LA COMMUNICATION ENTRE INFIRMIÈRE ET MÉDECIN DANS L'ENVIRONNEMENT PÉRI-OPÉRATOIRE: TRANSFORMER LES SOINS DE SANTÉ PAR DISCOURS ET ACTIONS

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Dans un article récent par Weeks[1], le discours traitant de la communication entre infirmière et médecin en situation de soins actifs est présenté et analysé selon les principes de l'analyse critique du discours[2]. Ce premier article permet une compréhension des éléments informant le discours entre infirmière et médecin ainsi que le rôle de celui-ci dans la reproduction de la dominance des médecins sur les infirmières. Cette compréhension permet une exploration plus poussée du rôle du discours au sein de la contestation de cette dominance. Le but de cet article est de suggérer des actions qui visent la transformation de la prestation des soins de santé.

1. Weeks, M. (2004). Nurse physician communication: Discourse analysis. *Canadian Operating Room Nursing Journal*, 22(4), 33-37.

2. van Dijk, T. (1993). Principles of critical discourse analysis. *Discourse & Society*, 4(2), 249-283.

NURSE PHYSICIAN COMMUNICATION IN THE PERIOPERATIVE ENVIRONMENT: DISCOURSE AND ACTIONS TO TRANSFORM HEALTH CARE

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ABSTRACT

In a previous article by Weeks[1], discourse regarding nurse physician communication within acute care settings is presented and analyzed following the principles of critical discourse analysis (CDA)[2]. An understanding of what shapes nurse physician communication discourse and its role in the reproduction of the dominance of nurses by physicians is gained in this previous article. This understanding allows for further exploration of the role of discourse in the challenge of that dominance leading to suggested actions to transform health care delivery, which is the focus in this article.

Does inappropriate communication and perhaps verbal abuse still exist in the perioperative environment? If so, is this directed from physician to nurse, from nurse to physician, or both? Are certain patterns of communication accepted as the norm and allowed to occur without question? How do these patterns influence the health care team? The patients and patient care?

Chances are that every operating room has a story or two regarding communication issues. When you bring together a variety of individuals and professions in one area it is virtually impossible to have consistently flawless communication patterns. However, when certain patterns have the potential to negatively impact the work environment and patient care, action must be taken.

In order to take action, it is important to first understand the foundation of communication patterns and the surrounding discourse. In this article understanding is provided as aspects of nurse physician communication discourse presented in Weeks[1] are summarized. The extent to which this discourse is present in the perioperative environment and how it influences health care delivery in this setting is also explored. Thoughts on discourses of resistance presented in Weeks[1] are summarized, and, based on the discourses of resistance, actions to transform health care in the perioperative environment are suggested. Finally, conclusions are drawn regarding the importance of a critical perspective in shaping health care delivery.

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NURSE PHYSICIAN COMMUNICATION DISCOURSE SUMMARIZED

Much discourse regarding nurse physician communication comes from the nursing community. It focuses on ineffective communication patterns and provides resources to help nurses to become more effective communicators.[3,4,5] It is claimed nurses continue to utilize the passive voice and deflective patterns when dealing with nurse physician communication issues.[6,7] When discourse regarding nurse physician communication arises from the medical community it focuses on legal aspects and expectations of physicians in regard to transfer of patient health data.[8,9]

The empirical/analytical perspective (experience and observation) dominates nurse physician communication discourse with a focus on the impact of effective communication as an aspect of collaboration that correlates with positive patient outcomes in acute care settings.[10,11,12,13] Other empirical research explores physician verbal abuse of nurses and the resulting negative effects on patient care and nurses job satisfaction.[14,15,16,17] While less prevalent, the interpretive paradigm is evident in literature and illustrates a focus on gaining understanding of the actual nurse physician relationship and communication patterns.[4,18,19,20]

Despite this interpretive focus that could lead towards a critical perspective (getting to the meat and potatoes of issues underlying established communication patterns), true unconstrained discourse is lacking while traditional links to empirical research and negative aspects of the nurse physician relationship dominate the discourse. For example, cultural factors influencing nurse physician communication related to gender role socialization such as role and goal conflict, and status and education difference are presented in the discourse.[3,19,21,22] However, rather than being challenged, cultural norms are seemingly accepted in that it is suggested nurses understand and enhance communication patterns by recognizing and accepting the influence of cultural factors.[4,18,19,20,23,24]

It is in regard to cultural norms that power relations are depicted in the discourse. Historically nurses have exhibited behaviour common to oppressed groups seeking approval from their oppressors – for this purpose, physicians.[16,25,26,27] Many nurses continue to view themselves as subordinate to physicians [19] and the media often perpetuates the portrayal of nurses as intellectually inferior to physicians.[28] The medical community perceives any struggle by nurses for autonomy and revised communication patterns as a possible encroachment on physician territory.[19,29] This is a potential basis for the view that while enhanced communication is necessary, a power shift is not required in order to achieve this. [23] Thus the interests of some physicians are served by allowing them to maintain superiority and ultimate power.

PERIOPERATIVE NURSE PHYSICIAN COMMUNICATION DISCOURSE

Superiority and power are predominant themes in the perioperative environment. This is because multidisciplinary teams work in a stressful patient care environment where team roles are often neither clearly articulated nor agreed upon by team members and hierarchy predominates based on historical stereotypes of the nurse physician relationship.[7,14] The potential for interpersonal conflict and verbal abuse rises in such hierarchal environments where power overrides effective communication.[5]

Despite many informal anecdotal accounts among nurses regarding ineffective perioperative nurse physician communication, limited formal literature exists. When it is found, this literature is often related to verbal abuse of nurses by surgeons.[14,15] Only one study was found that looked specifically at understanding perioperative nurse surgeon communication patterns, and the authors of this study report finding no other studies addressing the topic from this focus.[7] This study reveals the acceptance of cultural norms by nurses as evidenced by utilization of discursive strategies (changing the subject) to meet nursing goals while minimizing nurse physician tension.
In predominant perioperative nursing education texts emphasis is generally placed on the importance of communication for patient safety

and teamwork.[30,31] While verbal abuse is deemed inappropriate, however, excuses for harsh criticism of nurses by surgeons are made with comments such as "Keep in mind that much that is said is not personally directed".[31] Perhaps such comments have evolved from coping measures used by perioperative nurses who cannot leave an abusive situation in the midst of surgery.

Commentary from surgeons indicates a different perspective than that of nurses regarding the impact of hierarchy on teamwork. Surgeons often support hierarchies and, when they are positioned at the top, usually perceive teamwork and communication to be more effective than nurses do in such an environment.[32,33]

DISCOURSE INFLUENCE ON PERIOPERATIVE CARE DELIVERY

It is impossible for the different perceptions of surgeons and nurses regarding communication and subsequent actions not to influence perioperative care delivery. If nurses and physicians disagree on the dynamics of inter-professional communication, potentially detrimental patterns will continue. Verbal abuse, notorious in the perioperative environment, results in staff shortages due to absenteeism and difficulty recruiting nurses, which affects surgical schedules, turnover time and the level of nursing expertise available to patients.[15]

Even more significant is the observation that links surgical error to interpersonal aspects of functioning in the perioperative environment.[7] Nurses certainly associate effective communication with higher quality patient care.[10,11,12,13,32,33] However, the assertion is also made that not enough formal evidence exists to prove this correlation.[34]

DISCOURSES OF RESISTANCE SUMMARIZED

From an empirical standpoint, the question is raised regarding the ability of studies to adequately support the link between positive nurse physician communication and improved patient outcome due to lack of scientific rigour.[35] Organizations that choose to function in a hierarchal manner could cling to this view in support of maintaining strict lines of command and control.

Support for such a structure by physicians interested in maintaining actual or perceived power results in resistance to collaboratively driven inter-professional communication patterns. Evidence of physician resistance already exists indirectly in the form of lack of physician input into the discourse regarding what can be done to enhance nurse physician communication. More directly it exists when physicians place emphasis on the importance of understanding physician directed communication.[8,9,23]

Nurses who are accustomed to and prefer working 'under' physicians' authority and are not comfortable with or not willing to develop new roles in collaborative working relationships, may also resist the discourse surrounding changed nurse physician communication patterns. The result may be a resistance to the challenge of the cultural norms underlying nurse physician communication.

Any confusion on behalf of patients regarding who is responsible for their care could lead to further resistance to the change of the hierarchal nature of the nurse physician relationship. Some patients who continue to view physicians as the ultimate "gatekeepers" to health care may be reluctant to risk losing favour with their physician for fear of not finding another.

ACTIONS TO TRANSFORM HEALTH CARE

Patients must not be placed in the middle of the polarities in the nurse physician communication debate. Rather, it is imperative that their needs be placed as the reason for nurses and physicians to engage in logical debate toward the ultimate goal of collaborative patient advocacy.

Perioperative patients are particularly vulnerable to the influence of communication on care delivery. The most common recommendation for improving patient safety in the perioperative environment is to improve communication.[32] A critical look at the cultural norms underlying nurse physician communication discourse and discourses of resistance allows for suggested actions to transform healthcare that are related to research, leadership and education, and clinical practice.

RESEARCH

The need for further research regarding perioperative nurse physician communication is evident since only one published formal study directly addressing the role of communication among nurses and surgeons in the perioperative environment could be located.[7] Research is needed to not only look at the superficial nature of the communication, but to also look more closely at cultural factors underlying the verbal exchanges. Great consideration must also be given to how communication patterns affect patient care delivery in addition to its impact on the relationship between physicians and nurses.

The lack of empirical research is provided as rationale for the opinion that not enough evidence exists to prove the correlation between effective nurse physician communication and positive patient outcomes.[34] However, this perspective needs to be challenged as it is with critical discourse analysis and the use of grounded theory by Epsin and Lingard.[7] There may be additional methods of research, as yet unexplored, available for investigating the relationship between effective nurse physician communication and positive patient outcomes. For example, by recognizing that perioperative nurses and surgeons are in the optimal position to be immersed in nurse physician communication we bring to the forefront the potential for collaboration on methods of naturalistic inquiry such as heuristic research.

LEADERSHIP AND EDUCATION

Nurses' use of discursive strategies, passive voice and deflective patterns when dealing with nurse physician communication issues is partially a result of gender related leadership. Many of the leaders within the nursing profession are women who have experienced gender role socialization that impacts nurse physician communication. While strategies are offered to assist nurses in dealing with communication issues – particularly verbal abuse – little leadership is provided in the way of encouraging nurses to challenge the cultural norms that lay the foundation for dated communication processes between nurses and physicians. Nursing leadership needs to question comments that recommend nurses enhance communication patterns by recognizing and accepting the influence of cultural factors, and – even more alarming – suggesting nurses should learn more about individual physician preference as a way of coping with verbal abuse.[14] Suggesting this method as a way of 'coping' with verbal abuse actually leads to avoidance and does not prompt nurses and physicians to address faulty communication patterns.

One area where leadership is making progress is in regard to formal education. Joint education for nurses and physicians is suggested as a foundation to collaborative practice.[19,36] A good starting point is for nursing and medical faculties to partner in collaborative curricula that includes communication courses illustrating the effects of positive communication on teamwork and patient outcomes. It is prudent for medical and nursing students to study aspects of inter-professional teamwork together rather than in isolation from each other. Eventually they will be practicing together.

CLINICAL PRACTICE

Informally, physicians and nurses in the clinical environment already collaborate to teach perioperative nursing students and residents about surgical procedures. However, the underlying cultural factors impacting nurse physician communication and subsequent patient care are normally not addressed. Rarely does either professional group consider or discuss what the environment must be like for the other. The exclusionary and inclusionary concepts of othering (methods of engaging with others) presented in Canales[37] have merit here. The exclusionary aspects of the power that physicians hold, within hierarchal systems, and the resulting domination and subordination of nurses, can be exposed and discussed. The impact of such exclusionary practices on communication patterns can then be evaluated in order to prompt

a shift toward more inclusionary practices that combine the potential collaborative power of nurses and physicians. This will in turn lead to the development of more effective teamwork and more positive surgical patient outcomes.

As understanding and respect for each other's skill and knowledge increases, both nurses and physicians need to consider and present the clinical benefits of collaborative partnerships to patients. This will allow patients to understand the different, yet equally important, roles both professionals have in care delivery, thus challenging historical stereotypes.

CONCLUSION

If nurses and physicians communicate effectively with each other, the ultimate benefits to patients of truly collaborative inter-professional practice can be fully realized. Gaining awareness of and reflecting on the discourse and discourses of resistance that shape the standing perspectives on nurse physician communication are the first steps of gaining a critical perspective on the issue. However, in order to transform health care one must go a step further and take action. Through collaboration in research, leadership and education, and clinical practice, nurses and physicians can challenge the historically stereotypical nature of their inter-professional communication. This action will allow them to move into a new era where mutual respect and understanding replaces traditional hierarchy and turf protecting. Adopting all processes of a critical perspective in regard to nurse physician communication – awareness, reflection, *and* action – will enable nurses and physicians to collaborate on the crucial transformation of health care delivery to where patient care is the primary focus.

For more information on this topic please contact the author at mbweeks@shaw.ca.

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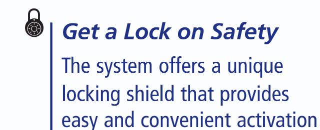

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