RESEARCH ARTICLE

Assertion Practices and Beliefs Among Nurses and Physicians on an Inpatient Pediatric Medical Unit

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ABSTRACT

BACKGROUND: Teamwork and communication are critical elements of safe and effective patient care. Standardized communication tools have been implemented in many health care organizations, but little is known about attitudes and perceptions of assertion, the willingness to "speak up," by nurses and physicians at an academic pediatric institution.

METHODS: We conducted 6 focus groups with nurses, residents, and attending physicians using a standardized semistructured focus group guide to promote discussion. Focus groups were recorded and transcribed, and results were analyzed by 2 independent reviewers to identify thematic content.

RESULTS: Three themes emerged: (1) interpersonal factors, (2) organizational factors, and (3) complexity of care environment. Subthemes were the roles of hierarchy, relationships, and communication and personality style; the value of using standardized communication tools such as SBAR (Situation, Background, Assessment, Recommendation), direct face-to-face communication, and geographic and technology factors; and the need for coordinated communication and agreement across care team members about the care plans. Nurses reported reliance on peers for decision-making, on when and how to assert on behalf of patient care. Nurses and residents experienced barriers to assertion from concerns of relationships and their position within professional hierarchies. Attending physicians were supportive of being asserted to by any care team provider.

CONCLUSIONS: Interpersonal relationships, power dynamics, and organizational factors impact care team providers' willingness to assert in the inpatient setting. Standardized communication tools are effective. Further development and implementation of communication models that support experience, peer reliance, and direct face-to-face communication are warranted to improve assertion communication in the inpatient setting.

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Teamwork and communication are critical factors involved in patient safety.[1–3] According to the Joint Commission, communication failures are a significant cause of sentinel patient safety events.[4] Many barriers exist to optimal communication among care team members, including nurses and physicians.[5,6] Power and role differential, hierarchy, and gender differences contribute to communication challenges between nurses and physicians.[7–9] Teamwork and communication dynamics have been studied in a variety of settings including the emergency department, ICUs, and labor and delivery and operating rooms.[10–18] Yet little is known on this topic in the pediatric inpatient setting at an academic hospital.

Understanding the components of escalation of care is essential to optimal communication to promote patient safety, and few studies have explored the human factors involved in this important communication process.[19] Escalation of care involves prompt action including communication with another care team member in response to a concerning clinical situation. For all care team members to safely and confidently advocate on behalf of their patients, it is important to understand the factors involved in these communications. Our specific aim with this qualitative study was to use focus groups to better understand the barriers preventing nurses and physicians from effectively asserting their concerns, and the facilitating factors that promote effective assertion communication.

METHODS

Setting

The study institution is a 373-bed academic, freestanding children's hospital. In 2011, a hospital-wide training system took place to teach all clinical care providers the standard communication tools of Situation, Background, Assessment, Recommendation (SBAR).

Study Design

This study was a single-site, qualitative study that used a series of focus groups across multiple provider types to identify barriers and facilitating factors of communication strategies used in an inpatient setting by medical team members. This study was approved as an exempt protocol by the institution's institutional review board.

Participant Recruitment

Study participants included nurses and physicians who worked on the inpatient medical unit. Patients cared for on the inpatient medical units are general acute care medicine patients, with occasional acute care surgery patient overflow. Eligibility criteria for nurses invited to participate included working a minimum of 0.5 full-time equivalents per week and 70% of their time spent in direct bedside care or in a charge nurse role. Charge nurses at the study institution supervise the bedside nurses, coordinate care and placement of patients on the unit, and assist with clinical duties as needed. Eligibility criteria for physicians invited to participate included being resident or attending physicians who work on the inpatient medical units. The residents were pediatric residents affiliated with the institution's university pediatric residency program. Residents needed to have completed at least a 1-month rotation on the general pediatric wards at the study institution. Attending physicians invited to participate must have been scheduled as an inpatient attending for at least 6 weeks per year on hospitalist, gastroenterology, or pulmonary service and must have completed at least 1 year of inpatient service at the study institution. Three waves of e-mails were sent to all eligible participants and focus groups were scheduled according to availability of participants.

Data Collection

Participants were assigned to groups on the basis of their role (nurse, resident, or attending) to promote honest and open dialog. A semistructured focus group guide was used that included open-ended questions about communication in general, and specific instances of participants' experiences with assertion communication. The development of the focus group guide content was based on literature review on team communication in health care. The focus groups were facilitated by the 2 primary authors (J.R. and R.S.), with 1 author directing the discussion and the other author taking notes, making observations, and asking clarifying questions toward the end of the session. During focus group discussions, participants were queried on facilitating factors and barriers to assertion communication experienced by participants while working among the clinical care team (Table 1). Participant demographic and experience data were also collected. Focus groups lasted 2 hours, on average, and were digitally recorded and transcribed verbatim.

Analysis

A team-based analytic method was followed. Two researchers conducted code development in an iterative fashion. A priori codes were created before the initiation of coding and based on the concepts included in the focus group guides. Then, these researchers independently conducted in-depth code development on the 2 nurse focus group transcripts. Codes were then refined and a coding framework was developed during debriefing sessions with the research team. Complete analysis of all of the subsequent focus group transcripts was completed by using the agreed-upon codes and framework following quality guidelines for qualitative research.[20] Triangulation of certain themes took place by presenting our themes to colleagues at our organization who are conducting primary data collection through an interview-based qualitative research project that explores barriers that nurses face when calling codes or rapid response teams. Their study also explores the interdisciplinary communication dynamics at our organization.

RESULTS

Participants

Focus groups were conducted between September 2012 and April 2013. A total of 36 inpatient providers participated in the focus groups, with 2 focus groups conducted for each specialty. Participants totaled 11 nurses (10 female), 16 pediatric residents (16 female), and 9 attending physicians (4 female). Nurse experience ranged from 1 to 16 years in their current role; pediatric residents were in

TABLE 1 Semistructured Focus Group Guide

Topics to be covered in focus group sessions: the topics that will be discussed in focus groups include the following:

1. Experiences during which the person providing care requested something that was needed for a patient from a member of the health care team
2. Disagreements between health care team members
3. Training/preparation for handling disagreements on the health care team
4. Bad patient outcomes related to communication failures
5. Disruptive, rude, and disrespectful behavior among health care team members
6. Responses to requests for something a nurse, intern, or resident thinks are needed for a patient's care

Initial focus group questions:

1. When you think about communication with care team members about the patients you care for, what comes to mind for you?
2. Think of a time when you needed something in order to provide direct patient care and you didn't get what you needed when you asked a member of the care team? Tell me about the scenario, what went well? What didn't go well? If it didn't go well, what got in the way of you getting what you needed on behalf of the patient?
3. How do you feel when you know you have to ask a member of the care team for something you think they might not agree with? What makes those conversations go well? What makes those conversations difficult? What keeps you from having those conversations? What might help make those conversations go better? What communication styles shut you down or keep you from speaking up?
4. What kinds of things go into your thought process when you know you need to contact someone on the care team for something you need for a patient? What makes you decide to call? How do you get to the point of deciding to make contact? What kinds of things make it easier for you to initiate contact? What kinds of things make it difficult for you to initiate contact?
5. What training have you had to handle situations that we are discussing here? What kind [specific models]? Was it helpful? How have you used the skills you learned during that training? Examples?
6. Think of a time when you've needed to act on behalf of a patient's needs and it went very well. Tell me about the scenario. What made it go particularly well (people involved, roles, training, etc)? Is there anything about that that could be used to help others be more effective with assertion?
7. Think of a time when a patient suffered a bad outcome because communication with a doctor/provider didn't go well. What happened? What could have been done differently to avoid the scenario? What could we do at our organization to prevent this from happening again?
8. Think of a time when you experienced any disruptive, rude, or disrespectful behavior from any care team member at CHC. What happened? How has this impacted your ability to communicate with this person in the future? What do you think could be done to help prevent similar situations like this from happening in the future at CHCO?
9. Now think of a time when you were the receiver of a request for help. What makes you realize that the person asking for help needs something? What cues you in to the fact that a response is needed from the person asking for help? What things make you more inclined to be more responsive? What things make you less inclined to be responsive?

CHCO, Children's Hospital Colorado.

their first ($n = 5$), second ($n = 7$), or third ($n = 3$) year of training; and attending physicians' experience ranged from 1.5 to 21 years in their current role, with specialties of hospitalist ($n = 5$), gastroenterology ($n = 2$), and pulmonary ($n = 2$) represented.

Themes, Subthemes, and Dimensions

Three main themes and 8 related subthemes emerged from the data regarding barriers and facilitators to assertion, including the following: (1) interpersonal factors (hierarchy, relationships, and personality and communication style), (2) organizational factors (standardized communication tools such as SBAR and direct face-to-face communication), and (3) complexities of care environment (coordinated communication and an agreement and understanding by all care team members of the plan of care) (Fig 1). A brief description of each theme and related subthemes, along with illustrative quotes, is presented below.

Interpersonal Factors

Interpersonal factors were identified by all groups as significant when deciding whether to assert. Although there were many different factors that were discussed, thematic analysis led to the identification of hierarchy, relationships, and personality and communication style as critical factors.

Hierarchy

The perception of power differentials played out in several ways when participants described when they decided to assert. There was a barrier for people to assert up the chain of command (to someone they perceived was above them in the hierarchy), whereas those at the higher end of the chain of command felt that others would easily assert to them. Reasons for these barriers included not wanting to appear incompetent in front of their colleagues, not wanting to go above someone in the hierarchy, and not feeling like they are heard on the basis of their perceived level of hierarchy. These themes were noted by providers within their own professional role strata (nurse to nurse, physician to physician) and across professional role strata (nurse to physician, physician to nurse). Comments from focus groups as follows:

> *I get frustrated as a bedside nurse when I'm pushing and pushing [meaning, asking and asking] and I can't get what I want done and I have to go to my charge nurse to get her on this side to have her approach the doctors… and then they're like "Oh, okay, that sounds good." and you're like, "I've been saying this all along [to the doctors]" … why do I have to involve my charge nurse and other nurses to get what I want? (Nurse)*

> *I found that even on rounds, if it's an attending who is willing to be respectful at least which the vast majority are when you're talking with them despite the hierarchy, I generally haven't felt that intimidated saying but why are you doing this?…Certainly if they're cutting you off or make you feel like an idiot because you don't agree with them then*

FIGURE 1 Categorization of themes and subthemes for assertion among nurses and physicians.

fine, I'm not going to say what I think. (Resident)

Relationships

Participants reported that simply having worked with a person over time increased the likelihood of asserting. Knowing a person's name, having met them, and having seen them in person increased a person's comfort with asserting to them. Especially if they have worked together for a significant period of time, the participants reported that the likelihood of assertion increased significantly. However, negative previous experiences had an adverse impact on a person's comfort and willingness to address concerns with a provider or nurse. Comments from focus groups are as follows:

When I go to talk to the nurse practitioners on the pulmonary team, we are very close. I feel very comfortable with them. ..It's always really a good communication because it's almost like we're friends…I think also that providers that you have good communication with, you have no problem [asserting to them]; you feel comfortable keeping in contact with them. If you had bad experiences with certain providers, it almost puts you on the defense just starting out that conversation which doesn't exactly put you in the best spot to start [asserting]. (Nurse)

Personality and Communication Style

Unsurprisingly, people were more likely to assert with someone whom they perceived as likely to respond positively to the assertion. There were several behaviors that were perceived by focus group members as a positive reaction. These included listening attentively, asking questions, taking time to discuss the situation (in person, if possible), and providing context and explanation if a disagreement took place. Likewise, there were many behaviors that participants reported would decrease the likelihood of being asserted to. These behaviors included avoidance (or ignoring the request), dismissiveness (public demeaning or expressing frustration to others), and being rude (including tone of voice and body language). The description of these behaviors suggested that they could be associated with certain individuals, and, at times, whole groups or units developed a reputation of being challenging to assert to. In the case of our focus groups, the members of 1 department were named consistently as being difficult to assert to. It was also commonly mentioned that direct feedback, occurring in a face-to-face fashion, to address communication difficulties was appreciated and well received. Comments from focus groups are as follows:

There was a night when I was on call and I was dealing with a nurse who clearly wanted specific things done for her patient but wouldn't come right out and say them. It was so incredibly passive-aggressive… and so it finally got to the point where I was the rude one and basically said, "What is it that you want to do because dancing around the idea is not getting us anywhere and clearly I'm not giving you the answer you want" and I am proud to say I later apologized to her. (Resident)

The physician's [negative] attitude transferred onto my [the nurse's] attitude.…The whole day I was uncomfortable and I felt like I couldn't ask for help and I [realized I] definitely need to learn how to assert … [because if not] I wouldn't ask them for help and then that's not safe for these three babies that I'm taking care of. (Nurse)

Organizational Factors

The use of standardized communication tools such as SBAR was frequently noted as a very valuable tool to promote clear, concise communication and to make it very clear what one's expectations are. Another standard communication tool used at our organization is the use of CUS (Concern, Uncomfortable, Safety) to clearly state one's level of concern for a clinical situation. The use of these standardized terms allowed caregivers in all roles the ability to make it known that they were expressing concern because the tools conveyed specific meaning and intended use in our organization. The use of standardized tools may have also promoted individuals' willingness to escalate up the clinical chain of command when concerns arose. Comments from focus groups are as follows:

And when they use it well, and if I get a call and it's following the SBAR format, and I'm not sure what to do, then they have actually prepped me very well for calling the senior and talking through about the concerns. That makes me be

able to go back to the nurse and address the concerns. (Resident)

I think it gives them something to fall back on, [like] a script. And when you have a directive such as SBAR and you can present things in a script, I think they feel more comfortable. More empowered to get what they are trying to get. (Attending)

Direct face-to-face method of communication was frequently mentioned as an important means of effective communication. Caregivers valued the opportunity to give direct feedback (face-to-face), because it gave the recipient a chance to respond directly. Providers also reported feeling more listened to or heard when conversations took place face-to-face rather than via the telephone and were more likely to feel comfortable speaking up. Face-to-face communication also facilitated relationships, which was mentioned previously in the interpersonal factors. Comments from focus groups are as follows:

The nurse walked into the workroom and sat down and said "Can I talk to you?"…and it was like an example of perfect communication because she came in and basically said "I'm concerned because of X, Y and Z" and then she had done her own legwork on it too. (Resident)

I can always tell when they're more serious about something. It's when they've come into the workroom to specifically ask. (Resident)

Geography and Technology

Working in a geographically large and technologically complex tertiary pediatric academic center presented logistical challenges to effective communication. Often due to the distribution of patients across several different units, phone or pager conversations were required and missed communication occurred (missed pages, dropped calls, etc.), which interfered with the clear expression of concerns. Face-to-face communication was more likely to happen when nurses and physicians were on the same unit and nurse and physician work spaces were geographically near each other. Day- and night-shift work also interfered with assertion and escalation of concerns, because residents and nurses wished to avoid waking up the attending or covering physician during nighttime hours, which led to a delay in expressing concerns. Comments from focus groups are as follows:

Whereas I find on the wards with people being spread out physically, in the hospital, it makes it more challenging and you are probably more likely to just call or send a page than you are to actually go to the bedside and talk to them. (Nurse)

Complexities of Care

The nature of the academic teaching center resulted in large care teams and multiple providers caring for each patient; thus, coordinated communication across the care team was essential for all care team members to understand the goals of care, criteria for escalation of concerns, and understanding of who should have been communicated with. Agreement and understanding of all care team members of the plan of care were found to be an important facilitator of care team members' ability and willingness to effectively assert their concerns. Comments from focus groups are as follows:

There were multiple specialties managing him…there were lot of discussions happening but in terms of what you actually can do for the patient to make progress was not happening. Nobody was talking to each other. I think his care suffered. (Resident)

I think a lot of times we don't acknowledge to the nurses that the residents and the nurses are like the 2 people that are usually stuck in the middle between families and different care providers and I found that acknowledging to the nurses that you also feel stuck in the middle a lot of times can help build a lot of camaraderie among the nurses and the residents. (Resident)

DISCUSSION

The main themes of interpersonal, organizational factors, and complexities of care are not new issues to health care. We found that the more specific themes of relationships, hierarchy, and personality style have a big impact on care providers' willingness to assert. Standardized communication tools such as SBAR, direct face-to-face communication, and geographical considerations are important factors to consider when exploring optimal communication practices; and complexities of care and agreement between care team members are essential to optimal communication. Several studies have been published that address communication in acute care settings such as the ICU,[11–13,21] the operating room,[15,16,19,22] and the emergency department[10]; however, the literature is sparse regarding communication practices in the inpatient pediatric ward setting at a tertiary academic pediatric hospital.[5] On the basis of the findings of our study, future consideration of formalized communication training to promote and support effective assertion practices is warranted. Several of our findings corroborate findings in other settings, including the importance of interpersonal factors such as hierarchy regarding care team providers' willingness to assert. We found that less-experienced nurses felt less comfortable speaking up about their concerns and relied heavily on their often more experienced peers for support and advice when asserting. More-experienced nurses tended to be more confident and comfortable asserting their concerns to physicians than their less-experienced counterparts, yet they tended to have more barriers calling an attending physician compared with a resident, especially if they did not have a previous relationship with that attending or they had a previous negative experience with an individual. Coombs[9] explored the roles of physicians and nurses in clinical decision-making in the ICU setting and noted that power and differential roles are key categories in her study setting. Specifically, she noted that "nurses feel that clinical decisions were controlled by medicine, leaving little opportunity to influence by nurses." Garon's qualitative study[23] also explored nurses' experiences of resistance (described as speaking up about workplace concerns) in the professional setting.

She found that nurse-physician relationships were reflective of the power imbalance within health care; yet, she also found that acts of resistance had positive effects on them and their institutions, with improved nurse-physician relationships being a key category that emerged.

Studies have supported the benefits of SBAR,[10,15,24–26] as did our study. All participant groups (nurses, residents, and attending physicians) noted that SBAR is a useful tool to promote clear communication, especially when the provider needs to assert his or her concerns. However, other factors were also important facilitators of assertion, such as direct face-to-face communication rather than paging or telephones. This factor was supported by optimal geography, such as workspaces located near each other, making it easy for the nurse to find the physicians for the conversation.

Our findings show the importance of agreement between all care team members, particularly including the nurses, patients, and families, and systems that aim to address and streamline communication challenges, particularly when multiple specialties are involved. One study in the ICU setting showed that using a daily goal sheet improved communication by providing clear and consistent information for nurses.[11] Often, breakdowns in communication occur when there is a misunderstanding of the care plan,[15] which can impede care team members' abilities to appropriately escalate those concerns. They may not know who is ultimately in charge of patient care decisions, which decisions have been made and why, or how to reach the care team providers in charge of care. All of these factors must be addressed when aspiring to optimal communication systems that support assertion communication.

Our study has several limitations. Two focus groups took place for each role (nursing, residents, and attending physicians) and focus groups were conducted with only those in the same role present. This choice was made to encourage more open discussion within the group, because we thought that the different roles present might inhibit open communication. We were also limited to 2 focus groups for each role, because of a limited number of participants available and budgetary limits for focus group participation. Within these constraints, we were able to validate the theme of interpersonal factors from another and similar qualitative research project on communication barriers to calling codes and RRTs at our organization. There was a high percentage of female participants in the nurse and resident focus groups, compared with the attending focus group. This distribution approximates the gender distribution in these roles at the study institution, which may have limited us from exploring gender issues, particularly relevant to power and hierarchy that have been addressed in other studies.[7,27] Generalizability is an additional limitation. Ours is a tertiary pediatric academic facility; thus, our findings may not be generalizable to other institutions, especially those that are not teaching institutions.

When considering optimal communication practices, understanding the role of relationships and hierarchy in the care delivery setting is important. Programs that promote relationship building (eg, orientation, social events, nurses and physicians "walking in each other's shoes") may result in improved communication practices related to assertion. Our study supports previously documented findings of the benefits of standardized communication tools such as SBAR; however, additional factors should be considered when addressing communication in large medical centers, such as opportunities for face-to-face communication and reduction of large geographical areas covered by small numbers of providers. In addition, systems that address complex communication situations when multiple providers are involved should be considered, such as standard rounding practices involving nurses, use of white boards or other communication tools, and frequent discussions among all care team members, including patients and families, to ensure that everyone is in agreement on care plans.

Communication in a large pediatric tertiary academic setting poses many challenges, and assertion communication is essential to safe patient care. More research is needed in this area to better understand optimal communication models that support all care team members' input and ability to share their concerns.

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