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From anticipation to confidence: A descriptive qualitative study of new graduate nurse communication with physicians

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Abstract

Aim: The aim of this study was to understand how new graduate nurses experience communication with physicians.

Background: Communication is necessary for high-quality health care delivery. With poor patient outcomes as a driving force, knowledge of the dialogue that occurs between new graduate nurses and physicians has been rarely explored.

Methods: This qualitative descriptive study involved 13 new graduate nurses from an academic teaching hospital in the south-eastern United States. Data for this study were collected using face-to-face and virtual interviews with a focus on having nurses describe their experience communication with physicians in their current practice.

Results: Analysis led to four themes that describe new graduate nurses experience communicating with physicians. Those themes were gaps in preparation, developing confidence, learning to communicate, and interprofessional care.

Conclusions: Effective communication with physicians is a stressor for new graduate nurses as they transition to practice. For these nurses, negative emotions in their anticipation of communicating with physicians were developed during their educational experience.

Implications for Nursing Management: The findings of this study emphasize the importance of enhanced interprofessional training in education and practice that facilitate effective communication between the two professions in the practice environment.

KEYWORDS
communication, education, interprofessional, patient safety, qualitative

1 | BACKGROUND

Disorganised and broken communication is a major source of adverse events within the health care setting (Ahmed et al., 2018). Despite

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various methods of communication in the health care environment, breakdowns in communication between nurses and physicians play a role in more than half of adverse events that occur in hospitals (Müller et al., 2018). Effective communication between nurses and physicians may contribute to an organisation's ability to improve patient outcome reliability (Stucky, Wymer et al., 2022). Despite the hope of technology integration as a means of improving communication, there is still work to be done regarding information exchange and its impact on patient care delivery (Haykal et al., 2020).

A consistent finding for poor communication is the perception by nurses that hierarchical attitudes limit physician acceptance of their input into the patient plan of care. Nurses have historically reported difficulty speaking up in patient care conversations during patient rounds, a perceived lack of resolution in disagreements with physicians, and believe that their input is not well received by the physician (Thomas et al., 2003). The power imbalance between nurses and physicians continues to emphasize the physician has decision making authority (Strachan et al., 2018). This authority may deepen the limited role nurses perceive they have in communicating with physicians. Hierarchical structures not only limit the voice of the nurse but also lead to variations in how nurses and physicians perceive communication. Recent research on the physician's perspective of communication with nurses found that, from the resident physician's perspective, communication with nurses was based on getting work done (Forbes et al., 2020).

When members of the interprofessional team can contribute their individual expertise to patient care, a collective force, effectively and efficiently, functions to provide health care. For each team member's contribution to be valuable, communication is necessary. When adverse events occur, the results may be death, or permanent harm. With poor patient outcomes as a driving force, and a persistent interest in nurse physician communication, significant improvements have not been made in improving the dialogue that occurs between nurses and physicians. The research portfolio of nurse–physician communication is not lacking in interventions that are narrow in scope and only applicable to specific contexts (Wang et al., 2018), but there is a lack of research investigating the experience of each discipline communicating with each other. An even larger gap in the literature is an understanding of how new graduate nurses perceive communication with physicians.

The new graduate nurse transition to practice is a highly researched field. Although numerous studies have discussed new graduate nurse and physician communication (Fink et al., 2008; Missen et al., 2016; Song & McCreary, 2020; Theisen & Sandau, 2013), they have focused on the new graduate's broad experience in the transition from student nurse to the health care environment. Much of this research has not specifically investigated how new graduates experience communication with physicians. Chandler's (2012) focus on the knowledge, relationships, skills, and attitudes in the first year of practice found new graduate nurse's experience "blurring" (p. 106) of roles on the interprofessional team. Deppoliti's (2008) qualitative focus on the new graduate's construction of professional identity discovered negotiations for power and authority occurred between nurses and physicians. Nurses that experienced disrespectful behaviour from physicians found ways to cope with this behaviour through increasing knowledge, experience, and observing other nurses (Deppoliti, 2008). Pfaff et al.'s (2014) focus on new graduate nurse confidence provides insight into the factors that challenge and facilitate confidence, such as respect, experience, difficult communication, and lack of experience, to engage in interprofessional collaboration. While these findings are important in understanding the new graduate's intent to participate in the interprofessional relationship, these studies do not differentiate the barriers between roles on the interprofessional team or provide a specific explanation of the new graduate's experience. A renewed focus on their experience will provide a better understanding of communication between new graduate nurses and physicians.

Elicited by a single open-ended question asking for difficulties in transitioning from student nurse, a seminal study by Casey et al. (2004) found that communication with physicians is difficult for new graduate nurses. A secondary analysis of qualitative data collected using the Casey-Fink Graduate Nurse Experience Survey also found concerns among new graduates related to their assertiveness with physicians (Fink et al., 2008). Analysis of this open-ended question provides some insight into the difficulties of new graduate nurses, but the ability to understand the depth of the experience of new graduate nurses communicating with physicians is lacking. Therefore, the purpose of this study is to understand how new graduate nurses experience communication with physicians.

2 | METHODS

2.1 | Design and sample

This study uses a qualitative descriptive design to understand the perspective of new graduate nurses' communication with resident physicians. Fourteen new graduate nurses agreed to take part in this research, nine females and four males. Participants were recruited through email campaign. Participants were included in the study if they had less than 2 years' experience as a nurse and worked in a setting where communication with resident physicians occurred daily. The experience of participants ranged from 7 to 24 months. Ten nurses were employed on adult medical-surgical units, and four were employed in paediatric units.

2.2 | Data collection

This study received IRB approval before participant recruitment. Data for this study were gathered in the form of virtual or face-to-face interviews. The authors interviewed each participant as a faculty-student dyad. The lead author has experience in qualitative interviewing and analysis. The student team member received training on interview technique prior to participating in this study. Virtual interviews were conducted due to a modification in the study protocol due

to social distancing guidelines as a result of the COVID-19 global pandemic. The researchers used semi-structured interview technique and began each interview with the over-arching question of "Tell me about your experience communicating with physicians in your current practice?" Probing questions were asked for clarification and further investigation of participant responses. All interviews were audio-recorded and transcribed verbatim. Consecutive interviews were scheduled with ample time between to ensure participants were not cross-exposed. Data collection and analysis occurred concurrently. Repeated themes were evident after 12 interviews were completed. The research team continued with two additional interviews to ensure data saturation.

2.3 | Trustworthiness

Two hours were allocated for interviews to ensure that participants were given as much time as needed to discuss their experiences communicating with physicians. The researcher ensured confidentiality of the participants to facilitate trust between the researcher and participant. Participants were informed that records of their experiences would remain in the possession of the researchers. Transcribed interviews were de-identified. Transcriptions were read multiple times to prolong engagement with the data.

Triangulation can also be achieved during the analysis of qualitative data. Having multiple researchers analyse qualitative data allows for the similarities and differences in findings to be investigated further. Each member of the research team analysed data independently. Regular meetings between the research team were scheduled to review findings and validate themes. Discrepancies were resolved by collectively returning to the raw transcripts that composed each theme and ensuring themes remained grounded in the participant data.

2.4 | Data analysis

Transcribed interviews were read multiple times prior to analysis. The overarching question was clearly delineated and reviewed during the analysis. With a clear understanding of the research questions, transcribed interviews were analysed line by line. Once line-by-line analysis and thematic extraction were completed, the researcher began to group themes into categories and continued until no further categories could be created.

Patterns and connections, within and between, categories were identified next. The data collected for this research were focused and analysed individually and by groups according to gender and years of experience. The data were also analysed for themes, key ideas, similarities, and differences in responses. Once categories were delineated within the data, the researcher compared responses between participants on similar themes. The researcher also analysed the data for relative importance of categories. The categories developed in this study were tallied and ordered to show importance. Finally, the data were interpreted for meaning and significance. Once data were analysed and triangulated by colleagues, the researcher took time to reflect on the analysis. Notes taken during analysis were reviewed prior to interpretation. Interpretation was completed with constant awareness and reflection on the purpose of this research.

3 | RESULTS

This study provides a beginning understanding of how novice nurses experience communication with physicians. Initial coding revealed 15 concepts from the transcribed interviews. Further analysis led to the development of four themes. The four themes interact to describe the new graduate nurse's experience communicating with physicians. Descriptive themes are gaps in preparation, developing confidence, learning to communicate, and interprofessional patient care. They support that effective and efficient communication with physicians is a stressor for new graduate nurses as they transition to practice. While a mixture of adult and paediatric nurses participated in this study, no differences in themes were observed during the analysis.

3.1 | Gaps in preparation

The preparation of new graduate nurses for communicating with physicians emerged as a theme in this study. More specifically, participants expressed a lack of preparation during their educational programs. Interactions with physicians were limited during clinical rotations. Limitation ranged from not allowing students to contact physicians, "I never called a physician. We weren't allowed to call physicians" (RN3) and "… you talk with your nursing instructors, but you never communicate with the physicians" (RN2), to discouragement from communicating with physicians, "In the program I went through they did not encourage physician interaction" (RN5). Participants also discussed a gap in the training they received and actual practice, "We studied about it [communication] from an academic standpoint through textbooks and simulation, but it's different" (RN6) and "… There's things they [instructors] told us, and we would be doing a lot, and it's completely different when you're out in the real world." (RN7). Simulation was mentioned as a methodology participants used to learn how to communicate with physicians. In these instances, the nursing instructor would take the role of the physician and sometimes imitate negative physician behaviour.

Participants also discussed the influence of stories related to bad physician behaviour. Other students and nursing colleagues in the workplace shared their stories of negative communication with physicians. Listening to these stories heightened participant's anxiety related to communicating with physicians, "I've heard different stories of, if you didn't come with the correct facts you might get fussed out" (RN4). Again, nursing instructors contributed to the anxiety by also telling stories of bad physicians' behaviour, "You hear these horror stories from people who are in your nursing class with you and from people you know, like even from our own teachers" (RN5). These

stories translate into fear in the practice environment. One participant spoke about her fear of interacting with physicians specifically fear in appearing "… dumb or overstepping" (RN8) when providing insight into the patient's condition with physicians.

When discussing education related to physician's communication, participants were also asked about their use of the mnemonic device SBAR. SBAR was found to be a subconscious guide to communication with physicians after they transitioned to practice. While learned in a very structured manner during their education, conversation with physicians used a less formal structure, "Before I make a phone call to a physician or walk up to speak to on, I try to formulate a little bit in my mind … kind of a subconscious SBAR I guess" (RN11). In some instances, SBAR was viewed as too detailed a device to effectively communicate with physicians. The amount of detail required by the physician was less than the amount of detail the new graduate nurses learned to communicate during their educational programs, "The doctor knows the patient, I don't have to go through SBAR. I feel like in school they wanted us to give more detail" (RN10).

3.2 | Developing confidence

All participants reported nervousness or anxiety when beginning to communicate with physicians as they transitioned to practice. Participants used words such as "scared" (RN3), "nerve-racking" (RN1), nervous (RN4), "frustrating" (RN6), and "flustered" (RN7) when describing communication with physicians. In describing the first impression of communicating with physicians, RN1 stated "… it was really nerve-racking … it was a lot of phone encounters versus face to face so that was painful." Another participant stated, "It's definitely gotten a lot better. When I first started, I was very nervous. I didn't know how or what to say to them" (RN4). RN3, referring to what made communication uncomfortable in the beginning, stated "When you first get started, they [physicians] know what's going on and you don't."

As confidence in their new roles improved, comfort with physician communication also improved. When asked what made RN4 more confident, he stated that "time and experience and getting used to it [communicating]" had improved his confidence. RN7's confidence was increased as she transitioned from student to licensed nurse, "When you actually get your license, you're a little bit more confident about it … but when you're a student, it's terrifying to talk to a physician." RN4 stated, "I'm more confident now. Before, I feel like I was on the phone stuttering … I didn't know if it was important to say, but now I can critically think more." Another participant highlighted that as nursing judgement improved in practice, confidence in making suggestions to physicians improved, stating "I used to jot give too many suggestions … the more my judgement improves the more I typically know what they [physicians] need."

Two participants did not express the initial low confidence of the other nurses. Instead, they had previous life experiences, before their nursing career, that allowed them to be more comfortable when they interacted with physicians as new graduate nurses. RN6 stated that he had no anxiety when communicating with physicians. He attributed his comfort with his prior experience in sales and his many years in the job market. RN5 had been a paramedic before entering the nursing field and a nursing assistant while in nursing school. According to this participant, this experience alleviated any preconceived notions of communication with physicians upon entering the nursing field.

3.3 | Learning to communicate

When speaking about their communication with the resident physicians, all the new graduate nurses spoke to how the actual format of the communication was almost universally informal and lacking structure. Most of the nurses claimed that most communication with resident physicians was not face-to-face interaction, but rather via various electronic programs offered through their hospitals. These programs often are compared with "text messaging apps" (RN8), or "like paging" (RN13), where nurses and resident physicians often cannot send more than a sentence's worth of information per message. All these methods of communication in turn have created an informal environment for the interprofessional communication to occur; the new graduate nurses (NGNs) describe multiple situations where they were both helpful and hurtful in terms of communicating the plan of care.

RN14 noted that this informal and brief method of communication is popular among the new residents and is often the preferred form of information dispersion. "I feel like they love to use secure chat because you can automatically send them a text page or whatever instead of having to call them." However, he continues to speak about how this sentiment is not shared by all the doctors, stating "the other facility that I was at they didn't like us using text communication because it was becoming a point to where it was interfering with the patients care, because some doctors were looking at it and some doctors were not."

Much of the informal communication described by nurses was associated with developing confidence through their transition to practice, and learning how to communicate with physicians was important. Communication was modified to meet the demands of the physician. Each participant reported this communication as "getting straight to the point" (RN2) or "straight to business" (RN1). In describing her perception of the physician, RN1 explained:

> You have to be to the point. What is it that you want from me kind of conversation? It's different from communicating with other nurses cause it's a lot more factual … They [physicians] are not going to necessarily care what else is going on with [the patient]. What is it that you need? Yes or No.

Patient information may be omitted when communicating with physicians. "I knew I needed to give them facts of what was going on, but some of it [patient information] I didn't" (RN4). "I feel the need to like leave other things out like how they did over night" (RN1). Patient

information is often modified depending on the physician, "When it comes to patient information obviously that's the facts, but how do you want me to present that to you [the physician]" (RN1). "… You kind of know what each doctor's gonna want … and you give them just that bucket of information" (RN7).

3.4 | Interprofessional patient care

Participants were also asked about their experience with interprofessional interactions. Specifically, participants were asked about their experience and participation in interprofessional rounds. This relationship did not exist in some instances, "He's doing his thing and I'm doing my thing … it's like two separate jobs instead of working as a team" (RN9). In other instances, nurses had to actively seek out interprofessional opportunities, and the level of activity depended upon the time available, "we barely see them … maybe if we had more time, we would be able to communicate" (RN10).

If participants were able to attend a conference with the physician and patient, they reported having little input or participation in the conversation but remain behind to answer clarifying questions for patients. "I have no input, but I'll listen to what they have to say … when they leave I'll stay behind to make sure they [patient] understood what just happened" (RN4). RN6 made a similar response, "Most of the time I just sit there and listen … a lot of times patients have questions after the physician leaves." In lieu of limited participation on interprofessional rounds, participants were asked how they developed their plan of care. Most participants developed their own plan of care from interpretation from written notes in the electronic health record, "I usually just follow along with what they say…relative to communication I would only have to go by the note … it's a guessing game" (RN1). The overarching consensus from this analysis was captured in this statement from RN3:

> At first it wasn't easy. You know as a student, you don't really communicate with physicians that much, and I mean when you call a doctor it's a huge, big deal.… Then when I first started, I had a preceptor, and even then I wasn't quite comfortable talking to them. … And then you get put on your own and it's all on me now.

4 | DISCUSSION

This qualitative study described the communication between resident physicians and new graduate nurses. Communicating with physicians is a demanding activity on the emotions of the new graduate nurse. Before ever communicating with physicians in practice, new graduate nurses have developed negative emotions in their anticipation of the experience. This negative anticipation may be influenced, in part, by poor academic preparation for real-world communication (Song & McCreary, 2020). This anticipation influences the quality and quantity of patient information that are transferred between the two providers of care.

The participants in this study identified a gap between their education preparation for communication with physicians and how this interaction manifested itself in practice. Similarly, Forbes et al. (2020) found that resident physicians perceived that their relationship with nurses varied based on the experience level of nurses. While an importance is placed on nurses communicating with physicians during educational preparation, sufficient experience communicating with physicians does not occur. In an era of health care that is pressuring interprofessional education and collaboration to improve the quality of health care, nurses must not remain isolated from physician partners. Furthermore, interprofessional education must continue in the practice environment after professionals leave the academic setting (Stucky, Wymer et al., 2022). It is not logical to expect nurses and physicians to practice interprofessional care but educate them separately. Instead of developing skill at collaborating with physicians' colleagues in reality-based situations, new graduate nurses' knowledge of communicating with physicians is developed through story telling with other students, colleagues, and nursing instructors. This perspective, void of any actual experience, creates anxiety and fear among new graduate nurses. As a result, communication with physicians becomes a skill learned after the new graduate transitions to practice with little guidance from peers and lacking and evidence base for best practices.

While simulations have gained popularity in the education of nurses, simulation is only as effective as how closely it models reality. Nursing instructor's imitations of physicians in simulations do not effectively model reality. The instructor, as model physician, is biased by their experience and perspective of communication with physicians. They are unable to model actual physician behaviour that is shaped by the physician's education and practice. This type of simulation only supports the segregated education of nurses and physicians and inadequately prepares new graduate nurses for the reality of communication with physicians.

The development of confidence among new graduate nurses has been documented (Casey et al., 2004). This study supports Casey et al.'s (2004) findings that confidence is gained during the first year of practice. Casey et al. (2004) addresses confidence gained from the new graduate nurses' clinical knowledge and critical thinking. The findings from this study provide a beginning understanding of the confidence of the new graduate nurse with communicating with physicians. A lack of confidence in communicating with physicians developed from inadequate preparation for communication in educational programs. In this study, the new graduate's confidence during communication with physicians varied according to previous life experiences. Participants with nursing as a second career used previous experiences to mitigate the lack of confidence evidenced their peers. For those who choose nursing as a first career, gaining confidence in communicating with physicians occurs once they transition to practice.

Communication is modified, based on experience, to meet the demands of physicians. In response to physicians' reactions to the content and quality of communication, new graduate nurses learn what the physician deems valuable independently from their own interpretations of what is important. Pertinent patient information is omitted due to the low value placed on some information. In these instances, communication is shaped by the physician's preference rather than the patient's presentation.

Health care team members lower in the communication hierarchy are often silent even when they have an opportunity to make a valuable contribution to care (Stucky, De Jong et al., 2022). This type of silence may be seen an attempt at saving face and illustrates how hierarchies can influence communication between nurses and physicians (Gardezi et al., 2009). This study supports the finding that the fear of being perceived as incompetent exists as a major barrier to communication between nurses and physicians. This fear results in withholding of patient information and conjures a range of emotions that limit the nurse's ability to effectively communicate important patient information to physicians.

Speaking up to employees of authority in the workplace is often viewed as challenging authority rather than simply asking questions or suggesting improvement (Kish-Gephart et al., 2009). The fear of challenging authority causes the employee to contemplate the negative consequences of speaking up. Kish-Gephart et al. (2009) state that workplace silence does not have to be activated by a bad encounter, but the cultural role of a dominant figure elicits a fear response in the employee to refrain from speaking up. Anticipated negative response from physicians greatly inhibits the nurse from openly communicating with physicians.

The new graduate nurse's experience communicating with physicians is shaped by multiple factors. Qualitative investigation provides a unique view of this experience. This study has attempted to show how this experience is shaped by gaps in education, confidence, conforming communication, and interprofessional patient care. The actual experience must be understood before effective interventions can be developed that improve the communication that occurs between new graduate nurses and physicians.

5 | CONCLUSION

The purpose of this study was to gain an understanding of the new graduate's experience communicating with physicians. Their experience was shaped by gaps in preparation, developing confidence, conforming communication and interprofessional patient care. This study adds to the understanding of the experience of communication by having new graduate nurses explain their real-world experience. This study is limited by its small sample size. Additionally, all participants were sampled from a single site. Future studies should be done to assess the physicians' experience communicating with nurses. Comparing the nurse's and physician's perspective may guide interventions that are better suited to address the deficiencies that persist in communication between these disciplines.

6 | IMPLICATIONS FOR NURSING MANAGEMENT

Understanding the perceptions of communication between new graduate nurses and physicians is critical for developing clinical environments that support high-quality patient care. Clinical leaders play a critical role in facilitating the transition of new graduate nurses to professional practice. While the implementation of transition to practice strategies remains important, nurse leaders must also recognize their role in picking up where academic education stops. With confidence not fully developed, and entering an environment where oversight and communication may be less structured, new graduate nurses may rely on nurse leaders to facilitate the development of positive nurse and physician communication. This study provides nurse leaders with insights that can assist with designing programs and strategies that facilitate new graduate nurse confidence in communication and contribution to the interprofessional team.

CONFLICT OF INTEREST

The authors have no conflicts of interest to disclose related to this research study.

ETHICS STATEMENT

This study received IRB approval from the University and Medical Center Institutional Review Board at East Carolina University (ID: 19-002037).

DATA AVAILABILITY STATEMENT

Research data are not shared.

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