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Abstract
Nurses occupy a central position in today’s increasingly collaborative health care teams that place a premium on quality patient care. In this study we examined critical team processes and identified specific nurse–team communication practices that were perceived by team members to enhance patient outcomes. Fifty patient-care team members were interviewed to uncover forms of nurse communication perceived to improve team performance. Using a grounded theory approach and constant comparative analysis, study findings reveal two critical processes nurses contribute to as the most central and consistent members of the health care team: ensuring quality decisions and promoting a synergistic team. Moreover, the findings reveal 15 specific nurse–team communication practices that comprise these processes, and thereby are theorized to improve patient outcomes.

Keywords
communication; communication, medical; constant comparison; grounded theory; health care; health care, interprofessional perspective; health care, outcomes; health care, teamwork; nursing; nursing, education

Teams are central mechanisms through which work gets accomplished, with increasing numbers of organizations embracing team-based structures to realize their goals (Eisenberg & Goodall, 2004). Teams enable organizations to coordinate efforts that not only improve internal and external production, but enhance service delivery to customers (Deeter-Schmelz & Ramsey, 2003). Furthermore, teams have been shown to foster organizational effectiveness, particularly in the area of decision making, as well as to enhance employee job satisfaction and performance (Kreps, 1991). The widespread use and value of team-based organizing is perhaps most visible in our nation’s health care system, because teams serve as the primary method of patient care delivery. Teams have long been used in the health care arena to maximize patient care effectiveness and efficiency (Poole & Real, 2003). In the current environment, teams are considered an integral part of health care delivery because patient treatment requires multiple inputs from across the health care continuum (Carson, Carson, Yallapragada, & Roe, 2001). Members of various health care professions must share their expertise and experience with others to help solve patient problems, identify medical diagnoses and treatment plans, and perform medical interventions. All of these activities center on the common goal of promoting positive patient outcomes.

If teams are the foundation of health care delivery, then “communication is the cement which holds teams together” (Poole & Real, 2003, p. 396). Effective communication between health care professionals is a necessary condition for the provision of quality patient care (Goldszier, 2004). Through communication, nurses, physicians, allied health professionals, and assistant personnel coordinate work efforts, collaborate in decision making, and combine their different skills as interdependent team members. Clearly, communication at the patient bedside is an important component of caregivers’ roles, but effective team

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interaction skills are also for the good of the patient (Bailey & Armer, 1998).

Nurse communication figures prominently in health care team processes, with scholars arguing that nurses are an essential link between the wide range of health care professionals who provide patient care (Miller, Joseph, & Apker, 2000). Traditionally, nursing roles have focused on bedside communication, with nurses providing education and emotional support for patients and their families. Current nursing roles still include bedside communication, but more recent considerations of nurse communication show that modern nurses also must collaborate with physicians, interact with allied health personnel, supervise assistant personnel, and coordinate care among disparate health care professions (Apker, 2001; Miller & Apker, 2002).

Given that nurses are central figures of the health care team who have the potential to unify patient care team members, they are in a unique position to enhance team functioning and patient outcomes (Apker, Propp, & Ford, 2005). What remains understudied is how nurses communicate with nonphysician team members and the ways in which nurse communication potentially helps the team achieve optimal patient outcomes. Extant literature has examined nurses’ task-based decision making, but the majority of this research has focused on nurses’ contributions to physician diagnoses and treatment. This overly narrow focus fails to capture how nurses’ collaborative behaviors extend to the entire health care team (e.g., assistant nursing staff, allied health care professionals) and potentially impact patient outcomes. Thus, the purpose of this study was to examine the critical communicative processes nurses contribute to in their roles on the health care team, and to identify the specific nurse–team communication practices that comprise these processes.

**Health Care Teams**

Teams have been hailed as the cornerstone of medical care, enabling health care organizations to better streamline medical services, implement quality improvement measures, and integrate health care provider roles (Poole & Real, 2003). Extant research demonstrates that effective team communication yields positive individual and organizational outcomes (Bailey & Armer, 1998; Poole & Real, 2003). For example, studies of professional collaboration among team members show that it enhances employee job satisfaction, fosters organizational commitment, heightens productivity, and boosts morale (Adams & Bond, 2000; Blickensderfer, 1996; Kalbfleisch & Bach, 1998). Furthermore, professional collaboration has been correlated with enhanced patient safety (Kosnik, 2002), improved patient care (Zwarenstein & Reeves, 2002), and better patient outcomes (Baggs et al., 1999).

Although the benefits of team-based health care delivery are clear, numerous challenges exist that might prevent health care teams from maximizing their collective performance at the patient bedside. Differences in the status hierarchy among the health care professions, particularly between physicians and nonphysicians, remain a powerful barrier to teams achieving true collaboration and shared decision making (Cott, 1997, 1998). The increasingly fast-paced nature of today’s health care system—compounded by reduced patient lengths of stay, higher patient acuity, and more patients—makes consistent and thorough communication among team members difficult (Espin & Lingard, 2001; Miller et al., 2000). A final, but no less important concern is that team members often are not physically present to interact directly about patient issues. Zwarenstein and Reeves (2002) argued that most health care delivery occurs with team members at dispersed locations and working at different times, factors that greatly affect the quantity and quality of team interactions.

**Nurse Communication in the Health Care Team**

Nurses are central figures in the health care team, and as the most consistent health care providers at the patient bedside, their responsibilities to connect the often disparate medical and ancillary professionals who make up the team have been heightened (American Association of Colleges of Nursing [AACN], 2002). Now, more than ever, nurses’ communication skill set must extend beyond traditional interactions with patients to the team context, where nurses are expected to build team morale and relationships, coordinate team tasks to facilitate care, and promote joint decision making (Wade, 1999).

Although extant research suggests that nurse communication improves health care team processes (AACN, 2002), less is known about how nurse discourse contributes to team performance in ways that enhance patient outcomes. Of note, there remains a lack of exploration of specific communication behaviors that nurses use in their team roles that ultimately might be linked to patient results. Consequently, the goal of the current study was to examine critical team communication processes and identify forms of nurse–team communication that comprise these processes and are perceived to improve patient outcomes. The following research question was posited to guide this research: What are the communication practices nurses employ with team members to enhance the likelihood of successful patient outcomes?
Methods

Organization and Participants

This research was conducted at a hospital in the Midwestern United States, a 348-bed tertiary facility that at the time of the study employed approximately 3,000 people, 85% of whom were female. The hospital was selected because of its strong focus on personnel development, teamwork, and nursing excellence. The hospital has won multiple awards in recent years for being on the leading edge of human resource management, and for its successful use of collaborative teams. It has achieved Magnet status, a national designation that is given to health care organizations that have successfully adopted a positive nursing culture by providing opportunities for participatory management and by recognizing nurses’ autonomy and professional status (Coile, 1999; 2001).

The teams examined in this study can best be identified as multidisciplinary, being composed of practitioners from multiple disciplines (distinguished based on the level of training and type of socialization members undergo) who work relatively autonomously but in conjunction with one another (Kresevic & Holder, 1998; Poole & Real, 2003). Multidisciplinary teams are typically hierarchically organized with a leader designated to coordinate overall patient care (Omland-Hand & Zeiss, 2000), and members often work sequentially rather than simultaneously within their own professional boundaries (Latella, 2000; Poole & Real, 2003). The teams examined in this study were comprised of the staff members who interacted most frequently and interdependently to deliver patient care. In consultation with the hospital, the multidisciplinary patient-care team was operationalized to include direct-care registered nurses (RNs), clinical nurse specialists (CNSs), licensed practical nurses (LPNs), physicians, patient-care assistants (PCAs), unit clerks, and unit coordinators/charge nurses (nurse managers). Although team size varied widely based on a unit’s patient mix (e.g., acuity, type of illness), the typical team consisted of 5 to 6 members.

Based on the hospital’s recommendations, team members were recruited from four clinical units of the hospital: surgical intensive care, neonatal intensive care, trauma care, and general surgery. These units were selected because they represented a diverse cross-section of patient-care team staff characterized by variations in unit size, levels of staff seniority, age of staff, and most importantly, levels of interface among patient-care team members. Team members in these units were solicited by a letter of invitation for voluntary participation. The letter included information about the purpose and potential benefits of the study, the time commitment, and confidentiality of contributions. The Institutional Review Board (IRB) of Western Michigan University, as well as the IRB of the study hospital, approved the study’s procedures. Established ethical guidelines were followed in the invitation to participate, the interview process, the informed-consent process, and maintaining the confidentiality of participants’ contributions. Team members who chose to participate were given the option of being interviewed individually or in a group setting. In this way participants could select the format in which they would feel most comfortable sharing stories about nurses with whom they worked. Additionally, all group interviews were comprised of participants holding the same position, to reduce any potential discomfort.

Seven group and 21 personal interviews were conducted. A total of 50 patient-care team members participated, including 25 staff RNs, 3 CNSs, 7 physicians, 6 PCAs, 4 unit clerks, and 5 unit coordinators/charge nurses. This represented a participation rate of 13.6% of the eligible patient-care team members, and each unit was represented adequately. The level of participation by position resembles the typical team composition on the units studied, with the exception of the clinical nurse specialists (CNSs). All 3 of the CNSs employed on the units participated, which is not surprising given that they were master-prepared nurses with roles focused on nurse research and education. The majority of the participants were full-time employees (89%) who worked the day shift (79%). They represented varying levels of organizational tenure, with employees who had worked less than 1 year (10.6%), 1 to 2 years (19.1%), 3 to 4 years (10.6%), 5 to 10 years (12.8%), 11 to 15 years (8.5%), 16 to 20 years (10.6%), 21 to 25 years (10.6%), and more than 25 years (17%).

Procedure

Participants were asked to fill out a brief demographic summary and an informed consent form. Participants were told that their responses would be confidential, and that no names or identifying demographic data would be tied to their contributions. A single semistructured interview guide was used for both individual and group interviews. Group interviews typically lasted 1 hour, whereas individual interviews lasted about 30 minutes. The researchers explained that the study goal was to explore “best practices” of nurses communicating with the patient-care team. Best practices (a term commonly used by the hospital’s employees) were defined as the communicative behaviors used by nurses that optimized patient outcomes. Thus, the nurse–team communicative practices sought from participants were behaviors perceived by team members to influence team performance and, ultimately, patient outcomes. The interviewers used a critical incident technique...
(Downs, 1988; Flanagan, 1954), a method requiring participants to recount memorable experiences, either positive or negative, for which they have first-hand knowledge (Query & Kreps, 1993). Using this technique, participants were asked to share stories in which nurses did (positive incidents) or did not (negative incidents) demonstrate best practice communication behaviors. Probes were used as needed to solicit more detail about the incidents shared, including asking for descriptions of how nurses responded verbally and nonverbally and how the nurses’ communication affected outcomes. This process was repeated until participants were unable to provide additional examples of incidents illustrating nurse communication practices. Although both positive and negative incidents were sought in the interviews, participants shared far more examples of exemplary nurse communication behavior than problematic behavior.

**Data Analysis**

In this study we took a dialogic approach to studying human interaction, one that recognizes communication as the enactment of human actors’ lived experiences (Bakhtin, 1981). In this light, organizational and/or professional roles (e.g., nurses, physicians, allied health workers) are defined through interaction and collective sense making (Weick, 1995). The dialogic approach also encompasses the relationship between researcher and participant. Here, we were mindful that research inquiry consists of sense-making and sense-creating processes that yield insights into the ways participants understand their world. In our interviews, we took steps to preserve participants’ perspectives in empathic conversation, listening for their experiences and capturing their authentic voices (Evered & Tannenbaum, 1992). We rejected the notion of participant as object in favor of viewing both researcher and participant as interpreters of a context that is undergoing ongoing construction (Buber, 1958). The process of inquiry allowed us to not only receive information from participants, but to revise our understandings of nurse–team communication through our interviews with coresearchers (study participants). The core research team consisted of the authors: three communication academicians, two communication graduate students (one who was a nurse at another hospital and one who was an administrator at the study hospital), and one nurse administrator from the study hospital. The extended research team consisted of team members who participated in our interviews and nurses leaders from the study hospital who provided feedback on our preliminary findings.

We examined approximately 600 typed pages of transcription using a grounded theory perspective with constant comparative analysis (Glaser & Strauss, 1967). From this perspective, theory is considered to be grounded in the relationships among the study data, and key themes are revealed, rather than imposed, through the coding process (Glaser & Strauss, 1967). Researchers engage in ongoing discovery, seeking to define, understand, and organize categories, as well as to integrate categories and their properties (Lindlof, 1995). Categories are constantly compared, revised, expanded, and reduced until they become “theoretically saturated” and new information adds little or no conceptual development (Glaser & Strauss, 1967). We approached the data using open, axial, and selective coding, taking care to ensure that the steps were used in a cyclical, simultaneous manner (Strauss & Corbin, 1998).

In the open-coding stage, transcripts were first read in their entirety by the three lead authors without making any notes. We then independently read the transcripts several times, each highlighting relevant portions of the text and making informal notes in the margins. We used Owen’s (1984) criteria for theme identification to aid in initial classification. Owen’s criteria include (a) recurrence—multiple descriptions with the same meaning, (b) repetition—use of the same wording multiple times, and (c) forcefulness—nonverbal behavior stressing the importance of the behavior (e.g., pitch and volume noted in the transcripts). We wrote analytic memos for emergent categories, which included the identification of key concepts pertaining to nurse–team communication, relevant quotations from the transcripts, and our own (second-order) reflective comments. The categories were refined and reduced into distinct parts and compared for similarities and differences (Strauss & Corbin, 1998).

In the axial-coding stage, we reviewed and refined their analyses by identifying and explaining conditions, actions/interactions, and consequences associated with phenomena (Strauss & Corbin, 1998). This stage also involved making links between categories and subcategories in an effort to achieve greater conceptual cohesion. The analytical memos were revised to reflect these explanatory and integrative processes. Moreover, we selected exemplars that illustrated categories and revised reflective comments based on group discussion and insights from relevant literature (Lindlof, 1995). We also conducted ongoing, informal, face-to-face member checks with two members of the research team who were nurses, along with three nurse leaders and administrators from the participating hospital. One or more of the members of the hospital attended meetings of the research team on a regular basis, offering comments on the emergent findings. The outcome of the member checks was refinement and validation of the study’s findings based on confirmation or disconfirmation of the researchers’ interpretations.

In the selective-coding stage, we refined and integrated categories to form a greater theoretical scheme (Strauss
We identified two overarching themes among the categories by constructing a storyline that demonstrated the integration of key concepts. We continually returned to the transcribed interview data and reviewed our analytic memos while creating a narrative that encompassed major categories and their linkages. The core story that emerged revealed that nurse communication in health care teams encompasses a complex set of behaviors which comprise two different, but related, processes that are theorized to enhance patient outcomes: ensuring quality decisions and promoting team synergy. Within each of these major themes were subcategories of specific nurse–team communication practices that illustrate the varied communicative requirements of today’s nursing role.

### Findings and Interpretations

Our analyses revealed that as nurses interact with members of the health care team they contribute to communicative processes that are perceived to influence patient outcomes. These processes represent overarching themes and are theorized to organize the complex set of communicative practices described below. The first critical process is ensuring quality decisions, and six nurse–team communication practices support this theme, including (a) seeking information, (b) processing information for physicians, (c) individualizing communication with physicians, (d) collaborating in decision making, (e) building credibility with physicians, and (f) communicating diplomatically with physicians. The second critical process is promoting team synergy, and nine nurse–team communication practices comprise this theme, including (a) coordinating the patient care team, (b) mentoring team members, (c) empowering lower-level team members, (d) advocating on others’ behalf, (e) managing conflict constructively, (f) listening actively to team members, (g) fostering a positive climate, (h) managing workplace stress, and (i) pinch hitting for team members (see Table 1). In the following sections we articulate the themes and supporting communication practices in detail.

### Ensuring Quality Decisions

Processing information collaboratively is essential to the performance of teams (Propp, 1999), and nurses are expected to play a key role in this process. Therefore, it is not surprising that the first overarching theme culled from the interviews focused on the process of ensuring quality decisions to enhance patient outcomes. Nurses are being asked to play a critical role in the decision-making processes surrounding patient care. They are expected to contribute their unique knowledge and expertise, participate in decision making with physicians, and create collaborative relationships with all health care team members (AACN, 2002). To ensure quality decisions, it is necessary that patient-care teams collaborate to work from an information base that is both sufficient (quantity) and accurate (quality) if they are to achieve improved patient outcomes. Based on their expertise, as well as the time that they spend at the patient bedside, nurses play a critical role in finding and providing needed information for the physician and the team. For example, although physicians typically only interact with patients during rounds, they must have current information from nurses about patients’ needs and medical conditions to effectively plan patient care. As one nurse shared,

[Physicians] rely on us a lot. So many times when the physicians come to make rounds they’ll try to abbreviate what they feel they need to do as far as looking up labs and whatever. So a lot of times they’ll come to us and say, “What’s going on, what do you need, what does the patient need?” I think that they rely on us a lot to do that, and ultimately I do think that that helps the teamwork and the outcome of the patient.

### Table 1. Critical Health Care Team Processes and Affiliated Nurse–Team Communication Practices

<table>
<thead>
<tr>
<th>Processes</th>
<th>Practices</th>
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<tr>
<td>Ensuring quality decisions</td>
<td>Seeking information, Processing information for physicians, Individualizing communication with physicians, Collaborating in decision making, Building credibility with physicians, Communicating diplomatically with physicians</td>
</tr>
<tr>
<td>Promoting team synergy</td>
<td>Coordinating the patient-care team, Mentoring team members, Empowering lower-level team members, Advocating on others’ behalf, Managing conflict constructively, Listening actively to team members, Fostering a positive climate, Managing workplace stress, Pinch hitting for team members</td>
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Given the complexity and intricacies of ensuring informed and collaborative decision making, six communication practices that comprise this critical process were identified from the interviews and are articulated below.

**Seeking information.** For nurses to ensure quality decisions, it is first important that they be well informed. This necessitates the nurse–team communication practice of seeking information from multiple sources. Participants commented that nurses are responsible for building their knowledge base and must search for the information needed to make educated decisions about patient care. Participants told stories that showed the need for nurses to actively solicit clinical and procedural information from physicians in multiple contexts, including during rounds, in face-to-face interactions, and via pagers or telephone calls. As one nurse explained,

[Nurses] should ask questions every day. If they don’t know why I write an order on a chart and they don’t understand why, they should ask me. ‘Cause how else are they going to be able to really feel confident about carrying it out?

Participants underscored the need for nurses to ask questions regarding patient care of all team members, not just physicians. That is, nurses must take extra steps to look for information sources beyond patients’ charts (e.g., patients’ accounts, allied health care professionals) to develop a wide-ranging information base.

**Processing information for physicians.** A related communicative practice that helps to ensure that the team has accurate and sufficient information from which to make decisions is processing information for physicians. Processing includes not only providing information to physicians, but also preparing and organizing the information before providing it. Specifically, participants explained that nurses must be proactive and select data that are relevant and useful. Consequently, nurses are expected to anticipate the information needs of others on the team and then access that information prior to communicating with them. As one nurse explained,

By having as much information prior to even contacting the physician, then she’s got everything in front of her—labs, meds, patient history, that kinda thing. So, by having the information she’s already done some footwork ahead of time. She’s already got details that are taken care of should she need that sort of information.

Processing information also incorporates providing information in a usable form to physicians to enhance the likelihood of better patient outcomes. Foremost, participants stressed the need for the nurses to organize information, to “get their ducks in a row” before communicating with physicians. In addition, they suggested that effectively processing information included vigilant behaviors such as carefully monitoring the information for its veracity, updating it when necessary, filling in omissions, and correcting it if it is inadequate. Finally, nurses are expected to filter the information, and then pass on only what is necessary to physicians. As one physician stated succinctly, “The thing that differentiates [effective nurses] more than anything else is an ability to discern what is important from what is not.”

**Individualizing communication with physicians.** A third communication practice designed to ensure quality decisions is nurses’ ability to individualize their communication when offering information to physicians. Interview findings suggested that one way nurses address time pressures and often limited contact with physicians is to create focused messages that are specifically adapted to meet the preferences of individual physicians. Participants offered the observation that nurses individualize information to meet physicians’ communication needs to increase the likelihood that physicians will listen to and use that information. This communication practice includes adapting messages based on the professional specialty, personality, and experience level of the physician, as well as individualizing the message based on the relationship between the physician and nurse. As one unit coordinator stated, “You begin to know what they [physicians] respond to better and you learn to know what is going to turn them off immediately. And so, you adapt.” Participants said that nurses’ ability to have meaningful input is limited if they are unable to adapt to physicians’ varying information needs.

**Collaborating in decision making.** As their professional status has risen, nurses have been empowered to exercise their professional judgment and participate more fully in problem solving (AACN, 2002). Reflecting this important development in the nursing role, participants argued that nurses should aid in the use of information attained, ultimately collaborating with physicians and other team members to make decisions about patient care. Although participants spoke of nurses’ need to involve all team members in collaboration, they focused primarily on physician–nurse collaboration and stressed that it should be a dialogue of equals in which a nurse is a “partner” in patient care. The collaborative communication practice described by participants incorporated a give-and-take relationship between nurses and physicians, including nurses actively listening, asking questions, and sharing their opinions with physicians.

Nurses are also expected to offer answers to solve problems. As one physician explained, “Some nurses will just simply act as a provider of information but not think about potential solutions. And that [thinking about
possible solutions], I think, is a fundamental part of nursing that establishes it as one of the cornerstones of the profession." In addition, when offering solutions about patient care, participants suggested that nurses should take a holistic perspective, integrating information and taking into account the future needs of patients.

**Building credibility with physicians.** Participants shared that nurses’ participation in decision making and problem solving at times is disrupted by a status hierarchy in which physicians’ solutions are more valued and nurses’ suggestions might not be solicited or, if offered, might be rebuffed. Given the potential opposition to nurses’ full collaboration, participants suggested that nurses sometimes need to engage in communication practices that build their credibility with physicians and help them overcome the potential devaluation or outright dismissal of their contributions. Interview findings provided insights into a number of ways that nurses must communicate to enhance the chances their contributions will be valued by physicians. Participants said nurses must communicate their experience and knowledge of nursing in a manner that demonstrates to physicians that they are fellow professionals. Building credibility with physicians includes articulately using the language of medicine. As one physician explained, a good nurse has “very precise, accurate use of the medical terminology.” Participants also said that displaying a calm, detached demeanor in reaction to emotional situations enhances credibility.

Building credibility also incorporates the need for nurses to be assertive in their dealings with physicians. Nurses must communicate in a manner that demonstrates their own belief in the value of their opinions. A physician expressed that he didn’t even want to be in the room with a nurse “who is ambiguous, insecure, maybe not confident that a problem exists, or pretty sure that a problem exists but can’t relay it properly.” Participants thought it is essential for nurses to approach physicians with the expectation of respect and to speak with confidence. Nurse assertiveness was viewed as especially important when nurses disagree with physicians. For example, a PCA described a situation she had observed in which a nurse’s ability to disagree with a physician helped avoid a medical error:

The nurse stepped in and said, “I don’t think it’s a med[cation] reaction; there’s something else going on here. She’s running a temp[erature], her confusion is increasing.” [The nurse] intervened with the physician and said, “Listen, I think she needs to go to one-on-one care.”

Participants argued that nurses must challenge physicians when information is wrong or inconsistent, and that their ability to do this has a direct impact on patient outcomes.

**Communicating diplomatically with physicians.** Whereas building credibility is one way to enhance nurses’ contributions to decision making, participants suggested that nurses also might need to communicate diplomatically with physicians by using communicative practices that conceal the extent to which they are solving problems (thus placating the hierarchy). A nurse explained how she could influence a patient-care decision by using an indirect style: “You can say what you want, what the patient needs, but know that you have to round about it. Let them think it’s their idea.” Another nurse stressed that one has to be particularly diplomatic with physicians when collaborating on patient diagnoses:

You don’t want to appear to be diagnosing the patient. The nurse has to be very careful about the way she says it because some physicians take real offense to “nonmedical” [laugh] people diagnosing the patients. Which means if I am trying to communicate a patient need I may gently come around until I can get to that point.

Participants also suggested that communicating diplomatically includes acting in a submissive manner when interacting with physicians (e.g., apologizing for bothering them, thanking them profusely for their help). Although communicating in this manner goes against the current call for nurses to be more assertive and to act as physicians’ equals, some nurse participants argued that at times it is necessary to communicate this way for the good of the patient. One nurse explicitly linked communicating diplomatically with physicians to improved patient outcomes:

[Nurses] have all been able to stand in the background and let somebody else take the credit because we know it’s in the best interest of the patient to get those things done. And there are a lot big egos to work around in the health profession.

**Promoting Team Synergy**

The patient-care team consists of members who have widely varied backgrounds and education. It is a team whose members might be in dispersed locations, work at different times, and vary greatly in the quantity of their interactions. The only clear, defining elements of membership are the common goal of patient care and the coordination needed to achieve that goal. Given the heterogeneity and loosely coupled structure of the patient-care team, the second overarching theme drawn from the interviews was the critical process of creating team synergy—helping a collection of individuals function as a coherent whole so that patient needs can be met.
As nurses are the most consistent caregivers at the patient bedside, they play a vital role in helping team members work as a whole by serving as both task and relational leaders. Nurses must not only ensure that team members understand and can perform their individual roles in patient care, they also must help to create the perception of “groupness” and cohesion by deemphasizing status distinctions among team members. As relational leaders, nurses promote synergy by addressing the effect of caregiving on their team’s socioemotional needs. The patient-care team works in an environment of physically demanding work, long shifts, understaffing, elevated patient loads, and high patient acuity. Consequently, promoting team synergy incorporates the need to create a productive workplace climate that helps team members reduce or cope with the stresses of their jobs, thereby improving the chances of the team’s success in a challenging environment. Nine communication practices nurses employ that comprise this process were identified and are articulated below.

**Coordinating the patient-care team.** To promote synergy, nurses must act as task leaders and coordinate the activities and roles of team members so that patient care can be accomplished efficiently and effectively. One participant used the apt metaphor of a (football) “quarterback” to describe this communication practice. Interviews suggested that the practice includes behaviors such as assigning responsibilities, explaining and clarifying role expectations, and coordinating others’ duties. One nurse explained how a good nurse coordinates others on the team to enhance patient care:

She’ll give direction, kind of in a bartering sense, like, “I’ll bag the baby. Can you go and call the physician? And ‘so and so’ [naming a colleague] would you be able to hand me the suction while I bag?” So she kinda calms the situation by giving it some order.

Moreover, participants suggested that coordinating is not only about assigning responsibilities, but also includes nurses managing team members’ information needs to enhance successful task accomplishment. For example, coordinating the team includes updating information during reports, communicating patient changes, and informing floaters of their responsibilities when they come on the floor. Additionally, nurses are expected to coordinate information with other departments or units.

**Mentoring team members.** A second communicative practice that nurses use to promote synergy is mentoring other members of the team in how to best perform their roles. Mentoring behaviors brought out in the interviews concentrated primarily on nurses guiding and providing support to other nurses, especially novices. One RN described fellow nurses who had mentored her on performing medical procedures: “Some of them will come to the bedside and they’ll encourage you to do it. They’ll talk you through it, so that you feel comfortable the next time to do it on your own.” Mentoring went beyond showing other nurses how to do their jobs. Nurses also often mentor others on how to communicate more effectively to facilitate patient care. For example, an experienced nurse might serve as a teacher or role model on how to approach difficult people or how to better address a particularly problematic work situation. Such mentoring includes providing encouragement for less experienced nurses. Mentoring, therefore, is not only about teaching other nurses how to perform their duties, but also about “taking people under their wings” and helping them develop confidence so that they can be stronger contributors to the patient-care team.

**Empowering lower-level team members.** Our interviews suggest that nurses are expected to address the task and relational needs of lower-level team members by empowering them to perform their roles in patient care more effectively. Participants said that nurses should communicate in ways that deemphasize the distinctions between their own positions and those lower in status. A PCA described a nurse who enacted this communication practice: “She includes everybody as a team. She isn’t someone who would break people down, such as ‘You’re just a PCA.’ . . . She puts everybody together as a part of a team for patient care.” The empowering communication practice includes nurses speaking with PCAs and unit clerks in ways that make them feel valued. For example, one nurse described how she tries to make everyone feel like a member of the team by respecting PCAs’ intelligence and contributions:

[Nurses need to] make them [PCAs] aware of what is going on with a patient, and don’t talk to them like they don’t know anything medically. . . . Just make them part of the team, because that’s what they are.

Empowering also includes encouraging lower-status team members to share their ideas, recognizing that their experiences with patients might provide valuable insights that might influence patient outcomes.

**Advocating on others’ behalf.** Participants noted that nurses face a status hierarchy that makes it difficult as they attempt to promote team synergy to ensure that everyone feels like a contributing team member. Thus, to give voice to members of the team who often do not have one, participants argued that nurses need to employ the communication practice of advocating on others’ behalf. Specifically, participants related stories about standing up for team members.
who, based on their status in the medical hierarchy, could not defend themselves. One participant described such an incident in which a nurse manager interceded between a physician and fellow nurse:

A blood pressure or something was wacky on the monitor screen, and one of the head docs [doctors] came in yelling at the [nurse], “What have you done to my patient?!”—which got her really upset. And the [other] nurse jumped right in and said, “Don’t you yell at my nurse. It’s not her fault. We were totally in charge of the situation.” She explained what happened and the doc backed down and later apologized to the nurse.

Several stories related by the participants described how nurses confronted physicians to change a problematic plan of care to achieve optimal patient outcomes. What came through consistently in these stories was the need for nurses to act as the voice of the patient or family, and to challenge the physicians if nurses believe poor decisions are being made based on a lack of information, flawed information, or a lack of sensitivity.

Managing conflict constructively. Another potential threat to team synergy is destructive conflict. As leaders of the team, nurses can address this barrier by ensuring that conflicts are managed constructively. Participants shared stories of how nurses confronted conflict in a professional manner, listening to the other team members’ perspectives while remaining objective, calm, and rational. A clinical nurse specialist stressed the importance of making others feel as though their side of an issue has been heard: “First, you acknowledge how they are feeling. You have to validate what their feelings are, if they’re angry or sad . . . to let the person know that you understand.”

Participants also spoke of the need for nurses to follow basic rules of courtesy when involved in a conflict. For example, one nurse provided guidelines for how a conflict should be handled, including looking at the issues objectively, engaging in conflict only in private areas, expressing a rationale for actions taken, giving the other person an opportunity to express his or her side, and remaining open minded even when they disagree with the other person. Finally, participants labeled nurses who avoid conflict as negative exemplars of best practices, and emphasized the negative consequences of failing to confront conflict directly.

Listening actively to team members. Another closely related communication practice that nurses use to promote team synergy is to listen actively to members of the team, thereby facilitating relationship development and creating a workplace climate that enables the team to function more effectively. Feeling like their contributions are valued serves as an intrinsic motivator that might help team members to cope with challenging aspects of the work environment. When describing active listening, participants said that nurses show approachability by welcoming questions from team members and addressing team members’ concerns in a nonjudgmental manner. A nurse described a colleague who is seen as open minded and approachable by team members:

She is willing to listen to whatever sort of comments and complaints they have, and act accordingly. If they are having a problem she will deal with it as opposed to letting it slide by or not doing anything about it.

Negative examples of active listening included nurses who failed to nonverbally show respect to other team members when they were speaking. A unit coordinator described nurses who failed to listen actively: “When you’re trying to talk and they are constantly grabbing charts, grabbing kardexes. You know, they don’t stop to acknowledge that you’re there saying something.”

Fostering a positive climate. To further create an environment in which team members can achieve synergy, participants suggested that nurses should employ the communication practice of fostering a positive climate by modeling an optimistic attitude about work. Participants often spoke of the need for nurses to be sanguine and to demonstrate that feeling through both verbal and nonverbal behaviors. Specifically, good nurses were said to make the workplace more pleasant through the use of humor, warmth, cheerfulness, and a friendly manner. A PCA described one nurse’s climate-building behavior: “She rarely complains. . . . She always has a real positive attitude. She’s funny; she makes humor a part of the job. . . . She’s warm and friendly and she’s just a lot of fun.” In contrast, some nurses had pessimistic attitudes that were perceived to have a negative impact on the work environment. A nurse shared a story about this type of disruptive behavior and how it made her feel:

We’ve got this one nurse on the floor and she drives me crazy. She’s always complaining. . . . She complains if there is an admitting nurse on the floor. And no matter what management does here, it’s not the right thing . . . And it drives me bonkers. Just shut up, we don’t want to hear ya.

Participants suggested that nurses also might foster a positive work climate by showing their appreciation of their
teammates with basic pleasantries and politeness. For example, a PCA explained how much it meant to be thanked for her contributions: “A simple, ‘thank you for helping me out today,’ that’s nice. Sometimes at the end of the shift somebody says, ‘You know, it’s been great working with you. Thanks for all your help.’ It goes a long way.”

Managing workplace stress. Despite the best efforts of nurses to foster a positive climate and make team members feel valued, at times workload issues and the fast pace of the hospital environment can be overwhelming. In these times, nurses can promote synergy by employing communicative practices designed to manage workplace stress. As described by participants, these behaviors are very similar to those of fostering a positive climate, the important distinction being that these behaviors are reactive rather than proactive. Participants shared stories of nurses managing workplace stress in situations that were unusually busy or chaotic, or when team members had become overwhelmed by the requirements of their work. In these types of situations, nurses are expected to take a leadership role and, in the words of one participant, “calm the situation by giving it some order.” Another participant shared a story about a unit coordinator who helped a nurse who had become so overwhelmed that she was unable to perform her work:

She noticed what was going on. This [other] staff member had a history of reacting like this at times. The unit coordinator was able to redirect, refocus, get the staff member back on track as far as getting her to refocus.

Participants argued that nurses play an important role in managing workplace stress by remaining calm and bringing order to chaotic situations, because “it doesn’t matter how bad it is,” explained one. “If you have good people working, you can make it. And the patients will be okay.”

Pinch hitting for team members. The final nurse–team communication practice identified as promoting team synergy is “pinch hitting,” or helping others to complete their tasks when they become overwhelmed by the demands of the work environment. This behavior served a strong symbolic function for team members in that it demonstrated nurses’ recognition of the teams’ interdependence, and demonstrated a willingness to support team members who were feeling overwhelmed. As one nurse described, “You have to depend on each other and everybody to do their part. ‘Cause when somebody crashes and you have three other patients, somebody has to pick up the slack.” The importance of pinch hitting behavior was reflected in the vividness of the metaphors used to describe this practice, including helping those who are “drowning,” “getting each other’s back,” and not allowing anyone to “crash and burn.” Participants stressed that pinch hitting was best done without having to ask for the assistance, and usually involved nurses performing tasks that were not part of their normal duties.

Discussion

It is clear that nurses occupy a central position in today’s increasingly collaborative health care teams. Indeed, in addition to performing their traditional patient-care responsibilities they are now expected to collaborate with a wide range of hospital personnel (White & Rice, 2001; Woods, 2002). Consequently, scholars have suggested effective communication with members of the patient-care team is a new role requirement for nurses (Coulon, Mok, Krause, & Anderson, 1996; Miller & Apker, 2002). Therefore, the present research was conducted to explore how nurses effectively communicate with team members and to better understand the connections between nurse–team communication and patient outcomes.

Analyses of interviews with patient-care team members revealed 15 nurse–team communication practices that participants perceived as “best practices” that nurses perform to enhance patient outcomes. The breadth of the behaviors identified illustrates that both task and relational communication are perceived as central to the achievement of positive patient outcomes, and team members recognize and expect that nurses make communicative contributions in both areas. Nurses appear to be uniquely qualified to enact the totality of the practices identified because of their expertise and proximity to patients and other members of the team. We theorize that their practices comprise two processes critical to patient outcomes: (a) ensuring quality decisions, and (b) promoting team synergy.

Communication practices that address the first critical process, promoting quality decisions, primarily center on nurses’ need to ensure the sufficiency and quality of the information used to make decisions about patient care. These practices included seeking out and processing needed information, as well as collaborating in a meaningful way in patient-care decisions. Identification of these types of communication practices supports past research on nurse–physician communication that has argued the importance of nurses’ contributing to information processing (Millward & Jeffries, 2001) and exercising their professional judgment by engaging fully in decision making (AACN, 2002; Martin, O’Brien, Heyworth, & Meyer, 2008; Wade, 1999). Moreover, the findings of this study extend our understanding of nurses’ contributions to decision making in the patient-care team in two important ways. First, past research has focused primarily on nurse–physician collaboration; however, our findings suggest that nurses also serve as bridges between the physicians and nonphysicians on the team, creating a vital...
communication link that encourages collaboration among all team members. Second, this study identified nurse–team communication practices used to address systemic barriers or constraints to the creation of a sufficient and high-quality information base. Despite the espousal of egalitarian models of teamwork, hierarchical relationships between nurses and physicians still exist (Bailey & Armer, 1998) in which physicians remain in power positions, retaining ultimate decision-making authority (Davidhizar & Dowd, 2001) and limiting nurses’ capacity to be proactive problem solvers (Martin et al., 2008). Our findings suggest that nurses combat this potential barrier to their collaborative contributions by employing communication practices such as building credibility, communicating diplomatically, and individualizing their communication with physicians.

The second critical process identified in this study was promoting team synergy. Because of the physical absence of physicians at the patient bedside, our findings suggest that nurses often are expected to serve as leaders of the team and, therefore, must address issues of integration and coordination of the remaining team members. Past research has suggested that nurses have taken on increased managerial responsibilities, including the management of assistant personnel (Apker, 2001; Cott, 1997). However, the synergistic communication practices identified in this study underscore the salience of nurses serving not only as task managers who coordinate the work of the team, but also as relational leaders of the health care team. Although effective communication with patients has long been a part of nursing practice, the rise in team-based health care delivery now necessitates that nurses display heightened interpersonal skills in collegial relationships as well (AACN, 2002). Our findings support this contention and suggest that some of the general communication practices that comprise this process include managing conflict among team members, listening actively, mentoring team members, empowering lower-level team members, and advocating for the needs of others. These types of communicative behaviors ultimately help to build team cohesion and create a participative environment in which all team members are better able to make substantive contributions to patient care.

Additionally, our findings support the notion that nurses’ contributions to promoting team synergy move beyond the enhancement of internal team relationships, and include helping the team manage their work environment. Health care teams provide patient care in a physically and emotionally demanding setting, and the resulting stress can cause burnout and potentially lead to negative outcomes (Miller, 2003). Our findings suggest that team members believe a positive, supportive workplace climate better facilitates patient care and, more importantly, they believe it is the role of nurses to help the team cope with the stress of their difficult environment. Nurses’ presence on the unit and their relationships with non-physician team members allow them to play an active role addressing members’ work-related emotional needs in several ways: (a) fostering a positive climate (b) bringing order to chaotic events and providing a calming influence, and (c) pinch hitting for other team members whose work has become overwhelming.

Although patient care is certainly a team-based effort, our findings suggest that nurses make a critical contribution to improved patient outcomes as they enact a wide variety of complex task and relational communicative behaviors. Researchers and practitioners have argued that the use of teams in health care leads to improved effectiveness (Risser et al., 1999), however, very few have investigated the relationship between specific group processes and outcomes (Poole & Real, 2003). Grounded theory and constant comparative analysis offer useful approaches to explore the connection between communication processes and health care team effectiveness by providing a lens to identify nurse behaviors that participants perceive to influence patient outcomes. Furthermore, although much past research on team performance has been disparaged for its overreliance on zero-history groups in laboratory settings performing unrealistic tasks (Waldeck, Shepard, Teitelbaum, Farrar, & Seibold, 2002), the present study enhanced ecological validity by exploring behaviors employed by “real” teams in a contextualized, naturalistic setting in the performance of their everyday task of patient care.

Although this study represents an important first step in understanding the relationship between nurse communication and team effectiveness, our findings are limited by the use of participants’ recall of nurse behavior, as there is the potential that their recollections might have been inaccurate or biased by social demand characteristics. Therefore, future research needs to continue to assess the validity of the nurse behaviors culled from participant interviews. A second limitation to the present study was the reliance on participants’ perceptions that particular nurse communication practices enhance health care outcomes. Future research will need to extend our initial findings by making explicit the connection between the behaviors identified in this study and the relative performance of patient outcomes.

**Implications for Health Care Organizations**

Not only has this study contributed in meaningful ways to the extant literature on nurse communication and team performance, it also provides pertinent information that health care organizations might apply to improve nurse communication and enhance team performance. First, it
is important for health care organizations to recognize the communication practices nurses must perform and to provide the necessary education to develop appropriate skill sets. Nurses are very well trained clinically, but they receive little formal education to enhance their communication skills. Moreover, what education they do receive focuses primarily on communication with patients rather than with the team (AACN, 2002). In addition, current nursing curricula fail to capture the breadth and complexity of nurse–team communication behaviors. Specifically, nurses need training to develop their leadership skills, as well as to expand their repertoire of interpersonal communication skills. Building on educational experiences in nursing school, health care organizations need to expand their inservice and training programs to reinforce these skills and ensure their transference to the team context. Organizations also need to create mechanisms to identify nurses who are deficient in team communication skills, and develop appropriate interventions.

Health care organizations also need to make systemic changes to cultivate a culture that supports nurses as they fulfill demanding role expectations. It is clear from the findings of this study that nurses are expected to enact a very diverse and intricate set of behaviors when interacting with the team. Even with proper education and training, the centrality and complexity of the nurses’ role might cause stress that can lead to burnout and turnover. Therefore, it is important for organizations to provide social support mechanisms that minimize nurses’ job-related stress and improve their quality of work life. Additionally, health care organizations need to address systemic barriers, such as the traditional status hierarchy between physicians and nurses, that might make it difficult for nurses to contribute fully, and to cultivate a culture of respect for the professional contributions of nurses to patient care.

Conclusion
As central and consistent members of the health care team, nurses are uniquely positioned to influence patient outcomes not only in the direct provision of bedside care, but also in their interactions with team members. Our investigation demonstrated that team members expect nurses to engage in specific communication practices to ensure quality decisions and promote team synergy. Health care organizations that desire to enhance multidisciplinary teamwork and thereby improve patient outcomes should take proactive steps to reinforce effective nurse–team communication practices and foster a culture of respect for nurse contributions to the team.

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