

Nurse-physician collaboration in intensive care units*

Zwarenstein and Bryant (1) in the Cochrane Collaboration have been reporting for years that only two studies fit their criteria for inclusion as interventions to improve collaboration of nurses and physicians. Interestingly enough, despite the lack of intervention studies, these authors seem to accept that collaboration should lead to improvements in care. More and more researchers have come to this conclusion. Drs. Hamric and Blackhall (2) in this issue of *Critical Care Medicine* provide yet another example. They found significant positive relationships between collaboration and a) satisfaction with quality of care and b) ethical climate for two groups of nurses and the single group of physicians studied. Collaboration also was related inversely to moral distress for one group of nurses.

This study had a number of strengths. The researchers studied healthcare providers in two quite different hospitals. They used instruments with the same or comparable questions for both nurses and physicians, which is in accordance with the belief that collaboration requires both parties to agree it is occurring. They developed a scoring mechanism combining frequency with intensity to measure moral distress in a new way.

The study is not perfect. Problems include basing questions asked on focus groups of residents and fellows, but studying attending physicians; using a collaboration scale developed for students with practicing nurses and physicians; changing one scale from site 1 to site 2; and encountering nonparticipating physicians in the second site.

One major point made by Drs. Hamric and Blackhall is their finding of both sim-

ilarities and differences between the two units studied, supporting their point that "unit cultures differ in important respects." This point has been made before, but without the type of supporting data supplied here (3, 4).

Drs. Hamric and Blackhall found stunning differences in some perceptions about the same interactions between nurses and physicians. These are particularly obvious in Table 4, where 48% of nurses perceived physicians as withholding prognosis information from patients, whereas only 10% of physicians believed they withheld; and although 75% of nurses expressed frustration with physician communication, no physicians had heard nurses express that frustration. Clearly there is work to do in communication across professions, and it behooves intensive care unit (ICU) providers to begin to take steps to open communication with each other.

A key issue raised by Drs. Hamric and Blackhall is the lack of specific suggestions for increasing collaboration. They propose the need for specific interventions, such as structured communications and attention to moral distress, recognizing differences between the two professions. I would add a few concrete suggestions that I found to be associated with unit level collaboration and improved patient outcomes: integrated patient records, joint practice committees, joint ICU leadership, scheduled interdisciplinary meetings, scheduled joint patient bedside rounds, written policies supporting collaboration, interprofessional orientation of new providers in the unit, and interdisciplinary in-services (5).

Other positive research findings related to physician-nurse collaboration date back to the early 1970s and include demonstrations of improvement in patient outcomes or satisfaction with work or both (5–14). There also have been some exciting recent interventional studies that have shown positive results in increasing collaboration and better patient outcomes (15–19).

Researchers have found improvement in ICU communication and provider satisfaction with structured communication

instruments (20–22) and with the addition of a nurse practitioner, clinical nurse specialist, or social worker to the medical team (15, 23, 24). Although none of these was specific to improving end-of-life collaboration in care, they do improve unit climate to support collaboration. Accompanied by the more specific intervention of structured communications related to moral distress, they could move providers from both professions closer to understanding one another and to working more closely with patients and families to improve care of the dying in ICUs.

Interventions specific to end-of-life care in the ICU have been generated by ICU nurse participants in research (25). Other successful interventions include case finding (26, 27), proactive ethics consultations (28, 29), and intensive communication (18, 19). Although these studies have either not been distinctly focused on collaboration or have lacked the perfect experimental controls to suit the Cochrane requirements, there is strength in numbers and repeated positive results. In many of these studies, the importance of providers collaborating not only with each other, but also with other care providers and with patients and families, is more and more supported in research results.

Judith G. Baggs, PhD, RN, FAAN
Oregon Health & Science
University
School of Nursing
Portland, OR

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*See also p. 422.

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“Search and destroy” for methicillin-resistant *Staphylococcus aureus* in the intensive care unit: Should this now be the standard of care?*

Methicillin-resistant *Staphylococcus aureus* (MRSA) is a blight on the medical landscape. The prevalence of MRSA in U.S. intensive care units (ICUs) has soared past 60% during this decade (1), making it the single most important multiple-drug-resistant organism tracked by the Centers for Disease Control and Prevention (CDC). First emerging in Europe at the start of the 1960s and in the United States in 1968

(2), MRSA was for decades strictly a hospital pathogen striking the infirm and immunosuppressed. However, today in the United States, upward of 20% of MRSA infections now start in the community (3). This scourge transcends continents, with a high prevalence observed in much of Western Europe, in the Far East, and throughout Latin America. MRSA is also more virulent. Infection specifically due to MRSA carries a higher mortality rate than that associated with routine bacteria; for example, the attributable mortality rate from MRSA infection is approximately 18 times greater than infection due to methicillin-sensitive *Staphylococcus aureus* (4).

How to repel the spread of this organism in the hospital has been the subject of ardent debate. Conservative forces like

the CDC/Healthcare Infection Control Practices Advisory Committee (5) cite the need to reinforce time-honored infection control practices that center on compliance with hand hygiene, standardized use of isolation and contact precautions such as gloves and gowns in patients infected with or colonized by MRSA, and the judicious use of antibiotics (5). By contrast, others such as the Society for Healthcare Epidemiology of America believe that the relentless proliferation of MRSA demonstrates the need for more aggressive measures, including the proactive surveillance of ICU patients on admission and during prolonged stays (6, 7).

Everybody agrees standard infection control practice has not been vigorously applied (8–10). Few caregivers appreciate that the most recent guidelines on hand

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