




Nurse-Physician Communication During Interdisciplinary Team Rounding: An Observational Study in Internal Medicine

Dhwani Krishnan ¹, Anna Dermenchyan ², Wendy Simon², Caitlin Chen¹, Sitaram Vangala³, Erin P Dowling ²

¹The Healthcare Improvement & Innovation in Quality (THINQ) Collaborative, Department of Medicine, UCLA Health, University of California, Los Angeles, CA, USA; ²Department of Medicine Quality, UCLA Health, Los Angeles, CA, USA; ³Department of Medicine Statistics Core, UCLA Health, Los Angeles, CA, USA

Correspondence: Erin P Dowling, Ronald Reagan UCLA Medical Center, 757 Westwood Plaza, Los Angeles, CA, 90095, USA, Tel +1 310-267-9643, Email edowling@mednet.ucla.edu

Purpose: Interdisciplinary team rounding improves communication in hospital settings by bringing together multiple disciplines to collaborate on a patient's plan of care. While prior research has demonstrated the benefits, the relationship between time spent at the bedside and the delivery of key clinical content remains less understood. This study examined whether physician bedside rounding time and nurse-physician interaction time influenced discussions of care plan elements and engagement of care team members.

Methods: We conducted an observational descriptive study at a quaternary academic medical center. Using a standardized observation tool, trained student observers recorded data from a sample of 1007 patient encounters during morning internal medicine rounds. Logistic regression was used to assess associations between bedside rounding time, nurse-physician interaction time, and discussions of the plan of the day, overall hospitalization goals, and anticipated discharge, as well as nurse and patient/family involvement.

Results: Of the 1007 encounters, 64.7% (n=652) included a nurse-physician interaction, with a mean interaction time of 6.1 minutes (SD=4.8). Longer bedside rounding time increased the likelihood of discussions about hospitalization goals (OR=1.60, 95% CI: 1.09–2.54) and anticipated discharge (OR=1.25, 95% CI: 1.02–1.54). Longer nurse-physician interaction time significantly increased the likelihood of nurse involvement across all three discussion topics and was also associated with greater patient/family engagement.

Conclusion: Longer bedside rounding and structured nurse-physician interaction both enhanced communication during rounds. Nurse-physician interaction time was the stronger predictor of inclusive discussions, underscoring the importance of structured approaches to engage nurses in interdisciplinary rounding.

Keywords: interdisciplinary communication, patient care team, physician-nurse relations, teaching rounds

Introduction

Effective communication in healthcare reduces adverse events, lowers hospital readmission rates, and improves patient satisfaction.^{1–3} Interdisciplinary team rounding (IDR), also referred to as multidisciplinary rounding or interprofessional rounding, enhances communication in hospital settings by facilitating collaboration among multiple members of the care team, including physicians, nurses, pharmacists, and social workers, in the discussion of patient care plans.^{1,2,4} The goal of IDR is to bring together different disciplines to share information and collaboratively develop a plan of care for the patient.⁵

Previous research indicates that having multiple disciplines involved in bedside rounding improves coordination of care and patient-centered decision-making.⁶ Specifically, nurse presence during bedside rounds improves patient satisfaction and care coordination.⁷ Several components of IDR, including logistical factors such as structured rounding frameworks, patient census, and the likelihood of nurse-physician (RN-MD) rounding,^{8,9} have been studied to understand the factors contributing to optimal outcomes. Additionally, the literature shows that specific content of IDR, including discussions on the plan for the day, overall plan for care, and anticipated discharge date, reduces the occurrence of adverse events.¹⁰

However, to the authors' knowledge, no studies have examined how logistical factors relate to the content driving patient safety. Specifically, no research has evaluated how the length of interaction and time spent at the bedside influence the presence or absence of key discussion topics during IDR. Although prior observational studies have shown that nurse presence increases the proportion of bedside rounding time, critical components such as the daily care plan, anticipated discharge date, and overall hospitalization goals are inconsistently addressed.^{8,11,12} There remains a knowledge gap on how these variables are related – whether components of the care plan are addressed equally or how often nurses are invited to take part in these discussions – underscoring the importance of quantifying how logistical factors shape the consistency and quality of patient care discussions.^{11,13}

Our institution, a quaternary academic referral center, conducts daily morning bedside rounds and afternoon IDR. The portion of morning teaching rounds involving the physician team, bedside nurse, and patient is designated as RN-MD rounding. Institutional leadership places a high value on these encounters, and multiple quality improvement initiatives have been implemented to increase rounding between physicians and nurses at the bedside.

In this study, we conducted a direct observational analysis to evaluate whether bedside rounding time (BRT)—the total time physicians spend at the patient's bedside—and RN-MD interaction time (RIT)—the duration of direct communication between the nurse and physician team—are associated with key communication activities during IDR. Specifically, we examined their relationship to the discussion of care plan elements, the involvement of patients, families, and nurses in these discussions, and whether physician teams solicited patient or family concerns.

Methods

Study Design and Setting

This was a descriptive observational study of consecutive patient encounters observed during morning internal medicine rounds at a quaternary academic hospital from October 2019 to March 2020. The unit of analysis was the patient encounter. Physicians and nurses were observed as part of their routine clinical activities and were not enrolled as study participants.

Bedside Observation and Data Collection

Observational data were collected on nurse-physician interactions for 1007 patient encounters during morning medicine rounds within five units. One “patient encounter” was defined as a single interaction between the physician team and the patient at bedside during rounds; thus, one patient requiring a multi-day stay may contribute to multiple encounters. Morning rounds included a team led by an attending hospitalist, along with a senior internal medicine resident, two intern-level internal medicine residents, and third- or fourth-year medical students. Rounds consisted of case discussions in a conference room, followed by bedside discussions, referred to as “walk rounds”.

Data collection was conducted by undergraduate and postgraduate student volunteers trained in quality improvement methodology and research. Observations involved physician teams and bedside nurses, both of whom were observed by student volunteers during the data collection period. To ensure consistency in observations, all 25 volunteers completed training sessions on rounding processes and the use of the data collection tool before beginning observations. Each student was assigned to a physician team via a sign-up form, with every effort made to ensure that each rounding team had a student assigned. Physician team members were unaware of the specific data being collected.

A standardized observation tool was developed by the study team, informed by published literature and tailored to institutional practice needs. The tool captured bedside rounding time (BRT), nurse-physician interaction time (RIT), discussion of care plan elements, and involvement of team members. Definitions of study variables are summarized in [Table 1](#).

Data were collected across the spectrum of patient acuity because patients are randomly assigned to teams rather than based on illness severity or anticipated length of stay. Confounders, such as time of day of data collection and rounding team composition, were standardized across teams (with variations only due to trainee schedules). The protocol and detailed data collection process have been described previously.^{14,15} Data were securely stored on an online survey platform.

While most RN-MD interactions occurred at the bedside, there were exceptions. For example, interactions could begin after the physician team had already arrived at the bedside or end before the team left. Conversely, interactions could also

Table 1 Definitions of Key Variables for Data Collection Tool

Term	Definition & Use
Bedside Rounding Time (BRT)	The total time the physician team spent at the patient's bedside.
RN-MD Interaction Time (RIT)	The duration of direct communication between the nurse and physician team.
Discussion During Rounds	Types and frequency of discussions that took place, and who is involved in those discussions. Data was collected on the occurrence of specific conversations: 1. Clinical Plan of Day 2. Clinical Plan for Hospital Stay 3. Anticipated Discharge Date And who were involved in the discussions (asked or responded to questions about, or otherwise provided input on, the specific topic at-hand): 1. Nurse 2. Patient/Family
Occurrence of an RN-MD Conversation	Whether or not a conversation occurred between the physician team and nurse, as opposed to the physician team merely acknowledging the nurse's concerns.

Note: Definitions of study variables used to characterize nurse-physician interactions during interdisciplinary rounding.

Abbreviations: BRT, bedside rounding time; RIT, nurse-physician interaction time; RN, registered nurse; MD, physician.

start before the team entered the patient's room or continue outside the room post-visit for information consolidation or treatment debriefing. Due to these variations, BRT and RIT were treated as separate variables in this study.

Ethical Considerations

The UCLA Office of the Human Research Protection Program (OHRPP) reviewed this project and determined that it did not constitute human subjects research under 45 CFR 46.102(l). A formal "Review Not Required" determination was issued and retained for institutional records. Because no identifiable patient or provider information was collected and all data were de-identified prior to analysis, informed consent was not required. Physicians and nursing staff were observed in the course of routine care.

Statistical Analysis

BRT and RIT were summarized using means and standard deviations, and their association was assessed using a Pearson correlation coefficient. Separate logistic regression models were constructed to evaluate the effects of BRT and RIT on whether discussions occurred regarding (1) the clinical plan of the day, (2) the overall plan for hospitalization, and (3) the anticipated discharge date. Additional models evaluated whether (a) the nurse, (b) the patient/family, or (c) both were involved in each type of discussion, as well as whether the team solicited patient or family concerns.

Regression results are reported as odds ratios (ORs) with 95% confidence intervals (CIs), corresponding to 5-minute increases in BRT or RIT. Analyses were restricted to patient encounters where an in-person RN-MD interaction overlapped with the physician team's bedside time, ensuring that all three care team members—physicians, nurse, and patient/family—were present during the interaction. All data preparation and analyses were performed using R version 4.3.1 (R Project for Statistical Computing; R Foundation) within RStudio version 2023.03.0+386. Statistical significance was defined as $p < 0.05$.

Results

In total, 1007 bedside encounters were observed for patients treated by six medicine teams over the study period. The mean number of patients per physician team per day was 10.67 (SD=3.72), while the mean number of patients seen at bedside per physician team per day was 6.27 (SD=3.31), with an average bedside rounding time (BRT) of 7.46 minutes per patient (SD=5.29). Of the observed encounters, 64.7% (n=652) included an RN-MD interaction, and 64.0% (n=417)

met the criteria for inclusion (Figure 1). The mean interaction time between the nurse and physician at the bedside (RIT) was 6.09 minutes per patient (SD=4.81).

Regarding discussion content, 95.2% of interactions included a discussion of the clinical plan for the day, 89.7% addressed the clinical plan for the whole hospital stay, and 59.2% mentioned the anticipated discharge date. Additionally, 91.8% of encounters included a solicitation of patient or family concerns (Table 2).

BRT was not associated with higher odds of discussion about the clinical plan of day (Table 3), nor was it associated with higher odds of nurse involvement in any of the three clinical topics (Table 4). However, longer BRT was associated with higher odds of discussing the clinical plan for the hospital stay (OR=1.60, 95% CI: 1.09–2.54) and the anticipated discharge date (OR=1.25, 95% CI: 1.02–1.54) (Table 3 and Figure 2).

Conversely, there was no association between RIT and the occurrence of any of the clinical discussion topics. However, for all three topics, longer RIT was associated with higher odds of nurse involvement, as well as increased odds that both the nurse and patient/family participated (Table 4 and Figure 2). Neither BRT (Table 3) nor RIT (Table 4) were associated with patient/family involvement alone. Both BRT (OR = 1.95, 95% CI: 1.20–3.47) and RIT (OR = 1.72, 95% CI: 1.09–2.94) were associated with higher odds that the physician team asked the patient or family for their concerns (Tables 3 and 4, Figure 2).

Although BRT and RIT are related, they are not necessarily subsets of one another. While longer BRT tends to predict longer RIT and vice versa, there is considerable variation in their relationship. In nearly one-quarter of cases, RIT exceeded BRT, indicating that RN-MD interactions sometimes occurred outside of the time the physician team was at the bedside. This may indicate that when BRT is longer, it does not necessarily translate into increased interaction with the nurse but may instead involve other team discussions or patient interactions. Given these nuances, the correlation between BRT and RIT ($r=0.35$) suggests a moderate relationship but leaves room for variation in how time is allocated during rounds. These differences indicate that BRT and RIT may influence discussion topics and participant involvement in distinct ways.

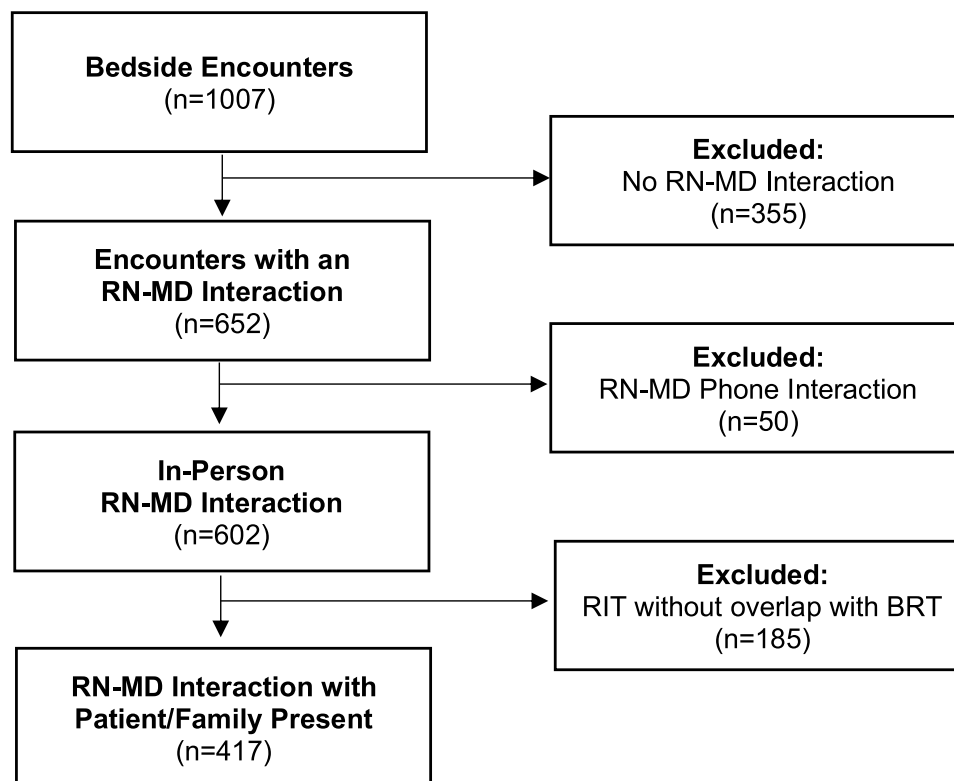


Figure 1 Observational Data Summary of Patient Encounters.

Notes: Diagram illustrating the number of patient encounters observed during morning internal medicine rounds, the number meeting inclusion criteria, and the subset with overlapping bedside rounding time (BRT) and nurse-physician interaction time (RIT).

Abbreviations: BRT, bedside rounding time; RIT, nurse-physician interaction time.

Table 2 Summary Statistics for Observed Encounters

Variable	Summary
Interactions Included in the Study	417
Mean Bedside Rounding Time (BRT) per patient, in minutes	7.46 (SD=5.29)
Mean RN-MD Interaction Time (RIT) per patient, in minutes	6.09 (SD=4.81)
Interactions Including a discussion on the clinical plan of day	95.2% (n=397)
Interactions Including a discussion on the clinical plan of the hospital stay	89.7% (n=374)
Interactions Including a discussion on the anticipated discharge date	59.2% (n=247)
Encounters where the physician team asked for patient/family concerns	91.8% (n=383)

Notes: Summary of nurse-physician interaction characteristics and discussion content from observed encounters. Percentages are based on the 417 encounters that met the inclusion criteria.

Abbreviations: BRT, bedside rounding time; RIT, nurse-physician interaction time; RN, registered nurse; MD, physician.

Table 3 Logistic Regression Results for Bedside Rounding Time (BRT)

	Odds Ratio	95% Confidence Interval	p-value
Clinical Plan of Day Discussion			
Occurred	1.32	0.83–2.44	0.31
Involved Patient/Family	0.86	0.67–1.12	0.22
Involved Nurse	0.90	0.74–1.11	0.32
Involved Both	0.85	0.70–1.02	0.09
Clinical Plan of Hospital Stay Discussion			
Occurred	1.60	1.09–2.54	0.03
Involved Patient/Family	0.91	0.70–1.22	0.48
Involved Nurse	0.92	0.76–1.13	0.43
Involved Both	0.89	0.74–1.08	0.24
Anticipated Discharge Date Discussion			
Occurred	1.25	1.02–1.54	0.03
Involved Patient/Family	0.85	0.64–1.20	0.31
Involved Nurse	0.94	0.75–1.18	0.57
Involved Both	0.88	0.69–1.09	0.25
Attending/Team Specifically Ask About Patient/Family Concerns	1.95	1.20–3.47	0.01

Notes: Odds ratios (OR) and 95% confidence intervals (CI) represent the effect of a 5-minute increase in bedside rounding time. p-values are provided for each outcome; $p < 0.05$ considered statistically significant.

Abbreviations: OR, odds ratio; CI, confidence interval; BRT, bedside rounding time.

Table 4 Logistic Regression Results for Nurse-Physician (RN-MD) Interaction Time (RIT)

	Odds Ratio	95% Confidence Interval	p-value
Clinical Plan of Day Discussion			
Occurred	0.89	0.59–1.43	0.59
Involved Patient/Family	0.83	0.62–1.14	0.23
Involved Nurse	1.94	1.42–2.73	<0.001
Involved Both	1.42	1.12–1.83	<0.001
Clinical Plan of Hospital Stay Discussion			
Occurred	1.11	0.80–1.61	0.55
Involved Patient/Family	0.87	0.63–1.23	0.40
Involved Nurse	1.75	1.32–2.38	<0.001
Involved Both	1.44	1.14–1.86	<0.001

(Continued)

Table 4 (Continued).

	Odds Ratio	95% Confidence Interval	p-value
Anticipated Discharge Date Discussion			
Occurred	0.99	0.81–1.22	0.94
Involved Patient/Family	0.73	0.51–1.06	0.08
Involved Nurse	1.79	1.30–2.55	<0.001
Involved Both	1.37	1.05–1.82	0.02
Attending/Team Specifically Ask About Patient/Family Concerns	1.72	1.09–2.94	0.03

Notes: Odds ratios (OR) and 95% confidence intervals (CI) represent the effect of a 5-minute increase in nurse-physician interaction time. p-values are provided for each outcome; p < 0.05 considered statistically significant.

Abbreviations: OR, odds ratio; CI, confidence interval; RIT, nurse-physician interaction time.

Discussion

Our study aimed to evaluate how logistical factors, specifically BRT, RIT, and nurse participation, shape the quality of patient care discussions during IDR. Our findings suggest that when physicians spend more time at the bedside, more comprehensive discussions of key care plan components, including discharge planning and overall hospitalization goals, are more likely to occur. While this observational study does not establish causality, the association underscores the importance of bedside time in ensuring comprehensive IDR. Given the time constraints physicians face, designing workflows that allow for longer bedside interactions could enhance communication and care planning.

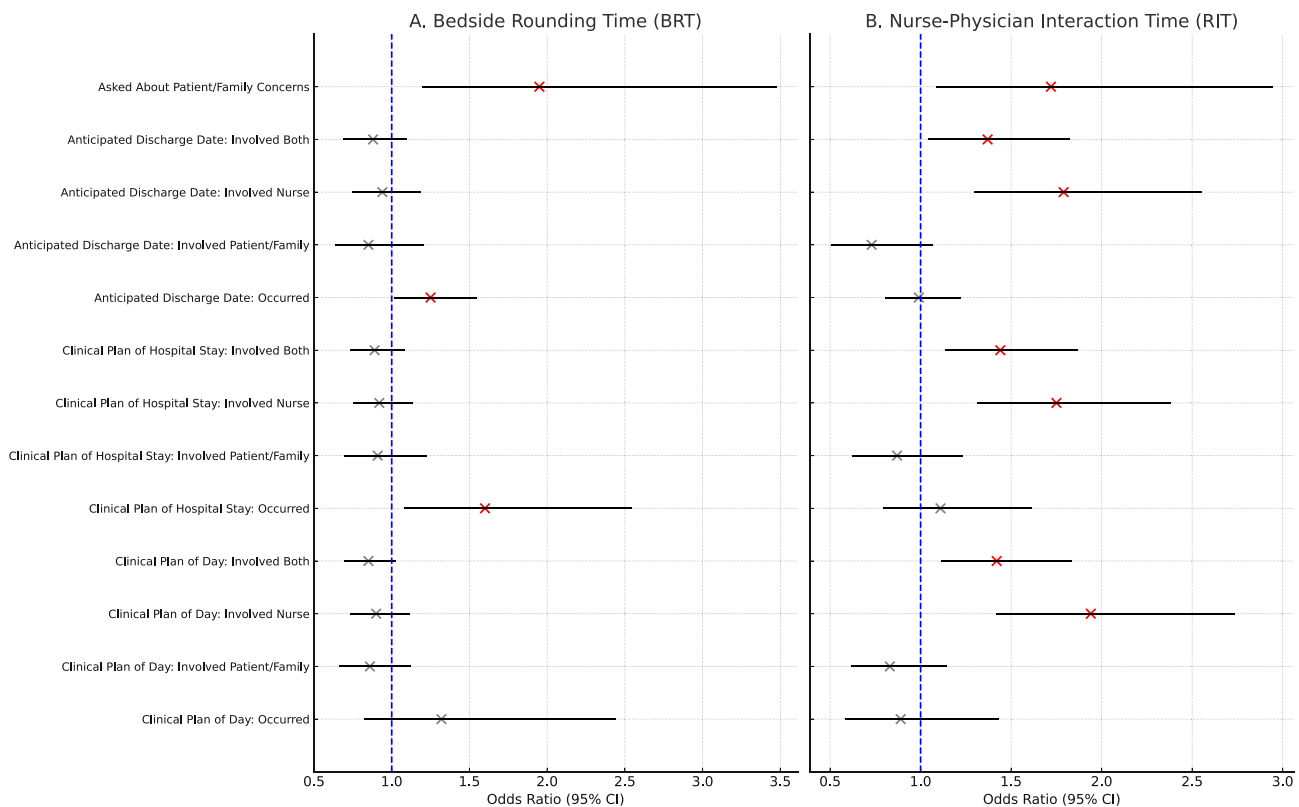


Figure 2 Logistic regression results for bedside rounding time (BRT) and nurse-physician interaction time (RIT).

Notes: Forest plots display adjusted odds ratios (ORs) and 95% confidence intervals (CIs) for key communication outcomes. Outcomes include discussion of the clinical plan of the day, plan for hospital stay, and anticipated discharge date; involvement of the nurse, patient/family, or both in these discussions; and whether the attending/team specifically asked about patient or family concerns. ORs represent the effect of a 5-minute increase in BRT (left panel) or RIT (right panel). Statistically significant associations (p < 0.05) are shown in red.

Abbreviations: OR, odds ratio; CI, confidence interval; BRT, bedside rounding time; RIT, nurse-physician interaction time.

Moreover, we observed that when nurses participated in bedside discussions, patients and their families were more likely to be actively involved in key conversations, including the plan of day, hospital stay, and discharge. This finding highlights the critical role of bedside nurses in interdisciplinary care and patient advocacy. Since longer BRT increases the likelihood of these discussions, and RIT is associated with greater patient/family involvement, alongside nurse involvement, our results suggest that both extended bedside time and structured nurse-physician interactions encourage physicians to solicit patient and family concerns more frequently.

Despite these insights, our study also revealed that in approximately one-third of observed bedside rounding events, no MD-RN interaction occurred. This finding highlights a critical gap in interdisciplinary communication and presents an opportunity for improvement. The absence of nurse participation in these encounters may limit the exchange of essential clinical information, reduce opportunities for care coordination, and potentially impact patient safety. Given the well-established benefits of interdisciplinary collaboration—including improved patient outcomes, reduced medical errors, and enhanced patient satisfaction—efforts to standardize and reinforce RN-MD communication during bedside rounding should be prioritized. Strategies such as structured rounding protocols, dedicated time for nurse-physician discussions, and enhanced team training in collaborative communication could help address this gap and foster a more integrated approach to patient care.

Implications

Given the ongoing challenges in nurse-physician communication, our study provides critical insights into the dynamics of RN-MD interactions during interdisciplinary rounding. Effective communication occurs when nurses are actively engaged and given space to voice their concerns. However, this opportunity is often limited, and nurse concerns may go unaddressed. Prior research has demonstrated discrepancies in how nurses and physicians perceive communication quality,¹⁵ with physician attitudes directly influencing nursing behaviors, team dynamics, and patient care.^{16,17} Moreover, physicians have lower reported awareness of the importance of physician attitudes to the nurse-physician relationship, specifically with respect to the value placed on nursing input and how physician behavior is linked to nurse satisfaction.¹⁸ Addressing these gaps is essential for improving collaboration and mitigating environmental stressors that affect rounding efficiency.

Encouraging nurse leadership and empowerment is a key strategy for strengthening interdisciplinary rounding. Studies have shown that interventions promoting nurse involvement improve teamwork and patient outcomes.¹⁹ In particular, collaborative communication models that incorporate structured learning modules and clarify the roles of nurse and physician leaders within the ICU have been shown to enhance teamwork while reducing stress caused by hierarchical dynamics.²⁰ Identifying and supporting nurse leaders in designing interventions for better communication can help bridge existing gaps.

Any initiative implemented by hospital leadership to optimize RN-MD rounding must be designed to integrate the clinical priorities of both professions. Strengthening a culture of mutual respect and leveraging the unique expertise of each team member in developing workflow solutions is critical. Increasing bedside time is beneficial, but structured communication remains essential. By addressing communication barriers through targeted interventions and evidence-based best practices, healthcare organizations can create a more cohesive and effective care environment, ultimately improving both team dynamics and patient outcomes.

Limitations

This study relies on direct observations conducted by student volunteers, introducing the potential for subjectivity in data collection. While training was provided to ensure inter-rater reliability, variations in interpretation and documentation may still exist. Additionally, as an observational study, we cannot infer causality between bedside time, nurse participation, and discussion content. Future research could explore interventions aimed at optimizing bedside rounding structures to enhance interdisciplinary engagement and patient-centered communication.

Conclusion

This observational study provides valuable insights into how logistical tools designed to support RN-MD rounding translate into meaningful clinical discussions that impact patient outcomes. Our goal was to evaluate the relationship between physician bedside rounding time, RN-MD interaction time, and the discussion of key elements in the care plan, including the involvement of the patient, family, and nurse. Findings indicate that longer physician bedside rounding time is associated with more frequent discussions about specific aspects of the clinical plan and increased efforts to address patient and family concerns. However, it is the duration of nurse-physician interactions that is a stronger prediction of greater engagement of both nurses and patients/families in these discussions.

These results suggest that operational improvement efforts focused solely on increasing physician time at the bedside may be insufficient. Instead, interventions should prioritize strengthening interdisciplinary communication and enhancing the role of bedside nurses as key advocates for their patients' daily care needs. By recognizing the critical influence of nurse-physician collaboration in bedside discussions, healthcare institutions can develop more effective strategies to improve patient-centered care and interdisciplinary teamwork.

Acknowledgments

The authors sincerely thank the Healthcare Improvement & Innovation in Quality (THINQ) student researchers and advisors for their invaluable contributions to this study. We extend our appreciation to former THINQ Fellows Christopher Huerta and Julia Kim for their assistance in designing the IDR tool and Perception survey. Additionally, we would like to recognize Vardaan Bal, Brittney Le, Sidhant M. Umbrajkar, and Aishwarya Natarajan for their contributions to the initial conception of this manuscript.

Disclosure

The authors report no conflicts of interest in relation to this work.

References

- Mercedes A, Fairman P, Hogan L, Thomas R, Slyer JT. Effectiveness of structured multidisciplinary rounding in acute care units on length of stay and satisfaction of patients and staff: a quantitative systematic review. *JBIS Database System Rev Implement Rep.* 2016;14(7):131–168. doi:10.11124/JBISRIR-2016-003014
- Burdick K, Kara A, Ebricht P, Meek J. Bedside interprofessional rounding: the view from the patient's side of the bed: the view from the patient's side of the bed. *J Patient Exp.* 2017;4(1):22–27. doi:10.1177/2374373517692910
- Hitawala A, Flores M, Alomari M, et al. Improving physician-patient and physician-nurse communication and overall satisfaction rates: a quality improvement project. *Cureus.* 2020;12(4):e7776. doi:10.7759/cureus.7776
- Beaird G, Baernholdt M, White KR. Perceptions of interdisciplinary rounding practices. *J Clin Nurs.* 2020;29(7–8):1141–1150. doi:10.1111/jocn.15161
- Henkin S, Chon TY, Christopherson ML, Halvorsen AJ, Worden LM, Ratelle JT. Improving nurse-physician teamwork through interprofessional bedside rounding. *J Multidiscip Healthc.* 2016;9:201–205. doi:10.2147/JMDH.S106644
- Heip T, Van Hecke A, Malfait S, Van Biesen W, Eeckloo K. The effects of interdisciplinary bedside rounds on patient centeredness, quality of care, and team collaboration: a systematic review. *J Patient Saf.* 2022;18(1):e40–e44. doi:10.1097/PTS.0000000000000695
- Fallahnezhad T, Aghaie B, Norouzadeh R, Ebadi A, Abbasinia M. The challenges of nursing presence at the patient's bedside from the perspective of nurses: a qualitative study. *Ethiop J Health Sci.* 2023;33(2):281–290. doi:10.4314/ejhs.v33i2.13
- Gonzalo JD, Wolpaw DR, Lehman E, Chuang CH. Patient-centered interprofessional collaborative care: factors associated with bedside interprofessional rounds. *J Gen Intern Med.* 2014;29(7):1040–1047. doi:10.1007/s11606-014-2817-x
- Manojlovich M, Harrod M, Hofer TP, Lafferty M, McBratnie M, Krein SL. Using qualitative methods to explore communication practices in the context of patient care rounds on general care units. *J Gen Intern Med.* 2020;35(3):839–845. doi:10.1007/s11606-019-05580-9
- O'Leary KJ, Buck R, Fligiel HM, et al. Structured interdisciplinary rounds in a medical teaching unit: improving patient safety: improving patient safety. *Arch Intern Med.* 2011;171(7):678–684. doi:10.1001/archinternmed.2011.128
- Stickrath C, Noble M, Prochazka A, et al. Attending rounds in the current era: what is and is not happening. *JAMA Intern Med.* 2013;173(12):1084–1089. doi:10.1001/jamainternmed.2013.6041
- Huang KT, Minahan J, Brita-Rossi P, et al. All together now: impact of a regionalization and bedside rounding initiative on the efficiency and inclusiveness of clinical rounds. *J Hosp Med.* 2017;12(3):150–156. doi:10.12788/jhm.2696
- Sang AX, Tisdale RL, Nielsen D, et al. How much time are physicians and nurses spending together at the patient bedside? *J Hosp Med.* 2019;14(8):468–473. doi:10.12788/jhm.3204
- Huang KX, Chen CK, Pesseguero AM, et al. Physician behaviors associated with increased physician and nurse communication during bedside interdisciplinary rounds. *J Hosp Med.* 2023;18(10):888–895. doi:10.1002/jhm.13189
- Natarajan A, Venegas MG 3rd, Mai D, et al. Perceptions and behaviors of nurses and physicians during bedside rounds in medical-surgical units. *Am J Crit Care.* 2024;33(5):364–372. doi:10.4037/ajcc2024308

16. Siedlecki SL, Hixson ED. Relationships between nurses and physicians matter. *Online J Issues Nurs*. 2015;20(3):6. doi:10.3912/ojin.vol20no03ppt03
17. Rosenstein AH, Naylor B. Incidence and impact of physician and nurse disruptive behaviors in the emergency department. *J Emerg Med*. 2012;43(1):139–148. doi:10.1016/j.jemermed.2011.01.019
18. Rosenstein AH, O'Daniel M. Disruptive behavior and clinical outcomes: perceptions of nurses and physicians. *Am J Nurs*. 2005;105(1):54–64; quiz64–65. doi:10.1097/0000446-200501000-00025
19. Tafelmeyer J, Wicks R, Brant J, Smith L. Incorporating nurse input and evidence into a newly designed unit to improve patient and nursing outcomes. *J Nurs Adm*. 2017;47(12):603–609. doi:10.1097/NNA.0000000000000554
20. Boyle DK, Kochinda C. Enhancing collaborative communication of nurse and physician leadership in two intensive care units. *J Nurs Adm*. 2004;34(2):60–70. doi:10.1097/00005110-200402000-00003

Journal of Multidisciplinary Healthcare

Publish your work in this journal

The Journal of Multidisciplinary Healthcare is an international, peer-reviewed open-access journal that aims to represent and publish research in healthcare areas delivered by practitioners of different disciplines. This includes studies and reviews conducted by multidisciplinary teams as well as research which evaluates the results or conduct of such teams or healthcare processes in general. The journal covers a very wide range of areas and welcomes submissions from practitioners at all levels, from all over the world. The manuscript management system is completely online and includes a very quick and fair peer-review system. Visit <http://www.dovepress.com/testimonials.php> to read real quotes from published authors.

Submit your manuscript here: <https://www.dovepress.com/journal-of-multidisciplinary-healthcare-journal>

Dovepress
Taylor & Francis Group