NEW GRADUATE NURSES EXPERIENCE COMMUNICATING WITH RESIDENT PHYSICIANS: A QUALITATIVE STUDY

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A Senior Honors Project Presented to the

Honors College

East Carolina University

In Partial Fulfillment of the Requirements for

Graduation with Honors

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Introduction

In the medical field, there are endless interprofessional relationships that work together to effectively provide individualized care for patients. In order for the care to be properly administered, the communication amongst the care team must flow as seamlessly as possible to prevent adverse events.

Adverse events occur when patients experience harm, preventable or not, during their stay within a hospital or clinic (Rafter et al., 2014). In American and European hospitals, the cost of adverse events may total close to 400 billion dollars annually (Dietsche, 2018). Disorganized and broken communication is a major source of adverse events within the healthcare setting, though it is a process that can be improved (Ahmed et al., 2018). For new professionals within their fields, this is especially true. This study seeks to understand how new graduate nurses, who have yet to gain substantial experience speaking to other professionals, perceive communication with resident physicians.

Background

Patient safety is of the upmost importance in all forms of healthcare across the world. Keeping patients safe is the basis on which most health care professional practice stands and is a constant discussion in hospitals who are continually trying to improve every year. Studies have been done to improve patient satisfaction with communication from nurses and residents separately. Some improvements have been found by using a pre- and post- quantitative model (Allenbaugh, Corbelli, Rack, Rubio & Spagnoletti, 2019). Current quantitative approaches to improve the communication between nurses and resident physicians appear to focus on improving the convenience of the physician, rather than improving the relationship or the

information discussed between the two parties (Goyal et al., 2018). While the previous studies focused on improved patient safety and administration of care, it is important to understand the perspective of the nurses to allow the transmission of patient health information to be used in the most effective way possible.

Though the focus of the current study is specifically concerned with new graduate nurses in the acute healthcare setting, there is a lack of scholarly research focused on communication in this group; whether discussing the various reasons for breakdown in interprofessional communication or otherwise. As a result, most of the articles included literature on nurse-physician communication as a whole; not limited by age or experience gap.

Literature Review

Search engines such as PubMed and CINAHL were accessed for this review. Inclusion criteria for articles included full-text scholarly articles written in English, published no earlier than 2015. Keywords for the study sources were as follows: nurse, nurse-physician, resident, communication, and new-graduate. Though the current study will follow a qualitative format, the articles included in this review utilized a variety of study designs and methodologies. Studies that included narratives written by nurses and physicians were sought after for this review, often published in the form of non-interventional, cross-sectional designs that utilized surveys and interviews as their primary form of data collection.

Review of the Literature

This review includes 20 articles completed in both quantitative and qualitative formats: ranging from observational studies to QI projects and long-term interventional studies. Studies included nurses and physicians, collecting through surveys (Topcu, Turkmen, Sahiner, Savaser

& Sen, 2017; Streeton et al., 2016; Ramos et al., 2016; Wang et al., 2018; Lusk, Lasater, Stoyles & Deckmann, 2018; Smith, Greenberg, Yeh, Williams, & Moloo, 2018; Hadu, Kassahun, & Kerrie, 2016; Collette et al., 2017), cohort studies (Edwards et al., 2017), interviews (Topcu et al., 2017; Ortiz, 2016; Ebrahim, Hassankhani, Negarandeh, Azizi, & Gillespie, 2016; Law & Chan, 2015; Walsh, Inouye, & Goldman, 2017), and multidisciplinary rounds (Streeton et al., 2016, Raffel et al., 2019; Edwards et al., 2017, Henkin et al., 2016) to gather data for their respective study. For the purpose of this study, journals reviewed included information and statistics on the communication styles of nurses and physicians, and how they often differ. While specifically seeking articles revolving around new graduate nurses and their experience with communication, there appeared to be a lack of research concerning that topic.

Alternatively, authors have investigated the reasons for miscommunication and subsequent breakdown in patient care with more experienced staff. Researchers attempted various interventions and questioning staff at how they believe problems arise and how they may be rectified. Thus, reoccurring themes from these articles have been organized as follows: form of communication, perceptions of communication, interventional studies and perceptions of the new graduate nurse.

Form of Communication

Within the hospital setting, there are numerous ways in which the staff communicate to each other and with patients to distribute vital information. Despite the numerous physical and virtual forms of contact, breakdowns in communication between nurses and physicians are at the root of more than half of adverse events (Müller et al., 2018). Adverse events are defined as unforeseen harmful events or situations involving patients over the duration of their healthcare stay, whether causing a chance of or actual damage to the patient. Most derive from human error,

commonly stemming from a bout of miscommunication during handoff or otherwise (Müller et al., 2018). Holmgre, Pfeifer, Manoklovich, and Adler-Milsten (2016) found that despite the integration of technology into the communication among healthcare staff, there is still much work to be done in terms of standardizing the information distribution to prevent further error.

As to be expected, there are differing ways of which nurses and physicians are initially taught to communicate with their coworkers upon leaving school. Nurses are taught the SBAR (situation, background, assessment, recommendation) format, which Foronda, Walsh, Budhathoki, and Bauman, (2019) found during their two-step simulation is often lost to physician-style prioritization once they reach the workplace. This learning curve for new graduate nurses can promote incorrect prioritization, leading to distrust in their abilities, further miscommunication, and patient harm (Foronda, Walsh, Budhathoki, & Bauman, 2019; Topcu et al., 2017). In fact, Topcu et al. (2017) conducted a cross-sectional study that identified nurse-physician miscommunication as being the origin for the majority of incorrect medication administrations. The various reasons for communication breakdown observed among multiple studies have caused for further research to be conducted; often including interventions to determine the best way to dispel continuing issues.

Perceptions of Communication

Tan, Zhou, and Kelly (2017) stated that the complex relationship between nurses and physicians, commonly coined the “nurse-doctor game,” continues to invoke challenges within their work dynamic. The clash of perceptions pertaining to the nurse-physician relationship was a vital theme in a study performed by Collette et al. (2017), in which there was a need for increased support at micro and meso levels within the healthcare system.

In a systematic review, House and Havens (2017) found that among the studies included, nurses and physicians had differing perceptions on what effective collaboration between the two parties consisted of. This could be seen through nurses overall desiring high equity, input into direct care, and two-way communication with physicians (House & Havens, 2017). Alternatively, the same review discovered most physicians and residents found themselves ultimately responsible for the patient's care, so while information gleaned from the nurses were found to be useful and appreciated, physicians defined themselves as the primary decision makers with a more hierarchical relationship than nurses often desired (House & Havens, 2017).

These findings are consistent with two other studies, conducted in Ethiopia and Beijing respectively. Hailu, Kassahun and Kerrie (2016), found that though nurses overall felt respected by physicians as coworkers, their place within the decision-making process for patient interventions were often overlooked. Despite their intimate knowledge of the patient's moment to moment state, there are continual concerns of nurses lacking direct input with the physicians regarding the patient's state, maintaining the sentiment that physicians are separate entities rather than one team.

Ramos et al. (2016) conducted an observational study evaluating nurses' feelings regarding their place and the effectiveness of physician communication during the death of a patient and subsequent conversations with the family. Consistent with the aforementioned literature, Ramos et al. (2016) found that the higher a nurse rated a physician on their communication, it corresponded with a higher quality of death for their patient.

Focusing on the nurses' perspective, Wang et al. (2018) discussed the importance of hospital managers facilitating growth of collaboration between nurses and physicians, such as team trainings, to promote mutual professional understanding.

Interventional Studies

Due to the frequency of miscommunication issues amongst the treatment team, studies have suggested interventions must be performed to "…address the interprofessional communication skills that are lacking in practice" (Tan, Zhou, & Kelly, 2017). A literature review completed by Renz and Carrington (2016) advise that further developed, more structured forms of communication should be established within the workplace and evaluated; looking to see if barriers of communication are thereby improved.

The literature included within this review used experimental studies; many involving the creation of interprofessional rounding (Raffel et al., 2019; Edwards et al., 2017; Henkin et al., 2016) or shadowing committees (Walsh, Inouye, & Goldman, 2017). The purpose of shadowing interventions was to allow each party to understand the full responsibility of the other, or to facilitate the growth of interprofessional trust and communication through rounding or committees.

One such study performed an experiment to have resident physicians follow experienced nurses, allowing the first-hand view of the nurse's position in care (Walsh, Inouye, & Goldman, 2017). This study helped the residents develop not only an understanding of a nurse's day-to-day responsibilities, but the residents later reported changing their practice due to the experience; such as double-checking orders, considering the time-constraints placed on nurses, and even checking in with nurses once a shift to discuss the status of the patient (Walsh, Inouye, & Goldman, 2017).

Another study performed by Streeton et al. (2016) utilized an observational interventional design; creating a multidisciplinary team to meet monthly and discuss current issues and trends

within the units. After the intervention concluded, the participants described of their enhanced trust and comfortability in sharing critiques amongst the team. This ideal was shared by studies that implemented interprofessional bedside rounds and Discharge Time-Outs, or IBRs and DTOs respectively (Henkin et al., 2016; Raffel et al., 2019).

Henkin et al. (2016) found that the lack of face-to-face communication during daily rounds was one of the major reasons for breakdown and dissatisfaction with communication. To address this issue, IRBs were created with a checklist to ensure structure and prevent information from being left out. After the study was completed, the pre- and post-test surveys were compiled; finding a 20% improvement in nurse input reception and improvement regarding the confidence between participants to speak up if an issue is detected (Henkin et al., 2016).

Studies concerning an interprofessional intervention such as Henkin et al. (2016) found that most breakdown is found during daily rounds. However, there are similar issues in respect to discharge care and information distribution during the time of the patient's departure (Raffel et al., 2019). Raffel et al. (2019) performed an interventional study revolving around a new form of rounding, coined "Discharge Time-Outs," or DTOs; performed at every patient discharge, complete with a checklist to prevent the disorganization later found during initial process.

Despite progress for nurse satisfaction and growth in communication being encouraging findings when interventions are performed, they were found to not be without issues themselves. Case in point, both the DTO rounds and QI studies performed by Edwards et al. (2017) and Smith, Greenberg, Yeh, Williams, and Moloo, (2018) found that while their interprofessional collaborations were initially successful, their overall intervention was unsustainable. A sentiment shared amongst them is that the initial improvements regarding nurse satisfaction, increased confidence in coworkers and overall face-to-face communication encourages staff to adapt this

rounding technique and QI projects to their floor and current workflow as necessary (Raffel et al., 2019; Edwards et al., 2017; Smith et al., 2018). Before being adjusted to the workplace, Smith et al. (2018) suggested that schools should stress professional confidence and multidisciplinary communication to give the students a jumpstart on a common career issue.

Perceptions of the New Graduate Nurse

While this study seeks to understand the perception of nurse-physician communication from a new graduate nurse (NGN) perspective, most studies that focus on the NGN population evaluate their sense of professional confidence rather than their relationship with physicians. Though aspects of communication are influenced by professional confidence, few articles assessed the communication itself.

Ortiz (2016) performed face-to-face interviews to inform her descriptive qualitative study; focused mainly on the professional confidence, or lack thereof, felt by new graduates. A convenience sample in New York described an overall trend of low professional confidence, though it may vary slightly depending on their unit placement. While lower confidence is to be expected with any new occupation, development of this quality is vital for the health of their patients. Although not specifically evaluating confidence, Law and Chan (2015) inquired participants in their study about speaking up, and why it is a common concern amongst new graduate registered nurses (NGRNs). The main findings were that the NGRNs felt they needed a more supportive environment to feel comfortable enough to speak out; most wanting a mentor to speak to during possible teaching moments (Law & Chan, 2015). These findings stressed the ongoing theme that support amongst healthcare professionals should be delved into further, such as in their respective programs, before the students feel the weight of their inexperience in the workplace.

Aside from the understood fear and lack of experience felt by new nurses, a qualitative study done by Ebrahimi, Hassankhani, Negarandeh, Azizi, and Gillespie (2016) in Iran looked at the specific barriers new graduates felt were specific to them once they entered their units. They found that ineffective communication was often preceded by the new nurses feeling coworkers lacked trust in them, argued their clinical judgement, and were unable to understand criticism (Ebrahimi et al., 2016). Although Lusk Monagle, Lasater, Stoyles, and Dieckmann (2018) found that NGNs improve their clinical judgment with mentors, the study continued the consensus that undergraduate programs must place further focus on the development of nursing students' confidence and ability to assess situations with their workplace counterparts to improve their experience once hired.

Despite the plethora of scholarly journals concerned with reasons for and improvement of nurse-physician communication, there are a stunning lack of studies dedicated to new graduate nurses who are experiencing this communication for the first time. Therefore, further understanding of their perspective regarding this transition is essential to comprehend nurse-physician communication altogether.

Purpose

The purpose of this study is to understand how new graduate nurses experience communication specifically with resident physicians. These new nurses go through a rapid adjustment period while learning the workflow of their chosen floor, which may operate with physicians and the rest of the healthcare team in a completely different form than the charting, paging, or face-to-face methods they were exposed to in their schooling. Miscommunication between nurses and physicians is a contributor to a staggering number of sentinel events reported to the Joint Commission but remains a poorly understood dynamic in healthcare. This issue is

present throughout hospitals, home-care facilities, and clinics around the world (Al-Hamdan, Banerjee & Manojlovich, 2018).

A previous study completed by Thompson Forbes III addressed how residents view their exchanges with nurses, finding that the workload of the residents greatly affects how communication is shaped (Forbes, Larson, Scott & Garrison, 2019). This study attempted to understand the perspective of the other member of the dyad, specifically new graduate nurses who are new to discovering how to communicate with resident physicians.

Methology

This study used a qualitative descriptive approach to understand the perspective of a new graduate nurse. An email campaign was conducted to recruit new graduate nurses that have graduated from an accredited program in the past two years and are active in practice at the bedside. Eight total interviews were completed and included in the results after achieving data saturation. Interviews were audio recorded and transcribed verbatim and analyzed using qualitative content analysis.

The participants were interviewed through video interviews, specifically via WebEx and Microsoft Teams due to the COVID-19 pandemic restrictions. The subsequent participant narratives and data were compiled and organized with respect to the common themes found during analysis.

Results

A total of six participants will be discussed within this results section. The participants are all new graduate nurses (NGN), and graduated from an accredited nursing program. Participants ranged from 23 to 26. There were five NGNs that identified as female, and one that

identified as male. Out of the six participants, two identified as African American with the other four identifying as Non-Hispanic White. The participants practice in a variety of clinical areas: adult medical (2), adult surgical (1), adult critical care (1), pediatrics (1), and pediatric critical care (1).

During this analysis, there were three major themes identified that describe the new graduate nurses' experience communicating with resident physicians. The themes were: Gaining Experience, Informal Communication, and Perceptions of Nurse Value. These themes provide insight into how communication is perceived by the NGN early in their career.

Gaining Experience

Overall, the theme of nurses gaining experience was most often explained by the new graduates in the context of increased confidence and learning to speak up. Many of the nurses spoke about how nurses are not often directly included in daily rounds completed by the resident physicians and their attendings, so they have to speak up when they believe that they have any information that must be brought to the attention of the doctors. Participant 2, a pediatric nurse stated:

> …if I wanted to say something, I had to say it and I had to sometimes like, interject… when I could 'cause they never really like asked and they would always listen when you said something, but it was like you were just kind of standing there unless you had something to say.

As new graduates, many of the nurses explained their feelings of intimidation and fear of reporting information the doctors believed irrelevant. For example, one nurse, Participant 4, spoke about how since she is a young nurse, she is nervous about how the resident physicians

might perceive her as "…dumb or overstepping" when she gives her insight into the patient's condition. This was similar to a response from Participant 1, who has been a nurse for just under two years. When asked about the most distinctive factor that has affected her personal experience with residents, she stated "I think it's been mostly experience. Because even looking at my first day after orientation, I was scared to talk to anybody like you know…So I think it really is just like learning what I've done so far and what's worked and what hasn't worked."

Participant 5, a nurse of two years, reinforced this idea of intimidation resolving once you gain clinical experience. He went on to describe how speaking to resident physicians becomes easier once the trends of patient health and what orders are commonly needed to help fix the problem are learned by the new nurse, as well as understanding his own skill. Participant 5 expressed his reasoning:

> I think that [feeling comfortable calling the residents] mostly occurs when you get more experience and when you get more confidence in your decisions that you make. 'Cause nine times out of ten when I first started it was like, oh, I didn't know what the patient probably needed, but now that I got some experience, now I know…what to typically to ask the doctor for. 'Hey this patient is doing this, this patient is doing that, can we get this type of medication?'

In addition to feeling at ease during exchanges, Participant 5 also explained that over time, he felt his nursing judgment had improved enough to make forward suggestions to the resident physicians. "I used to not give too many suggestions when I first started. But as I said, the more stuff occurs more and more and more…I typically know what they need."

Therefore, they determined that as they gained experience practicing nursing, their certainty in their skill and nursing judgement aided them in their ability to step into physician rounds, calling and addressing the resident physicians, and making suggestions in the patient's care.

Informal Communication

When speaking about their communication with the resident physicians, all of 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 the majority of communication with resident physicians was not face-to-face interaction, but rather via various electronic programs offered through their hospitals. These messaging systems vary from hospital to hospital but the most used were Cortex and SecureChat via Epic. These programs often are compared to "text messaging apps" (Participant 1), or "like paging" (Participant 4), where nurses and resident physicians often cannot send more than about a sentence's worth of information per message. All of these methods of communication in turn have created an informal environment for the interprofessional communication to occur; the NGNs describing multiple situations where they were both helpful and hurtful in terms of communicating the plan of care.

Participant 5 noted that this informal and brief method of communication is popular amongst 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.

> But the other facility that I was at they didn't like us using SecureChat 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…and like I said some of the new population, they have their phone right in the hand, they can just get on it [SecureChat]. Some of the older ones [resident physicians] they weren't being involved on their phone a lot so they weren't ever getting my messages.

One NGN, Participant 4, discussed video-chatting, a form of telehealth that has increased in popularity during the COVID-19 pandemic. She stated that increased used of this technology has caused issues with communication such as the nurse not being included during the provider's appointment with the patient. Participant 6 detailed how at her hospital, the setup of the paging system has created roadblocks in the communication, especially since the beginning of the pandemic.

> I think they use the Voalte phones so they have the Voalte app [on their personal phones]…and that's how they get our pages. However, they can't respond to us with that. So if they need to call us back and say like, 'hey, like I'm gonna come see your baby in like ten minutes' they have to get on a hospital phone to communicate with us to call us back on… I felt like that really might break up the communication because oh now they have to go in, find a hospital phone that they can use, and especially now with COVID and everything. A lot of other units aren't allowing people to just pass through [and use their phones]…so I feel like it really does actually delay the communication…it has taken them a lot longer to respond.

In addition to the format of communication, the composition of the information is often not presented in the way taught in nursing schools. The SBAR (situation, background,

assessment, recommendation) formula of relaying report is not routinely used as it was learned during educational programs. The limited use of SBAR is primarily due to the limited abilities of texting technology and the efficiency needed in communication between the NGN and the resident physician.

However, most of the nurses reported a similar statement to that of Participant 3, where "…if you actually talked to them in person, well, we try to use SBAR [because of no restrictions on information limit]." Participant 4 expanded on this idea of differing styles due to technology, stating "…especially if I'm sending a page, you know you only have so many characters that you're allowed to send like in the message. And you know, if they're going to call you back, you wanna have answers to all their questions [so SBAR is utilized then]."

Perception of Nurse Value

The final theme was that of the nurses' perceptions of their value to the residents. Though the overall view of their interactions with resident physicians was positive, most of the new graduates noted they perceived varying levels of respect from the doctors.

Reflecting the negative experiences with resident physicians, few of the nurses reported feeling as though they were treated as "just the nurse" (Participant 2) and not as a critical informant of the patient's care. This was coupled with the fact that about half of the nurses in the study noted that resident physicians are often not aware of the nurse's qualifications in regards to care. For example, Participant 1 spoke about common questions nurses receive from residents. "I guess it's a lot of procedural things and they're like we want to put in an NG tube there. Like, can you guys do that?" Furthermore, Participant 5 gave an example about how he has been asked to remove chest tubes, draw labs, and other procedural tasks that may be out of the nurse's bounds:

> [I told the resident physician] I couldn't do a blood culture off the port and she just kept going on. She kept telling me oh I need to do a blood culture of the port I need. I've told you I can't do it, so…I would actually went to my charge nurse and I told her 'Hey, can you tell this resident? I can't do such and such? Maybe she'll believe you when it comes from you.'

In contrast, all of the nurses did describe their positive experiences with resident physicians, and how resident physicians of all years and experience levels actively listen to the nurse's suggestions when the nurse speaks up. Participant 1, a nurse on a Med-Surg unit, expressed how she felt the value of the nurse comes from their personal interactions with the patient.

> I feel like the value comes from probably my interaction with the patient and the patient's family, and how that differs between the interaction between the patient and the patient's family with the residents. I feel like sometimes, you know, patients will tell me or be a little more candid with me then they will the resident.

She goes onto explain how nurses will often hear information from the patients due to their frequent interactions, and how many resident physicians see the importance of this access to the patient.

Participant 3 also spoke on this subject, explaining how on her floor the nurses are required to go through a special educational program in order to work on that unit. The educational fellowships are developed by collecting interprofessional input from the nursing staff and attending physicians, as "…they are very conscious of education at the hospital." She felt this required program greatly added to the resident physician's opinion of the nurses' judgement.

So we go through a lot of training to be able to take care of these patients…I think they value hearing us [because of it] and if we have any suggestions than they are very, they're all ears for us…And I feel like that education really helped [increase our value to them].

Participant 2 while also speaking about how resident physicians often realize the worth of the nurses stated "…you need to learn how valuable nurses are to appreciate them. Then I feel like some of the younger ones might not have had that chance yet." The other responses by nurses mirrored this, as many claimed that though the value they perceive they have to the resident physicians does not often have a rhyme or reason, they felt like overall once the doctors realized their importance, they would not forget it.

Discussion

This qualitative study described the communication between resident physicians and new graduate nurses. Furthermore, we attempted to understand the dynamic nature of the relationship and the multitude of components that affect it. While interviewing six new graduate nurses from an accredited program, three main themes have been discovered throughout the course of the interviews. The act of gaining experience, the informality of resident physician-nurse communication, and the nurses' perception of their value were common threads in the interviews.

The most considerable effect on communication between the resident physicians and the new graduate nurses was the experience level of the nurses. This supports a study by Forbes et al. (2019), where resident physicians claimed that a major factor that promoted their work relationships with the nurses was often the expertise the nurses held; developed after years at the bedside (Forbes et al., 2019).

The format of information between nurses and resident physicians was described primarily as informal in nature. This was facilitated by the use of communication technology that resembled texting that only allowed for so much information in one message. Despite the stress placed on perfecting the SBAR format in nursing schools, the participants claimed it was often lost to the information prioritization encouraged by resident physicians; a theme supported by a study completed by Foronda, Walsh, Budhathoki, and Bauman in 2019. Interestingly enough, the NGNs denied little to any affect that the COVID-19 pandemic held on the method or composition of communication with resident physicians, despite the policy changes instilled in the hospital setting.

Finally, the nurses' perception of their value to the resident physicians often seemed to rely on the resident physicians realizing how a nurse participates in the patient's treatment. Participants claimed that some resident physicians were not aware of the scope of a nurse's practice, leading to asking for procedures outside of their skill or undermining their position on the team. Without realizing the value of a nurse's perspective on the care team, resident physicians may perpetuate a hierarchical attitude and limit nurse input in decision making, a phenomenon noted by both Forbes et al. (2019) and House and Havens (2017).

Recommendations

Understanding the components of communication between nurses and resident physicians, both positive and negative, provides insight into how it may be continually improved for future medical practice. After speaking to the new graduate nurses, many agreed that inculcating emphasis on interprofessional communication within both nursing and medical programs would prove to be beneficial once the students transitioned to the workforce. This

notion was supported by the deviation of the strict SBAR reporting format in clinical practice, and the common lack of understanding the resident physicians had of the nurse's role.

Further research pursuing a deeper understanding of the methods of electronic communication in the medical setting should be performed, as there was a stunning lack of this information in literature despite the prevalence it posed in this study. This along with studies revolving around the effect of the COVID-19 pandemic within healthcare teams should be conducted, following the limited information gleaned on it from this narrative study.

Limitations

When designing this study, careful consideration was utilized to retrieve the best possible candidates from whom to receive our information. However, this caused limitations for our study as well. All participants were sampled from the same nursing school with limited years of nursing practice experience. The demographic of the interviewees was narrow in scope, as five of the six participants were Non-Hispanic White females and all participants were only within a four-year age gap. Though the study was focused on new graduates, graduates from other programs could have provided additional insight on communication with resident physicians. Additionally, due to the emphasis on confidence found over the duration of the study, interviewing nurses with varying levels of experience could have yielded a more diverse range of results. Despite the limitations, the in-depth narrative format of the study allowed for focused analyses of the information provided.

Conclusion

While there are countless studies being conducted every year to improve patient safety through healthcare communication, few focus on the personal perspectives of new graduate

nurses in the field. By obtaining detailed testimonies from new nurses, the factors contributing to communication breakdown were more deeply understood as opposed to the same question posed in statistics from quantitative analyses. The most prominent influences of the communication of new graduate nurses and resident physicians in this study were the experience level of the nurse, the nurse's perception of their value, and the format and formality of the communication itself. By focusing on new graduate nurses, the gaps in professional conversation were identified, allowing for hospitals and professional educational programs to further improve the future of interprofessional communication.

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