Nurse Physician Communication – Discourse Analysis

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LA COMMUNICATION ENTRE INFIRMIÈRE ET MÉDECIN – ANALYSE DU DISCOURS

La communication sous toutes ses formes fait partie intégrale de la vie quotidienne; dans le domaine des soins de la santé, elle peut faire la différence entre la vie et la mort. La communication inter-professionnelle peut avoir un effet négatif ou positif sur le partenariat critique qui existe entre les professionnels de la santé et les patients. La communication entre les infirmières et les médecins est d'une importance particulière ainsi que l'objet de beaucoup d'attention depuis plusieurs années. Dans cet article, le discours au sujet de cette communication en situation de soins actifs est présenté et analysé en suivant les principes de l'analyse critique du discours[1] afin de déterminer la façon dont ce sujet est discuté et compris par la société ainsi que le rôle que joue ce discours dans la reproduction de la dominance des médecins sur les infirmières.

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

NURSE PHYSICIAN COMMUNICATION – DISCOURSE ANALYSIS

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ABSTRACT

Communication in any form is an integral part of daily life and within the realm of health care can mean the difference between life and death. A vital partnership exists between health care professionals and patients that can be either negatively or positively affected by inter-professional communication. Of particular importance, and the focus of much attention over the years, is the communication between physicians and nurses. The discourse regarding this communication within acute care settings is presented and analyzed in this article following principles of critical discourse analysis (CDA)[1] to determine the way the topic is discussed and understood in society and how this plays a role in the reproduction of the dominance of nurses by physicians.

THE DISCOURSE OF NURSE PHYSICIAN COMMUNICATION

Discourse simply refers to expressing oneself using verbal and/or written words.[2] Discourse analysis is not unlike reading between the lines to determine the meaning behind what is actually said/written. Take, for example, conversation within a relationship when one partner asks the other how they are and the response is a curt 'fine'. Usually this means the person is not really fine and it is left up to the partner to figure out what is really going on. To take this a step further in discourse analysis one not only tries to figure out what is really going on, but also why the partner is saying 'fine' rather than using direct open communication.

Studying and analyzing such communication patterns is done to reveal the underlying sources of power, dominance, inequality, and bias and how these sources are initiated, maintained, reproduced, and transformed within certain social, economic, political, and historical contexts.[1] The foundation for nurse physician communication is rooted in the historical origins of the two professions and is layered with gender issues and inequity in regard to socioeconomic status, employment status, education preparation, and work practice.[3,4] The roots are strong in that conversations with health professionals today result in reflection on these very themes when offering rationale for ineffective communication patterns.

Much of the discourse comes from the nursing community outlining faulty nurse physician communication patterns and providing

resources for nurses to become more effective communicators.[5,6] Despite the emergence of available resources, often nurses continue to use the passive voice and utilize deflective patterns when dealing with communication issues.[7,8] Little discourse specifically regarding nurse physician communication comes from the medical community and when it does the focus is often on legal aspects and what physicians expect in regard to communication in terms of transfer of patient data.[9,10]

Paradigms (Models) Present in and Dominating the Discourse

Not everyone will see nurse physician communication in the same light, as individuals do not view the world in identical fashion. Personal values, beliefs and life experiences form what is often referred to as individual worldviews. While there are many individual worldviews, dominant categories can be formed by grouping together common views and creating models or paradigms. Three such paradigms in the realm of social science include **empirical/analytical, interpretive,** and **critical**, with the primary tenets of each being objective control, understanding, and free unconstrained discourse respectively.[11]

Much of the discourse on nurse physician communication originates in formal research from the **empirical/analytical perspective** (experience and observation) with a large focus on communication as an aspect of collaboration that, when effective, correlates with positive patient outcomes in acute care settings.[12,13,14,15] Other empirical research regarding nurse physician communication explores physician verbal abuse (particularly in operating rooms) of nurses and the resulting effects on patient care and the job satisfaction of nurses.[16,17,18,19] Throughout the empirical literature the common theme arises that although it is recognized that nurse physician communication impacts patient care, communication patterns are not always effective and are sometimes destructive.

From an **interpretive** standpoint the focus is gaining understanding of the nurse physician relationship and communication patterns.[20,21,22,23] The theme remains regarding ineffective communication patterns, however, strategies for change based on the understanding of the patterns is the focal point.

While attempts to understand the communication patterns provide hope in moving towards a **critical** perspective, true unconstrained discourse – laying all cards on the table – is lacking. Traditional ties to empirical research and the focus on the negative aspects of nurse physician relationships are maintained and dominate the discourse, reducing the potential for the development of truly new approaches that will lead towards understanding and enhancing nurse physician communication.

Cultural Factors Influencing the Discourse

Many cultural factors influence nurse physician communication along the lines of socioeconomic status and gender, and awareness of these is present in the discourse. Such factors cited include role conflict, status difference, education differences, and goal conflict.[5,21]

"As the role of the nurse continues to expand, the boundaries between what is considered to be medical care and what is deemed nursing care become less obvious".[5] Physicians may find role blending threatening to their power stance thus negatively impacting their communication with nurses. Specific communication patterns may be interpreted as the sole method of maintaining power.

The status difference between physicians and nurses, developed as a result of both social and gender perspectives, has an influence on communication patterns. By virtue of both their relative position of power and their income most physicians run in different social circles than nurses.[24] This lessens the chance of similar communication patterns. The result is the development of communication patterns and mutual understanding primarily within, and limited to, the context of workplace situations. Gender stereotypes, that for years have generally shaped how women and men are expected to communicate, further limit the development of shared patterns of communication. Traditionally the expected communication patterns of women and men are complaisance and assertiveness respectively. It is common for women who are assertive to be labeled, unfavourably, as aggressive. Communication patterns of women are often not easily changed, even with increased education, due to the lasting influence of the gender expectations on which they were raised.

Education does, however, lead to more nurse responsibility for patient care and nursing autonomy, which may, in turn, further strain nurse physician communication patterns. While nurses and doctors require different education, it is the different types of education that may be a more important determinant of subsequent nurse physician communication patterns. "Physicians are taught to be decisive, independent problem-solvers, whereas collaboration and advise-seeking are encouraged in nursing education."[5]

Goal conflict may result due to the influence of different education backgrounds on determining the priorities for patient care. Discourse from the medical community indicates that extensive patient chart documentation and nursing time spent with patients is seen as an attempt to document nursing independence from physicians and that this view, along with poor communication, results in a power struggle leading to the polarization of patient care.[25]

Depiction of Power Relations in the Discourse

While both the medical and the nursing communities present a power struggle between nurses and physicians each group depicts the power relationships somewhat differently. The medical community sees nurses' struggle for independence and revised communication patterns as a possible detriment to patient care and does not recognize the need for a power shift in order to enhance communication. In the nursing community desired communication pattern changes are seen as essential for quality patient care, however, an interesting point to note is the lack of focus on power shifts in that the elevated status of physicians has come to be the accepted norm. The medical community, for the most part, sees no need for new communication patterns and wants to keep the status quo. The nursing community wants to improve communication and seems to feel this can be done while accepting the power status of the physicians.

What are depicted equally in both camps are the existence of the power differences and the bearing of cultural factors. Within the discourse the social status of physicians is reproduced time and time again without truly being challenged. For example, strategies are suggested for ways nurses can understand and enhance nurse physician communication through recognition of role differences and communication patterns.[20,21,22,23] However, it would seem the dominance that goes with the elevated social status of physicians is accepted. The concept of doctors' orders remains a predominant underlying point in formal communication between nurses and physicians.

Interests Served

Despite the reproduction of physician dominance over nurses – perhaps serving the interests of some physicians – the interests of nurses are served in the discourse. Through research, and the sharing of examples of both effective and ineffective nurse physician communication patterns, awareness of the discourse surrounding the issue is generated. This will in turn prompt further consideration of an important issue and perhaps eventually lead to critical discourse analysis.

Interests of acute care facilities are also served by the discourse. Facilities that recognize the benefit of collaborative work environments in cost savings, through positive patient outcomes and in increased staff retention rates, can direct conscious effort toward policies and programs that enhance nurse physician communication.

Absent Views and Voices

For a population reportedly dramatically affected by nurse physician communication patterns, the views and voices of patients are noticeably absent. Much of the discourse is presented amongst professionals and in literature sources not readily accessible to the general public. Therefore, knowledge of how nurse physician communication can potentially impact patient outcomes is likely not widespread

with exceptions being legal cases directly related to faulty nurse physician communication.

While physicians who are interviewed and included in studies provide feedback on nurse physician communication, much of the interest and research on this topic comes from the nursing community. In this respect the voices of physicians are absent perhaps presenting an underlying discourse regarding their interest and concern in regard to nurse physician communication.

The views of acute care centers in regard to nurse physician communication are also absent. Administrative structures could have a huge impact on the development of nurse physician communication and, given the research on patient outcomes, one may wonder why facilities are not more vocal and proactive in regard to nurse physician communication.

Discourses of Resistance

Further studies could potentially challenge current research by demonstrating lack of conclusive evidence that nurse physician communication impacts patient outcomes. It is reported that the question has been raised regarding the ability of studies to adequately support the link between positive nurse physician communication and patient outcome due to lack of scientific rigour.[26] Organizations that choose to function in a hierarchal manner could pick up on such potentially inadequate research and use it in support of maintaining strict lines of command and control between doctors and nurses.

Resistance from physicians, who are fearful of losing actual or perceived power, could challenge the discourse surrounding the importance of nurse physician collaboratively driven inter-professional communication patterns. Evidence of this resistance already exists indirectly in regard to the lack of input in the discourse by physicians regarding what can be done to enhance nurse physician communication. Perhaps more directly it exists when physicians place emphasis on the importance of understanding physician directed communication.[9,10,25] Nurses who are accustomed to, and prefer working 'under', physicians' authority and are not comfortable in, or not willing to learn, new roles in collaborative working relationships may also resist the discourse surrounding changed nurse physician communication patterns. Any confusion on behalf of patients in regard to who is responsible for their care could lead to resistance of changes to the hierarchal nature of the nurse physician relationship.

CONCLUSION

The result of continuing the current discourse regarding nurse/physician communication is beneficial in many regards in that it encourages people to pay attention to communication patterns. Discourse analysis must also be utilized to look beyond the current patterns to the underlying reasons that the patterns remain the same. Doing so will prevent the current discourse from being used to conceal, and reproduce, the dominance of nurses by physicians. This is especially the case in acute care areas – such as the perioperative environment – where communication patterns can be particularly poor and verbal abuse is often prevalent. When it is understood what shapes discourse and its role in the reproduction of dominance, the role of discourse in the challenge of that dominance can be better explored. This then allows for suggested action to transform health care delivery, which will be the focus of a future article in regard to nurse physician communication discourse in the perioperative acute care setting.

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

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