

Communication Breakdowns

The Problem of Intraprofessional
Relating in Hospice and Palliative Care

March 7, 2008



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Communication In Hospice and Palliative Care

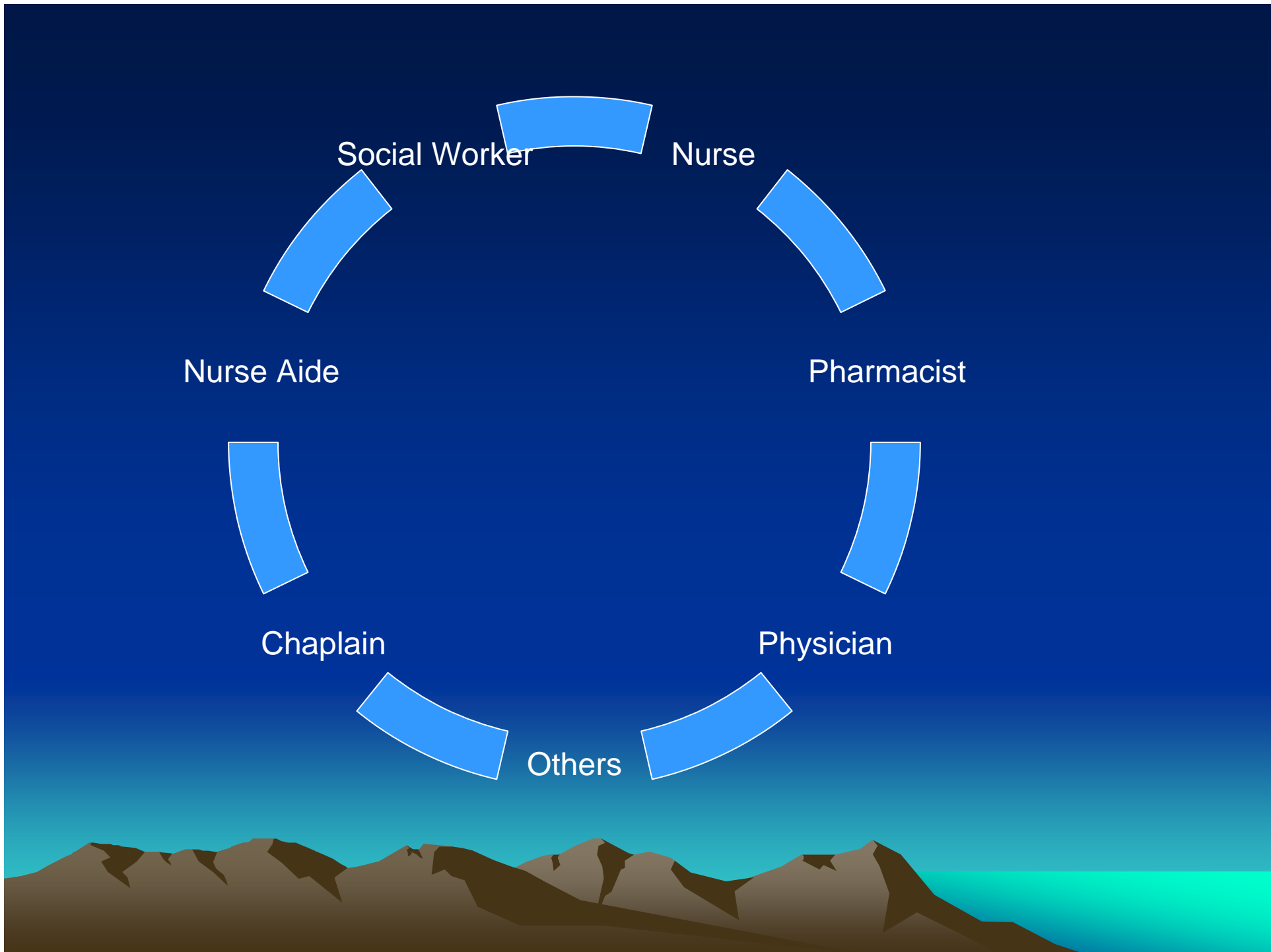
- Most of the literature focuses on patient / professional communications in hospice
- Much less is written about communication between members of the interdisciplinary team (IDT) in hospice/palliative care
- A LOT of research and writing about general communication between healthcare professionals in general, especially nurse-doctor interaction



Ideal IDT Communication

- Ideally, power should be equally shared between members of the ID Team
- All members should have a equal chance to give input, both in the formal team meeting and in smaller informal groups
- The “leader” of the discussion will change according to the situation





Contrast That to the Traditional Medical Power “Totem Pole”

- Physician has most power and say
- Nurses and other disciplines are subjugate to the doctor – even if they say more (in volume) than the physician
- Nurses aides are subjugate to the nurses
- A hierarchy like this affects openness of communication; it is influenced by the *perceived* receptiveness of the superior₃



Another Problem – Different Dialects

- Doc: The hypokalemia could cause Vfib
- Chap: His Calvinist upbringing conflicts w/ his adopted Unitarian stance
- Nurse: The woundvac's leaking so he needs more Kpads and A&D
- Soc. Work.: I am worried that if APS is called the INS will get involved
- Volunteer Coordinator: *Huh???*



The Result? Inadequate Communication, Which Leads To:

- (Usually unintended) hurt feelings
- Important conflict left unresolved – and patient issues also left unresolved
- Intra-team stress and tension
- Verbal and nonverbal abuse
- Members leave the team, seek employment elsewhere
- Poor patient outcomes, poor palliation



Who Suffers the Most (Besides the Patient?)

- This intraprofessional stress affects all IDT members, but current research shows nurses may be affected most of all
- Lack of job satisfaction is a major cause of nurses leaving employment and even leaving the nursing profession.... current nursing shortage is more a lack of career longevity than lack of graduates



Specific Communication Struggles

- Physician ↔ Nurse
- Nurse ↔ Nurse
- Chaplain ↔ Other team member
- Soc. Worker ↔ Other team member
- Nurse Aide ↔ Other team member



Physician - Nurse

- I am a little concerned about how I will be received by the nurses in the audience – doctors are more often than not seen as *the problem* when it comes to conversing with nurses. Why? Because WE ARE!
- So am I like a skunk trying to teach a rose how to smell better?



Physician - Nurse

- Traditional relationship has been that the physician holds the power and the nurse should defer to that power – but the nurse has more information about the patient's current situation
- Nurses are expected to be apologetic, submissive, passive, not question the doctor, and DEFINITELY not “show the doctor up” by displaying more knowledge!



The Doctor – Nurse Game₄

- Reported in 1967 to describe the “hoops” nurses must jump through when talking to doctors about patients
- In reporting to the doctor, the object of the game is: the nurse is to be bold, have initiative, and make significant recommendations while at the same time appearing passive. This must be done in such a way so as to make the recommendations appear to be the doctor’s idea



Physician - Nurse

- Hospice nurses have 2 different types of physicians to interact with:
 - Community/ referring physicians
 - Hospice medical directors (full or part – time)
- The problems – and approaches – to these 2 types are slightly different



Physician - Nurse

- In hospitals, the culture is changing – first in larger cities. Nurses are being urged to communicate with physicians as peers with a different perspective to bring to the patient care table; ***collaboration***₁
- Achieved through nurse training with the support of administration, nursing executives, and medical staff leadership



Physician - Nurse

- Optimally, *interactions between hospice medical directors and nurses should be collaborative also.* Nurse and doctor should come to an agreement on how to proceed on patient care. If disagreement persists, other members of the team should be involved (exception: emergencies that require immediate action)



Physician - Nurse

- Interactions between hospice nurses and **community / referring physicians** may require a different approach
 - If the doctor holds to the old power totem pole, then nurses may have to play the “doctor – nurse” game to some extent to avoid offense and lost referrals



Physician - Nurse

- Interactions between hospice nurses and **community / referring physicians.....**
 - If communication is especially difficult, then the medical director or nurse supervisor may need to intervene
 - Brainstorm for innovative ways to improve relations, communication and patient care without offense



Phone Calls

- Placing a good phone call: a skill and an art that *can & should be learned/ acquired*
- Can be a source of stress to nurses, especially when calling *certain* physicians
- Frustrating to physicians, especially when a *certain* nurse is calling
- FOR EXAMPLE.....



SBAR Tool ₁

- A tool to help nurses prepare before contacting a physician; ***great for phone calls***
- **S**ituation: what's going on with the patient
- **B**ackground: what is the clinical setting
- **A**ssessment: what I think the problem is
- **R**ecommendation: what would I do to correct the problem



SBAR Example

- **S:** Dr. Lee, I am calling about Mr. Wood, who has a fever and productive cough
- **B:** He is your 89 y/o man with COPD; he has been exposed this week to influenza
- **A:** His right lower lobe has no breath sounds, resp. rate 28, O2 sat. now 88%
- **R:** I think he has pneumonia. Can you order an antibiotic and SVN's, or can our medical director come see him?



Nurses: Making SBAR Phone Calls Work

- Always identify yourself by name
- ALWAYS have the chart/ med list/ allergies available when you initiate the call
- Anticipate questions; organize thoughts
- Do not ramble – mainly just the essentials
- Speak with CONFIDENCE, like the professional you are!
- Practice the call?



These Strategies Work.....

-For most Physician / Nurse interactions. However, what if (despite best efforts) the communication situation is too toxic?
- Let's get into a more serious topic: ***nurse abuse by physicians***



Physician Abuse of Nurses

- Verbal abuse: words that “humiliate, degrade, or otherwise demonstrate a lack of respect for the dignity and worth of another individual”₇
- Women often perceive verbal abuse as *even more damaging than physical abuse!*₇
- Nurses: main receivers of verbal abuse; patients, families, other staff, physicians



Types of Verbal Abuse, Ranked by Frequency and Stressfulness ₇

- | <i>Category</i> | <i>Rank of: How often</i> | <i>Stress</i> |
|-------------------------|---------------------------|---------------|
| Ignoring | 1 | 2 |
| Abusive anger | 2 | 1 |
| Condescending | 3 | 3 |
| Blocking/diverting | 4 | 4 |
| Trivializing | 5 | 6 |
| Abuse disguised as joke | 6 | 8 |
| Accusing, blaming | 7 | 5 |
| Judging, criticizing | 8 | 7 |

Other Categories of Verbal Abuse₁₁

- Rejection / refusal to help
- Terror (threats of harm)
- Sexual harassment
- Exploiting – treating like a servant
- Use of expletives
- Name calling
- Sarcasm
- Vocal tone and inflection



Nonverbal Abuse Occurs Also ¹¹

- Rude gestures and facial expressions
- Isolation and exclusion (acknowledging all around except you)
- Aggressive body stance (hulking shoulders, arms crossed, getting close into another's "personal space")
- Silence; refusal to answer when addressed



Effects of Abuse on the Abusee 7

- Intense feelings (listed in order from most common to least common) –
- Anger, frustration, disgust, embarrassment /humiliation, sadness/hurt, shock/surprise, misunderstood, powerless, helpless, intimidated, overwhelmed, threatened, defeat, shame, confusion, guilt, fear



Effects of Abuse on the Abusee

Many nurses have a *permanent psychological scar* from an abuse event, and can describe what happened years ago as if it had occurred yesterday₁



Effects of Abuse

- Almost all nurses have experienced abuse from physicians, and most within, at least, the last 6 months₁
- Physicians actually suffer some from their abuse, too – they have a long term negative relationship with the nurse and her/his coworkers, and are less likely to be notified of problems (patient suffers too)₁



Why Do A Significant Number of Doctors Verbally Abuse Nurses?

- Not looking for excuses for the behavior – looking for reasons behind it. If we understand what makes doctors more likely to do this, then when they abuse it is not taken so personally₁
- No evidence that physicians were *born* with a higher genetic tendency to abuse; therefore, much of it probably comes from training, culture, and external influences₁



Why Do A Significant Number of Doctors Verbally Abuse Nurses?

- Abuse of nurses modeled to them by their supervising doctors during training ₁
- Many if not most of physicians were verbally abused in med. school / residency ₅
- Increased stress – higher malpractice rates plus declining reimbursement for care means many physicians are working longer hours ₁



More Reasons for Physician Verbal Abuse

- Ego – in residency training a strong ego is actually promoted as a good thing, especially in the surgeon's culture. It can take a lot of “chutzpah” to have the confidence to do high risk, high responsibility procedures / decisions ₁
- High self expectations – “I have to have all of the answers; if I don't, I will fail” ₁



More Reasons for Physician Verbal Abuse

- Chauvinism – Most doctors have been male, most nurses female. There is the tendency to persist in the male-female roles that we saw our parents live in
- Actually, female docs feel the pressure to fit into the “boy’s club”; they often act like male physicians when it comes to nurses. Nurses, however, feel doubly betrayed when “one of our own” abuses them ₁



More Reasons for Physician Verbal Abuse

- Loss of autonomy – physicians are having their decisions challenged by HMO's, insurance companies, and hospital quality assurance committees. Now they are losing patients to nurse practitioners running their own clinics. Collaborating with a nurse seems like another loss of authority, or even helping the competition



Don't Doctors See How Horrible They are Being?

- The short answer: No, they usually don't.
- Studies show that physicians usually rate their negative behavior much milder, their relationship with nurses much better, their collaboration with nurses much better, and the cause of the problem much differently.....than nurses do.
- Bottom line: most of us docs *don't get it*



For Me.....

This strikes too close to home



Situations Where Abuse is More Likely to Occur ₁₀

- After hours phone calls from a nurse to a physician
- When patient care or orders have been delayed or perceived as slow
- When patient care is perceived as poor or inadequate
- Questioning or seeking to clarify an order
- After sudden changes in patient status



Why Do Nurses Put Up With It?

- Nurses often see themselves as powerless compared to doctors – lower on the totem pole
- The culture of nursing has been, in the past at least, to be subservient to physicians instead of peers to them. It takes a united effort to reshape this (and is occurring, slowly, in many places)



What Can Be Done?

- Organizations should have zero tolerance for abuse. (TNA has a z.t. policy)
- Nurses should strive for formal education and certifications. The more a nurse knows, the more even the playing field, and the higher the chance for collaboration and communication₁
- Medical directors should educate themselves about their optimal role in the ID Team (i.e., they are everyone's peer) – AAHPM Med. Dir. course₂



What More Can Nurses Do? ₁

- Develop relationships with your physicians. If they know you by name, they are less likely to abuse you
- **Ask** the physician for a more collaborative relationship! Surprisingly, many may agree to one



What Can Nurses Do?

- When conflict arises, constantly remind physicians of the common goal: ***excellent patient care***
- Confront abusive behavior:
 - Set boundaries (assertiveness training)
 - Get nurse manager or medical director help
 - If the hospice medical director is the abuser, demand counseling



Physicians – What Can You Do About This?

- First realize that you will not be self-aware of the severity of your problems!
 - Get feedback on your behavior and on your communication with nursing staff
 - Take steps to change:
 - Formal instruction on listening/communicating
 - Abuse/anger therapy
 - Get to know nurses and address them by name
 - **Ask** nurses to actively collaborate with you!



Nurse – Nurse Communication

- Nurses speak the same professional language, but a unique problem exists
- “Horizontal hostility”₆
 - When nurses criticize, snipe at, gossip about, snub, and act rudely toward their fellow nurse that they work with.
 - Abuse from physicians is one of the causes! Nurses feel powerless to respond to it so they take it out on each other.



Horizontal Hostility₆

- Nurses who report the most conflict with other nurses also show the highest rates of burnout; more likely to leave nursing
- UF study: even minor rudeness deteriorates job performance, not just emotionally, *mentally*
- Yet nurses long for camaraderie and solidarity with their peers
- One nurse: “only nurses have told me how much I can’t accomplish...I feel more highly valued by physicians, social workers, and the public...”



Horizontal Hostility – How Can Nurses Address This? ₆

- Defuse intense anger – do not retaliate
- Release anger by forgiving. To forgive does not condone the behavior, but rather is a refusal to be embittered by it
- Consult an expert if conflict is festering in the workplace
- Strive to exhibit care and compassion for your colleagues (break the bad cycle)



Horizontal Hostility – How Can Nurses Address This? ₆

- Compliment rather than complain (especially important for nurse managers)
- Build relationships as a team – cultivate “team spirit”.



Chaplain / Social Worker Communication with IDT Members

- Discussed together because the issues are similar
- Often feel not as valued as “clinical” members of team
- Not allowed to speak as much in IDT mtg.
- Psychosocial and spiritual issues are more abstract, less concrete than physical issues – communication is more difficult



Chaplain / Social Worker Communication with IDT Members

- But we know that suffering psychosocially and spiritually can be just as severe, and at times worse, than physical suffering
- A way to start addressing this:
 - Have chaplains and social workers present before the nurse does at IDT meeting
 - Not just “# of visits”
 - In-services for the rest of the team on what these disciplines do.



Nurse Aides

- As the members of the team with the least amount of formal education, NA's can feel intimidated when faced with communication with the rest of the team; often only talk to nurses.
- Start with asking for their input on every patient at IDT meeting (have them come)
- Emphasize to them their value to the other team members. (They know the patients value them)



Yes, There Will Be Conflict

- *It is a normal part of the IDT process* - will always arise in situations where there are conflicting needs, like our patients have
- Conflict does NOT mean abuse!
- Conflict is usually seen as something to be avoided
- But if regarded and treated correctly, can actually promote healthy change



Conflict

- For many people, ANY conflict is upsetting 8
- Often the automatic response is to avoid conflict by escaping or shutting down emotionally
- This, however, negates effective conflict management (the problem is still there), *and* opportunities for personal growth are lost 8



Conflict

- IDT conflict that is not dealt with is costly:
 - Lower morale
 - Lower productivity
 - Increased absenteeism and turnover
 - Increased team resistance to change
 - Stunts emotional and professional growth



Conflict

- Conflict management is something that can be taught and learned
- This is now considered an essential skill for nurses, counselors, chaplains, (and should be for all ID Team members)!
- The best thing about conflict management is that it insures high quality patient care by maximizing IDT communication



Styles of Conflict Management ⁸

- Collaborative – conflict confronted in a non blaming, problem solving manner. Work through each others' differences to achieve creative solutions
- Compromising – assumes that everybody cannot get everything they want, so all must give a little up to get goal accomplished



Styles of Conflict Management ₈

- Accommodating – willing to give up our own goals to preserve the relationship; but the patient may need what we wanted.
- Forcing – use whatever means we have to get our goals accomplished – but may destroy our relationship with the conflictor
- Avoidance – steer clear of conflict at all costs – goals not met and relationship less healthy.



Styles of Conflict Management⁸

- Style

	relationships	goals
Collaborative	+	+
Compromising	d	d
Accommodating	+	-
Forcing	-	+
Avoiding	-	-

(d = depends on the situation)



In Closing

- Communication is given too little attention in many areas of our lives, yet few skills are as important to the failure / success of our work, patients, mission, marriages, and friendships. Expert communicating requires good listening as well as speaking, and to be perfected it must be *taught and learned.*



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