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ETHICS CASE

Prioritizing Cross-Disciplinary Teaching and Learning and Patient Safety in Hospital-Based Environments

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Abstract

In this case scenario, Darvid is a medical student who perceives that practicing his physical examination of a patient at a specific time conflicts with nursing care. His predicament highlights the importance of interprofessional communication. Darvid is hesitant to communicate with the nurse, and his fear is exacerbated by the hierarchical structure of the academic health care setting, exemplified by the senior resident's dismissive response to his concerns. This paper argues that every opportunity should be made to prioritize students' learning but that the patient's needs must come first. The nurse in this case is in a position to help Darvid assess the priorities in this situation, but he must first feel comfortable discussing his concerns. Interprofessional education can serve a valuable role in facilitating open communication.

Case

Darvid is a third-year medical student starting his first inpatient hospital-based clerkship, in internal medicine. He is following Mr. S, an 81-year-old man with diabetes who was admitted to the hospital for pneumonia. Darvid is expected to visit Mr. S each morning before 8 a.m. rounds to see how he is feeling and to perform a physical exam, which gives him opportunities to practice his patient interview and exam skills and to learn more about pneumonia and diabetes. He is expected to report his findings to the team during morning rounds. The internal medicine first-year resident physician, Dr. Alexa, also visits Mr. S each morning and is responsible for prescribing his medications and ordering tests.

One morning when Darvid arrives at Mr. S's room, a nurse, Jemma, is at the bedside, getting ready to measure Mr. S's morning glucose after a finger stick and then to help him to the bathroom. Darvid doesn't want to interrupt her work, but there are only a few minutes before morning rounds. He decides to wait outside the room until Jemma is finished with her tasks but has to leave for rounds before getting to see Mr. S. As he's waiting outside the room in the hallway, Dr. Alexa asks him what he's doing. He explains that Jemma was in the room and he didn't want to interrupt. She responds that he's here

to learn how to be a physician and needs be more assertive so that he can see the patient before rounds; she adds that Jemma can come back to Mr. S later.

The next day, Darvid finds himself in the same situation. He needs to be prepared for rounds shortly and wants to respect Dr. Alexa's instructions, but he also thinks the care Jemma provides is more important to Mr. S's health than being seen by a medical student seeking practice opportunities. He's not sure whether he should interrupt Jemma's work or come back later and risk being underprepared for rounds again and receiving a poor evaluation from Dr. Alexa. Darvid wonders whether a practical scheduling solution could be found; he also wonders whether he should talk with Jemma, but he's not quite sure what to say.

Commentary

In this case, Darvid experienced what he perceived as a conflict between accomplishing the task assigned to him (practicing his patient exam) and not interfering with nursing care. His predicament highlights the importance of interprofessional communication. Had Darvid felt comfortable talking through his quandary with Jemma, the problematic situation would most likely have been avoided. Ultimately, the patient's needs must be foremost in guiding decision making, and team members' willingness to communicate effectively and discuss their needs and concerns is central to accomplishing this goal.

Interprofessional Communication: Setting Priorities

Mr. S's medical situation is not emergent; neither is this an isolated encounter in which Darvid loses a learning opportunity. Mr. S's need to use the bathroom in private and have his blood glucose measured take precedence over training, particularly since Mr. S has diabetes, and Jemma might need to intervene if his blood sugar is above or below the desired range. Ideally, Darvid should feel comfortable discussing his concerns with Jemma, who could have helped him assess whether it was an appropriate time for him to examine the patient. For example, could Mr. S wait to use the bathroom or was his need urgent? Could Darvid talk to Mr. S while Jemma checked his blood glucose? If these options were not feasible, Darvid and Jemma could have decided upon a mutually agreeable time for him to return to perform his assessment within the morning routine (barring an emergency). Darvid could then report his conversation with Jemma to the team, explaining his plan to return. As Darvid recognized, Dr. Alexa is the first-year resident directing Mr. S's clinical care, so the patient was not put at risk by Darvid's returning at a later time.

Hierarchical Health Care Settings

The hierarchical structures of academic medical centers can create a dynamic in which junior professionals or trainees feel too intimidated to talk to senior professionals [1]. This dynamic is compounded by a hospital cultural tendency to view nurses as physicians' subordinates who have less (rather than different) knowledge and narrower

scopes of practice. Poor communication related to power dynamics can result in fragmented care and risk for patient harm [1], and it can interfere with learning, as this vignette demonstrates. Dr. Alexa's response to Darvid's predicament is problematic on several levels. Telling Darvid to "be more assertive" and that a nurse can "come back" to the patient later pits the professions against each other, devalues nursing care, and expresses a fundamental misunderstanding of nurses' work hour-to-hour at patients' bedsides. This perspective fails to recognize the potential clinical implications of interfering with necessary nursing care and the clinical and ethical implications of fostering animosity between members of the team.

The situation presented an opportunity for Dr. Alexa to teach Darvid about the importance of cross-disciplinary communication with colleagues and about the contributions each discipline makes to the care of the patient. She could have made him feel more comfortable by encouraging him to discuss his problem with Jemma, thereby giving him permission to talk through his concerns with his colleague. Because this is Darvid's first inpatient rotation, he is likely unfamiliar with some clinical norms (for better or worse) and the dynamics of interprofessional hospital relationships. He thus would have benefitted greatly from encouragement to ask Jemma about the situation rather than being censured for not expressing more dominance or "standing his ground." Darvid's timidity might have been a function of his newness and student status, but it resulted in a lost learning opportunity for him. Creating a culture in which learners are afraid to speak up is detrimental to them as learners and can put patients at risk for harm.

Prioritizing Learning

Neither nursing nor medicine can operate alone, particularly in inpatient settings. Both professions' clinical and ethical goals rest on the common ground of achieving that which promotes patients' health and wellness. Toward this end, professions must educate and train high-quality, competent professionals, which necessarily requires time and space for learning and practice. Every opportunity should be taken to prioritize all health professions students' learning, as long as patients are safe. Hospitalized patients are vulnerable and in need of care, and their receipt of appropriate and timely clinical care should not be compromised by the learning needs of any health care trainee. Often certain interventions can wait a finite period of time, but if patients are not receiving necessary or appropriate nursing care, as determined by the nurse, then their care is being compromised. Indeed, a strong nursing presence, reflected by lower nurse-to-patient ratios, has been linked to lower hospital-related mortality and adverse events [2]. The opposite has been demonstrated as well; a higher nurse-to-patient ratio has been linked to increased rates of mortality and deaths following serious complications among surgical patients [3]. Thus, timely nursing care is inextricably linked to patient safety.

Jemma's role as Mr. S's nurse is instrumental in carrying out the plan of care hour-to-hour, assessing Mr. S's response to this plan, and noticing and intervening when something has changed or gone wrong. For example, given an acute clinical change such as a sudden drop in blood sugar, Jemma has an obligation to intervene immediately, document the change, and notify the medical team. Because Jemma (as the nurse) is at the bedside more consistently than most other team members, she is likely to notice subtle changes quickly. Jemma's responsibilities as a nurse are not expendable or tangential to the clinical plan of care; indeed, without nursing expertise, the plan of care could not be executed.

The perceived priorities of one discipline—either medicine or nursing—cannot take precedence over the perceived priorities of the other in all circumstances, which is why members of the health care team need to communicate about the patient's immediate needs and arrive at a shared plan of action. In a situation in which nursing care and medical education appear to be in conflict, it is necessary to prioritize the patient's needs, goals, and values. Both nurse and physician team members should consider the clinical and ethical implications of the range of possible care decisions. Could this patient be at risk for harm (including feeling like his or her dignity or privacy has been undermined) if nursing care is delayed? Will the clinical team lose potentially valuable information to guide future care if a student does not have access to the patient at this moment? Darvid and Jemma could have worked through these considerations and arrived at a decision that was optimal for the patient and acceptable to all.

Communication Problems and Overcoming Communication Barriers

Poor communication among members of the health care team is a significant source of potential patient harm [4]. A retrospective review of 16,000 in-hospital deaths found that communication errors were the leading cause of death and occurred twice as frequently as errors due to deficits in clinical skill [4]. Unlike this vignette, in which Darvid (a physician-in-training) was hesitant to talk to Jemma (a nurse), nurses often are hesitant to challenge decisions made by physician members of the health care team. One survey found that 58 percent of nurses had been in situations in which they felt that it was "unsafe" to speak up to colleagues or that nobody listened [5]. New graduate nurses, in particular, have been found to acquiesce to decisions made by senior members of the team, often at the cost of doing what they perceive to be the "right thing" [6].

The fear of speaking up is a multifactorial problem within the health care work and training culture and environment [7]. Hierarchies and perceptions of "groupiness" among professions within those hierarchies perpetuate this problem [7]. Less senior staff can feel hesitant to challenge decisions made by more senior staff, and perceived "out-group" members (such as trainees or nurses) can feel too intimidated to speak up to an "in-group" member (such as an attending physician) for fear of being ignored or censured [7]. Thus, interventions aimed at improving communication among team members must

address communication problems at multiple levels—individual, group, and organizational. Weller and colleagues [7] recommend seven actions to overcome communication barriers: teaching effective communication strategies, training teams together, training teams using simulation, defining inclusive teams, creating democratic teams, supporting teamwork with protocols and procedures, and developing organizational cultures that support cross-disciplinary equality among health care team members.

Improving communication between team members and creating a culture in which speaking up is expected can improve patient outcomes. For example, Pronovost and colleagues' [8] seminal checklist project decreased catheter-related bloodstream infections in an intensive care unit. The intervention involved clinician education about central-line infections, a central line cart that facilitated easy access to all necessary supplies, and a checklist to help ensure adherence to sterile technique and infection control practices [8]. A critical element in the success of the intervention was that it authorized all team members to stop the procedure if a deviation from the checklist was noted. In other words, the intervention provided each and every team member with permission to speak up, regardless of his or her perceived rank or seniority in the hierarchy.

Interprofessional Education

Interprofessional education (IPE) can also serve a valuable role in facilitating communication among members of the health care team. IPE is defined as "an intervention where the members of more than one health or social care profession, or both, learn interactively together, for the explicit purpose of improving interprofessional collaboration or the health/well-being of patients/clients, or both" [9]. IPE emphasizes communication, mutual respect, and shared planning or decision making [10].

IPE can be helpful in teaching clinicians from different professions to value the unique role that each professional can contribute to a patient's care. The opportunity to put oneself in the shoes of the "other" can help members of one profession understand tensions and stressors faced by members of a different profession [11] and has been shown to improve team communication among medical, nursing, and pharmacy students [12]. A recent review of 15 studies reported that 7 studies demonstrated improved collaborative team behavior as a result of IPE in operating rooms and emergency departments; due to the diversity of interventions and outcome measures, however, generalizable inferences were not possible [9]. Thus, IPE holds promise for improving interprofessional communication, and more work should be done to explore expansion of its effectiveness. In this situation, IPE experience could have bolstered Darvid's confidence about speaking up and Dr. Alexa's appreciation for Jemma's work.

Conclusion

All health professionals are in the business of taking care of people's health care needs. Each health care profession possesses a unique knowledge base and its professionals possess skill sets that are invaluable in providing competent, comprehensive, safe, and ethical patient care. Fostering collaboration and communication among professionals from different disciplines, and creating systems in which this is the norm and expected, can help prepare health care team members to best meet the patient's needs.

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