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Communication in the Interdisciplinary Health Team in Intensive Care: A Qualitative Study

Comunicación en el equipo interdisciplinario de salud en cuidado intensivo: un estudio cualitativo

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ABSTRACT

Introduction: Interdisciplinary communication is an essential component in intensive care. This is a specialized and multidimensional environment that requires continuous interaction among health team members. Effective communication is fundamental to patient outcomes, quality care, and safety. **Objective:** To describe the category "Communication: a key element for the interaction of nurses with the interdisciplinary team." **Methods:** A qualitative study was conducted using grounded theory analytical tools as per Corbin and Strauss. Twelve nurses from an adult intensive care unit participated. The sample was determined by data and theoretical saturation. In-depth interviews were conducted. **Results:** Communication is a key element for nurses' interaction with the interdisciplinary team. The following subcategories emerged: involving the team in patient care, precise and consistent communication, understanding and building empathy, communicating with trust and respect, and communication interference. **Conclusions:** The participating nurses consider communication an essential process in their interaction with the interdisciplinary health team. It serves as a means to exchange information, make joint decisions, and is characterized by being constant and fluid. They also recognize situations where communication interference occurs.

Keywords
interdisciplinary communication; critical care nursing; patient care team; critical care.

RESUMEN

Introducción: La comunicación interdisciplinaria es un componente esencial en cuidados intensivos. Este es un escenario especializado y multidimensional que requiere la interacción permanente entre los miembros del equipo de salud. La comunicación efectiva es fundamental para la evolución de los pacientes, el cuidado con calidad y seguridad. **Objetivo:** Describir la categoría "comunicación: elemento clave para la interacción de la enfermera con el equipo interdisciplinario". **Métodos:** Estudio cualitativo con herramientas analíticas de la teoría fundamentada, según Corbin y Strauss. Participaron doce enfermeras de

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una unidad de cuidado intensivo adulto. La muestra estuvo determinada por los datos y la saturación teórica. Se utilizó la entrevista en profundidad. **Resultados:** La comunicación es un elemento clave para la interacción de la enfermera con el equipo interdisciplinario. Emergieron las siguientes subcategorías: involucrando al equipo con los cuidados, comunicación precisa y constante, conociendo al otro y construyendo empatía, comunicándonos con confianza y respeto e interferencia en la comunicación. **Conclusiones:** Las enfermeras participantes consideran la comunicación un proceso esencial en su interacción con el equipo interdisciplinario de salud. Es el medio para intercambiar información, tomar decisiones conjuntas, y se caracteriza por ser constante, fluida, reconociendo que se presentan situaciones de interferencia en este proceso.

Palabras clave
comunicación interdisciplinaria; enfermería de cuidados críticos; equipo de atención al paciente; cuidados críticos.

Introduction

Communication is a dynamic process fundamental to human existence, growth, change, and behavior. It involves the exchange of thoughts, opinions, and actions among individuals, encompassing their needs and expectations (1). From the perspective of symbolic interactionism, people communicate meanings derived from interactions with others, who act based on the interpretation of those meanings (2). Communication is vital in any activity and, in complex environments such as intensive care units (ICUs), it is crucial for work dynamics within the health team and for patient safety (3).

ICUs provide specialized and interdisciplinary care to critically ill patients, leveraging enhanced monitoring capabilities and multiple support modalities for potentially life-threatening conditions (4). *Interdisciplinarity* in this study refers to cooperation among various disciplines, fostering mutual enrichment. It involves a sense of unity, reciprocal relationships and actions, and shared interpretations across *scientific disciplines* to address common goals—in this case, the comprehensive care of critically ill patients.

An interdisciplinary team consists of individuals who identify and regularly interact to carry out common tasks with shared goals. The team is characterized by diverse skills and knowledge, with all members participating in decision-making processes, assuming clearly assigned leadership roles, maintaining temporal stability and a shared work history, collaborating closely in a coordinated manner, and fostering mutual trust, shared values, and reflexivity to systematically review their performance and objectives (5-8).

In intensive care, communication is a key factor in improving the quality of care and patient safety. In the ICU, its complexity, multidimensionality, volume of activities, use of various medications, multiple procedures, task simultaneity, and the stressful environment make the healthcare team prone to errors. The information and task overload, as well as interactions with a large number of professionals during a shift in the ICU, often lead to communication gaps (9,10). In this context, communication becomes a facilitating tool for shared work and a positive work environment, for identifying incidents and adverse events, and for promoting the development of strategies, checklists, and continuity of care (11-13).

Studies by Sigmon et al. (14) and Boev et al. (15,16) have reported that effective communication is a critical component of collaboration. ICUs where nurses and physicians collaborate effectively exhibit lower rates of central line-associated bloodstream infections and ventilator-associated pneumonia. ICU nurses and docotrs tend to have stronger communication when nurse-to-patient ratios are lower. Nurses in these studies associated communication with patient safety and improved outcomes. In critical situations, such as cardiac arrest, clear communication facilitated workflow. Conversely, nurses identified situations where communication breakdowns and personality clashes hindered nurse-doctor collaboration, especially during patient decompensation. They also noted that communication is a learned process not included in their professional training (16).

Other research has highlighted barriers to communication within the health team, such as unclear team member roles, ineffective ways of providing and receiving information, the absence of team meetings, decision-making discord, and changes in patient treatment plans without communication (17-20).

In Colombia, Maldonado Gutiérrez (21) identified various aspects of nurse-doctor communication, such as listening skills, empathy, understanding, trust, respect, and clarity of information, which promote interprofessional communication and positively impact patient outcomes and the healthcare system. However, obstacles such as differences in professional opinions, individual decision-making, hierarchies, and lack of information flow were also noted. In Cartagena (Colombia), literature reports have focused on aspects related to working conditions, nurse-supervisor interactions, work climate, interpersonal relationships, or communication and coordination within hospital services from a positivist perspective (22-24).

Evidence specifically exploring the process of communication between nurses and the in-person interdisciplinary health team (specialist physicians and physiotherapists) caring for critically ill patients is limited. Thus, this qualitative research aimed to understand the interaction process between ICU nurses and the interdisciplinary team from the nurses' perspective in adult intensive care in Cartagena, Colombia. This article describes the category "Communication: a key element for the interaction of nurses with the interdisciplinary team."

The study provides a perspective on nurses from an interdisciplinary approach, focusing on essential elements of communication and its dynamics. This serves as a resource to strengthen and reinforce positive aspects while also reorienting and improving the challenges encountered.

Methods

This was a qualitative study utilizing grounded theory analysis tools as proposed by Corbin and Strauss, which employs systematic procedures to develop a theory. Grounded theory allows for a rich and in-depth description of data, interpreting and analyzing it to explain the studied processes (25). The study was conducted with twelve nurses working in an adult ICU in the city of Cartagena, Colombia, within a medium- to high-complexity healthcare institution.

The sampling method was theoretical and intentional. The sample was determined by the data obtained from the study participants, which was considered rich and valuable. Theoretical saturation was achieved at the point where no new properties, dimensions, or relationships emerged during the analysis (25). Participant selection was guided by theory construction and constant comparison, aimed at selecting individuals who could enhance the discovery of variations among concepts and enrich the category. As data were collected and analyzed, new participants were included until data saturation was achieved (25).

Other factors influencing sample size determination included the nature of the topic. There were no difficulties in understanding the phenomenon or in participants expressing their experiences and articulating the data that emerged from the interviews. Moreover, the study phenomenon was clearly defined (26).

Participant selection criteria included nurses actively participating in the health team, performing consecutive shifts in an adult ICU in Cartagena, with a minimum tenure of six months, and volunteering for the study.

In-depth interviews were employed (19). The interview guide was based on key elements of interdisciplinary interaction processes. Each interview was conducted uniquely, adapting to the individual characteristics of the informants. Consequently, questions were modified based on the evolving analysis of the information. Interviews lasted an average of 40 minutes and were conducted over three months. They were audio-recorded and subsequently organized and

fully transcribed by the principal investigator using Word® and Excel® software.

Institutional authorization and approval were obtained prior to participant recruitment. Nurses were approached in the unit, informed about the study, and meetings were scheduled outside their programmed shifts for those who voluntarily agreed to participate. Each nurse was interviewed separately, in settings outside the ICU, to ensure privacy and a comfortable environment. Preliminary interviews were conducted with two nurses who were not part of the study to assess the appropriateness of the questions, the interview setting, the recording quality, and the transcription process. After each interview, the researcher recorded thoughts, interpretations, analyses, and questions in memos and a field diary to guide data collection (25).

Data analysis followed the grounded theory analytical tools of Strauss and Corbin, simultaneously executing open and axial coding (25). Each interview was examined line by line, fragmenting the narrative and noting incidents. Each fragment and phrase was assigned a coding number based on the interview ID, paragraph, and page number. Data were constantly compared, exploring similarities and differences until categories and subcategories emerged (25). Finally, during axial coding, categories were related to their subcategories for greater precision and understanding of the phenomenon under study (25).

This research was classified as minimal risk, according to Colombia's Resolution 008430 of October 4, 1993 (27). The study was approved and authorized by the Research Committee of the participating institution. The research adhered to international ethical guidelines cited by the Council for International Organizations of Medical Sciences, *the Belmont Report,* and the Declaration of Helsinki, including obtaining informed consent, respecting autonomy and human dignity, ensuring confidentiality and privacy, and guaranteeing participants' anonymity through numerical codes (28-30).

The following methodological rigor criteria for qualitative research were applied: **Credibility:** The results of this research are based on authentic and accurate sources, supported by recorded and transcribed interviews. Furthermore, the results were shared with participants, who confirmed and agreed with the interpretations. **Confirmability:** Results were compared, examined, and discussed against various epistemological references supporting the study, the researchers' conceptual stance, and creativity. **Transferability:** This criterion does not imply generalizing results to a broader population, as this was not the purpose of the qualitative study. Instead, it considers that parts or the essence of the findings can be applied in other contexts (31). This study may serve as a reference for analyzing nurse-health team interaction processes in other cities and clinical settings beyond ICUs.

Results

A total of 12 nurses participated in the study, with ages ranging from 23 to 55 years, averaging 35.4 years. Their ICU experience varied from 8 months to 10 years, with an average of 3 years. Regarding postgraduate education, 16.6% had specialized studies. Below is the category "**Communication: a key element for the interaction of the nurse with the interdisciplinary team.**"

Participants reported that communication with the health team is fundamental and essential for interaction. It enables them to know one another, reach agreements, share experiences and knowledge, express their needs and opinions, ask questions, and stay informed about patient care, team dynamics, and the ICU.

Nurses recognized the importance of clear communication within the team for their own well-being and that of the patients. They emphasized that this process occurs in a context of respect and trust, prioritizing patient safety. This category comprises the five subcategories shown in Figure 1.

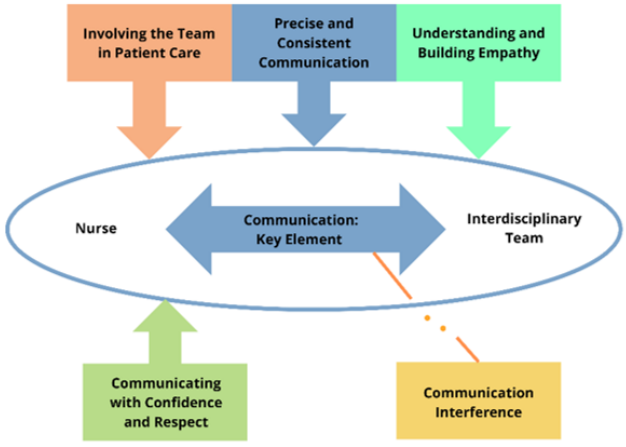

Figure 1.
Subcategories of Communication as a Key Element

Involving the Team in Patient Care

Participants highlighted the importance of considering each team member's opinions and decisions regarding patient care. Collaboration involves everyone in the activities and interventions performed on patients. This was expressed in their own words:

> The doctor is always with the assigned nurse, asking questions. Therapists are always asking questions. The physical therapist always says, 'Boss, can I disconnect this from the patient? Can I remove this? I'm going to get them up, I'm going to sit them down.' They always ask us so as not to do something that might harm the patient. (E8)
>
> I really like teamwork, and I get involved in it. I don't like to compartmentalize. It's not just about doing my part and that's it but understanding what's going on here, why it's happening, and if something happens here, I get involved just the same. (E3)
>
> So, it's better to ask or provide information: 'Look, Doc, this is happening.' It's better than overstepping. (E4)

Precise and Consistent Communication

The participants reported that communication is detailed and meticulous, particularly regarding patients' health conditions and the functioning of the ICU, to prevent and avoid errors in care. They strive to be thorough when communicating and informing the team, aiming to cover as much information as possible about patient management, changes, and follow-ups. They make an effort to maintain a clear flow of information about all occurrences throughout their shifts, continuously and consistently. For the nurses, communication among themselves is an act of responsibility, viewed as a duty to ensure safety for both the team and their patients. Responding to the needs of the patients, the service, and the care provided, there is a mutual necessity to communicate and stay informed. In their own words, they narrated:

> There is good communication. Communication is always patient-centered... Nothing is left hidden or unsaid; everything is communicated. (E8)
>
> There are things we consult on: 'Hey, the ventilator, what's the patient's FiO2? How were the blood gases?' It's mutual—they ask us things, and we provide feedback. (E6)
>
> We use the same nursing language, covering even the smallest details. (E5)
>
> "Everyone knows what they have to do… They immediately say, 'Boss, I already did this or that.' We inform each other and keep track of everything happening with the patient. It's not like everyone is doing their own thing. Everyone is focused on the objective." (E4)

Knowing the Other and Building Empathy

For nurses, maintaining close and understanding relationships with their team members is important. This allows them to understand each other and establish effective interactions, avoid conflicts, and achieve common goals. Participants expressed: " In general terms, work in the ICU is good. There's understanding." (E12)

> I talk a lot with them. I really enjoy talking to people, especially those who are pleasant or can teach me something. So, during shifts, we talk with the physiotherapists and doctors; we remember many things together. (E2)
>
> You have to know everyone you work with to know how to address them, how to approach them. (E4)
>
> You can't work as if you were complete strangers. You must always have empathy with your coworkers, some kind of affinity, and that's good because it improves the work, fosters teamwork, and helps all processes develop better. (E11)

Communicating with Confidence and Respect

Nurses indicated that they feel free and comfortable to express themselves, ask questions, contribute, and provide information. They believe there is mutual respect within the team, and their assessments and opinions are taken into account for patient care. Some of their testimonies include:

> There is confidence to approach, to ask questions, to suggest things, and also to report any type of event that may have occurred. (E3)
>
> All points—those that have not been done or those that are going to be done—are discussed. There is a lot of respect among everyone. (E7)
>
> They are approachable, and we are empowered to say, 'Doctor, I think this patient has this issue.' They respond, 'Let's check it out,' or, 'No, boss, it's not that,' but the doctor usually listens to what we say. (E12)

Interference in Communication

Participants also described how insufficiently detailed communication or instances of miscommunication or interruptions can create barriers within the health team. Their testimonies include:

> The ICU is a stressful area; it requires great care and precision. Sometimes… There's what's called the 'broken telephone.' When information is passed on to the next day, it doesn't always go as you said it, and problems can arise because it wasn't delivered as intended. (E12)
>
> If there's no good communication—since interpersonal relationships depend on it—you can't do things right. Definitely, if we don't understand each other, no one knows when to do one thing or another. Everyone just goes their own way, and there won't be that sense of socialization or acting for the patient's benefit. (E8)

Discussion

The findings of this research align with those of authors such as Verd-Aulí et al. (13), who revealed how nurses and doctors describe interprofessional collaboration as a practical experience involving individual and collective contributions toward common objectives. This collaboration allows for consensus-building and decision-making in a context of listening, commitment, and engagement to deliver better care.

Peixoto et al. (32) demonstrated that a multidisciplinary approach in the ICU results in improved patient outcomes and quality of life. They described the benefits of collaborative and cooperative approaches compared to traditional hierarchical models of subordination. Assertive communication enhances team members' awareness of each other's knowledge and skills. A multidisciplinary perspective can lead to reduced mortality rates and shorter hospital stays, while also addressing the physical, emotional, and social needs of patients.

Similar findings were reported by Costa et al. (33) in a study conducted in Philadelphia. The authors found that effective communication is essential to recognizing minimal changes in patient conditions, whether positive or negative. Nurses mentioned feeling that doctors involve them in patient care by asking questions, seeking their input, and valuing their opinions.

Similarly, Al Khalfan et al. (34) documented that nurses conduct thorough evaluations of patients and must discuss their clinical findings with doctors. Docotrs, in turn, should be willing

to listen to nurses to achieve a comprehensive understanding of the patient. Both physicians and nurses have distinct responsibilities, but they share the common goal of improving patient well-being.

Wang et al. (35) emphasized that effective communication contributes to the satisfaction of both patients and the healthcare team. They also identified strategies for improving nurse-physician communication, such as checklists, joint and structured handoffs, as well as team training in an environment of mutual respect and trust. Along these lines, Boev et al. (16) highlighted in their study the utility of training, education, and seminars on assertive communication skills, which could be integrated into nursing and medical education.

In a qualitative study in Brazil, participating nurses recognized the importance of communication for teamwork. However, they expressed that shortcomings were attributed to the stressful environment of the ICU. They noted the need to learn how to communicate better and highlighted how team communication failures could lead to errors that negatively affect patients (36). Similarly, Fassier and Azoulay (37) reported that communication issues and gaps are major sources of conflict in the ICU, along with personal animosity and distrustful behaviors. These conflicts impact team cohesion, lead to burnout, and increase staff turnover.

Verd-Aulí et al. (13) noted barriers to communication between doctors and nurses in intensive care. For example, doctors mentioned that limited space in the ICU hindered orderly rounds. Additionally, they observed that nurses often played a passive role during interprofessional rounds, with minimal or no participation. Physicians expressed that they strive to involve nurses by asking questions about patient status. These results contrast with those described in this article, which emphasizes the active participation of nurses in the interdisciplinary team. Nurses feel empowered to intervene freely, with their actions being essential and positively impacting patient recovery and service dynamics. This breaks the traditional hierarchical paradigm of power and subordination between nurses, physicians, therapists, and other healthcare professionals. The article underscores the importance of communication processes not only for patients but also among professionals within the ICU, an area that has been underexplored.

Barnard et al. (18) documented that effective communication between therapists and nurses depends on a genuine need to exchange information for patient care. This includes the ability to process and utilize information and the availability of shared spaces to facilitate communication. Therapists value the bedside information nurses gather, perceiving them as "holders" of critical data. Additionally, nurses are expected to act as intermediaries between patients, families, and other professionals.

Costa et al. (33) found that trust among team members is reinforced when they know each other well, fostering effective interpersonal relationships. For instance, respiratory therapists rely on nursing staff for ventilator management, responding to their calls without hesitation. In contrast, Junaid and Muhammad (38) identified barriers to communication in healthcare teams, such as workload, job dissatisfaction, lack of empathy, and hierarchical interactions. Liu et al. (39) pointed out that hierarchy influenced expected interactions, creating barriers to effective communication when information flow depended on a single channel directed toward the team leader or attending physician. The same authors highlighted that accessibility and feeling heard and respected were crucial for participants. Relationships were strengthened through scheduled meetings aimed at improving care quality by promoting team interaction.

King's theory (1) emphasizes that communication between nurses and the health team is essential for safe and effective patient care. It is the responsibility of each professional to provide accurate information when planning care, and it is the nurse's duty to examine patient information to implement appropriate therapies.

Limitations of the Study

Due to the qualitative nature of this study, its results are confined to the specific context of the adult ICU and the perspectives of the participating nurses. Therefore, further research involving the viewpoints of other professionals and in different clinical settings is warranted. Another challenge was the availability of time for some participants to conduct the interviews.

Conclusions

The participating professionals understand communication as a key and essential process in the interaction between nurses and the interdisciplinary team in intensive care. It serves as the medium for interacting, forming relationships, sharing information, reaching consensus, making agreements, and making decisions. When communication is precise, constant, and fluid, it enables team members to involve and understand one another, maintain empathy, and foster trust and respect. However, participants also acknowledge the existence of barriers and interferences in this process. The interdisciplinary focus of health teams emphasizes the importance of recognizing each member's role in achieving a shared objective: ensuring patient safety, well-being, and effective teamwork. This study highlights the significance of considering healthcare professionals' perspectives and actions, as they directly influence patient recovery.

It is essential to continue strengthening communication processes in clinical practice, as well as within academic programs and curricula. Communication should be conceived as an interprofessional tool that promotes nursing participation and leadership. Undergraduate education should implement strategies for providing feedback before, during, and after nursing interventions in all areas (theoretical, practical, and simulation), within contexts of interdisciplinarity. This approach would allow nurses to build their learning curve through ongoing interaction with other professionals.

Another useful strategy for communication in both clinical and academic contexts involves the application of standardized and systematic tools, protocols, guides, and checklists that encourage assertive communication during critical interactions (e.g., interdisciplinary rounds and care transitions). Health institutions should ensure appropriate spaces and time for feedback and communication.

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Conflict of Interest

The authors declare no conflicts of interest.

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