Title:
Interprofessional Collaboration: Nurses and Physicians Continue to View Collaboration Differently

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Session Title:
Promoting Interprofessional Teams

Keywords:
Collaboration, Interprofessional and Leadership

References:


Abstract Summary:
The purpose/target audiences of this presentation are healthcare leaders who want to learn methodologies to assess the nurse – physician interprofessional collaborative environment. Attendees will learn how perceptions of collaboration vary by provider role and/or practice area and the interpersonal interactions that are critical to collaborative practice.
Learning Activity:

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<tr>
<th>LEARNING OBJECTIVES</th>
<th>EXPANDED CONTENT OUTLINE</th>
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<td>The learner will be able to describe how provider role and practice area influences perceptions of collaboration.</td>
<td>Summarize a brief historical overview and explain study results indicating that nurses and physicians viewed collaboration differently. Physicians did not view collaboration differently based on primary practice area, but nurses did vary by practice area.</td>
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<td>The learner will be able to discuss how a mixed methods approach may produce a fuller understanding of collaboration perspectives.</td>
<td>Discuss how quantitative findings were enriched by qualitative themes of rounding, respect, roles, and communication. Specific quotes will illustrate the themes, thereby providing guidance for potential future interventions.</td>
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Abstract Text:

Purpose:

Interprofessional collaboration fosters quality and safety clinical outcomes and is a requisite element in our complex healthcare delivery environment. Yet, as noted by The Joint Commission (2009), the relationship between nurses and physicians has been a major determinate of the quality of healthcare. Hierarchical power relationships between nurses and physicians were first described by Stein in 1967. Power dynamics, whether real or perceived, impede teamwork, collegiality, and patient advocacy. Although significant progress has been since Stein’s seminal article, conflict and discord persists leading to errors and increased healthcare costs (Crawford, Omery, & Seago, 2012; Nair, Fitzpatrick, McNulty, Click, & Glembocki, 2012).

Frontline nurses at a southwestern United States community acute care hospital identified collaboration as a topic of research interest. Seven frontline nurses developed a research study to explore interprofessional collaboration. The team was sponsored by medical and nursing leadership and mentored by two PhD prepared clinical nurse specialists.

The purpose of the research study was to investigate the current state of collaboration between nurses and physicians at a non-profit acute care hospital in the southwestern United States.

Methods:

Following Institutional Review Board approval, the frontline nurses conducted a non-experimental, concurrent mixed methods study. Quantitative data included the use of two instruments. The Positive Professional Practice Environment Assessment Scale (PPEAS) consists of 13 items on a 1-10 point Likert Scale. Eight items are scored from disagree (1) to agree (10); three items are scored from insignificant (1) to significant (10), and two items are scored from poor (1) to excellent (10). The scale produces an overall score and four subscale scores (presence of positive physician characteristics, presence of positive nurse characteristics, presence of positive organizational characteristics, and presence of positive decision making characteristics The PPEAS has an overall Cronbach’s alpha of 0.86 with subscale alpha’s from 0.73 - 0.89 (Siedlecki & Hixson, 2011). The Collaborative Behavior Scale – Shortened (CBSS) has eight items with a 1-4 point Likert scale (1 = rarely; 4 = nearly always) and produces an overall score to measure the degree of collaborative behaviors. The CBSS has reported a Cronbach’s alpha of 0.96 (Stichler, 2013). Recruitment via convenience sampling included 355 nurses and 82 physicians who
completed the quantitative instruments. One focused qualitative question *(If you could improve collaboration between physicians and nurses, what two strategies/priorities/areas would you suggest?)* resulted in responses from 144 nurses and 53 physicians. Data was analyzed using SPSS, Version 22 and by first cycle holistic and second cycle thematic coding.

**Results:**

Analysis of quantitative data was completed using descriptive statistics, t-tests, one-way analysis of variance analysis and post-hoc Sheffé. Physician respondents were predominantly male (81.35%), with a mean age of 51.95 years and 19.7 mean years in practice. The majority were board certified (93.7%) and primary practice areas were surgical (45.0%), medical (27.5%), or anesthesia (21.3%). Nurse respondents were predominantly female (90.95%), with a mean age of 44.17 years, and 17.51 mean years in practice. Most nurses had bachelor’s degrees in nursing (67.0%), and 51.3% had a specialty certification. Primary practice areas were inpatient units (acute care 22.6%; progressive care 22.1%, intensive care 21.0%). Comparing the two professions, physicians generally rated collaboration significantly higher than nurses as measured by the PPEAS overall score (physicians $M = 8.05$, $SD = 1.36$; nurses $M = 7.69$, $SD = 1.39$, $p = .037$) and CBBS (physicians $M = 3.40$, $SD = 0.55$; nurses $M = 2.69$, $SD = 0.76$, $p < .001$). Two PPEAS subscale scores were also significantly higher for physicians than nurses. On positive physician characteristics, physician scores ($M = 8.02$, $SD = 1.37$) were significantly higher than nurses ($M = 6.73$, $SD = 2.05$, $p < .001$) and positive decision-making characteristics were also higher (physicians $M = 7.84$, $SD = 2.06$; nurses $M = 7.02$, $SD = 2.22$, $p = .003$). Nurses ($M = 8.87$, $SD = 1.42$) scored higher than physicians ($M = 8.05$, $SD = 1.82$, $p < .001$) on the positive organizational characteristics. There were no significant differences between professions on the presence of positive nurse characteristics. Physician perceptions of collaboration did not vary by primary practice area. Nurse perceptions of collaboration varied significantly by practice area for the PPEAS overall score, the CBBS, and the two subscale of positive physician characteristics and positive decision-making characteristics ($p < .001$) Post hoc Sheffé comparison tests revealed, in general, nurses working in the emergency department and procedural areas rated collaboration significantly higher than nurses in other areas. Despite the close physical proximity of their work environment, nurses working in the operating room scored collaboration lower than nurses working in most other departments ($p < .05$).

Qualitative data analysis produced four interpersonal and interactional themes of rounding, respect, roles, and communication.

**Conclusion:**

Physician respondents perceived a greater level of collaboration than nurse participants, which is congruent with prior quantitative research findings (Nair et al., 2012; Wauben et al., 2011). The distinct differences in nurses’ collaboration scores by practice area support the concept of unit level influences on interpersonal relationships (Donaldson & Mohr, 2000). Qualitative data analysis revealed respect and rounding as methods to improve collaboration from a nursing perspective, while physicians emphasized role delineation as a potential improvement area. Improved communication was a priority emphasized by both professions.

Nurse leaders can influence the interprofessional environment by recognizing entity level measures of collaboration may not be reflective of a unit level work environment. Assessment of provider interprofessional dynamics at the unit or department level is paramount to addressing and improving relationships in the clinical setting. As the current study has shown, collaborative perspectives vary by role and settings. Successful interventions to improve interprofessional practice should recognize these differences and tailor strategies based on an understanding of the specific practice environment. In this study, the richness of exploring collaboration through both quantitative and qualitative methods resulted in a more robust assessment of the interprofessional environment. Collaborative interprofessional interactions are critical to achieve and sustain quality patient outcomes and interprofessional role satisfaction.