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ORIGINAL ARTICLE

Interprofessional collaboration in joint clinical sessions in an intensive care unit: Perceptions of nurses and physicians☆

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KEYWORDS
Collaborative practice;
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Abstract
Introduction: Collaborative practice is an interpersonal process in which different professional disciplines that share objectives interact, participate in decision-making and provide comprehensive and quality care. The joint clinical sessions offer the opportunity to interact and improve communication between professionals and optimise results in practice.
Aim: To explore perceptions of nurses and physicians about collaborative practice in joint Intensive Care Unit clinical sessions.
Method: Critical discourse analysis, through semi-structured interviews and field journals, using as theoretical reference the concepts of Campus, Capital and Habitus by Pierre Bourdieu. Participants: nurses and physicians of the Intensive Care Unit, who were recruited by intentional sampling. Semi-structured interviews were conducted and a discourse analysis was then performed. The interviews were coded by all the researchers, then shared and the data were interpreted in the context in which they were collected.
Results: Five categories emerged: 1) Concept: integration and involvement of a team with collective contributions and shared objectives, 2) importance: it increases patient safety, improves professional satisfaction and quality of care, 3) factors: the absence of culture organisations make collaborative practice difficult, 4) role: the nurse perceived that she plays a passive role (listener) during the clinical rounds and the physician an active role (communicator) and, 5) improvement strategies: to establish a schedule and balance interprofessional tasks.

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Conclusions: There is a need for empowerment in active participation by nursing staff in joint clinical sessions. The medical group should be more aware of the humanistic perceptions that other professionals can bring. Encouraging active listening in physicians, improving real communication by nursing staff and generating a space where respect and confidence prevail, will favour interprofessional work dynamics.

PALABRAS CLAVE
Práctica colaborativa;
Sesiones clínicas;
Percepción;
Satisfacción;
Trabajo en equipo;
Unidad de Cuidados Intensivos

Colaboración interprofesional en las sesiones clínicas conjuntas en una Unidad de Cuidados Intensivos: percepciones de enfermeras y médicos

Resumen
Introducción: La práctica colaborativa es un proceso interpersonal en el que interactúan diferentes disciplinas profesionales que comparten objetivos, participan en la toma de decisiones y proporcionan una atención integral y de calidad. Las sesiones clínicas conjuntas ofrecen la oportunidad de interactuar y mejorar la comunicación entre profesionales y optimizar los resultados en la práctica.
Objetivos: Explorar las percepciones de enfermeras y médicos sobre la práctica colaborativa en las sesiones clínicas conjuntas en Unidad de Cuidados Intensivos.
Método: Estudio de análisis crítico del discurso, a través de entrevistas semiestructuradas y diarios de campo, usando como referencial teórico los conceptos de Campus, Capital y Habitus planteados por Pierre Bourdieu. Participantes: enfermeras y médicos de una Unidad de Cuidados Intensivos, reclutados mediante muestreo intencional. Las entrevistas fueron codificadas por todos los investigadores, posteriormente se hizo una puesta en común y se interpretaron los datos en el contexto en el que fueron recogidos.
Resultados: Emergieron 5 categorías: 1) Concepto: integración e implicación de un equipo con aportaciones colectivas y objetivos compartidos, 2) importancia: aumenta la seguridad del paciente, mejora la satisfacción de los profesionales y la calidad de atención, 3) factores: la ausencia de cultura de organizaciones dificulta la práctica colaborativa, 4) rol: la enfermera percibió que tiene un rol pasivo (oyente) durante las sesiones clínicas y el médico un papel activo (comunicador), y 5) estrategias de mejora: establecer horario y conciliación de tareas interprofesionales.
Conclusiones: Existe una necesidad de empoderamiento en la participación activa por parte de las enfermeras en las sesiones clínicas conjuntas. El colectivo médico debe tener más en cuenta las percepciones humanísticas que pueden aportar otros profesionales. Fomentar la escucha activa en los médicos, mejorar la comunicación real por parte de las enfermeras y generar un espacio donde impere el respeto y la confianza, favorecerán la dinámica de trabajo interprofesional.

Introduction

Interprofessional collaborative practice has been defined by many authors as an activity where 2 or more professionals from different disciplines interact to improve the clinical care of patients and their families.[1–5] The processes for interprofessional collaboration are complex as they require interaction between professionals with different world views in a complicated and changing environment.[6,7] Despite evidence of the benefits of collaborative practice between nurses and physicians, this model of practice remains the exception rather than the rule.

For interprofessional collaboration to become a reality, a number of key elements[2,8,9] are necessary, such as the description and recognition of the responsibilities, competencies and roles of each profession, clear and shared goals, a shared team identity and commitment, interdependence and integration of team members, democratic and participatory approaches, good communication, joint development of protocols and standards, appreciation and tolerance of differences and disagreements between professionals, and respect for the work of each team member.

Joint interdisciplinary sessions are considered a form of interprofessional collaboration linked to ''excellent practice'' where exchange of information builds a common and

What is known?

Interprofessional relationships and collaborative practice are recognised as crucial in the management programmes and policy of the most internationally prestigious public service health programmes. Through interprofessional collaboration, the participation of all professionals in clinical decision-making is promoted and optimised, focusing on the needs of the patient.

What does this paper contribute?

Safe healthcare requires effective procedures and practice to reduce failures, errors and adverse outcomes. Effective and efficient interprofessional practice between nurses and physicians is critical for patient care and treatment.

comprehensive vision of the patient's situation, the development of a common and coherent action plan is discussed, and opportunities are created to detect, correct errors and avoid conflicts.[9–11] They provide a space and opportunity to improve the quality and safety of care, plan treatment and increase learning opportunities.[12] Joint clinical sessions are not only environments where each team member has the opportunity to contribute their experience and knowledge to analyse and reflect on best practice, they also have a creative purpose.[13] Interprofessional collaboration in an intensive care unit (ICU), joint clinical sessions and the involvement of physicians and nurses in the assessment and evaluation of patients and their families are strongly related to improving the effectiveness of clinical decision-making and the clinical safety of the care provided.[14] The ICU is a space where different professionals with different roles and competencies interact. It is a dynamic, complex and sometimes stressful working environment where a team approach and interprofessional collaboration are essential.[13]

The research question was ''What are the discourses of ICU nurses and physicians on interprofessional collaboration in joint clinical sessions?''. We believe that exploring the different discourses of professionals from both disciplines will lead to a better understanding of the current context of professionals in terms of interprofessional collaborative practice in joint sessions, and the creation of other participatory and democratic environments for decision-making in ICU. To this end, our main objective is to explore nurses' and physicians' perceptions of collaborative practice in joint clinical sessions in the ICU. The specific objectives were: a) to explore the concept of collaborative practice according to the professional discipline, b) to explore the importance of collaborative practice, c) to identify the factors that influence conducting joint clinical sessions from the perspective of the different professionals, d) to describe the perception of the role of nurses and physicians in joint sessions, and e) to describe the improvement strategies proposed to improve interprofessional collaboration in joint sessions.

Method

A study with a qualitative narrative design was conducted, specifically a critical discourse analysis,[15] through semi-structured interviews and field diaries, using concepts raised by Pierre Bourdieu as a theoretical reference. The fundamental objective of critical analysis of discourse is to make evident the ideological and social implications of the use of language that are often kept somewhat hidden.[16] We look to the concepts of Habitus, Capital and Field by P. Bourdieu[17,18] to conceptualise and question the relationship between power and knowledge, and how this relationship remains anchored in the practices of the different health professionals in relation to interprofessional collaboration in joint clinical sessions. Field is a historical entity, a network of relationships between people and of interests that are shared by the agents or institutions acting in it and that have access to different types of capital.[19] The Field is a structure of relations of force between agents or institutions involved in the struggle for the distribution of a specific capital.[20]

Capital is the resources that are put into play in the fields, whether social, cultural, economic or symbolic in nature.[19] Capital manifests itself through wages, cultural centrality, publications, etc. Access to Capital creates hierarchies within the Field and defines that which is considered legitimate within it.

The Habitus is the active presence of the whole past which gives practices their relative autonomy with respect to external determinations of the immediate present.[20] It is the system of dispositions though which we perceive, judge and act in the world and which responds to the internal practices of the professional group that are built and structured on ideas and values internalised by the person and by the social context in which they operate.[21] These unconscious dispositions that the individual internalises in the course of their socialisation lead them to perceive, think and act in a certain way.[22]

The study was carried out in the ICU of a referral hospital, between May and October 2018. Twenty-one professionals from the four ICUs participated, neurotrauma, medical, coronary and cardiac surgery. Joint sessions are currently held in a different way in each unit, depending on the dynamics of the professionals and setting.

The professionals met the inclusion criteria of more than 5 years of experience in ICU to ensure minimum exposure to the study phenomenon. Professionals who only worked night shifts, resident interns with experience of less than 5 years and nursing students were excluded. Participants from the different units were recruited through purposeful sampling.

Semi-structured interviews lasting approximately 30–45 min were held and explored using an interview script, which began with a general question and later raised specific questions on the research objectives.

The interviews were recorded on audio tape and then transcribed. They were conducted in a space in the hospital itself that ensured minimum conditions of privacy and quiet. The first two authors (XV and MM) also kept a field diary in which they recorded their reflections and the data generated in the context of the interview and outside it.

Inductive and deductive strategies were used for the analysis and the phases proposed by Taylor and Bogdan[23] of discovery, coding and discounting were followed. In both the discovery and coding phases, categories were identified in advance in relation to the objectives, while codes were identified emergently. Finally, contextualisation data collected

in the field diaries of the 2 primary researchers (XV and MM) were added).

In accordance with the confirmability criteria defined by Lincoln and Guba,[24] we ensured rigour through researcher triangulation, data triangulation, information saturation and researcher reflexivity.[25] Throughout the research study, the fundamental principles of the ethics of respect, beneficence, nonmaleficence and justice were respected (Belmont Report, 1978). All the participants signed their informed consent, participation was voluntary, confidentiality and anonymity were ensured and no names or profiles that could identify participants were disclosed. The original recordings were destroyed on completion of the analysis. The work was presented to and approved by the hospital's research committee.

Results

Eleven nurses were interviewed, 80% women and 20% men, with a mean age of 46.1 (±7), mean work experience 19.4 (±7.1); and 10 physicians of whom 60% were men and 40% women with a mean age of 42.9 (±9.6) and mean work experience of 17.4 (±10.2).

The analysis identified emergent codes related to the following categories defined in advance from the following objectives: 1) Concept, referring to the ideas, opinions or ways that the professionals understand interprofessional collaboration, 2) Importance, i.e., the usefulness or interest for the professionals, 3) Factors, relating to the elements, causes or reasons conditioning interprofessional collaboration in the joint clinical sessions, 4) Role, i.e., the competencies, functions or role that the professionals exercise during these sessions, and 5) Improvement strategies, referring to the actions and future proposals for change or improvement.

How do you define interprofessional collaboration between physicians and nurses?

The nurses defined interprofessional collaboration as practice in which individual contributions are made by each profession both jointly and collectively, and where there are shared or common clinical objectives and criteria. Therefore, they considered that this type of practice integrates 2 types of voice or contribution, specific to each profession according to their competencies, along with that of other professionals.

''When different professionals share objectives and interventions for better patient treatment (Nurse 4).''

''Working together as a team and taking everyone's opinions into account and everyone working towards better patient wellbeing (Nurse 15).''

The physicians focussed the meaning of interprofessional collaboration on consensual process for joint decision-making.

''Being able to reach a consensus with the entire team. By team, I mean all staff working in ICU and not only in care but also decision-making, both in diagnostic processes and treatment (Doctor 3).''

Both groups of professionals considered interprofessional practice as that where professionals have the capacity for listening, compromise and involvement, and eventually, coordinate knowledge and skills to provide better care.

''A multi-disciplinary team is where everyone contributes their grain of sand to the care of the patient and everyone has to listen to everyone (Nurse 8).''

''Integration between the whole team is needed, not only between doctors and nurses, but also between all ICU staff, in these units is where it is most noticeable . . . (Doctor 1).''

Why do you consider that interprofessional collaboration in joint sessions is useful or important?

The nurses felt that interprofessional collaboration in joint clinical sessions is important because it increases patient safety, helps to improve professional satisfaction, improves the quality of care we deliver to patients and families, and facilitates the flow of work.

''I think that through collaborative practice we gain in care quality and safety, for me it's a priority in every sense (Nurse 19).''

''Work flows much better. For both staff and patients, because you then see it in quality for the patient and then you leave happier and satisfied as a professional (Nurse 16).''

Both the physicians and the nurses perceived this type of practice model as particularly essential and a priority in an ICU, due to the characteristics of the critical patient and, fundamentally, their complexity.

''It's fundamental, especially in this specialty! It might not be so important in others, but it is in ours. The trend is increasingly to place the patient at the centre of care (Doctor 2).''

''I would say it was a cornerstone, I think that our setting is especially defined by teamwork and with teamwork if there is no collaborative practice, I think that it is difficult to get things done (Doctor 3).''

What factors condition interprofessional collaboration in the sessions?

The nurses identified as a difficulty the lack of organisational culture and systematic and jointly agreed dynamics for conducting joint clinical sessions as factors that condition interprofessional collaboration in the joint sessions.

''It's not always possible for nurses to do this at the same time. Because they don't ask you if it's OK to hold the session at that time, they ask each other and if they say yes, they sit down. If the nurses are doing something else, it doesn't matter. Doctors don't care much about nursing in this regard (Nurse 8).''

The physicians highlighted the architectural structure of the units as a difficulty, which makes it difficult to find an appropriate and accessible physical space to hold joint sessions.

''If... even if you push me... to physical space conditions, we don't take advantage of the space, we don't make full use of it. For example, I mean, going into a limited, reduced physical space... maybe it makes this difficult... because if I have to lean against the door frame, I can't see the meeting properly, well I could use the time to continue doing other things and they'll tell me if it was important or not (Doctor 3).''

Both the doctors and the nurses perceived other elements that could make it difficult, such as ambient noise, interruptions to the clinical sessions or the nurses' work overload.

''The alarms. Depending on the day, you can have the ward round together, and another day you sit down and get up a thousand times and you lose the thread and you're not even there anymore (Nurse 12).''

''Essentially the nurses' workload... Because we doctors are more or less organised, we can delay the ward round by half an hour or an hour... and sometimes it's difficult for them to attend. (Doctor 17).''

On the other hand, the professionals coincided in identifying trust between professionals, the professional seniority or experience of the nurse and individual predisposition as facilitating elements.

''I think that it's very important that they participate, but I also believe that only those who have been there for longer do so more, because I think the others feel respect for being able to speak in front there or they believe that if they make any comments they'll be criticised. Those who've been there for more years have more confidence with the medical team and feel less concerned about what ''they're going to say about me'' (Doctor 5).''

''I do think trust has an influence because people always take opinions into account ... they don't consider people who haven't been there long, compared to those who've been there longer and carry more weight in the department (Nurse 18).''

What is the role of professionals in the joint clinical sessions?

In terms of roles, the nurses considered that in general they take a passive role during the joint clinical sessions. Their role is limited to listening and participation is very occasional or almost non-existent. They perceived that the physicians attach very little importance to the information that they can provide in relation to the patient. They agreed that they are the professionals who know the patient better because they deliver continuous care at the bedside.

''We nurses listen and sometimes participate, always on our own initiative or almost always, not in an inclusive way. We are not asked for our opinion on any aspect related to the patient. We can provide a lot of information, can't we? But I would say that it's a more passive role, because we're not allowed to participate at all (Nurse 19)''.

''Bearing in mind that the same doctors are not always with the patient, the role of the nurse is not what I'd call essential, but it is important because our vision is possibly more continuous, that is to say we have a comprehensive knowledge of the patient's condition without numbers, nor analysis. Throughout the day I believe that we have a comprehensive vision of the patient and that we can communicate it when the doctors are doing their part (Nurse 13)''.

The physicians perceived that they play an active role. It is they who usually lead, inform and communicate during the joint sessions. From their point of view, it is the physicians who invite the nurses to answer certain questions to be heard and it is the nurses who are withdrawn or passive, since despite having a lot of potential they often lack involvement or communication skills.

''Sometimes I try to ask nurses about opinions or visions of the patient and I always try to get nurses to participate by asking them some questions; the nurse has a hard time participating. From my point of view I always try to get them to participate more and it doesn't work out (Doctor 6).''

''They have incredible potential and I don't know if it's a communication problem. They're kind of ''withdrawn'', aren't they? (Doctor 2).''

Both professionals agreed that the joint sessions are led by the physicians and that decision making is not by consensus, but unilateral, with medical information or treatment prevailing over nursing care. Nevertheless, they recognised the importance of consensus and information regarding care and the comprehensive assessment of the patient and the family, although this is not a priority nor even a determining factor in making clinical decisions. Furthermore, they stated that leadership does not depend on professional status or discipline, but on experience, knowledge and authority to deal with certain situations.

''Ideally, these would be consensus decisions or choices, and this is not always the case. There have to be leaders within the group, leaders defined perhaps by career or experience and by the kind of decisions that can bear more weight or otherwise. Not everything is about diagnosis or treatment. It's the whole environment of the patient, their family, care and there nursing should bear much more weight in decisions (Doctor 3).''

''I think that sometimes we are taken into account, in terms of care, which is what the nurse really does, treatment, of course not, but in terms of care we are sometimes taken into account, but not very much. I would say that even what is strictly nursing care, they take on, it's not completely unilateral, not in terms of care (Doctor 19)''.

''I think the medical role is very important and deciding which antibiotic, deciding whether to wake a patient up. I think that it is the doctor's decision that prevails, and the nurse will tell you that they've not seen them to be poorly or that they have had a bad night or that they have a lot of mucus and such... but you end up trying anyway because what prevails is the doctor's decision (Doctor 5)''.

What improvement strategies do professionals propose?

The nurses proposed combining interprofessional tasks as actions to facilitate joint sessions. They considered that the dynamics in the unit are organised throughout the working day according to the times, objectives and plans of the medical group. Organising the tasks of both groups during the working day in a coordinated and systematic way would encourage the attendance and participation of all team members. In addition, they consider that access to joint ward rounds should be made easier. The closed circles that physicians form around a table or computer when clinical sessions are held make it difficult for nurses and other professionals to participate.

> *''Simply informing what time you will be visiting, a simple ''invitation'', is how we can organise ourselves. The non-verbal language, the way they have to sit in a closed circle means that I have to make room for myself, that is, we're going to do the ward round if you want you can listen to us. The doctors sit down and you're back there, in the second row, ''in the henhouse'' (Nurse 9)''.*
>
> *''They arrive at the last minute to do everything they had planned to do first thing. If we were all organized, it would be better (Nurse 12).''*

The physicians and nurses proposed holding short joint clinical sessions. Joint sessions at the patient's bedside and of short duration can be more open and participative, as they allow all members of the team caring for the same patient to attend.

> *''They are too long for my liking, you can't be there the whole time, listening or participating. They just get to your patient and you have to leave. When there are different opinions on a patient, they can easily be there for half an hour... They should be shorter (Nurse 12)''.*
>
> *''I think we should structure them better, we should make them more productive, i.e., shorter. It's terrible! We're really not punctual, and this is a criticism... and there's no way (Doctor 2).''*

Both professionals raised the need for a change in attitude or culture regarding joint clinical sessions. Professionals should naturally assume the identity of an interdisciplinary team, encourage the participation of all professionals and equal relationships between peers.

> *''I mean, I would like it to be more participatory. It's true that little by little it is getting better in that regard, I think that it's not quite as participative as I would like it to be. Nurses are always open to much more collaboration between doctors and nurses (Doctor 6).''*
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> *''This is it! A change of attitude! Yes, there needs to be a change in attitude, it needs to be put to the chief medical officer, to whom it'll really matter, and talk to them (referring to the doctors) but.... I think it'll be difficult after so many years and it's always worked like this here (Nurse 15).''*

Discussion

In ICU, specifically in the context of joint clinical sessions, specific power struggles take place, where physicians and nurses define and take different positions according to an unequal distribution of knowledge, practices, competencies, resources, habits, use and control of space and time. As other authors indicate, interprofessional relationships between physicians and nurses are still hierarchical, where nurses are perceived as doctor's helpers or there to carry out their instructions, while physicians are perceived as leaders of the health team and have the power in clinical decision-making.[26,27] Physicians and nurses see the ICU as an appropriate and essential context for interprofessional collaborative practice.[28] Both professional groups perceived the importance of interdisciplinary work in the quality of care of particularly complex and critical patients, because they require comprehensive, continuous and systematic monitoring and assessment compared to other types of patients. Nurses, in particular, consider that interdisciplinary collaboration is particularly important for professional satisfaction, efficiency and clinical safety in the care of patients and their families.[29]

In both groups the perception and practice in relation to interprofessional collaboration in joint clinical sessions is sometimes contradictory. Thus, there is a pre-discourse on the phenomenon under study that has not yet translated into daily clinical practice, especially in terms of the definition of the concept, its importance, their roles and those of others in the sessions and finally in the proposed strategies for improvement. Furthermore, there are elements in the discourses of the physicians and nurses that coincide, and others where differences are evident. Even though the physicians and nurses describe interprofessional collaboration in a way that is close to scientific evidence, their practice is still far from this ideal.

Both professionals identified factors determining the success or failure of interprofessional collaboration at different levels: relational, those that occur in the relationship between the professionals themselves, such as trust, communication, respect, recognition of roles and competencies, the experience of the nurses, the biomedical or pathophysiological viewpoint and individual predisposition; procedural, those conditioning the dynamics, procedures or practices such as shared objectives and criteria or times and agendas; organisational, those relating to the hospital or unit itself, such as lack of interprofessional culture, work overload of nurses, architecture.[5,13,27–29]

In joint clinical sessions, nurses are perceived and perceive themselves as professionals with a secondary or complementary role in which they are limited to carrying out instructions, acting as listeners and carrying out few interventions, which, when they do so, are little appreciated by physicians.[26,27] Nevertheless, both professionals consider the nurse to have the most comprehensive and complex knowledge of the patient and their family. Information relating to psychosocial, emotional or clinical aspects of care is given less value and consideration than that relating to treatment, pathophysiology or diagnosis. The role of the nurse in joint sessions has not been discussed in depth and it is important to address their role and contribution, as

well as their ability to interact as a member of the interdisciplinary team.[30] In contrast, physicians are perceived and seen as leaders, communicators and final decision-makers in the care plan.[31] There is some tension in the perception of the role of both professionals, as physicians feel that nurses have a lack of involvement and participation in clinical sessions, while nurses feel that their voice is dismissed or undervalued.

Both professionals also identify strategies for multi-level improvement, and agree that both professionals and organisations require a change in culture in this regard and that there must be inter-professional diversity, putting the needs of patients before the particular interests of each professional.[29] A positive attitude on the part of professionals towards this practice will improve quality of care, encourage consensus in the team, professional satisfaction and knowledge of the patient's needs.[27]

Limitations

This study has limitations inherent to the conversational techniques used, and therefore the discourse may not coincide with the action or daily practice of the professionals. Despite this, contradictions between discourse and practice emerge in the interviews.

Conclusions

The physicians and nurses had dominant and standardised discourses regarding collaborative interprofessional practice in joint clinical sessions, although these discourses remain far removed from the evidence on interprofessional collaboration. Both the nurses and physicians are aware of the importance, usefulness and the potential of these collaborative practices in promoting and improving comprehensive patient- and family-centred care plans. They perceive that the traditional structures of joint ICU sessions make interprofessional collaboration difficult. The nurses express the need for empowerment and active participation in joint clinical sessions. The physicians feel that they should take more account of the more humanistic views that nurses bring to patients, encourage more active listening, and a space where respect and trust prevail.

Implications of the study

This project could have several implications that will affect professionals, patients and families alike. Knowing the views of both groups provides an opportunity to improve participation in clinical sessions and make joint decisions. Improving the practice of interprofessional collaboration will improve patient/family satisfaction, quality of care and clinical safety.

Conflict of interest

The authors have no conflict of interest to declare.

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