which was helpful when a considerable amount of information was needed from a small sample and when it was important to allow respondents themselves to identify factors that contribute to their perceptions (Gould & Fontenla, 2006). The researcher began with relatively neutral, descriptive information, which laid the foundation for questions that accessed the participants’ perceptions, opinions, values, and emotions (Merriam, 2009).

Researchers must design interview questions that elicit answers from participants that address the research question. The wording of questions should not suggest textbook answers, but elicit honest depictions of perception (Rubin & Rubin, 2005). The researcher used a pilot study to test if interview questions would obtain the type of information the study sought. Piloting strengthens study reliability and confirmability by helping the researcher decide the best methods to ensure participant comprehension, determine the amount of interview structure needed and revise and refine questions and analysis strategies (Luck & Rose, 2007; Neuman, 2003). Piloting also helps determine if potential participants believe the research topic is important, and if they are willing to talk about it (Smith, et al., 2009).
The first three interviews with a physician, a nurse, and a UAP served as a pilot for the interview guide (Addendum F) and set the tone for other interviews. The pilot study helped determine in real time the best methods to support participant comprehension and communication, and helped identify areas that needed adjustment prior to the actual study (Luck & Rose, 2007). Unlike quantitative data collection, which converts variables into specific actions before and separate from data gathering, qualitative data collection is a flexible, ongoing process (Neuman, 2003). The pilot interviews were tape recorded with the individual participant’s permission. The same consent form was used for the pilot interviews as for the main study. However, the participant responses in the pilot were not included in the overall study. The researcher revised the interview guide (see Appendix G) based on the pilot interview results. The revised interview guide allowed participants to share their experiences and provided structure to keep the interviews focused on the area of interest (Dilley, 2004).

During the first two pilot interviews, the researcher was nervous and found it difficult not to interject personal feelings and bias into the conversation. For instance, when UAP Jane Doe Pilot talked about communication and teamwork, the interviewer responded, “I believe in working together…at times what happens in my experience is…” The investigator reflected on this interview and realized that interjecting personal feelings might have tainted the information collected from that point. The researcher gained more confidence and skill with each successive interview, resisted the urge to interject personal feelings and allowed participants to openly discuss their experiences. The researcher took half an hour to unwind, meditate, and relax prior to subsequent interviews so that the researcher’s mental discomfort would not threaten the truth-value
of the data obtained and data analysis (Moustakas, 1994; Poggenpoel & Myburgh, 2003; Rubin & Rubin 2005).

**Validity and Reliability**

Validity and reliability are critical concepts in research. Validity is a measure of the truth or accuracy of a claim or proposition (Burns & Grove, 2005; Cooper & Schindler, 2003; Neuman, 2003). Reliability refers to the consistency and accuracy of a measurement tool in gauging the phenomenon under study (Neuman, 2003), and describes how well an instrument will produce similar results under different circumstances, assuming nothing else is changed. Validity describes how well an instrument measures what it intended to measure (Roberts, Priest, & Traynor, 2006). Tape-recording the semi-structured interviews minimized loss or misrepresentation, thereby enhancing validity and reliability, or the believability and trustworthiness of research findings and helped prevent spurious and incorrect study conclusions (Salkind, 2003).

There are two major types of validity: internal and external. Internal validity indicates that there are no errors in the research design and external validity refers to the ability to generalize research findings from the sample to a larger range of settings (Neuman, 2003) and is largely a measure of whether the research makes sense beyond the confines of the data collected (Cooper & Schindler, 2003). The researcher followed specific guidelines set by the hospital’s Institutional Review Board (IRB). The IRB reviewed all areas of the study prior to granting permission to carry out the study. Also a mentor from the hospital’s research department supervised the research project. These measures insured that the study design, data collection and data analysis were consistent.
and thereby enhanced the study’s internal and external validity. Regardless of the type of research, validity and reliability are concerns that must be addressed through careful attention to a study’s conceptualization and how the data are collected, analyzed and interpreted; and the way findings are presented (Cooper & Schindler, 2003; Merriam, 2009).

Credibility, confirmability and transferability are concepts used in qualitative research to evaluate internal and external validity. Credibility is comparable to internal validity, confirmability is comparable to objectivity, and transferability is comparable to generalizability (Malterud, 2001). The researcher insured credibility, confirmability and transferability by triple checking the transcripts and notes against the original audiotape recordings, and maintaining records of all information. In qualitative research, ensuring validity and reliability involves conducting studies in an ethical manner (Merriam, 2009). In phenomenological research, external validity is judged in terms of meaningful coherence between results, data, and the techniques by which findings are reached (Garza, 2007).

Reflexivity or self-examination is important to enhancing the trustworthiness of qualitative research (Malterud, 2001). Reflexivity refers to a researcher’s ability to account for his or her feelings and influences on the study (Schmidt, 2005). The researcher is a member of the hospital’s nursing staff and entered the project with her own set of ideas and experiences about interdisciplinary communication among physicians, nurses and UAPs. The researcher reflected on her perceptions and provided a detailed, candid account of her biases, preconceptions and reactions to participant responses, and acknowledges how those biases and preconceptions might have affected

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data interpretation. Researchers must explain their biases, dispositions, assumptions, experience, worldview, and theoretical orientation to the study so that the reader may understand how the researcher’s values and expectations influence its conduct and findings of the study (Merriam, 2009). The researcher acknowledges that the topic may have been too close to her point of reference, that her mental and other discomfort could pose a threat to the truth-value of data collection and analysis (Poggenpoel & Myburgh, 2003), and recognizes her place in the meaning-making process as she seeks to understand the study phenomenon (Schmidt, 2005). The researcher’s facilitative interaction is critical to creating a context where participants share rich data about their experiences and life-worlds (Poggenpoel & Myburgh, 2003).

**Data Analysis**

Data analysis for the study began during the interview process and involved actively listening to participants, reviewing and transcribing audiotapes, and identifying themes in the data. Unlike in a quantitative study, data analysis in a qualitative study is an ongoing process that begins with data collection (Neuman, 2003). In qualitative research, it is preferable to conduct data analysis simultaneously with data collection (Merriam, 2009). In phenomenological data analysis, a researcher attempts to reflect on participants’ lived experiences based on interactions such as interviews (Finlay, 2008). Therefore, during the interviews, the researcher paid close attention to the dialogue and interactions and jotted down initial impressions, observations and emerging patterns when appropriate (Neuman, 2003). In this manner, the researcher began some rudimentary analysis (Merriam, 2009). Also, interview sessions were spaced so as to allow the researcher to begin examining data between interviews. The interviewer looked for responses and
interactions or additional questions that arose and could be used to enhance subsequent interviews and to sharpen research questions (Neuman, 2003). Qualitative research spreads data analysis throughout the study and the results of early data analysis guide subsequent data collection (Merriam, 2009; Neuman, 2003). Interviews and analysis continued until the participant supply was exhausted and data saturation occurred. Preferably, in qualitative research, data collection and analysis cease when sources of information are exhausted, categories are saturated, regularities emerge, and “over-extension,” or the sense that new information bears no connection to any viable emerging categories, occurs (Merriam, 2009).

**Data Coding**

The researcher carefully transcribed, coded and examined the interviews for patterns and themes with the help of NVivo 9 software. The researcher listened to the audiotapes at least three times before, during and after the transcription process to ensure accuracy. Researchers can listen to audio taped interactions and code variables of interest directly into the transcription, re-listening as often as necessary (MacLin & MacLin, 2005). While transcribing audiotapes of interviews, researchers become intimately familiar with the data (Merriam, 2009). Interview notes were used to verify context of the data, ensure that nothing was excluded or missed, and enhance understanding of emerging themes. Data coding is a process by which researchers transform raw data into a more manageable form that aids in determining relationships or connections (Neuman, 2003). Encoding data arranges the information so that themes can be identified and developed (Fereday & Muir-Cochrane, 2006; Yoshikawa, Weisner, Kalil, & Way, 2008). NVivo 9, an example of computer assisted qualitative data analysis (CAQDA) software,
provides tools to help code, organize and analyze qualitative data (QSR International, 2007; Gibbs, 2002). NVivo 9 allowed the researcher to keep a high-quality record of hunches, ideas, searches and analysis and provided easy access to data (Gibbs, 2002).

The researcher generated a list of preliminary categories or provisional codes based on the research question, literature review, and interview guide prior to beginning data collection. Then pattern coding or inferential coding was used to identify emergent themes (Saldaña, 2009). Provisional codes or categories for the current study (Table 2) included: (1) roles in patient care, (2) others’ view of your role, (3) communication, (4) collaboration/teamwork, (5) conflict, (6) patient safety, and (7) ideal interdisciplinary communication and collaboration. Each category was further separated into physician, nurse and UAP perceptions. The preliminary coded responses from physicians, nurses and UAPs were then re-examined and compared looking for recurring themes or patterns (Basit, 2003; Gough & Scott, 2000). The researcher selected chunks of text and applied codes to them, as well as retrieve all similarly coded text without losing the data’s context so the researcher could perform additional analysis on the data as desired. Recurring themes determined when data saturation occurred.

**Summary**

Chapter 3 presented the method and design for the current study. Qualitative research was appropriate for the study because the method focuses on social reality and meaning, and on interactive processes (Neuman, 2003). Qualitative research draws on participants’ intuition and experiences in order to generate findings that are meaningful to them (Goering et al., 2008). The Schutzian lifeworld phenomenological orchestra study described by Malhotra (1981) was an appropriate theoretical model for the study because
it illustrates the dynamics among physicians, nurses and UAPs. Phenomenology examines participants’ lived experiences from their own perspectives (Merriam, 2009).

Chapter 3 also discussed the research question, data collection method, instrumentation, validity and reliability, and data analysis process. The phenomenological interview is the method of choice to uncover the essence or meaning of experiences (Merriam, 2009). Chapter 4 presents a detailed report of research findings, the data collection process, interview responses, and emergent themes.
Chapter 4

Results

The purpose of this qualitative, phenomenological study was to explore how physicians, nurses and UAPs describe their individual functions and their roles as providers of safe patient care. The study also aimed to explore how members of each discipline view the functions and roles of members of the other disciplines. The central research question for this study arose from a desire to address the problem of medical errors that plague health care and threaten patient safety (Ross, 2008; Wakefield, 2002; White, 2002). Researchers have identified interdisciplinary communication and collaboration as important factors in developing a patient safety culture (Scherer & Fitzpatrick, 2008). This study addresses the gaps in prior research and will increase understanding of interdisciplinary communication and collaboration among physicians, nurses and UAPs. The results of the study may be used to facilitate patient safety.

Data Analysis

Once the interviews were carefully transcribed, the data were coded and analyzed using NVivo9 a computer assisted qualitative data analysis program. The researcher developed seven provisional categories based on the research question, literature review and interview guide: roles in patient care, others’ view of your role, communication, collaboration/teamwork, conflict, patient safety and ideal interdisciplinary communication and collaboration. As the researcher reviewed participant responses, words or phrases were initially coded and placed into the categories. Subsequently, the researcher examined each category for recurring themes, first within the individual
disciplines, then between the disciplines. The most common responses are presented along with outliers.

**Major Findings**

The current study suggests that the physician-nurse hierarchy exists, but may be changing. Physicians see themselves as the primary patient care decision makers, but many physicians advocate for and seek out nurse input. Nonetheless, some nurses reported that physicians still order them around. Physicians do not have much to say about UAPs. Physicians and UAPs in this study admitted that they have very little contact with each other. UAPs had a more significant relationship with nurses, which they described as uncooperative and hierarchical. Perceptions among nurses and UAPs differ as to the reason for the negativity. Most nurses in the study stated that it is difficult to work with UAPs, while UAPs frequently reported that nurses talk down to them. Physicians, nurses and UAPs had different perceptions of what interdisciplinary communication and collaboration means. Physicians and nurses work together or consult each other at times, but UAPs are rarely included in any type of patient discussion.

**Pilot Interviews**

After receiving approvals from the Institutional Review Boards of the University of Phoenix and the hospital, the investigator used a criterion-based, non-probability convenience sample for the study (Merriam, 2009; Neuman, 2003). The first physician, nurse and UAP study respondents were used to pilot the interview guide (Appendix F) in order to determine whether the questions would elicit participant responses that address the research question or would need to be adjusted (Luck & Rose, 2007; Neuman, 2003; Rubin & Rubin, 2005).
Once the researcher obtained consent (Appendix C), the researcher personally conducted, audio taped, transcribed and coded the pilot interviews. Pilot participants were coded as MD-JDP, RN-JDP and UAP-JDP. The researcher reviewed the pilot responses and placed them into the seven provisional categories, roles in patient care, others’ view of your role, communication, collaboration/teamwork, conflict, patient safety, and ideal interdisciplinary communication and collaboration. The responses to the question about roles are presented here (see Appendix HS for other responses).

**Pilot Interview Responses**

**Physician’s role.** MD-JDP initially did not understand the first question. He looked puzzled. After a brief pause he said, “My role as a physician? I would say I work here as a hospitalist.” He went on to explain:

> It is someone who takes care of patients only while they are in the hospital, essentially. I view my role as helping people recover from an acute illness and transitioning that care to their out-patient doctor…A physician’s role is to educate patients on their health and promote opportunities to improve their own health with medication, lifestyle changes, these sorts of things…be someone the patients can tell their medical problems to.

RN-JDP stated,

> The physicians, they know their patients when it comes to what’s wrong, like diagnosis…how to diagnose and prescribe and stuff like that, but they don’t know the patients the way we do…Like sometimes I’ll be talking to the doctor and I’ll say, ‘This person has…’ and they’ll say, ‘Really?’
RN-JDP shrugged her shoulders. She did not elaborate on that point and the researcher did not probe further. UAP-JDP did not speak about the doctor’s role.

**Nurse’s role.** When asked about the nurse’s role, MD JDP stated:

The nurse’s role is to do the daily general care of the patient, giving medication, making sure they get their meals, making sure they get to and from the bathroom…providing a…[pause]…helping the doctor with the patient and being a bridge to communication there, and a backup of checks and balances to what the doctor is ordering…I think nurses are helpful in educating the patients and things like insulin injections, Lovenox injections, and things of that nature.

RN-JDP stated:

A nurse is somebody who cares for a patient when they are sick, more than just giving meds and doing doctor’s orders…To me, I care for each patient as if he was one of my family members, how I would want my family member to be treated if they were sick. So that’s what I do. I talk to patients and end up learning a lot in terms of who they are and where they come from and things like that. I have a lady now, she is in a lot of pain. So you just stand there and hold her hand, be there for her…I love my job. I love what I do.

UAP-JDP stated:

I think the nurse’s role is just like mine. It’s just to take care of the patients. Don’t go in there and tell the patient you’ll come back and never get back. Just yesterday, a nurse went into a patient’s room and put the patient on the bedpan, telling the patient she would be back. The patient told me the nurse never came back.
**UAP role.** When asked about the UAP role, MD-JDP stated:

I think nursing attendants are very important. With all the stuff that’s going on now and all the other responsibilities that we have a lot of the care falls on to the nurse and subsequently to the nurse’s aid. Most of the complaints I get from the patients are not like specific to their medical problem, but just they need help getting to the bathroom or they didn’t like their food today, which is a lot of the nurses aide kind of area.

According to RN-JDP,

The CNAs know more about the patient. I actually learned a lot about patients through the CNAs, because they spend a lot of time with them too, especially on this floor when doing AM care…because of the type of patients on our floor, everybody needs assistance.

UAP-JDP stated, “I feel good about being a nursing attendant.” She elaborated:

I get here in the morning and the first thing I do is give out water pitchers to the patients who need water…The next thing is when food comes up, we feed everybody that needs to be fed and we set up the patients that need to be set up. And the next thing we do is when they are finished eating, we clean them up, give bed baths, make them comfortable.

**Instrument Changes after Pilot**

The interview guide was adjusted based on the pilot interviews (Appendix H). For instance, the wording and order of some questions was changed. The researcher decided to remove the word “feel” from the questions. For example, question 4, “How do you feel others view your role and how does that make you feel?” was changed to, “What are your
thoughts on the role of physicians, nurses and nursing attendants?” Question 4 was then changed to Question 3. The wording in Question 7 was similarly changed and moved to Question 9.

**Participants**

Study participants included 12 physicians, 16 nurses (including three nurse practitioners), and 11 UAPs (Table 1). The MD John Doe 5 interview was excluded from the data analysis because most of his career was spent in academia and he did not meet the inclusion criterion related to direct patient care. Three nurse practitioners (NPs) consented to participate and were interviewed. However, the investigator decided not to include the NP interviews in the data analysis because they were not part of the original study plan and the sample size was not large enough to do a subgroup analysis (Neuman, 2003). The majority of physicians were male attending physicians. The nurses and UAPs were mainly female.

Table 1

*Participant Characteristics*

<table>
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<th>Characteristic</th>
<th>Physician</th>
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<td>15</td>
<td>8</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21-30</td>
<td>2</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>31-40</td>
<td>4</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>41-50</td>
<td>2</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>&gt;50</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High School</td>
<td>-</td>
<td>-</td>
<td>6</td>
</tr>
<tr>
<td>Some College</td>
<td>-</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>Associate Degree</td>
<td>-</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>Bachelors</td>
<td>-</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Masters</td>
<td>-</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>MD</td>
<td>12</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Three physicians had educational degrees beyond the basic for a medical doctor (MD) degree. All nurses had an associate’s degree or higher. Some nurses were actively pursuing higher education. One nurse was pursuing a doctorate degree. Participant practice areas included the intensive care unit (ICU), cardiac care unit (CCU), cardiac telemetry, medical-surgical, operating room, emergency department, and psychiatric unit.

**Roles in Patient Care**

Half of the physicians described their role as medical plan managers/decision makers/coordinators, who care for all aspects of the patient (Table 2). A few describe the physician as a teacher. One physician (MD Jane Doe 3) described the physician as a conductor and the nurse as the first violinist. One physician, an intern, said the physician is just passing through.

Many nurses said the physicians assess patients, make a diagnosis, write orders, make treatment decisions and are not on the floor for a very long time. A few nurses described some physicians as arrogant, abrupt and short tempered. UAPs also noted that physicians make diagnosis and treatment decisions but do not spend much time in the units. In addition, most UAPs reported that they have very little interaction with physicians.
Table 2

Physicians’ Descriptions of the Physician Role

<table>
<thead>
<tr>
<th>Description</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>We care for patients.</td>
<td>4</td>
</tr>
<tr>
<td>We take care of the whole patient.</td>
<td>2</td>
</tr>
<tr>
<td>We are teachers.</td>
<td>3</td>
</tr>
<tr>
<td>Medical plan/decision-maker/coordinator.</td>
<td>5</td>
</tr>
<tr>
<td>We are all learning.</td>
<td>2</td>
</tr>
<tr>
<td>Doctors are just passing through periodically (rotation).</td>
<td>1</td>
</tr>
</tbody>
</table>

Many nurses say they love nursing and describe their role as a compassionate which includes giving medication, taking care of all of the patients’ needs, following physician’s orders, and sometimes questioning orders. In short, “It is a lot of work” RN Jane Doe 11) (Table 3). A few nurses mentioned that part of their role includes delegating work to nursing attendants. One nurse used a waitress metaphor to describe nursing.

I see myself as a waitress juggling things. Each patient is a person coming in to eat at the restaurant. I have to get them what they need at certain times and then I still have orders from my boss to carry out certain things. The restaurant boss can be the doctor, the nurse manager, the assistant nursing care coordinator (ANCC), or it can be the patient. (RN Jane Doe 11)

The majority of physicians stated that nurses are an integral part of patient care and protecting patients; nurses pay attention to details the physician may not be aware of. Many physicians stated they see the nurse as the person doing things like giving medications, collecting blood samples, taking vital signs, and alerting them to changes in the patients’ conditions or things the patients might not say to the physician. Most physicians stated that they appreciate the knowledge they gain from what nurses know
about specific cases because nurses spend more time with the patients. MD Jane Doe stated, “If you didn’t have your nurses around, you would not know what is going on with your patients.” Almost half of UAPs stated that the nurses take care of the whole patient, including dispensing medications. On the other hand, just as many UAPs also note that some nurses are not helpful with patient care, such as cleaning patients. Two UAPs said the nurse role is similar to the UAP role. Only one UAP said nurses just follow doctors’ orders.

Table 3

Nurses’ Descriptions of the Nurse Role

<table>
<thead>
<tr>
<th>Description</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Take care of the whole patient (including medications)</td>
<td>6</td>
</tr>
<tr>
<td>I like being a nurse</td>
<td>5</td>
</tr>
<tr>
<td>We care about patients (compassion)</td>
<td>4</td>
</tr>
<tr>
<td>A lot of work</td>
<td>4</td>
</tr>
<tr>
<td>Meticulous documentation</td>
<td>4</td>
</tr>
<tr>
<td>Patient advocate</td>
<td>4</td>
</tr>
<tr>
<td>Delegate to UAPs</td>
<td>3</td>
</tr>
<tr>
<td>Partner with the patient</td>
<td>1</td>
</tr>
</tbody>
</table>

Almost all of the UAPs described their role as making patients comfortable. Many UAPs stated they assist patients with their personal needs (i.e., bathing, feeding, ambulating, toileting). Half of the UAPs stated they assist the nurses. Also, half of the UAPs said that they love their jobs. A few UAPs said their role was similar to the nurse role, except that they do not dispense medication. One UAP described herself as a role model.
Table 4

*UAP Descriptions of the UAP Role*

<table>
<thead>
<tr>
<th>Description</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Make sure patients are comfortable</td>
<td>8</td>
</tr>
<tr>
<td>Take care of patients</td>
<td>6</td>
</tr>
<tr>
<td>Assist the nurse</td>
<td>5</td>
</tr>
<tr>
<td>I love my job</td>
<td>5</td>
</tr>
<tr>
<td>Assist patient with daily needs such as feeding</td>
<td>4</td>
</tr>
<tr>
<td>My job is similar to the nurse except for medication</td>
<td>3</td>
</tr>
<tr>
<td>Role model</td>
<td>1</td>
</tr>
</tbody>
</table>

Most physicians did not comment about the UAP role in patient care. A few physicians said UAPs assist nurses and assist patients with daily needs. Two physicians admitted they were not sure what a UAP does. Most nurses stated the UAP assists the nurse and assists patients with daily needs. Many nurses commented that the UAP role is important to care. However, an equal number of nurses said sometimes it is difficult to work with UAPs. A couple of nurses said some UAPs think they are nurses and another couple of nurses acknowledged that UAPs have a heavy workload.

Table 5

*Nurses’ Descriptions of UAP Role*

<table>
<thead>
<tr>
<th>Description</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assist the patient with daily needs</td>
<td>7</td>
</tr>
<tr>
<td>Assist the nurse</td>
<td>6</td>
</tr>
<tr>
<td>Important to patient care</td>
<td>5</td>
</tr>
<tr>
<td>Sometimes it is difficult to work with UAPs</td>
<td>5</td>
</tr>
<tr>
<td>I use to be a UAP</td>
<td>4</td>
</tr>
<tr>
<td>UAPs should be respected</td>
<td>4</td>
</tr>
<tr>
<td>Nurses should work with UAPs</td>
<td>3</td>
</tr>
<tr>
<td>Some thing they are nurses</td>
<td>2</td>
</tr>
<tr>
<td>They have a heavy workload</td>
<td>2</td>
</tr>
</tbody>
</table>
Others’ View of Your Role

Many physicians believe that nurses see physicians as the major decision makers who write orders. Some physicians said nurses respect them and look to them for guidance. Many physicians commented that they gain valuable information from the nurses, but they had different ideas of what valuable information means. For example, MD John Doe 9 stated:

I like nurses to ask questions, because it makes a lot of difference in patient care. You want a role model like Nurse B…For instance, she’ll call and say, “I think this patient has tachycardia and I want you to come and look at the monitor.” She will call a consult. If you find somebody like that, every physician will be up to par.

MD Jane Doe 7 stated, “You kind of grow to appreciate how much information and knowledge you gain from what nurses about a specific case, it’s a medical view, but it’s a different cut of the same view.” The researcher did not probe further into what the physician meant. On the other hand, MD Jane Doe 4 stated, “Nurses know some things to do with the systems but not to the degree that the doctors would have to know but basically you both have the same end point.” The interviewer did not probe into what the same end point meant. Most physicians just shrugged their shoulders when asked what UAPs thought of the physician role.

Most nurses stated they believed physicians thought they were superior to nurses and tended to order nurses around (Table 6). One nurse, who worked in the critical care and medical-surgical area stated, “I believe that physicians in the intensive care unit (ICU) listen to and value nurses opinions more than on the medical-surgical unit.” Many
nurses and UAPs stated that physicians do not spend much time with the patients. One UAP stated that technically the physician is the head of the team, but the nurse is the actual head because once the physician does his part, he is gone.

The majority of physicians stated that UAPs assist the nurse and assist patients with daily needs. Two physicians stated they did not know what a UAP does. Many nurses stated that UAPs think nurses believe they are superior to UAPs. Most UAPs agreed with UAP Jane Doe 11, who said, “Some nurses know that you’re capable and know how to take care of a patient, but some of the nurses feel like you are just there to clean patients.” Physicians and UAPs stated they have little or no interaction with each other.

Table 6

*Most Common Descriptions of How Others View Your Role*

<table>
<thead>
<tr>
<th>Description</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physicians</strong></td>
<td></td>
</tr>
<tr>
<td>Nurses understand the physician is the primary decision maker</td>
<td>4</td>
</tr>
<tr>
<td>Nurses think we write orders.</td>
<td>2</td>
</tr>
<tr>
<td>I think nurses respect physicians.</td>
<td>2</td>
</tr>
<tr>
<td>Nurses look to the physician for guidance.</td>
<td>2</td>
</tr>
<tr>
<td><strong>Nurses</strong></td>
<td></td>
</tr>
<tr>
<td>Some doctors feel they are superior and order you around.</td>
<td>6</td>
</tr>
<tr>
<td>I think some nursing attendants may not realize how much we have to do.</td>
<td>2</td>
</tr>
<tr>
<td>Physician thinks I follow orders.</td>
<td>2</td>
</tr>
<tr>
<td><strong>UAPs</strong></td>
<td></td>
</tr>
<tr>
<td>Some of the nurses feel like you’re just there to clean, and run errands</td>
<td>6</td>
</tr>
<tr>
<td>Some nurses look down their noses and boss you</td>
<td>6</td>
</tr>
<tr>
<td>I really don’t know how doctors feel about the UAP</td>
<td>5</td>
</tr>
<tr>
<td>Some nurses disrespect UAPs</td>
<td>4</td>
</tr>
<tr>
<td>Some doctors really see what we do and that it is important</td>
<td>2</td>
</tr>
</tbody>
</table>
Communication

Physicians, nurses and UAPs all said that communication is critical in health care. The general consensus among physicians was that good communication helps avoid patient care mistakes.

Communication is essential in any field. In medicine, it is particularly important because you delegate work on behalf of the patient. You have to be clear on your assessments and management plan, and this has to be laid out very carefully to the patient, your colleagues, to nursing staff, and aides who are participating in care.

(MD John Doe 6)

Most physicians stated that communication should be mainly a verbal face-to face two-way interaction. Almost all nurses agreed with that description (Table 7). UAPs described communication in a variety of ways, but mainly referenced verbal communication or “speaking with a person.” The majority of physicians, nurses, and UAPs also agreed that how something is said is just as important as what is said. The majority of UAPs said communication with nurses should be considerate and respectful. A few physicians also noted that although written communication is important, it is often inadequate among physicians. A few UAPs said they try to keep to themselves and do not speak much; they only speak to nurses when it is necessary.
Table 7

*Most Common Comments on Communication*

<table>
<thead>
<tr>
<th>Comment</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physicians</strong></td>
<td></td>
</tr>
<tr>
<td>Is vital/essential</td>
<td>6</td>
</tr>
<tr>
<td>Is mainly a verbal, two-way exchange</td>
<td>6</td>
</tr>
<tr>
<td>Should be clear, straightforward, and deliver all necessary information</td>
<td>5</td>
</tr>
<tr>
<td>Can be sketchy between physicians</td>
<td>4</td>
</tr>
<tr>
<td>Helps prevent things from being missed/mistakes</td>
<td>3</td>
</tr>
<tr>
<td>How we frame or phrase things is important</td>
<td>3</td>
</tr>
<tr>
<td>Physicians’ written communication is poor/inadequate</td>
<td>3</td>
</tr>
<tr>
<td><strong>Nurses</strong></td>
<td></td>
</tr>
<tr>
<td>Mainly verbal, two-way, face-to-face</td>
<td>8</td>
</tr>
<tr>
<td>Doctors should communicate about the patients’ plan/order</td>
<td>6</td>
</tr>
<tr>
<td>How something is said is just as important as what is said</td>
<td>7</td>
</tr>
<tr>
<td>Physicians talk more to each other than to nurses</td>
<td>5</td>
</tr>
<tr>
<td>Should be clear and concise</td>
<td>5</td>
</tr>
<tr>
<td>Is important/essential</td>
<td>4</td>
</tr>
<tr>
<td><strong>UAPs</strong></td>
<td></td>
</tr>
<tr>
<td>How something is said is just as important as what is said</td>
<td>6</td>
</tr>
<tr>
<td>Nurses should speak nicely/respectfully to UAPs</td>
<td>6</td>
</tr>
<tr>
<td>Is mainly a verbal, two-way exchange</td>
<td>3</td>
</tr>
<tr>
<td>Nurses should communicate with UAPs</td>
<td>3</td>
</tr>
<tr>
<td>I don’t say much; I try to keep to myself</td>
<td>3</td>
</tr>
<tr>
<td>Is important to patient care</td>
<td>3</td>
</tr>
</tbody>
</table>

**Collaboration/Teamwork**

Most physicians stated that taking the time to build the physician-nurse relationship is time well spent because it enables clear communication and helps to ensure that important patient information is not missed. Many physicians said that multidisciplinary meetings/rounds that the hospital called “multidisciplinary” in which the physician, nurse and social worker discuss patients’ discharge readiness are important. UAPs are not typically included in those established meetings. A few
physicians noted that knowing the staff and keeping the nurses informed of changes to patients’ care plan is important. MD Jane Doe 3 compared interdisciplinary collaboration to an orchestra:

Each of these people are parts of an orchestra which, when everybody is doing their job together, number one, they know what the music is supposed to be. The patient is a symphony, that’s the center and everybody else plays, but somebody has to be a leader to say who plays what when.

A couple of physicians also noted a hierarchy among physicians.

A majority of nurses stated that nurses and UAPs should work together, while some other nurses said all three groups should work together. Some nurses talked about having interdisciplinary rounds/meetings with the charge nurse or nurse manager, social worker and physician. Many said those meetings were sometimes helpful. Still other nurses said teamwork/collaboration depended on who was involved. UAPs said it was important for nurses to work with them and help them with patients’ personal care. The majority of UAPs thought teamwork meant that everyone should work together for the patients’ benefit. Many UAPs also thought that getting reports from nurses was important to teamwork and patient care.

Sometimes while the call bell is ringing, you’ll have a patient that needs total care, but your hands are too dirty. You can’t run to catch that bell. So someone else—it could be the RN; it could be the manager, the doctor, anybody—it’s a team. (UAP Jane Doe 7)
Table 8

Common Comments on Collaboration/Teamwork

<table>
<thead>
<tr>
<th>Comment</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td></td>
</tr>
<tr>
<td>Physician-nurse relationship is important</td>
<td>6</td>
</tr>
<tr>
<td>Interdisciplinary rounds/meetings are important</td>
<td>5</td>
</tr>
<tr>
<td>Knowing staff helps</td>
<td>3</td>
</tr>
<tr>
<td>Nurses should be kept informed of changes in plans/orders</td>
<td>3</td>
</tr>
<tr>
<td>Physician teams should collaborate</td>
<td>2</td>
</tr>
<tr>
<td>There is a hierarchy among physicians</td>
<td>2</td>
</tr>
<tr>
<td>Nurses</td>
<td></td>
</tr>
<tr>
<td>Nurses and UAPs working together</td>
<td>6</td>
</tr>
<tr>
<td>Doctors, nurses and UAPs working together</td>
<td>4</td>
</tr>
<tr>
<td>Depends on the people involved</td>
<td>4</td>
</tr>
<tr>
<td>Interdisciplinary rounds/meetings</td>
<td>4</td>
</tr>
<tr>
<td>Working together</td>
<td>4</td>
</tr>
<tr>
<td>Physicians and nurses working together</td>
<td>3</td>
</tr>
<tr>
<td>UAPs</td>
<td></td>
</tr>
<tr>
<td>Teamwork is everyone working for the patient</td>
<td>7</td>
</tr>
<tr>
<td>Nurses and UAPs working together</td>
<td>5</td>
</tr>
<tr>
<td>Getting reports from nurses is important</td>
<td>4</td>
</tr>
<tr>
<td>UAPs working together</td>
<td>2</td>
</tr>
<tr>
<td>Nurses should not just delegate</td>
<td>2</td>
</tr>
</tbody>
</table>

Conflict

Physicians, nurses and UAPs stated that poor communication could cause conflict. Some attending physicians mentioned that it bothered them when another physician (consult, intern or resident) did not inform them of a change in their patient’s condition. Many UAPs and nurses discussed conflict with each other. Many nurses said that some UAPs get angry when you ask them to do something, many UAPs said that some nurses look down on them. According to UAP Jane Doe 8, a nurse told her, “I don’t do nursing attendant work.” UAPs also thought that nurses do not want to help with patients’ personal care needs. A few nurses mentioned that aggressive physicians are a challenge.
Patient Safety

Physicians, nurses and UAPs all stated that their roles are important to patient safety. Physicians and nurses talked about avoiding mistakes such as medication errors. Physicians and nurses also noted that communication is important in order to avoid mistakes. MD John Doe 9 relayed an experience that deeply affected him.

Communication is key in any field in any field. In medicine, it is particularly very important because, first of all, you have to delegate work on behalf of the patient. You have to be very clear on your assessment and management plan for the patient and it has to be laid out very carefully to your colleague. You avoid mistakes by doing this…The message was [verbally] relayed to my fellow to apply wet to dry dressings for two days…the message was [supposedly] relayed to the residents…Five days later, the patient had the same gauze…the patient bled when the gauze was removed…I should have spoken directly to the resident…I think it is on the physician to make sure everybody understands.

The majority of UAPs spoke about avoiding patient falls, as did a few physicians and nurses. Some nurses noted they should be attentive to what UAPs say about patients.

Ideal Communication and Collaboration

Many physicians believe that ideal collaboration involves making rounds with the physicians, nurses, and social workers. A few physicians agreed with MD John Doe 12, who said:

The ideal example would be there would be one attending, one resident and primary medical care team on every floor. At the same time there should be a fixed cardiologist, immunologist, every group so there are not 10 different
specialty people from the various groups…The nurses and nursing aides are coming in…and we discuss the cases.

Many nurses said that it is important for physicians to at least inform them of changes to the patient care plans or orders. Most UAPs indicated that they thought it was important for nurses to help with patients’ personal needs and for nurses to give UAPs a report on patients. Many UAPs also noted that there should be an atmosphere of mutual respect among nurses and UAPs. According to UAP John Doe 2, “It [ideal teamwork] is the involvement of all who partake in the care of a patient, no matter what your position is. All roles must be considered important and critical to patient care.”

Summary

Physicians, nurses and UAPs voluntarily shared their thoughts about their individual roles and the roles of members of the other disciplines in patient care. Participants also shared their experiences with communication and collaboration/teamwork. The investigator carefully examined participants’ statements and stories. The stories told by physicians, nurses and UAPs provided insights into how they define themselves and members of the other disciplines, and their cultural norms (Gibbs, 2002). Chapter 4 presented the basic findings and themes for the study. Chapter 5 presents a discussion of the investigator’s interpretation of the findings, the limitations, implications and significance of the study, as well as recommendations for further research.
Chapter 5

Conclusions and Recommendations

The purpose of this qualitative, phenomenological study was to explore how physicians, nurses and UAPs describe their individual functions and their roles as providers of safe patient care. The study also aimed to explore how members of each discipline view the functions and roles of members of the other disciplines. The central research question guiding the study was: How do physicians, nurses and UAPs perceive each other’s roles in patient care and interdisciplinary communication and collaboration? Study results might improve health care leaders’ understanding of interdisciplinary communication and collaboration among physicians, nurses and UAPs and facilitate patient safety.

The study provides valuable knowledge to other researchers, professionals, and the public. The current climate of evidence-based practice urges professionals to collect, interpret and apply research findings (Johnson & Waterfield, 2004; Wynd, 2002). Phenomenological researchers communicate and demonstrate the importance of participants’ accounts and researchers’ interpretations by presenting results in a coherent and logically presented report (Aisbett, 2006). In Chapter 4, physician, nurse and UAP participants shared their thoughts and experiences. In this chapter, Van Manen’s (2002) concept of reflective writing provides an insightful way to present the investigator’s analysis of the study’s results in order to better understand interdisciplinary communication and collaboration among physicians, nurses and UAPs.
Discussion

In qualitative phenomenological analysis, a researcher reviews and thinks about what occurred throughout the study process and then presents his or her interpretation of the results. The objective is to bring about understanding of some aspect of the participants’ lived world or lived experience (Van Manen, 1990). The reflective cognitive stance generally characterizes the phenomenological attitudes or the perspectives individuals develop as they reflect on and analyze their innate world-directed points of view (Sokolowski, 2000). Phenomenology requires a process of intuiting in which the investigator attempts to be open and view a phenomenon from a fresh perspective by deliberately departing from habitual ways of perceiving things; it can bring about unexpected riches that go beyond the findings and outcomes (Finlay, 2009). Through imaginative variation, the phenomenological investigator explores possible meanings by looking at the phenomenon from various angles (Moustakas, 1994).

Roles in Patient Care

Physicians, nurses and UAPs were asked to describe their roles in patient care. A significant number of physicians viewed themselves as the major decision-makers and medical plan managers. MD John Doe 12’s statement supports the conductorless orchestra model: “All roles are very connected to each other because patients get triaged at certain levels.” Many nurses described their role as providing compassionate care for the whole patient. The nurses were also responsible for documentation and patient advocacy. Most UAPs said their role was to assist nurses and make patients comfortable. Potter and Grant (2004) noted that UAPs consider their role to be similar to the nurse’s role and display positive concern for their patients. In this study, a few UAPs also
described their role as being similar to the nurse’s role. That number would be even higher if the description, “assisting the nurse,” was factored in because most UAPs include patients’ personal care needs when they use the word “assisting.” Both nurses and UAPs said they love what they do. Research indicates that patient care and safety requires a team effort, in which every health care team member plays a substantial role (Clancy, Farquhar, & Sharp, 2005).

**Others’ View of Your Role**

Participants described their impressions of each other’s roles and the relationships among roles. Some physicians said that nurses view the physician as the major patient care decision-maker. Other physician responses were evenly divided between physicians believing that nurses think physicians write orders, nurses look to physicians for guidance, and nurses respect physicians. The majority of nurses said that some physicians feel nurses are inferior and order them around. Similarly, most UAPs said nurses think UAPs are inferior and order them around. UAPs also said that nurses do not recognize or respect what UAPs contribute to patient care. Lack of respect threatens patient safety because it inhibits the collegiality and cooperation essential to teamwork, stops communication, and undermines morale (Lucian et al., 2002a).

**Communication**

Physicians, nurses and UAPs acknowledged that communication is essential in health care. Research indicates that providing quality patient care begins with clear and appropriate communication, and collaboration is impossible without communication (Arford, 2005; Weeks 2004). The majority of physicians and nurses noted that verbal face-to-face communication is important, whereas only a few UAPs specifically
mentioned face-to-face communication. Most nurses and UAPs said that how things are said is just as important as what is said, whereas only a few physicians made that distinction. However, many physicians said that communication should be clear, straightforward and concise. Nurses and UAPs stated it was important to receive both written and verbal reports. Nurses wanted physicians to keep them informed about patients’ care plans and UAPs wanted the same from nurses. Some UAPs also noted that they avoided talking with some nurses unless it was absolutely necessary. Mistakes are more likely when health care providers are reluctant to speak with one another (Morrison & Nolan, 2007).

**Collaboration/Teamwork**

Physicians, nurses and UAPs said that working together is important. However, their definitions of working together varied. According to Gardner (2005), having different definitions of collaboration presents a barrier to working together. Many physicians noted that the physician-nurse relationship was important. Physicians also thought interdisciplinary rounds/meetings with nurses and social workers were beneficial, and some nurses agreed. Very few nurses or physicians mentioned including UAPs in those rounds/meetings. On the other hand, some nurses did say that physicians, nurses and UAPs should work together.

Results of this study indicate that UAPs value respect for their profession and autonomy similar to Gould and Fontenla’s (2006) findings about nurses. For many UAPs, working together meant nurses should help them with the patients’ personal needs. For instance, UAP Jane Doe 3 stated that it is not appropriate for a nurse to leave a patient who asks for a bedpan and look for a UAP. The nurse should place the patient on the
bedpan, then inform the UAP and ask him or her to check the patient (unless the nurse needs help placing the bedpan).

**Conflict**

Longo (2010) noted that attention is often focused on physicians when it comes to disruptive behavior. Therefore, the investigator expected nurses to tell stories about physician misconduct and disruptive behavior. However, only a few nurses brought up that topic. The main issue that bothered nurses was when physicians did not keep them informed about new orders or changes in patients’ care plans. RN Jane Doe 11 gave an example:

Let’s say there is a discharge order. The doctors will tell the patient at 5 o’clock in the morning. So the patient is waiting around and at 9 o’clock he is looking for the nurse, “When am I going home? They told me I was going home.” The patient is already dressed, ready to go and upset with me.

UAPs, on the other hand, spoke about nurses’ behavior toward them. While some nurses said that UAPs get upset when nurses ask them to do things, many UAPs said they do not like the way many nurses speak to them and that many nurses do not help them with patients. If a patient asks for ice, for instance, and the nurse is not busy, the nurse can get the ice rather than taking the time to look for a UAP to do it. Some UAPs said they avoid talking to nurses unless absolutely necessary. Failing to speak with a nurse might delay patient care. Burke and colleagues (2004) noted that inadequate communication among health care providers creates an atmosphere that generates hostility, frustration, and distrust, which lead to inferior patient care. Also, strong
negative emotions can contribute to apathy, error rates and decreased productivity (Hornstein & deGuerre, 2006).

**Patient Safety**

According to Clarke (2006), patient safety requires doing the right things for the right patients at the right times. Each health care provider does what he or she can within his or her scope of practice to safeguard patients. In this study, physicians and nurses focused on avoiding mistakes such as medication errors. Physicians also stated that interdisciplinary meeting or rounds were important to ensuring patient safety. Physicians and nurses also said that communication was important to prevent patient care errors. Most UAPs also said that they communicate patient needs to the nurse. Previous research indicated that UAPs perceive themselves as communication facilitators between nurses and patients (McLaughlin et al., 2000; Workman, 1996). Other studies indicated that nurses depend heavily on UAPs (who provide 21% of total patient care nursing hours) to assist with increasing patient care needs (Chapman & Law, 2009; Howe, 2008). Most UAPs in this study talked about preventing falls among patients.

We check the patients every hour and ask them if they need to go to the bathroom and make sure the call bell, phone and personal items are within easy reach because reaching for those things and trying to walk without assistance can cause an accident. (UAP Jane Doe 11)

**Ideal Communication and Collaboration**

Physicians and nurses thought it would be ideal to have interdisciplinary rounds or meetings. According to MD John Doe 2, interdisciplinary meetings “force people to speak to each other and that type of teambuilding improves patient safety.” MD John Doe
10 said physicians and nurses should interact often because “they spend more time with patients and are aware of the minute-to-minute, hour-to-hour changes that the physician might not be readily aware of, which impacts decision-making and patient safety”. RN Jane Doe 11 supported that position: “Because I am with the patients about 11 hours and look at patients every hour, I know if there is the slightest change.” RN Jane Doe 11 said the same thing about UAPs: “They see the patients more than the nurses sometimes…they also come to us if there are changes.” She relayed a story of a patient that suddenly became short of breath as the UAP was feeding her. Only a few nurses mentioned that the UAP should be included in the interdisciplinary meetings. Most UAPs stated that nurses should be considerate when a UAP is busy. “If I am doing something, some nurses wait for me to give a patient cups or ice” (UAP Jane Doe 1). Successful collaborative interaction includes nonhierarchical control among mutually respectful equals (Stupak & Stupak, 2006; Taylor, 2009).

**Implications**

Meeting today’s increasingly complicated dynamic health care needs requires a variety of health care providers. No one provider can meet all patient needs. Yet, when a variety of professions are involved in patient care, there is a possibility of fragmented care. Fragmentation of care contributes to medical mistakes (Retchin 2008; Weinberg, 2002). Interprofessional collaboration, which allows providers to build an understanding that reflects both independent and shared decision-making, prevents fragmentation and increases effectiveness of health care delivery (Thiele & Barraclough, 2007). Reeves and Lewin (2004) noted that lack of time for teambuilding, confused roles, effects of professional socialization, and power and status differentials block interprofessional
collaboration. A professional group’s perception of how they should work with other professions influences their interpretation of collaboration (Rodger et al., 2005). Therefore, building a cohesive interprofessional health care team begins with gaining an understanding of the individual members.

Previously, Stein (1968) described the physician-nurse relationship as a game that is hierarchical in nature. In the past, nurses did not directly confront doctors about patient care issues. Davies and colleagues (1999) similarly suggested that the physician-nurse-patient relationship was like a family, in which the doctor was the father and head of household, the nurse was the subservient wife and the patient was the obedient child. Over time nurses began to rebel against the notion of submission and sought a more professional, well-educated, independent, and skilled image (Radcliffe, 2000; Reeves et al., 2008). This study’s results indicate that a hierarchical relationship still exists in the hospital setting. Physicians, nurses and UAPs still tend to see the physician as the person in charge. Evidence also shows that the UAP role was and still is often stereotyped (Stokes & Warden, 2004). On the other hand, the patient’s role in health care has dramatically changed. The patient is now at the center of the health care process. Patient-centered care means that the patient is an active participant in his or her care (Stavrianopoulos, 2012). According to MD Jane Doe 3:

My definition of patient centered care is the patient is a symphony, that’s the center and everybody else plays, but somebody has to be the leader to say who plays what when. Because the patient can identify with the leader as being the person to whom everything else can be funneled.
While MD Jane Doe 3 was talking about the physician as the team leader, this definition can be slightly adjusted and used for the conductorless orchestra model. In a conductorless orchestra, the leadership role rotates so that everyone experiences being a leader and a follower; there is no hierarchical control (Jagd, 2010). It was surprising to find that only one nurse mentioned the importance of including the patient in the decision making process.

Malhotra’s (1981) Shutzian lifeworld phenomenological orchestra study provided the theoretical basis for the metaphorical conductorless orchestra model, which guided this study aimed at understanding interdisciplinary communication and collaboration among physicians, nurses and UAPs. During a successful performance, each orchestra member (physician, nurse, and UAP) sees and hears the music from a different vantage points or perspective and has a different stock-of-knowledge or talent, but individual perspectives and various talents collaboratively blend to form a symphony (patient centered care) in which the individual performances complement each other (Bartolovich, 2007). To produce a cohesive performance, orchestra members must have a working understanding of how each individual member contributes to a particular music score. Each orchestra member steps into the lead, using his or her talents as the score indicates. Patients enter the hospital with a variety of issues. It follows that meeting those needs would require varying levels of expertise. True interdisciplinary communication and collaboration cannot occur without changing the hierarchical attitudes that reinforce disrespectful behavior (Lucian et al., 2012a).
Significance

Patient safety in the health care environment is a major concern. Health care leaders struggle to insure that patients receive safe quality care. An organizational culture provides the framework for the values, beliefs and norms that are important to an organization (Arford, 2005; Casida, 2008). Since health care regulatory agencies hold hospitals accountable for patient safety, it is important to develop an organizational culture of safety (Sammer & James, 2011). Building a culture of patient safety requires effort, a change in organizational thinking, and depends on the individual and group values, attitudes, perceptions, competencies and patterns of behavior that signal a commitment to the organization’s aptitude for health and safety management (Stavrianopoulos, 2012). Research indicates that a strong culture of safety can be a successful way to prevent medication errors and injuries from falls (Sammer & James, 2011). Casida (2008), Clarke (2006) and Infante (2006) promoted using a systems approach to preventing patient harm and creating a culture of patient safety. It is time for physicians, nurses and UAPs to examine and recognize how their interaction or lack thereof can present a barrier to developing a culture of patient safety. Lack of respect is tolerated and reinforced in part by the hierarchical hospital culture (Lucian et al., 2012a). Understanding and aligning physician, nurse and UAP perceptions of interdisciplinary communication and collaboration might help health care leaders develop patient safety systems that providers will embrace, thereby creating a true culture of safety. As Hofmarcher and colleagues (2007) noted, lack of cooperation and collaboration hampers efficiency and quality goals.
Limitations

Phenomenological investigators must prepare themselves to engage participants in meaningful interaction. The interviewer’s skill or lack thereof affects data collection and ultimately data analysis (Mitchell, 2011). To illuminate how the researcher influences data collection and analysis, it is important that the researcher maintain a reflexive stance, casting a self-critical gaze (Mitchell, 2011). Phenomenological reflection and reduction help researchers understand themselves and the people around them that might influence the researchers’ perceptions (Moustakas, 1994). The researcher found it difficult to get some participants to expand on answers. The researcher’s experience in interviewing patients did not sufficiently prepare the researcher for the study. In addition, the researcher missed asking the question, “How do these roles affect patient safety?” during the initial interview with three participants, which may have influenced their responses. In addition, re-interviewing UAP John Doe 6 might have influenced his responses since the interview was longer the second time.

Recommendations for Future Research

An investigator’s findings might answer some questions, but the findings also lead to other questions. No question is ever truly completely answered and no object can completely be seen (Van Manen, 2002). The phenomenological researcher only momentarily gazes at the object as it moves from the darkness into the light and descends back into the darkness. Van Manen (2002) described the phenomenological gaze using the example of Orpheus and Eurydice. When Orpheus’ wife, Eurydice, dies, he is so grief stricken that he ventures into the underworld to bring her back. Orpheus’ songs were so enchanting that the creatures of the underworld allowed him to reach Hades, the lord of
the underworld, in order to convince him and his wife Persephone to grant his wish to return Eurydice to the surface world. The wish was granted under the condition that Orpheus could not glance back at Eurydice until she reached the surface. Just before Orpheus and Eurydice reached the surface, Orpheus briefly glanced back at Eurydice and she was drawn back into the darkness. Just before she disappeared, their hands almost touched. As a researcher looks back into the darkness (reflects), the essence of the object or phenomenon changes. The researcher can therefore never quite see the true meaning, and further exploration of the phenomenon is always needed.

A follow up study is recommended, but with additional recruitment strategies and strict adherence to the interview guide protocol. Using a snowball technique in which participant provide contact information of others that might be interested in study participation might be more effective (Noy, 2008). Also, the difficulty the researcher experienced recruiting intern and resident physicians suggests a need to investigate the reasons why. There may be an issue involving physician perceptions of nursing studies and their importance in health care (Weeks, 2004). MD Jane Doe 4 (attending) and MD John Doe 8 (intern) suggested that attending physicians might have been easier to reach because they have more predictable schedules and are not called to multiple units as often as interns or residents. Most of the physician participants in this study were attending physicians. Perhaps investigating and gaining a better understanding of the perceptions of physician, nurse and UAP roles among attending physicians, interns and residents would help change the hierarchical hospital culture and pave the way for acceptance of a conductorless orchestra model of patient care. Collaboration, communication, and coordination of care are limited in hierarchical hospital structures because isolated
Results of this study suggest a toxic nurse-UAP relationship. Another study might delve deeper into the reasons for this toxicity. Also, a comparison of the perceptions of the physicians, nurses and UAPs in various units might be helpful. Further understanding the physician-nurse-UAP relationship might be useful in developing strategies to promote the adoption of a conductorless non-hierarchical work environment and facilitate the development of a culture of patient safety in the hospital. Investigating physician, nurse and UAP perceptions by gender, age and education might also yield useful information. Moreover, another study might investigate the contextual factors outside of the physician, nurse and UAP control that impact interdisciplinary collaboration, such as organizational culture, health professions culture, regulations, knowledge base, and liability.

Summary

The number of medical errors in health care is a major problem. The specific problem addressed in this study is inadequate interdisciplinary communication and collaboration among physicians, nurses and UAPs needed to insure patient safety in an intricate health care environment. Patients expect, demand and deserve quality care when they enter the hospital. Gone are the days when patients blindly followed physician orders. Today’s patients are more involved in their care decisions, and the centuries-old standard of physician-dominated discussions has gone by the wayside (Stavrianopoulos, 2012).
Conclusions

The increasing complexities of patient care present daunting challenges for health care providers, which make it difficult for any one health care provider to handle every aspect of a patient’s health care needs. Consequently, physicians, nurses and UAPs manage different elements of patient care. However, having various people involved in patient care can lead to fragmentation of care. To prevent fragmentation of care, physicians, nurses and UAPs must communicate and collaborate. Collaboration, however, is complicated and challenging, especially since physicians, nurses and UAPs have their own subcultures within the hospital, and have different professional identities, perspectives and skills (Stein-Parbury & Liaschenko, 2007). Building a culture of patient safety should begin by changing the dysfunctional hierarchical hospital culture, aligning health care providers’ perceptions, attitudes, knowledge and skills and acknowledging the importance of communication and collaboration (Scherer & Fitzpatrick, 2008; Weinberg, 2002).

This study suggests that the old subservient relationship that existed between physicians and nurses has improved (Reeves et al., 2008). Many physicians acknowledge the importance of nurses’ knowledge and expertise. On the other hand, the study indicates such a relationship now exists between nurses and UAPs. UAPs, like nurses, are proud of their role in patient care and struggle for the same respect and recognition from nurses that nurses seek from physicians.

Study results also suggest a multidisciplinary-interdisciplinary triad among physicians, nurses and UAPs. Most of the time physicians, nurses and UAPs operated as separate health care providers who barely spoke to each other. Physicians and nurses
sometimes operated as interdisciplinary or inclusive colleagues who shared open
dialogue, but UAPs were rarely included in any meaningful patient dialogue. UAPs were
routinely excluded from patient care decision meetings and consistently reported that
nurses thought they were superior and belittled UAPs. In many cases, that perception
prevented UAPs from talking to nurses unless they thought it was absolutely necessary.
UAP reluctance to speak with nurses could mean that valuable patient information might
be missed. UAPs also reported that they had to request, but often did not get written or
verbal report/communication on their assigned patients. Inadequate communication and a
dictatorial, authoritative arrangement among health care providers foster hostility,
frustration and distrust, which hinders collaboration and jeopardizes quality patient care
(Burke, et al., 2004; Sopow, 2006; Thiele & Barraclough, 2007). Creating a shared
culture requires an investment in trust, which is essential to develop shared goals (Jagd,
2010). Therefore, physicians, and especially nurses, must recognize, respect, and include
the UAP in health care decisions. Adoption of a hospital organization culture based on
the conductorless orchestra model would eliminate hierarchy, and recognize physician,
nurse and UAP contributions to care, thereby establishing and supporting a culture of
patient safety.
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Appendix A

Invitation to Participate

Dear Colleagues

My name is Gwendolyn Lancaster. I am a nurse at St. Luke’s-Roosevelt Hospital and a doctoral student at the University of Phoenix. I invite you to participate in a research study I am conducting entitled, *Understanding Interdisciplinary Communication and Collaboration Among Physicians, Nurses and Unlicensed Assistive Personnel*. The purpose of the study is to explore how physicians, nurses and unlicensed assistive personnel (such as certified nursing attendants, medical office assistants, and technicians) describe their individual roles and the roles of members of the other disciplines in providing safe patient care. The study is based on the belief that understanding perceptions among these health care providers can be used to enhance patient safety.

Your participation will include a private interview and discussion. The interview will take place in a convenient location of your choice at the hospital center. The interview session will last from 40 to 60 minutes and be audio taped. A light snack or lunch will be provided.

Your participation is voluntary and you may withdraw from the study at any time. Your participation will involve interviews with open-ended questions that allow you to speak freely about your experiences. A light snack or lunch is a direct benefit of your participation. Indirectly, your participation could result in improvement in understanding interdisciplinary communication and collaboration, which is important to maintaining patient safety.

The results of the study will be published but your identity will remain confidential. Your name will not be disclosed to any external party. Data from the study will be securely stored in a database maintained by and accessible only to me in a locked file cabinet. There are no foreseeable risks from your participation in this study. If you are interested and/or have any questions or concerns, you may contact me by phone at [insert phone number] or by email at [insert email].

Sincerely,

Gwendolyn Lancaster, RN, CCRN, MSN/ed
St. Luke’s-Roosevelt Hospital
Doctoral Candidate
University of Phoenix Online
CALLING ALL PHYSICIANS, NURSES, NURSING ATTENDANTS, ED TECHS, OR TECHS AND MOAs

At

ST. LUKE’S

You are invited to participate in a study entitled

*Understanding Interdisciplinary Communication and Collaboration Among Physicians, Nurses and Unlicensed Assistive Personnel*

The study involves individual, privately held, one-on-one interviews to discuss your thoughts about what interdisciplinary communication and collaboration means and how it affects patient safety.

For more information contact the principle investigator:

Gwendolyn Lancaster, RN, CCRN, MSN/ed
Doctoral Candidate

gwendolynlancaster@stlukes.edu
Appendix C

Informed Consent Form

ST. LUKE’S-ROOSEVELT HOSPITAL CENTER/UNIVERSITY OF PHOENIX
INFORMED CONSENT FOR PARTICIPATION IN RESEARCH:
PARTICIPANTS 18 YEARS OF AGE AND OLDER

Gwendolyn Lancaster
Principle Investigator

Print name of subject

Understanding Interdisciplinary Communication and Collaboration Among Physicians, Nurses and Unlicensed Assistive Personnel
Title of Project

IRB # 11-153

Purpose

This is a research study. The purpose of this research is to explore how physicians, nurses and unlicensed assistive personnel (such as certified nursing attendants and support associates) describe their individual roles and the roles of members of the other disciplines in providing safe patient care. Your participation will include one interview and discussion session. Open-ended questions will be used to help stimulate discussion about your experiences. The interview will take place in a convenient location of your choice. A light snack or lunch will be provided. The interview will be audio taped. The study is based on the belief that understanding your feelings and perceptions of interdisciplinary communication and collaboration can enhance patient safety. Participants will be encouraged to ask questions and express concerns as often as they need. A minimum of 30 total participants representing an equal number of physicians, nurses and unlicensed assistive personnel (UAPs) will be asked to participate. This is a single institutional study.

Duration

The single interview session will last approximately 40 to 60 minutes.

Risks

There are no foreseeable risks from your participation in this study. However, the fear of reprisals might be a real or perceived stressor for participants. Maintaining confidentiality
will alleviate the risk of reprisal. Your participation is voluntary and you may withdraw from the study at any time verbally or in writing. The researcher will confirm participant withdrawal from the study in a written notice within three days of notification for the participant’s records and piece of mind.

**Benefits**

A light snack or lunch is a direct benefit of your participation. Indirectly, your participation could result in improvement in understanding interdisciplinary communication and collaboration, which is important to maintaining patient safety.

**Confidentiality**

If you consent to participate in this research, your personal information will be kept confidential and not be released without your written permission, except as described in this section or as required by law. Your personal information may be shared, to the extent necessary, among the research staff, with the Institutional Review Board and research oversight staff.

Your name will not be reported in any publication; only the data obtained as a result of your participation in this study will be made public. A fictional name will be assigned to each participant and colors will describe units. The researcher will keep a code log of assigned names and unit colors. The code log, personal information, history and experiences will be kept in a database on a private password protected laptop computer. The laptop computer, tape-recorder and any handwritten notes will be secured in a locked file cabinet. Only the researcher will have access to the computer and information throughout the study. A hospital research mentor will only be involved in an advisory capacity. The mentor will only have access to participant information at the researcher’s discretion and in the researcher’s presence. The mentor will sign a nondisclosure agreement. The mentor will not be present during interviews. All data collected will be destroyed after five years.

**Contact**

If you have any questions or concerns about this project, you may contact:

Gwendolyn Lancaster, the principle investigator at: [contact information] or by email at [email address].

**Compensation**

Participants will not receive monetary compensation.

**Summary**

As a participant in this study, you should understand the following:
1. You may decline to participate or withdraw at any time without any penalty.
2. Your identity will remain confidential.
3. Gwendolyn Lancaster, the researcher, thoroughly explained the study and all of your questions or concerns have been addressed.
4. If the interview is tape-recorded, you must grant permission for the researcher, Gwendolyn Lancaster, to tape record the interview. You understand that the information from the tape-recorded interview may be transcribed. The researcher will structure a coding process to assure that your name remains confidential.
5. The information gathered from the interviews will be stored on password protected laptop computer and kept in a locked file cabinet. All information will be destroyed after a period of five years.
6. The results of the study will be used for publication.

Acknowledgement

“By signing this form, you acknowledge that you read the study description and understand the nature of the study, the potential risks to you as the participant, and the means by which your identity will be kept confidential. Your signature on this form indicates that you are 18 years of age or older and that you give your permission to voluntarily serve as a participant in the study described.”

Signature of the interviewee ______________________ Date ________________

I, Gwendolyn Lancaster, have clearly and fully explained to the above subject the nature, requirements and risks of the study.

Signature of the researcher _______________________ Date ________________

_________________________________________________________________

DISTRIBUTION: Original to investigator, copy for subject

- Adapted from existing consent from the University of Phoenix and St. Luke’s-Roosevelt Hospital Center
Appendix D: Non-Disclosure Agreement

Non-Disclosure Agreement

Dr. Martha L. Wiggins acknowledges that in order to provide the services to Gwendolyn Lancaster (hereinafter “Researcher”) who is a researcher in a confidential study with the University of Phoenix, Inc., Martha L. Wiggins must agree to keep the information obtained as part of his/her services (as more fully described below) confidential. Therefore the parties agree as follows:

1. The information to be disclosed under this Non-disclosure Agreement ("Agreement") is described as follows and shall be considered "Confidential Information":

Any information that could possibly be linked to participant identities, including but not limited to personal information such as names will be considered confidential. The hospital mentor will serve only in an advisory capacity and not actively participate in the research. The hospital mentor will not be present during interviews and will have access to participant information only at the researcher’s discretion and in the researcher’s presence. All information shall remain the property of Researcher.

2. Martha L. Wiggins agrees to keep in confidence and to use the Confidential Information for the purpose of advising the researcher only and for no other purposes.

3. Martha L. Wiggins further agrees to keep in confidence and not disclose any Confidential Information to a third party or parties for a period of five (5) years from the date of such disclosure. All oral disclosures of Confidential Information as well as written disclosures of the Confidential Information are covered by this Agreement.

4. Martha L. Wiggins shall upon Researcher’s request either destroy or return the Confidential Information upon termination of this Agreement.

5. Any obligation of Martha L. Wiggins under this Agreement shall not apply to Confidential Information that:

   a) Is or becomes a part of the public knowledge through no fault of Martha L. Wiggins;
   b) Martha L. Wiggins can demonstrate was rightfully in its possession before disclosure by Researcher/research subjects; or
   c) Martha L. Wiggins can demonstrate was rightfully received from a third party who was not Researcher/research subjects and was not under confidentiality restriction on disclosure and without breach of any nondisclosure obligation.
6. Martha L. Wiggins agrees to obligate his/her employees or agents, if any, who have access to any portion of Confidential Information to protect the confidential nature of the Confidential Information as set forth herein.

7. Martha L. Wiggins shall defend, indemnify and hold the Researcher and the University of Phoenix harmless against any third party claims of damage or injury of any kind resulting from Martha L. Wiggins’ use of the Confidential Information, or any violation of by Martha L. Wiggins of the terms of this Agreement.

8. In the event Martha L. Wiggins receives a subpoena and believes he/she has a legal obligation to disclose Confidential Information, then Martha L. Wiggins will notify Researcher as soon as possible, and in any event at least five (5) business days prior to the proposed release. If Researcher objects to the release of such Confidential Information, Martha L. Wiggins will allow Researcher to exercise any legal rights or remedies regarding the release and protection of the Confidential Information.

9. Martha L. Wiggins expressly acknowledges and agrees that the breach, or threatened breach, by it through a disclosure of Confidential Information may cause irreparable harm and that Researcher may not have an adequate remedy at law. Therefore, Martha L. Wiggins agrees that upon such breach, or threatened breach, Researcher will be entitled to seek injunctive relief to prevent Martha L. Wiggins from commencing or continuing any action constituting such breach without showing or providing evidence of actual damage.

10. The laws of the State of New York shall govern the interpretation and validity of this Agreement and the rights of the parties.

11. The parties to this Agreement agree that a copy of the original signature (including an electronic copy) may be used for any and all purposes for which the original signature may have been used. The parties further waive any right to challenge the admissibility or authenticity of this document in a court of law based solely on the absence of an original signature.

IN WITNESS WHEREOF, each of the undersigned has caused this Agreement to be duly executed in its name and on its behalf:

Printed Name of the hospital mentor: Martha L. Wiggins  
Signature: ___________________________________________  Date: _____________

Address: __________________________________________  

Printed Name of Researcher: Gwendolyn Lancaster  
Signature: ___________________________________________  Date: _____________

Address: __________________________________________  

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PREMISES, RECRUITMENT AND NAME (PRN) USE PERMISSION

St. Luke's-Roosevelt Hospital-St. Luke's Site

Name of Facility, Organization, University, Institution, or Association

Please complete the following by check marking any permissions listed here that you approve, and please provide your signature, title, date, and organizational information below. If you have any questions or concerns about this research study, please contact the University of Phoenix Institutional Review Board via email at IRB@phoenix.edu.

☐ I hereby authorize Gwendolyn Lancaster, a student of University of Phoenix, to use the premises (facility identified below) to conduct a study entitled Understanding Interdisciplinary Communication and Collaboration Among Physicians, Nurses and Unlicensed Assistive Personnel.

☒ I hereby authorize Gwendolyn Lancaster, a student of University of Phoenix, to recruit subjects for participation in a study entitled Understanding Interdisciplinary Communication and Collaboration Among Physicians, Nurses and Unlicensed Assistive Personnel.

☒ I hereby authorize Gwendolyn Lancaster, a student of University of Phoenix, to use the name of the facility, organization, university, institution, or association identified above when publishing results from the study entitled Gwendolyn Lancaster.

Gregory J. Calliste
Name

Chief Administrative Officer
Title

St. Luke's Hospital
1111 Amsterdam Ave

[Signature]
Date
Appendix F

Interview Pilot Guide

<table>
<thead>
<tr>
<th>Question</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introductory Information</td>
<td>Welcome and introduce self to participants. Thank them for taking time to participate. Remind participants of the purpose of the interview, procedures to ensure confidentiality, informed consent, and the length of the interview. If informed participants when recording.</td>
</tr>
<tr>
<td>Question 1</td>
<td>How do you describe your role?</td>
</tr>
<tr>
<td>Question 2</td>
<td>Describe the role of physicians, nurses or nursing attendants (depending on the participant).</td>
</tr>
<tr>
<td>Question 3</td>
<td>How do these roles affect patient safety?</td>
</tr>
<tr>
<td>Question 4</td>
<td>Describe how you feel others view your role (doctors, nurses, or nursing attendants) and how that makes you feel.</td>
</tr>
<tr>
<td>Question 5</td>
<td>How do you define/describe communication?</td>
</tr>
<tr>
<td>Question 6</td>
<td>How do you define/describe interdisciplinary collaboration?</td>
</tr>
<tr>
<td>Question 7</td>
<td>How do you feel interdisciplinary communication and collaboration affect patient safety?</td>
</tr>
<tr>
<td>Question 8</td>
<td>Describe your feelings about interdisciplinary communication and collaboration now? Does it exist and to what extent?</td>
</tr>
<tr>
<td>Question 9</td>
<td>Describe an ideal example of interdisciplinary communication and collaboration.</td>
</tr>
<tr>
<td>Closing</td>
<td>Thank participants again for their participation and candor.</td>
</tr>
</tbody>
</table>
## Appendix G

### Interview Guide

<table>
<thead>
<tr>
<th>Interview Guide: Understanding Interdisciplinary Communication Among Physicians, Nurses, and Unlicensed Assistive Personnel</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date:</strong></td>
</tr>
<tr>
<td><strong>Introductory Information</strong></td>
</tr>
<tr>
<td>Welcome and introduce self to participants. Thank them for taking time to participate. Remind participants of the purpose of the interview, procedures to ensure confidentiality, informed consent, and the length of the interview. Explain that the questions are open-ended and designed to stimulate conversation. Encourage participants to speak whatever comes to mind. “If you think of stories that can illustrate your point, that would be very helpful.” Inform participants when recording.</td>
</tr>
<tr>
<td><strong>Question 1</strong></td>
</tr>
<tr>
<td>Tell me a little about yourself (i.e. age, position, education, years of service, experience).</td>
</tr>
<tr>
<td><strong>Question 2</strong></td>
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<td>How do you describe your role as a physician, nurse or nursing attendant (depending on the participant) in patient care?</td>
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<td><strong>Question 3</strong></td>
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<td>What are your thoughts on the role of physicians, nurses and nursing attendants (depending on the participant)?</td>
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<td><strong>Question 4</strong></td>
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<td>How do these roles affect patient safety?</td>
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<td><strong>Question 5</strong></td>
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<td>Describe how you believe others view your role (physicians, nurses or nursing attendants).</td>
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<td><strong>Question 6</strong></td>
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<td>How do you define/describe communication?</td>
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<td><strong>Question 7</strong></td>
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<td>How do you define/describe interdisciplinary collaboration?</td>
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<td><strong>Question 8</strong></td>
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<td>How do you think interdisciplinary communication and collaboration affect patient safety?</td>
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<td><strong>Question 9</strong></td>
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<td>Describe your thoughts about interdisciplinary communication and collaboration now? Does it exist and to what extent?</td>
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<td>Describe an ideal example of interdisciplinary communication and collaboration.</td>
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<td><strong>Closing</strong></td>
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<td>Thank you for your participation and candor.</td>
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Appendix H
Pilot Interview Responses

MD-JDP

Interviewer: How do you describe your role as a physician in patient care?

A: My role as a physician? I would say I work here as a hospitalist…It is someone who takes care of patients only while they are in the hospital, essentially. I view my role as helping people recover from an acute illness and transitioning that care to their outpatient doctor…A physician’s role is to educate patients on their health and provide opportunities to improve their own health medication lifestyle changes, these sorts of things, be someone they can tell their medical problems to.

Interviewer: How do you describe the role of the nurse?

A: The nurse’s role is to do the daily general care of the patient, giving medication, making sure they get their meals, making sure they get to and from the bathroom…Helping the doctor with the patient and being a bridge to communication there, also and a backup of checks and balances to what the doctor is ordering.

Note: At this point, the interviewer got sidetracked and did not follow the interview guide precisely and jumped to communication.

Interviewer: I noticed you mentioned communication. What do you mean?

A: I think nurses are helpful in educating the patients and things such as insulin injections, Lovenox injections, and things of that nature. Physicians and nurses have good communication together so they’re not making any mistakes, specifically when medications are involved.
Interviewer: Describe an ideal situation for communication between the physician and the nurse.

A: An ideal situation is when the doctor orders something in the computer and should they have a follow up conversation with the nurse. Tell them what they ordered and why. And then they can both discuss what the goals are for the patient during this hospital stay.

Interviewer: So it would be more of a collaboration? Is it a two-way thing or is it the physician telling the nurse what he/she thinks they should do?

A: I think it should go both ways. I think there is sometimes, but it doesn’t always happen. It has to happen on a more consistent basis.

Interviewer: Can you describe a collaborative situation?

A: I think the way it exists now on most floors is that most of the doctors are just putting in orders and seeing the patients on their own and talk to the nurse if they need something immediately or if they just happen to just run into the nurse.

Interviewer: How about the physician-physician communication?

A: You mean like between us and consults and things like that? I think physicians on our own team are usually rounding together. So I think communication is pretty good as far as that is concerned… I mean, we usually communicate with each other through the notes in the chart. I would like it if the consulting doctor would call me after he sees the patient. That doesn’t happen too often, not often enough… I think that nurse-to-nurse communication is usually pretty good with their sign outs and everything. Whenever I find a covering nurse, they usually know what’s going on with the patient. So I think that’s good. Like I said, it could definitely be improved upon… What I would
really like is what they do at Sloan. The nurses all carry phones. You just call the phone and you say to the person’s name and where ever the nurse is on the floor, they can pick up and talk to you. So you always know, as long as you know the nurse’s name you can find them. Sometimes you can’t find the nurse. Sometimes I want to talk to the nurse, but their on their break or they’re busy with their other patient or right down the hallway and get pulled away to see another patient.

Interviewer: What does teamwork mean to you?

A: Teamwork means a group of people working towards a common goal. That in the hospital is...the nurses, the doctors, the nurses aids all trying to get the patient to the best possible health so that they can go home.

Interviewer: What do you think about the other roles in health care, the nurses and nursing attendants?

A: I think they are very important. With all the stuff that’s going on now and all the other responsibilities that we have a lot of the care falls onto the nurse and subsequently to the nurse’s aid. Most of the complaints I get from the patients are not like specific to their medical problem, but just they need help getting to the bathroom or they didn’t like their food today, which is a lot of the nurses aid kind of area. I think in the hospital they definitely...nurses and doctors I can see them as equally as important to the patient’s health while they are in the hospital.

RN-JDP

Interviewer: How do you describe your role as a nurse?

A: Somebody who cares for a patient when they are sick. More than just giving meds and you know, doing doctor’s orders. I care for each patient as if he was one of my
family members. And how I would want my family member to be treated if they were sick. So that’s what I do…Talking to patients, getting to know them…I end up learning a lot from my patients in terms of who they are and where they come from and things like that. And you know, meeting the family…and just being there for them, like if they need anything. You know. I have a lady now, she is in a lot of pain so you just stand there and hold her hand. You can’t just go, so you stay. I never get out of work on time. When you leave here on time, there is something you are not doing. I don’t know how some people do it. [we laughed]. I guess it’s just my time management isn’t really good. I have really bad time management but I love my job. I have not once gone home and said I hate my job. I like working here and I love my job. I love what I do. I don’t know if I’d feel differently if I worked somewhere else.

Interviewer: How do you describe the physicians, role, the physician and the CNA?

A: The physician, they know their patients when it comes to what’s wrong, like diagnosis…how to diagnose and prescribe and stuff like that, but they don’t know the patients the way we do. You know what I mean? Like sometimes I’ll be talking to the doctor and I’ll say, “This person has…” and they will say, “Really?”

Interviewer: So, what about the CNAs?

A: The CNAs, they know more about the patient. I actually learned a lot about patients through the CNAs, because they spend a lot of time with them too, especially on this floor with the AM care. Because on our floor, it is all hip and knee replacement. So everybody needs assistance. You know. So the CNAs do spend a lot of time in the rooms. So, they know the patients well too.
Interviewer: How would you describe communication? What does communication mean to you?

A: You know something is bothering the patient and the patient tells the CNA, I expect them to tell me. You know. Which they’re pretty good about, but sometimes I feel there’s a lack or they forget to say something or something that’s important they don’t realize it is important and don’t mention it. Maybe because it is busy. I don’t know. Like if I had been looking at vital signs and like Oh my patient had a temperature at 2 o’clock like that’s important to tell me that and like also when they empty the Foley. Sometimes they don’t document the output or they don’t tell me. And then it’s hard to tell if the output is good or not.

Interviewer: How would you describe the relationship between nurses?

A: It depends where you work. I have seen plenty of conflict between nurses. Um, I’ll never forget one day I floated to another floor and the night nurses came in and they were…I was new and they were literally arguing in front of the nurses’ station about assignments and it was loud and I was like, really, is this for real? I’m sure everybody could hear them… One time I floated to 8E and I was in a room with a patient on contact precautions and I needed help moving. So I came to the door and there was 2 nurses sitting at the COW. It was my first experience on 8E and I said could one of you help me move this patient and they said get the nursing assistant and I said I don’t know where they are and they said have the unit secretary get the nursing assistant. So they made me have the unit secretary page throughout the rooms for the nursing assistant.

Interviewer: How about the nursing attendants?
A: The nursing attendants? I have no problems with any nursing attendants. They all help me if I ask. But I feel that it’s because I help them if they ask. I’ll help move a patient, get them bathed, especially if it’s a heavy patient. And I find that when I go to floors, they nursing attendants actually help me more than they help the other nurses, because I help them, I thank them, and I appreciate what they do. But there’s some nurses who expect them to do everything. And they [CNAs] talk, and you can hear they don’t like helping certain people. They’ll do what they have to but they won’t go above and beyond for that person.

Interviewer: What about doctors?

A: The only thing with doctors is I think…like I feel sometimes they don’t listen to us. We had a situation here and we were explaining to the doctors something is not right…like they need to learn to trust us cause we see the patients more than they do and if we say something is wrong, something is not right…We can’t diagnose like they do…like we didn’t go to medical school but they have to trust our instincts and follow up on it.

Interviewer: Any examples of nursing attendant?

A: They understand. I think some people are just lazy. I know it sounds awful. Nurses, nursing attendants, every department…You can tell who’s here because they want to be here and who’s here because they want a paycheck. There’s a big difference. I don’t ever really see…you know they listen. But the thing is sometimes like nurses talking down to a nursing attendant, which is terrible.

Interviewer: How do you think that would affect the CNA’s performance?
A: I wouldn’t do anything for her. If I was the CNA, I wouldn’t do anything for the RN. To me that’s…like when I introduce my CNAs to the patient, I always say this is a nurse…I say we’re your nurses. You know, they may not be a registered nurse and can give medications, but they are still doing nursing. You know, they are still doing care. They are part of the team.

Interviewer: Tell me more about being part of the team.

A: Sometimes when the doctors round I try to stay in but I feel uncomfortable. I feel like they’re like watching…I don’t know why, but I feel like they don’t like it when I am there and then I always…when the doctors round on a patient, I always go in and ask the patient and see what the doctor told them. I ask, what did they say. Cause the doctors will round with the patients, tell them what’s going on, what the plan is and leave the floor. And so I have no idea, and they patient will be like, “Oh the doctor said I’m leaving in an hour.” And I am like “Oh, Ok…” And then sometimes at change of shift there’s a quick [nurse] report, diagnosis, medical history, allergies…you know, SBAR. But sometimes there is more to it…You can say what is going on with the patient today and so like I know our reports can take a while… I remember when I started here on Clark 5 we use to do interdisciplinary rounds and they always had an attending…It was a non-teaching attending…I can’t remember their names. It would be the nurse manager, the social worker, attending…the attending knew all the patients on the floor. And whoever the nurse was would sit and go over the plan for every patient. Here, we do interdisciplinary rounds on Tuesdays and Thursdays with our social worker…With our patients discharges there’s a lot… It is good from a social point of view, but the medicine part or the actual…there’s nothing.
Interviewer: Interdisciplinary rounds are not…

A: It’s just signing a paper. (She put her hands up and looked o the ceiling and huffed.) These doctors, they round with the interns and the residents so grab the nurse with you. It’s not that hard. It’s one extra person. You’re doing it anyway…and you don’t have to speak in laymen’s terms. Do it as you normal. We just eavesdrop. We pick up what we pick up. And sometimes I feel like even with the doctors if you point out things to them…like I do try to go in the patients rooms when they…sometimes I feel awkward and stuff…like they say “whatever”. But there are some doctors though that are really good and they really do, they’ll come and they’ll say to you…and I’ll say, “What’s the plan?” Usually if you ask um they will tell you they blow you off and be like, “Oh, don’t worry about it.” You have to ask. Not all nurses ask. I’m just nosey.

UAP-JDP

Interviewer: How do you describe your role as a nursing attendant?


Interviewer: Unclear?

Response: Unclear what I do? Like taking care of people?

Interviewer: For instance, I am a nurse… What do you think a nursing attendant is? I need to know how you feel about your role in the health care profession, how do you feel as a nursing attendant. Describe being a nursing attendant.

A: I feel good about being a nursing attendant. You know like as long as I have someone to come with me and be with me when I have to do some of the patients that I can’t do by myself. I need someone to be with me at all times with that kind of situation. I get here in the morning the first thing is to give out water pitchers to the patients who
need water, the ones that doesn’t need we don’t give. The next thing, when the food come
up, we feed everybody that need to be fed and we set up the patients that need to be set
up. And the next thing we does is when the finished eating we clean them up, give bed
baths, make them comfortable…

Interviewer: How do you think the nurses feel about your role?

A: I can see some of them is not really into with us…Some of them does…You
can tell the one that doesn’t because when you ask them to help you they will say…Oh,
get another attendant to help you. They don’t understand that I am a nursing
attendant/assistant. They are supposed to be assisting me…you know… I’m assisting
them.

Interviewer: How does that make you feel?

A: It makes me feel bad. It makes me feel very bad.

Interviewer: How do think communication…what is communication to you?

A: Communication is everything out in the open, telling me about your patients in
the morning time. You tell me what’s going on with this patient so I’ll know. You tell me
if this patient…They will put the signs up, but they don’t tell you what’s going on. You
have to go ask them what kind a isolation is this patient. Some of them will tell you and
some of them just like…two or three of them you can get the reports from but the rest of
them don’t say anything.

Interviewer: What kind of information do you think you would need?

A: I will need everything about that patient, whatever is going on with that
patient.
Interviewer: How do you feel that working together, interdisciplinary collaboration affects patient satisfaction?

A: Working together? Like I say some of them don’t even do that. You have to go in there by yourself. You and the nurse or whomever go in there together. Let the patient know you are there together to help the patient. If you can’t someone by yourself, you need someone there to help you.

Interviewer: Do the nurses or physicians listen to you in that kind of an incident?

A: Some of them do and some of them don’t and they will tell you, Oh…that patient’s been taking that for days and says…Maybe the doctor did not get a chance to tell them. Some patients will say, “Well, my head is hurting or my some part is hurting.” I would say, did you tell the nurse, No. Or they might say, I told them but they never come back.

Interviewer: How do you handle that situation?

A: Sometimes I just say, “Oh, they’ll be back. Somebody called them and they got busy, but they’ll be back.” I put it together like that. I would go tell the nurse and they would say, “Oh, well, I just been in there, I’ll go back in there later.” [She used a harsh tone] It makes me feel very sad. You know why? Because if they don’t go back in there you know what the patient is going to think? They’ll think that I didn’t tell them.

Interviewer: How important do you think you role is?

A: I think it is very important. You know it’s good because sometimes the patients tell me things about what the nurses do. I tell them (nurse) but they just act like they want to ignore it. Some of these nurses really do ignore these patients.

Interviewer: How do you feel the nurse feel about your role?
A: Some of them would say, Oh, I’m an RN. What’s that supposed to mean? We are all here to do the same thing. The only thing I cannot do is give the patient medication. That’s the only thing I cannot do and put IVs and stuff, but the rest of the stuff I can do.

Interviewer: So, what do you think a nurse’s role is with the patient?

A: I think the nurse’s role is just like mine, it’s just to take care of the patients. You know like make sure they take care of the patient. Don’t go in there and tell the patient, Oh I’ll be back and never get back. Just yesterday, went into the patient’s room put the patient on the bedpan telling the patient, I’ll be back. She told me she [nurse] never came back. I didn’t know the patient was on the bedpan. They need to tell us when they put the patients on the bedpan. We need to talk to each other. You don’t have to love her. You do that on the outside. This is the inside. The patient care comes first. You have to take care of you patients first.

Interviewer: Describe an ideal example of teamwork and communication.

A: I think teamwork and communication is when I get here in the morning time, the nurse will sit down and say, “Let me tell you about all my patients, tell you what happened last night. If you have any problems you come to me. When you get ready to do a patient, that you can’t do, you come to me and we will do it together.