

# Nurse–doctor interactions during critical care ward rounds

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## Summary

- This paper describes the participation of critical care nurses in ward rounds, and explores the power relations associated with the ways in which nurses interact with doctors during this oral forum of communication.
- The study comprised a critical ethnographic study of six registered nurses working in a critical care unit.
- Data collection methods involved professional journaling, participant observation, and individual and focus group interviews with the six participating nurses.
- Findings demonstrated that doctors used nurses to supplement information and provide extra detail about patient assessment during ward rounds. Nurses experienced enormous barriers to participating in decision-making activities during ward round discussions.
- By challenging the different points of view that doctors and nurses might hold about the ward round process, the opportunity exists for enhanced participation by nurses.

*Keywords:* communication, critical ethnography, nurse–doctor relationships, nursing relationships, ward round.

## Introduction

### BACKGROUND

The ward round is acknowledged as a valuable time for health care professionals to come together in an effort to develop an integrated plan of care (Busby & Gilchrist, 1992). In this oral forum of communication the goals are to enhance

the quality of patient care, share information, address patient problems, plan and evaluate treatment, and increase learning opportunities for staff (Felten *et al.*, 1997). Effective collaboration between health care professionals during the ward round is therefore an important requirement for enhancing the quality of patient care and decision making.

### LITERATURE REVIEW

Despite the need for effective interdisciplinary collaboration, there has been limited emphasis on interactions

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between nurses and doctors during the ward round process. Relevant literature has focused on interactions between doctors and patients (Reynolds, 1978; Linfors & Neelon, 1980; Blanchard *et al.*, 1983; Fox, 1993) or between patients' relatives and doctors (Bains & Vassilas, 1999; Kassity, 1999). The importance of the ward round as a teaching strategy for doctors and nurses has also featured in the literature (Sedlak & Doheny, 1998; Segal & Mason, 1998).

Studies involving nurse–doctor interactions during the ward round have identified nurses' passivity and their lack of confidence about asserting themselves in discussions (Sanson-Fisher *et al.*, 1979; Weiss & Remen, 1983; Busby & Gilchrist, 1992; Mallik, 1992; Whale, 1993; Wright *et al.*, 1996; Felten *et al.*, 1997). As a means of dealing with the issue of nurses' passivity, Busby & Gilchrist (1992) recommended that all members of the multidisciplinary team should participate in egalitarian communication. To achieve this goal, they suggested that nurses should become more assertive and participate actively in discussions and decision making, while doctors should relinquish some control of the ward round.

While these studies present some insight into nurse–doctor interactions during the ward round (Sanson-Fisher *et al.*, 1979; Weiss & Remen, 1983; Busby & Gilchrist, 1992; Mallik, 1992; Whale, 1993; Wright *et al.*, 1996; Felten *et al.*, 1997), there are a number of problematic issues. The investigators have not examined the techniques used by doctors to sustain dominant medical practices during the ward round. They have failed also to consider nurses' resistance to these dominant practices and the strategies adopted by doctors in dealing with this resistance. Similarly, they have not addressed the complex power struggles that characterize nurse–doctor interactions in the ward round. Thus, without clarifying the context characterizing ward round interactions, nurses have no starting point from which to challenge the status quo by becoming more assertive. This paper explores the power relations associated with the ways in which critical care nurses interacted with doctors during the ward round. Space does not permit analysis of the gender and class relations, although these concerns are equally important.

## Methodology

### METHODOLOGICAL FRAMEWORK

Critical ethnography was the methodological framework chosen for the study, which involved an extensive analysis of a critical care environment. While a traditional ethno-

graphic framework relies on the researcher making sense of the culture under investigation, critical ethnography encourages participants to engage in the collection and creation of texts from various forms of documentation, and to collaborate in the meaning-making process of analysis (Street, 1992; Manias, 1998; Manias & Street, 2000). In this study, participating nurses used the research data to challenge each other's ideas and interpretations, and to uncover the taken-for-granted, habitual activities informing interactions between nurses and doctors during the ward round. This methodology was considered appropriate because it enabled us to intensively examine the complex network of nurse–doctor interactions associated with one critical care setting. As this methodology provided an opportunity to work with unstructured data from a variety of data collection methods, the nature of the ward round could be explored in depth and over a sustained period. As the participating nurses considered different sources of data, they began to understand, analyse and challenge their experiences. They were also able to uncover the hidden practices associated with ward round interactions that had previously remained unacknowledged.

### THE RESEARCH SITE AND PARTICIPANTS

The study was undertaken in a critical care unit of an acute care hospital in Australia. While 75% of beds were provided for general intensive care or high dependency patients, 25% of beds catered for patients who had undergone cardiothoracic surgery. Four male medical consultants were employed in the unit, with only one consultant present or 'on call' at any one time. These consultants had the role of supervising and co-ordinating their team of doctors, from residents to registrars, as well as assuming the overall medical management of patient care. The critical care nursing manager guided the overall nursing activities of the unit. The unit also comprised nurse coordinators, who were responsible for the day-to-day running of the clinical environment. Clinical nurse specialists were regarded as nurses with specialized skills in clinical practice, research, and education, and were also given a patient load. Staff nurses were allocated a patient load and also participated in education and research activities.

Preliminary informal meetings were conducted with nursing staff in the critical care unit to determine those nurses willing to participate and to provide them with details of the research. Information sheets and consent forms were distributed and nurses were invited to contact us if they were interested in participating. As part of the

hospital protocol, nurses were given a 'cooling off' period before making their final decision in order to allay any sense of coercion or obligation. Nurses who had worked for at least 1 year in the critical care environment, and who represented a variety of work experiences and backgrounds, were eligible for inclusion in the study. The cross-section of nurse co-ordinators, clinical nurse specialists and staff nurses was purposive in an effort to epitomize diverse views. These experienced nurses were no longer attempting to master specialized skills relevant to the clinical area but rather were beginning to think about their professional relationships in a critical way.

The research group comprised six registered nurses who worked in the critical care unit under investigation. These nurses requested to be known by the following names: Alexis, Ashling, Bridget, Brook, Josephine and Marguerite. Pseudonyms were also used for other health care professionals mentioned in the data. All but two participants worked full-time in the unit. All participants had completed critical care postgraduate qualifications. In their role as nurse coordinators, two participants were responsible for the nursing management of the unit. Two other participants worked as clinical nurse specialists, whilst a further two were employed as staff nurses. The study was approved by the hospital ethics committee, which was assured that confidentiality of all health care professionals involved in the study would be maintained.

#### DATA COLLECTION

Data collection methods included professional journalling and participant observation, along with individual and focus group interviews. For professional journalling, the first author of this paper documented her professional interactions involving nursing and medical staff over a 3-year period during employment as a clinical nurse specialist in the unit. Professional journalling is an effective research tool for developing open-mindedness, critical analysis, synthesis and evaluation of clinical practice. It includes comprehensive descriptions of experiences as they happen, together with their interpretations. While the writer is often the only person to read the journal, it may also be shared with other individuals to enable critical reflection and professional development (Street, 1990; Holly, 1992; Cameron & Mitchell, 1993; Richardson & Maltby, 1995; Manias, 2000). For this study, professional journalling provided an avenue for addressing the complexities of nurse-doctor interactions and identifying taken-for-granted assumptions in the workplace (Cameron & Mitchell, 1993). During participant observation, each participating nurse was observed

during the course of one shift on three separate occasions. This process allowed us to analyse the effects of mobility and space on interactions during the ward round (Street, 1992). Participants were also asked to clarify certain points about the content and description of field notes from observations.

Two in-depth interviews were conducted with each participant to further understand the ways in which participants were located in power relations that shaped how they communicated with doctors and other nurses. Interviews were tape-recorded and transcribed, and each participant was informally contacted for verbal feedback on her interview. Three focus group interviews were also conducted, which provided opportunities for participants to challenge the meaning of collected data.

#### DATA ANALYSIS

Data analysis comprised frequent readings of the ethnographic accounts in an effort to increase familiarity. The initial process involved a form of textual analysis, in which the activities and events were examined in relation to the ward round culture (Holloway & Wheeler, 1996). This process allowed us to develop broad issues for consideration before subjecting the data to more detailed analysis using the following questions:

- What positions or perspectives do nurses and doctors adopt when they are speaking during the ward round?
- How do they exercise power in their activities and conversation?
- What is the effect of nurses' and doctors' use of space during the ward round?
- When and how are nurses and doctors examined during the ward round?
- Which practices are apparent as nurses and doctors participate in the ward round?

#### Findings

##### STRUCTURAL SPACES OF THE WARD ROUND

The ward round format involved a two-stage process. Firstly, the medical resident gave case presentations of all critical care patients in a discussion room, which constituted the 'room' component of the ward round. In this room was an overhead projection screen, which displayed patient data from Data-View, the clinical computerized database system. The medical consultant documented patient decisions arising from discussions on the database system. Secondly, each patient was reviewed at the bedside by the multidisciplinary team, which constituted

the ‘bedside’ component of the ward round. This format of the ward round differed from a more traditional approach where the rounds are conducted completely at the bedside. Bedside discussions of patients’ progress and plans of care may be intimidating for conscious patients and family members. Furthermore, interruptions caused by telephone calls and bedside equipment could lead to communication problems amongst doctors and nurses. The two-stage process of the ward round was an attempt to overcome the disadvantages of a traditional bedside format.

An important issue arising from the different locations for this oral form of communication concerned the contradictory nature of the term ‘ward round’ and its purpose. In the following interview excerpt, Marguerite contested the term ‘ward round’ within the context of its structural location:

Marguerite: I think that the round is not really a round.

Researcher: With the way it is conducted?

Marguerite: It is a very loose term. It’s not a round... It’s a room, we don’t have a round. We have a room... It all just happens in front of a screen in the discussion room. We don’t go around the patients to make decisions.

Researcher: Well perhaps it should be known as a room round [both laugh].

Marguerite: Well, admittedly the doctors will then go and visit the patient after they have been in the room. Their argument is, yes, they do see the patients. They do their round after their get-together in the discussion room. However, their judgements and their decisions have already been made [in the room]. That’s often also been typed [by the consultant] into the patient’s notes as they finish discussing each patient.

For Marguerite, the ward round was far removed from its more concrete, traditional meaning, that is, decision making at the bedside. Instead, nurses observed the consultants ‘going around’ the patients with the aid of a technological screen and advanced clinical computerized database, situated in a private discussion room.

#### MARGINALIZATION OF NURSES’ CONTRIBUTION

As consultants presided over activities in the discussion room, they could regulate the physical visibility and therefore the nurses’ contribution during the room component of the round. The nurse coordinator called in nurses from the bedside to be involved in ward round discussions. In the following dialogue, Marguerite high-

lighted the tensions between the nurses’ needs to feel that consultants valued their presence in the discussion room and nurses’ needs to provide quality, ongoing patient care at the bedside:

Marguerite: I think the opportunity is there for them [nurses] to have a say, if they happen to be in the room [laughs]! My experience has been... at least 95% of the time, that by the time I get into the room they’ve [the doctors] already started. So I don’t hear what’s said before I got in there.

Researcher: How does that make you feel?

Marguerite: Well, you come in and you’re not quite sure what they’ve talked about, or what the resident’s said already. You’re on the back foot, aren’t you? ... I had an example ... just recently. I went into the discussion room, discussed my patient ... and as I was leaving, I said, ‘Well, who do you want to do next?’ and they told me. So I went back out to Alexis, the next nurse ... and said, ‘Okay, you’re next’, and she said, ‘Oh, I can’t at the moment. Could you ask them perhaps to do bed 2?’ I think she had to do something with the patient. So I went back to the discussion room, put my head in the door and said, ... ‘Alexis can’t come at the moment, are you able to do bed 2 instead?’ and the response was, ‘Oh well, no, don’t worry, we’ll carry on. We’ll catch up with her later.’ So they just carried on with the discussion about her patient. ... The format suits the medical staff, not necessarily for better patient care, and not necessarily for the better overall functioning of the unit... I don’t think it’s a deliberate thing to try and exclude the nursing staff. I wouldn’t say that at all. But you get the feeling that if the nurse is there, well, that’s fine, but if she isn’t, well, it doesn’t really matter.

Nurses often experienced a sense of marginalization during their encounters with doctors in the discussion room. Doctors considered the ward round primarily as a review and teaching space for junior doctors. While doctors granted nurses an opportunity to attend the room component of the ward round, if these nurses were subsequently unavailable, doctors continued to discuss patients’ progress and care. Nurses were not considered essential to this process. Unfortunately, as the doctors presided over their private space for the entire period while nurses darted in and out, there was little opportunity for nurses to exert any influence over the proceedings or to convince doctors to wait for a colleague. This situation had implications for patient care if nurses were not available to present patient and family issues from a nursing perspective.

## THE NURSE AS INFORMATION GIVER

Besides the doctors' practice of not waiting for bedside nurses during room discussions, the actual construction of these discussions further made nurses feel that their contribution was not valued. This is indicated in the following entry from the field notes:

The nurse coordinator called me into the discussion room for the ward round. The overnight registrar already began describing the events leading up to the patient's admission... The resident provided information about the patient's neurological observations, while I filled in the gaps with more detailed information. A discussion then ensued between the doctors on night shift and those on the day shift. I looked on, feeling almost powerless to speak. The consultant then typed up the patient's plan of care for the remainder of the day, based on the medical discussion.

When the consultant was satisfied that medical issues had been adequately attended to, he turned to me and said: 'What about general house-keeping matters?' I was extremely annoyed that he relegated nursing issues to the domestic domain, but I said nothing about my displeasure.

Following medical discussions in the room, consultants invited contributions from nurses regarding their concerns or questions about patients. This invitation constituted a process whereby nurses were provided with a space to speak and contribute to discussion. Doctors used nurses to supplement information and provide extra detail to a medical assessment already given by the resident. This process of communication involved the doctors passively accumulating extra details that nurses provided about patients. By designating nursing care to 'house-keeping matters' the consultant marginalized both the sophisticated technical knowledge of the nurse as well as the experience of being with the patient and relatives. Communication in this form did not facilitate nurses to collaboratively engage in the interpretation, analysis or clarification of knowledge that is pivotal to collegial debate or appropriate clinical decision making.

Following the resident's presentations of patients, nurses provided comprehensive patient data. This contribution set the scene for medical debate and discussions about patient care. On commencing these discussions, doctors relegated nurses to the 'background' as if they were invisible. Doctors no longer required the contribution of nurses in debates about the patient's plan of care. As demonstrated in the previous example, the nurse felt devalued as she was not invited to participate in medical

discussions about management options. The ultimate decision lay with the consultant, who documented the plan of care into the computer. This plan was a synthesis of his ideas and other doctors' suggestions. Nowhere was the nurses' contribution heard or seen in this plan of care. Once the consultant had documented the plan of care, nurses became visible again. The consultant asked nurses if they had any questions, granting them a chance to speak when the decision had already been taken.

In the initial phases of the study, participants believed that doctors provided nurses with many opportunities to speak. On critical reflection, when these opportunities were analysed, it was apparent that nurses were only speaking at particular instances and on specific topics. For example, the following account demonstrated how Bridget moved through this critical reflective process. Initially, she was satisfied that the doctors' invitation for questions at strategic points of the ward round constituted an adequate acceptance and contribution of nurses' input:

Bridget: I think in the discussion room, the doctors are actually particularly open to nurses. They actually make a point of asking [if the nurses have any questions]...

Researcher: Okay, that may be so, but often, in my experience I am just sitting there and waiting for a break in the conversation... and it is usually after they've finished discussing their piece... that they do actually refer to me and say, 'Well, have you got anything to say?'

Bridget: Why do you have to wait? Why does one have to wait for the invitation to say anything?

Researcher: Otherwise you'd be interrupting.

Bridget: Well then, interrupt them.

However, after analysing the situation, Bridget conceded in her second interview that interruptions were rare. She concluded that nurses could only participate in certain portions of the ward round discussion. Critical reflection provided the basis on which all participants could understand the extent to which nurses contributed in ward round interactions. This is exemplified by Bridget:

Bridget: Often, they [the nurses] don't say anything until they're asked. They're allowed to speak only at specific times and not at other times... It's like a last minute token thing that's tagged on the end. The whole attitude to nursing needs to be changed in the round... They call us the 'tag' team, these doctors, we're involved with 'tagging', so even they acknowledge it and we let it happen.

Bridget demonstrated the way that the research process had raised her critical awareness of power relations in the ward round. She employed a metaphor that doctors

themselves used in their conversations about nurses' contributions in the ward round discussion. Doctors spoke of nurses as a 'tag team', which in this context had two meanings. Firstly, nurses had taken turns in fetching or 'tagging' each other for the patient presentation in the private room. Secondly, the tag also referred to particular spaces in the ward round discussions, where nurses were granted the opportunity to speak. Here, the nurses' contribution to the patient's assessment was important to the forthcoming discussion of the patient's progress and plan of care. Following the discussion, an opportunity for nurses to ask questions provided the signal for doctors to progress to the next patient.

#### CREATING AN OPPORTUNITY TO SPEAK: CONTESTING 'ROOM SPACES'

Historically, the resident's presentation of patients on the ward round has been an important method of communication for doctors (Linfors & Neelon, 1980; Fox, 1993). Following concerns voiced by various health professions that they have not been adequately involved, nurses and other health care professionals have become incorporated into recent constructions of the ward round (Felten *et al.*, 1997). Nevertheless, the main role of the round as a communication and teaching process among doctors continues, thereby limiting input from others on behalf of the patient. Given this emphasis on doctors' communication needs, nurses have adopted the position of passive bystander during the ward round.

Within the room component of the ward round, the resident's patient presentation was the most difficult time for nurses, as they did not always agree with the resident's portrayal of the patient. Nurses were sometimes reluctant to disagree whilst at other times they openly asserted their views. The following interview excerpt illustrated the tensions arising from one resident's presentation that was openly contested by a nurse:

Brook: I was talking to a nurse about this very thing [finding a time to speak during the resident's presentation]. She was saying that on the ward round, when the resident was discussing her patient, the resident said to the consultant, 'Mrs Bloggs [sic] slept well last night', and the nurse was going, 'No, she didn't.' and then the resident disputed it by saying, 'Yes, she did.'... and the consultant said, 'Okay! Which one is it? Did she sleep or didn't she sleep?' and the nurse was saying, 'Well, you know, I've been beside the bed for 10 h and I should know. Well, it's just basically my word against his, isn't it?'... The consultant did not want to side with

anyone. If there was a column for sleep on Data-Vue that documents sleep on an hourly basis, it may be believed then.

Neither nurse nor resident was able to provide empirical evidence to support their version of events and agree about what happened, so the consultant showed no allegiance or preference to any particular stance. Brook contended that the only way in which the consultant would accept the nurse's version of events was if she documented the information on the computerized database system.

Nurses experienced enormous difficulties in raising relevant patient issues during the ward round. The ward round presentation was the place where residents demonstrated to consultants their skills of assessment and interpretation of patient observations, so their professional reputation was on display. Consultants then judged the standard of the residents' performance. Nursing knowledge was an adjunct to this process. It was acknowledged that nurses had a forum for discussing patient care in the nursing handover. However, this handover had no impact on medical decision making in the unit. Therefore their input to the medical ward round was considered by nurses to be essential for appropriate patient care planning.

#### CREATING AN OPPORTUNITY TO SPEAK: CONTESTING 'BEDSIDE SPACES'

When the doctors moved from the room to the bedside area, nurses persisted in feeling undervalued. Ashling detailed this view graphically in the following interview excerpt.

Ashling: The environmental impact of the ward round is such that when everyone is gathered around the bedside, the nursing staff are pushed to the back of the bed area [by doctors] and away from the patient, which represents hierarchical power to me. And they [nurses] always have to try and physically push their way to the front. It is also an issue of patient protection because often ... medical staff aren't particularly good at protecting the patient's privacy... and I think the doctor is quite rude at times at the bedside, and this is disrespectful for the nurse, and to the nursing profession.

In the discussion room, the consultant provided nurses with the opportunity to speak at a designated time and space. Behind closed doors, doctors regulated the entry and departure of nurses. Within this private environment, doctors called upon nurses when they were ready. However, within the public domain, nurses could not exercise a similar policing function with doctors' access to the bedside area.

As the following field notes attested, although one nurse tried to create some privacy for the patient and herself, she was unsuccessful. Her space and time with the patient had suddenly become the doctors' space and time:

I was in the middle of trying to clean my patient up and redo his dressings when the ward round came in. Despite the 'Knock before entering' sign, drawn curtains and closed door, the doctors and nurse coordinator gave no warning they were about to enter. With a mask wrapped round my face and sweat pouring down my forehead, I felt extremely vulnerable and conspicuous. The consultant asked me why a particular set of blood test results was not available. I replied that I did not know they had to be done. He retorted, 'I know the unit's very busy, but they really need to be done.' Mentally, I checked off all the tasks that I needed to complete compared to the minute number I already accomplished. The registrar and consultant fired questions at the two residents, as I stood there...

Not only were nurses silenced at the bedside while doctors congregated around the area usually reserved for nurses, but nurses also felt insecure when doctors encroached on their space at inopportune moments. Overcome by feelings of vulnerability, the nurse was unable to continue the patient's dressings while the doctors discussed his progress and future plans. The transition from invisibility to visibility occurred momentarily when the consultant asked if a particular task had been performed. Thereafter, the nurse reverted into obscurity as the registrar and consultant queried the residents about various aspects of the patient's care. Interestingly, the nurse coordinator was also invisible in this process as the doctors did not direct any of their discussion to her.

## Discussion

For the ward round process, doctors and nurses communicated in different spatial locations of the critical care unit. Initial communication within the private space of a discussion room was followed by patient observation in the public space of the bedside. The study demonstrated the authoritative position of the medical consultant in directing communication and decision making on the ward round, which also supports the findings of previous studies (Weiss & Remen, 1983; Busby & Gilchrist, 1992; Whale, 1993). Behind the closed doors of the discussion room, consultants regulated the entry and departure of particular bedside nurses for the ward round, depending on which patient was to be the focus of discussion.

Consultants also regulated the time when other health care professionals could speak.

Generally, doctors acknowledged nurses' current and comprehensive knowledge about patient assessment. Through consultants' regulation of nurses' activities, doctors were able to acquire comprehensive knowledge about the current status of patients to enable effective decision making. As a result, the ward round provided an effective, formalized process of education and training for doctors. Residents gave the patient presentations, which were supplemented with relevant and current information from bedside nurses, while consultants directed medical discussions for planning patient care. While nurses benefited also from the educational role of the ward round, the consultants directed the extent and type of knowledge discussed in an effort to address the needs of junior doctors. Furthermore, consultants were able to adjust the nurses' capacity to contribute to decision making by a process of differential visibility. Differential visibility refers to when 'nurses become visible or invisible to others depending on the person, the place, the time and the forms of symbolic representation' (Street, 1995: p. 51). Following the medical resident's patient presentation, the consultant encouraged bedside nurses to provide supplementary patient information. At this point, nurses were useful and thus visible. Consultants facilitated this encouragement by direct questioning of nurses, prolonged eye contact and active listening to nurses' comments. Conversely, during medical discussions of patient care, nurses appeared invisible. At this time, the consultants' use of verbal and non-verbal cues with nurses, such as direct questioning or establishing eye contact, was virtually absent (Whale, 1993). By manipulating dialogue in this manner, medically directed decisions could be made. During these medically orientated discussions, nurses struggled to find a time and space to speak.

When nurses were able to speak during the ward round, they provided patient assessment information and asked questions on the patient's or family's behalf. Essentially, the nurses' contribution and communication during the ward round was reactive, which contrasted with the proactive stance of consultants. In a reactive contribution, nurses responded to a patient issue that was introduced by another health care professional. Very rarely did nurses introduce a new problem into the discussion. Indeed, as demonstrated in Busby and Gilchrist's study (1992), many of the nurses seemed to consider the ward round as the province of the medical staff. Nursing rounds were undertaken during the shift handover, which provided nurses with the opportunity to discuss patient care with each other. However, nurses' difficulties in contributing

proactively during medical ward round discussions may have had serious implications for patient care, especially as these decisions were made behind closed doors.

Also important for this study was the effect of mobility and space on the ward round process. Apart from Fox (1997), Spain (1992), and Street (1992, 1995), research literature has placed little emphasis on the effects of space and mobility on the communication processes. Yet, as demonstrated through the research methods of participant observation and professional journaling, space and mobility influenced ward round communication in different ways. Nurses tended to conduct their work within the public spaces of the bedside, where their communication was interspersed with constant interruptions (Street, 1995). By contrast, medical consultants typically made their patient care decisions in private spaces, such as the discussion room. Such private spaces were free from the interruptions and ‘messiness’ of the bedside. Decisions made away from the bedside meant that there was greater acknowledgement of objective assessment as these were more clearly observable on the computerized database system. More subjective concerns had to be relayed by nurses who were present at the bedside. In providing opportunities for nurses to speak at strategic times during the ward round, consultants demonstrated an awareness of subjective knowledge that only nurses held, which supports the findings of Mallik (1992). If, however, nurses were unable to attend the room presentation of the ward round, these more subjective concerns were often not discussed.

The effects of mobility and space also demonstrated the intense pressure and workloads of bedside nurses, and the conflicts that arose for nurses who wished to participate in the room component of the ward round. This observation was also found in Segal & Mason’s (1998) study of ward rounds. In the current study, nurses were reluctant to leave their patients to participate in the room component of the ward round, as this participation interrupted and conflicted with their demands at the bedside. Similarly, conflicts were created when the ward round moved to the bedside area, as interruptions to patient care activities affected the extent to which nurses could communicate in the process.

#### LIMITATIONS

The findings of this paper present an ethnographic study of one critical care unit and therefore cannot be generalized to other units. Nevertheless, nursing staff in other hospital settings can use the findings to challenge their own and their colleagues’ activities during the ward round. Another limitation is that the findings proceed from a

collaborative analysis that represents the critical reflections of the nurses and researchers but does not include medical perspectives. It is important therefore to emphasize that nurses cannot address concerns about the ward round themselves; doctors must also be involved in the process. Hence, it would have been of interest to determine the interpretations and perspectives of doctors who were located at different levels of the medical hierarchy, such as consultants, registrars and residents. By understanding and challenging the different points of view that doctors and nurses might hold about the ward round process, the opportunity exists for enhanced interactions and collaboration.

Further research could explore nurses’ and doctors’ activities during the ward round in different types of units, such as medical and surgical wards and other speciality units. Different units could be compared to explore how nurses and doctors relate to each other during ward round interactions. Similarly, different groups of nurses and doctors in the hospital hierarchy could also be further examined to understand better how they interact during the ward round process.

#### Conclusion

This study has highlighted the contextual influences of a critical care environment, ward organization, and the particular interests and values of nurses and doctors in the ward round from a nursing perspective. Nurses and doctors invested a great deal of time and resources in the ward round process; yet nurses were disgruntled by the ways in which it was structured.

Changes are needed to make the ward round format a more effective and collaborative process of communication for participating nurses and doctors. For this particular critical care environment, it may be argued that the situation would not be improved by increasing the nurses’ level of assertiveness, as has been argued previously (Whale, 1993). The ward round served the interests of medicine because it provided a formalized process of education and training for junior doctors. Junior residents gave patient presentations, which were supplemented with relevant and current information from bedside nurses, while consultants directed medical discussions and debates for planning patient care. While nurses have opportunities to contribute in ward round interactions, inequities are often present. Hence, there is room for improvement in nurse–doctor interactions if patients’ interests are to be served.

Collaborative input from nurses involves changing the current structure so that the nurses’ input becomes more visible. One possible means of achieving this visibility is

by following the resident's presentation in the room by a nurse's presentation at the bedside. All this information could then be considered by all members of the ward round team in order to arrive at collaborative decisions about patient care.

Challenges to the traditional structures of the ward round will enable nurses and doctors to become more aware of their contributions, and to promote the ward round as a site for collaborative and supportive communication. The process of critical reflection can be used as an effective means of improving collaboration. Using this process, the ward round is then more likely to become a creative space in which both nurses and doctors can develop strategic plans for patient care, and can openly share their clinical activities with each other and with other health care professionals.

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