

Physician-Nurse Relationships: Patient Outcomes Hang in the Balance

EXECUTIVE SUMMARY

Like “Ozzie and Harriet,” “Father Knows Best” and other TV shows of the 1950s, hospitals and other healthcare providers try to portray themselves as ideal ‘families’ of caregivers in whose hands we are safe and secure. Underneath this harmonious veneer, of course, can be a different reality. Stressed-out doctors too busy to really know their patients, nurses stretched thin from an ever-worsening workforce shortage and medical-error challenges that plague even the most reputable medical centers unfortunately have become all too familiar.

Add to these the problem of the dysfunctional physician-nurse relationship, which has emerged as a central factor in some of the critical challenges facing healthcare systems today, from the workforce shortage to patient outcomes. Much of the issue is cultural and rooted in long-standing patterns of medical education and social status.

In an extreme scenario, doctors are imperious and abusive toward nurses, who they view as underlings. Nurses, turned off by boorish attitudes, are reluctant to communicate with physicians and see another reason to bolt the profession in droves. On the other hand, doctors, under increasing

pressure on many levels, are frustrated with nurses who waste their time with vague requests based on inadequate information about the patient. Complicating the issue is the increasing number of foreign doctors and nurses, raising associated language and idiom misunderstandings.

Ultimately, of course, it’s patients who suffer. Evidence for this has been building for years. Today, a combination of the workforce shortage and the need to improve patient safety—including the adoption of technologies to do so—is forcing hospitals and health systems to address the issue of how MDs and RNs get along. Patient welfare truly hangs in the balance.

Ed Septimus, MD, medical director for infectious diseases and occupational health at Memorial Hermann Health System in Houston, says one of the factors driving the nursing shortage is a huge ‘hassle factor,’ in good part related to the dysfunctional physician-nurse relationship.

Experts, not partners

Improving the work environment starts with simple things.

“If you talk to people in the trenches, it doesn’t have to involve monumental change. Just creating opportunity for

pressure on many levels, are frustrated with nurses who waste their time with vague requests based on inadequate information about the patient. Complicating the issue is the increasing number of foreign doctors and nurses, raising associated language and idiom misunderstandings.

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**Ed Septimus, MD,
Medical Director,
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conversation between physicians and nurses in a non-threatening environment will go a long way," he says. IT can help if it is centered on the workflow to

enable doctors and nurses to more effectively and efficiently carry out their jobs.



*Sutter Roseville
Medical Center*

Barbara Nelson, chief nursing executive at Sutter Roseville Medical Center

outside of Sacramento, Calif., says the issue of MD/RN relationships is part of a larger issue related to areas of similar processes involving people who need to have information in a very timely manner.

She says the issue is broader than just physicians and nurses. For example, when clinical personnel—not necessarily doctors—call the help desk communication problems can arise because of a perceived authoritarian tone on the part of the caller.

Blindly going where no nurse has gone before

"It really has to do with any hierarchical relationship that exists. We're pretty hierarchical in healthcare," says Nelson. Partly that's because licensing gives physicians a certain power. But nurses are licensed as well.

"It is the nurse's responsibility to advocate for the patient, not to blindly go where the doctor says to go. That notion of 'Anything you say, I will do,' is still predominant," she says, adding that physicians practice the way they are socialized and taught in medical school.

At the same time, Nelson acknowledges, "There's a huge educational gradient" that separates nurses and physicians. Physicians' level of education dwarfs nurses' in terms of duration and complexity. "The concept of the doc as captain of the ship is very strong," which can be an impediment at times to better teamwork, she says.

One answer is to make the chain of command more accessible in day-to-day procedure. Sutter Roseville has done this by embedding an algorithm into each plan of care that enables all clinical professionals—doctors, nurses, technicians—to institute the "Chain of Command." Partly driven by the fact that Sutter is self-insured, the Chain of Command procedure arose out of their analysis of risk mitigation methods at the organization.

The Chain of Command is a procedure to follow if any healthcare professional has reason to doubt or question the care provided to any patient, or believes that the best interests of the hospital or its patients have been or may be jeopardized by the behavior of any hospital employee or medical staff member. If the RN and treating physician are unable to resolve the concerns, or if the physician is unavailable, the RN must promptly notify the director, clinical manager or administrative supervisor. If resolution is still not achieved, the issue goes up a clearly specified Chain of Command.

Scripted for success

For example, the organization reviewed procedures like VBACs (vaginal births after cesarean) to determine the chain of command and when exactly clinicians might fail to follow it. Articulating the chain of command better is Sutter Roseville's attempt to script procedures to enhance communication and outcomes, she says, for example, to call the right doctor and not the surgeon; to have the information needed

and not put the doctor on hold, which makes them furious.

Another common problem is the belief that doctors always know their patients. Particularly on weekends, it may not be the case that a covering physician knows the patient that he or she is being asked to treat. Failed communications around the assumption that the physician knows the patient being talked about are a frequent source of tensions in the nurse physician relationship. Add to that the need to give a lot of basic patient information to a covering physician, so taking up valuable time (for both the physician and nurse), and there is another source of potential stress.

Nurses need to act as the physician understudy, asking him or her what they want to know about their patients in quite specific terms. This is especially true on the weekend. Doctors essentially sign-off when they leave for the weekend and don't talk to the on-call physicians who take over for that period.

And Nelson says the idea of the team caring for the patient is another illusion. "Most of the nursing workforce is a part-time workforce." Other factors weakening teamwork: the healthcare environment is plagued by shortages and there's lots of anger. Doctors are mad at managed care, shrinking reimbursement and the government. "The rules changed for them in mid-stream in terms of responsibility, debt and office-load commitment," she says.

Getting out of Dodge

Mary Pynn, CNO at St. Paul, Minn.-based HealthEast Care System, says the nursing shortage and patient safety are two driving factors for nursing executives like her to focus on the physician-nurse relationship.

She cites statistics that put the nursing shortage at 11% nationally and 20% in California; it's expected to hit 1.5 million by



**Mary Pynn, CNO,
HealthEast Care
System, St. Paul,
Minn.**

HealthEast
Care System

2020. "It's critical to improve the work environment not only for today but for tomorrow," Pynn says, adding that a study by Linda Aiken at the University of

Pennsylvania found that one out of five nurses is planning to leave the profession within a year. Nurses also cite dissatisfaction with clinical team members, including physicians, Pynn notes.

In terms of patient safety, the literature is replete with evidence that communication of team members is critical to patient outcomes. "So physician-nurse collaboration is not only critical from a job-satisfaction perspective, but in terms of patient care," she says.

"Studies also show that abusive behavior by physicians puts patients at risk. Nurses are intimidated to call physicians who are on-call during a weekend.

Another study by the VHA on the west coast found that there was a significant discrepancy between how physicians see themselves valuing nurses and how nurses see physicians valuing nurses. The VHA study also found that disruptive behavior by doctors—often triggered by the RN calling the MD inappropriately on the weekend or off-shift—resulted in RN turnover.

Nurse Retention

Pynn says that each organization has to create a culture of retention for nurses built upon communication and teamwork between MDs and RNs, but also including all caregivers. To initiate that effort, HealthEast conducted a root-cause analysis centered on a sentinel event in the OB

WELCOME
NEW
MEMBER

Scottsdale Institute is proud to welcome new member Spectrum Health in Grand Rapids, Mich.

Spectrum Health is the largest health system in the Grand Rapids region, with seven acute-care hospitals, 13,200 staff, 1,900 licensed beds, 1,600 medical staff, more than 130 service sites and a network of 326 primary care physicians. It has the only Level 1 Trauma Center, children's hospital and regional burn center in west Michigan and is the largest provider of cancer care in the region. The health system annually has 60,000 acute-care admissions, 10,000 births and 200,000 emergency visits.

Welcome Matt VanVraken, President, Spectrum Health Hospitals, David Alexandar, MD, President, DeVos Children's Hospital, Gordon Mudler, President, Hackley Health, Tom Kauffman, President, Reed City Campus, Lori Portfleet, President, Spectrum Health Continuing Care, Mike Freed, EVP/CFO, Patrick O'Hare, Corporate CIO, and the entire Spectrum Health team.

Upcoming Events

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July 9, "Enterprise Storage for Medical Imaging," a presentation and discussion by John Collins and Gary Quinn, Hewlett Packard, describes key imaging solutions, and how servers and SAN technology, coupled with leading imaging applications, bring quality, reliability and scalability to the medical imaging environment.

July 15, "Ambulatory CPOE: Benefits Measurement," Blackford Middleton, MD, MPH, MSc, is Chairman of the Center for Information Technology Leadership (CITL) Executive Committee, Director of Clinical Informatics Research & Development for Partners HealthCare, and an Assistant Professor of Medicine at Harvard Medical School. He quantifies the opportunity for safety improvement as defined by the CITL research data, and demonstrates how the CITL tool can improve quality, cut costs and improve the bottom line.

July 22, "Automating Syndromic Surveillance: Lessons Learned from SARS," Brian Keaton, MD, Attending Physician and EM Informatics Director, Summa Health System, and Board of Directors, American College of Emergency Physicians, and Ed Barthell, MD, EVP and CIO, Infinity Healthcare, present lessons learned in *more events on next page*

department. "We found that we did have an opportunity to improve physician-nurse collaboration," she says.

HealthEast's review found that to improve the collaboration required an interdisciplinary approach and that MDs and RNs had very different perceptions of how they treated each other. Doctors felt that their communication was much more respectful than the nurses did. However, physicians wanted more direct or to-the-point communication: "If you want me to come in and see the patient, say so."

RNs felt they should be trusted more by the MDs. Also, the review found that although face-to-face communication was the best, it occurred the least.

As a result, HealthEast developed an algorithm for physician-nurse collaboration that requires nurses to determine the patient's specific needs and to review them with the charge nurse before calling the doctor. The OB nurse must state clearly why he or she is calling and outline the information covering such items as weeks of gestation, labor status, fetal strip evaluation and risk factors. Finally, the nurse must obtain orders specific to the patient's delivery.

Take an algorithm and call me in the morning

HealthEast surveyed physicians before and after instituting the algorithm and an associated education program for nurses. The survey found that doctors felt nurses were giving them clear reasons for the call 50% of the time compared to only 30% before the new system. Asked if they were getting enough information to develop a plan of care and the positives jumped to 90% from 60%. And when asked if the nurse collaborated with them on the plan, the same improvement to 90% from 60% occurred.

Finally, the health system is looking at incorporating the algorithms from its OB

pilot into an overall coordination of care aimed at improved patient outcomes.

In another MD/RN collaboration initiative, HealthEast's medical staff executive committee began working on improving MD handwriting, improving the legibility of signatures and beeper numbers and exploring ways to eliminate disruptive physician behavior. Physician teams based at each of HealthEast's four hospitals are implementing the initiative so that it becomes a doctor-to-doctor conversation on this particular issue, to help them realize they have a great impact on the environment and involve listening to get at root causes.

HealthEast also sponsored a keynote at its winter medical staff conference on MD/RN collaboration in order to create a culture of retention and patient safety.

Fail to rescue

Karlene Kerfoot, senior VP for nursing and patient care at Clarian Health Partners in Indianapolis, cites studies 10 years ago that ICU mortality rates declined when physicians and nurses collaborated.

She notes that "failure to rescue" occurs when a patient's condition is worsening and the nurse waits to call the MD until the last minute and the patient outcome is worsened. "You put off talking to the people you don't feel comfortable talking to," says Kerfoot.

Clarian launched its Knowledge-Driven Care initiative two years ago after the first IOM report to emphasize evidence-based medicine and best practices. Nurse and doctors meet in teams to determine those best practices.

Three months ago, Clarian unveiled its PCOT (patient-centered outcomes teams) strategy in which nurses, physicians and other caregivers literally "huddle" everyday on the unit to determine the plan of care. As logical as that sounds, it hasn't been done traditionally in most hospitals, says Kerfoot.

From nursing to holistic care

A veteran nurse said she had learned more in the last six months from PCOT than she had in the previous 15 years, according to Kerfoot, adding that it offered the nurse a new opportunity to work with others like social workers and made it possible to do total patient care. “Before, she said she was just doing nursing, but now had a chance to do holistic care,” recalls Kerfoot.

“Physicians are enjoying their work much more, because they have someone to talk to,” she says. “It used to be the nurse would make rounds [which was an opportunity to collaborate with MDs], but downsizing in the last 10 years has eliminated that process.”

Kerfoot has also overseen development of an important new nursing role at Clarian over the past three months: the “Safe Passage Nurse.” The Safe Passage Nurse is a regular staff nurse specially trained in three areas:

- Human Factors (how fatigue and other factors affect human performance)
- Complexity Theory (more and more errors occur as systems become more complex)
- Authority Gradient (from aviation: feel free to speak up to the captain)

Safe Passage Nurses aim to proactively look for areas of potential medical errors. “They see the unit in a very different way than before and can eliminate opportunities for mistakes on the unit,” says Kerfoot. The Safe Passage Nurses come together once a month in a council to share information unit to unit.

Speak up or forever hold your tongue depressor

The Authority Gradient is the key factor in the Safe Passage model affecting how physicians and nurses relate. It

defines the classic case—first identified in the airlines—in which workers are afraid to raise issues with people they consider their superiors. By educating nurses on how the Authority Gradient works, Clarian hopes to eliminate it from the clinical setting and free nurses up to raise issues with physicians.

More national efforts are underway that could have a positive impact on the physicians/nurse relationship. The American Nurses Credentialing Center, part of the American Nursing Association, launched The Magnet Recognition Program in the mid-1990s to recognize healthcare organizations that provide the best nursing care and to disseminate best practices among nursing systems.

Magnet-designated Hospitals are those that meet standards of excellence as defined in the ANA’s scope of practice for nursing administrators (<http://nursing-world.org/ancc/magnet/About.htm>).



**Linda Urden,
Chairperson, Magnet
Recognition Program,
Indianapolis**

Magnet Recognition Program. “You can draw a lot from it,” in terms of good relationships in the healthcare setting, she says.

While there is not a specific standard that speaks to the nursing/physician relationship, the Magnet standards do speak to interdisciplinary collaboration, says

Linda Urden, chairperson of the

I’m unique. You’re unique.

“One of the key things we find is that is an overall culture of quality and search for excellence. You can’t have quality outcomes without input and active participation by all team members. It is key for

Upcoming Events continued

automating surveillance, the critical importance of integrating surveillance into patient care systems and processes, the community public health commitment that is required, and how their work is being used by CDC and others to help set direction for surveillance in our industry.

July 30, “Managing Clinical Practice Variation: A Case Study in Effecting Change,” Executives from Evergreen HealthCare, Kirkland, WA, along with Linda Lockwood, FCG, present a case study highlighting their community hospital’s work in reducing clinical practice variation. An overview of project drivers, methodology, metric setting, outcomes and lessons learned will be shared regarding work in Congestive Heart Failure. Focus will also include strategies for clinician engagement and use of technology as a driver for clinical change.

August 6, “Lower your TCO with IT Consolidation,” a review of leading practices and results presented by Hewlett Packard.

August 13, “The Role of Computerized Clinical Documentation in Creating a Healthy, Healing Work Culture and Integrated Care,” Bonnie Wesorick, RN, MSN, CEO and Founder, and Laurie Shiparski RN, MSN, Clinical Practice Model Resource Center, lead this session that will guide participants in evaluating their organizations for the

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Upcoming Events continued

presence of the elements needed to create and sustain healthy, healing work cultures, integrated care and successful computerized clinical documentation. A self-evaluation will help participants with efforts to implement computerized documentation.

August 19, "Kaiser Permanente on IT and Medical Technology Planning," David Watson, Chief Technology Officer, Kaiser Permanente, describes how KP approaches strategic technology planning.

August 20, "Evidence-Based Practice and Automation," Diane Hanson, RN, BSN, MM, Marti Rheault, RN, MSN, and Donna Mayo-Rosa, RN, MSN, Clinical Practice Model Resource Center, explain how an interdisciplinary documentation system should be based on a professional practice framework, meet diverse regulatory requirements, support a body of evidence, and be designed to create and sustain a healthy healing work culture and integrated care. They demonstrate how evidence-based clinical practice guidelines can be integrated throughout, and support patient-care by combining technology with documentation tools and resources.

August 22, "Cerner Implementation Discussion Group: PharmNet Medication Management," Larry Baucum and Dan Coate, FCG, will present *more events on next page*

medicine and nursing to include allied health professionals as well. Each member brings a uniqueness and respect and acknowledge each other. From that focus other collegial relationships fall in place," says Urden.

"It's the doctors who say I wouldn't be here if it weren't for the nurses. The nursing care is why I bring my patients here to this hospital," she says. Also, nurses who are looking to relocate ask where the Magnet facilities are as they consider various job opportunities.

"The lack of the 'C' words—collegiality, communication and collaboration—result in a high incidence of medical error and sentinel events," declares ChrysMarie Suby, principal and senior consultant with the Bloomington, Minn., office of the Labor Management Institute, which focuses on employee scheduling and staffing for hospitals.

She says two major studies have provided motivation behind the new emphasis on MD/RN relationships. First, a groundbreaking study in 1985 by Bill Knaus at George Washington University, found a 50% higher mortality rate on units with poor relationships among physicians and nurses. Second, the 1999 report on medical errors by the Institute of Medicine for the first time publicly hammered home the scope of the problem.

Who knows the patient?

Carol Ann Cavouras, principal and senior consultant with the Phoenix, Ariz., office of the Labor Management Institute, says some of the tension that occurs between physicians and nurses today is cultural, especially with foreign physicians. "But most of all, many physicians are under a lot of stress. They don't know their patients well and expect the nurse to know those patients." The situation is exacerbated because with the nursing shortage

many hospitals are relying on newly hired nursing graduates who lack experience and information about patients.

"It puts the physician in a vulnerable position," she says.

Cultural issues play a big role in states like California, which have a relatively high number of doctors from overseas. "American nurses can be assertive and that can lead to clashes with foreign doctors," whose cultural backgrounds tend to support the old-fashioned model of male or physician superiority, says Cavouras. Also, young nurses—in their 20s and 30s—won't tolerate being yelled at by physicians.

One ray of hope is that for the first time more than 50% of U.S. medical school classes are female.

The doctor as the ultimate workaround

But the bottom-line is that doctor behavior can affect overall staffing patterns. "I recall when I was a CNO there was a chief of staff who was incorrigible. Nurses would find out when he was working and schedule their time off," she says.

Other factors play a role, of course. Physicians are so busy these days that they require a hassle-free environment. "Doctors want things at their fingertips," Cavouras says. Technology can improve things, however. For example, nurses are more likely to carry cell phones now and that means they can communicate much more easily and efficiently, eschewing the traditional beeper.

But much of the solution is sociological. The Labor Management Institute encourages healthcare organizations to first conduct written or telephone surveys to determine such factors as how physicians and nurses express themselves on the units. Next, organizations should build formal frameworks such as committees involving

both nurses and physicians that do case reviews and scrutinize outcomes. “You have to get nurses and doctors communicating, even to the point of doing strategic planning together—whenever an opportunity for interfacing arises,” says Cavouras.

Suby cites examples such as Banner Health, which offers attorney-led training classes addressing the issue of harassment in the workplace, with an emphasis on fostering communication. Massachusetts General sends out letters to physicians warning them that disruptive behavior can result in the revocation of privileges. “This is not something handled at the lower level, but at the senior executive and medical leadership level,” she asserts.

Satisfaction guaranteed

Suby says more and more hospitals are incorporating communication and collaboration components into practice models because they see it as improving patient satisfaction. “When you look at the benefits: to the patient, perception of care is better and length-of-stay drops; for the physician, patient clinical outcomes are improved; for nurses, they learn how the physician wants to communicate, so their work environment improves; and for the organization, a positive impact on the nurse vacancy rate,” she says, such focus on physician-nurse relationships is clearly of strategic importance.

The Chicago-based American Organization of Nurse Executives (AONE) published this March a monograph called “Healthy Work Environments: Lessons from the Field,” which addresses what AONE calls one of the key “leverage points” in the nursing shortage.

The report describes the optimum healthcare work environment as one which turns the old hierarchical model on its head: “The organizational structure that supports communication and collaboration is the one

that creates a positive environment...The flattened organizational structure encourages communication and employee involvement in decision-making...Decisions made at the team level are consistently honored...The emphasis on teamwork capitalizes on people as social beings and allows for the creativity that occurs when people with various knowledge, experiences, perspectives and visions come together to do work.”

Collaborate or die

An even more recent brief published by the Washington, D.C.-based Advisory Board tackles the issue head-on. Entitled “Creating a Culture of Nurse-Physician Collaboration,” (Original Inquiry Brief, April 29, 2003) the article details the experiences of five healthcare organizations with low nurse-vacancy rates due partly to good physician-nurse relationships.

The Advisory Board brief identifies four tactics that contribute to positive physician-nurse relations:

1. *Actively solicit and implement physician feedback on satisfaction with nursing on a regular basis.* “Informal or formal surveys open the channels of communication and may diffuse issues which have a negative impact on physician-nurse relations.”
2. *Open the lines of communication.* Nurses’ presence on various hospital committees encourages communication between nurses and physicians.
3. *Establish channels to deal with abusive physician behavior.* “Hospitals with strong cultures of nurse-physician collaboration have specific channels in place to deal with abusive behavior on the part of physicians.”
4. *Focus on clinical competence, nurse leadership.* “Physicians will collaborate with individuals whom they respect professionally.”

Upcoming Events continued

their views and facilitate a discussion to provide insights about the Medication Integration process for current or future PharmNet users. We will also include time for participants to share their own experiences and lessons learned.

August 27, “Achieving Interdisciplinary Integration at the Point-of-Care: Defining Scope of Practice Before Automation,” Tracy Christopherson, RRT, Kathy Wyngarden, RN, MSN, and Michelle Troseth, RN, MSN, Clinical Practice Model Resource Center, summarize interdisciplinary scope of practice delineation work done over a two-year period. Presenters will cover nine clinical disciplines and explain how clarity on scope of practice forms the basis for evidence-based clinical practice guidelines, computerized clinical documentation, and interdisciplinary integration at the point-of-care.

August 28, “Pursuing Perfection: Health Partners update,” Alan Abramson, Senior VP of IT and CIO, and Kevin Palattao, Senior Director, Care Systems Improvement, Health Partners, MN, present an update on their journey to perfection as a RWJF grant winner for the Pursuing Perfection initiative.

September 3, “Skill-Building for Successful Computerized Clinical Documentation,” Laurie Shiparski, RN, MS, Laurie Levknecht, RN, BSN,

more events on next page

Upcoming Events continued

and Tracy Christopherson RRT, Clinical Practice Model Resource Center, demonstrate that successful automation requires the presence of certain skills in both those who lead and those who will use the computer to support advancement of practice and/or service. These skills include participating in meaningful conversation, managing the common dilemmas, and building strong partnerships.

September 10, "Mobile Devices and Clinical Efficiency," an update on devices and their successful use and impact in the clinical setting presented by Hewlett Packard.

September 11, "CPOE: A Report on Community Hospital Results," David Classen, MD, and Jane Metzger, VP, First Consulting Group, review their research on CPOE progress in community hospitals. The research report is available at both FCG and CHCF websites.

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Cultures are deeply rooted in hierarchy

While the workforce shortage may be a leading motivator to focus on physician-nurse relationships, at least one expert says the issue transcends the need to attract and retain nurses.

"The whole issue is exaggerated by the shortage, but it's really about a hierarchical model embedded in our culture," asserts Bonnie Wesorick, RN, MSN, founder and CEO of the CPM Resource Center in Grand Rapids, Mich., which helps healthcare organizations become the best place to receive care.

"I was professionally raised in a hierarchical environment involving bosses and subordinates, not partnerships," she says. "The typical healthcare infrastructures were deeply rooted in hierarchical relationships and the skills of partnership were not understood or nurtured. Providing quality care is not about who is the boss but who has the expertise to best serve the person needing healthcare. One of the major barriers to partnership between nurses and physicians is the lack of clarity on the scope of professional nursing. The lack of clarity existed not just with physicians but with nurses themselves and with healthcare leaders. A core element for partnerships is respect for each other's unique contribution. It is hard to honor and respect another's expertise when one is uncertain about what it is."

The CPM Resource Center has addressed this fundamental issue by not only clarifying nursing's unique scope of practice and providing evidence-based tools and resources to help nurses practice but by creating system infrastructures to bring nurses, physicians and the interdisciplinary colleagues together in partnership. According to Wesorick, the nature of the work to achieve partnership has a sense of spirituality because it is a choice to connect with another at a deeper level of humanness. That connection is not around the power or control of being boss but honoring and supporting the individual's choice to be a healer.

Conclusion

Whether approached from the perspectives of clinical quality, social engineering or spirituality, the physician-nurse relationship is changing. The newly emerging relationship is based on collaboration, mutual respect and teamwork. However, as with all cultural change, there remain multiple, deep-seated obstacles that will require concerted effort and follow-through to overcome. Still, with factors like the nursing shortage driving this change and new technologies to support communication and decision-making, it's not a question of "if" but "when." And with patient outcomes having in the balance, it's got to be sooner than later.

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