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ORIGINAL ARTICLE

Physicians and nurses view on their roles in communication and collaboration with families: A qualitative study

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Abstract

Background: Families are introduced as new partners in interprofessional communication and collaboration during hospitalisation of an adult patient. Their introduction into the healthcare team has consequences for the roles and responsibilities of all healthcare professionals. Role clarification is thus needed to create optimal communication and collaboration with families.

Aim: To gain insight into how physicians and nurses view their own roles and each other's roles in communication and collaboration with families in the care of adult patients.

Methods: A qualitative interpretive interview design was used. Fourteen semi-structured interviews, with seven physicians and seven nurses, were conducted. Data were analysed according to the steps of thematic analysis. For the study design and analysis of the results, the guidelines of the consolidated criteria for reporting qualitative studies (COREQ) were followed. The ethical committee of the University Medical Center Groningen approved the study protocol (research number 202100640).

Findings: Thematic analysis resulted in three themes, each consisting of two or three code groups. Two themes "building a relationship" and "sharing information" were described as roles that both nurses and physicians share regarding communication and collaboration with families. The role expectations differed between physicians and nurses, but these differences were not discussed with each other. The theme "providing support to family" was regarded a nurse-specific role by both professions.

Conclusion: Physicians and nurses see a role for themselves and each other in communication and collaboration with families. However, the division of roles and expectations thereof are different, overlapping, and unclear. To optimise the role and position of family during hospital care, clarification and division of the roles between physicians and nurses in this partnership is necessary.

KEYWORDS

collaboration, communication, family, healthcare professionals, inpatients nurses, physicians

INTRODUCTION

In recent years, there has been growing awareness of the importance of involving family in the care for older patients in particular [1, 2]. Given the aging population and the scarcity of resources in European healthcare systems, demand for informal caregivers to participate in care is rising [3]. Care for older people will be increasingly provided by informal caregivers in close collaboration with healthcare professionals at home for as long as possible [4].

A family caregiver (e.g., a partner, child, neighbour, or friend) is important for a patient's informal support and care [5, 6]. They are generally considered to be experts on the patient's needs and care situation. However, during hospital admission, healthcare professionals are inclined to take over care, and families tend to fade into the background [7]. As a result, family knowledge about the patient is often utilised ineffectively, and families receive insufficient information and support about their hospitalised family member [8]. At the same time, research indicates that preparedness for the caregiver's role at home depends on the support that families receive from healthcare professionals in the hospital [2, 8, 9].

For family support in the care process, the roles of the most important healthcare professionals involved—in this context, physicians and nurses—must be clear. Lack of clarity regarding physicians' and nurses' roles can lead to ambiguity and inefficiency in the provision of care. An example, similar information may be requested repeatedly causing annoyance in patients and caregivers alike, or conflicting (medical) information may be shared that causes confusion [10]. With the increasingly important role of family during hospitalisation, there is need for role clarity between physicians and nurses regarding their communication and collaboration with the patient's family.

BACKGROUND

Healthcare professionals should view patients' families as partners in the care process [1, 11]. Various models have been developed for involving families in hospital care. Patient- and family-centered care (PFCC) is a care planning model based on a collaborative partnership between the healthcare team, patients, and families. PFCC is defined as "working with patients and families instead of simply doing things to them or for them" [12]. Within a collaborative partnership, care plans take the family context into account, and thus prepare families for continuation of care at home [13–15]. Including patients and families in the care team strengthens health systems and improves health outcomes [16].

The core concepts of PFCC are dignity and respect, information sharing, participation, and collaboration [17]. Communication is information sharing that should be done in a timely, accurate, open, and satisfying manner [18]. A relationship of mutual trust and respect must be built to allow families to share their values and priorities regarding the care of their family member [11, 19]. Family–professional collaboration refers to these supportive relationships, where mutual understanding occurs and shared decisions can be ensured [20, 21].

To ensure interprofessional communication and collaboration, the roles, and responsibilities of all involved in the care situation should be clear [22]. Role clarification ensures that healthcare professionals, patients, and families can complement and strengthen one another during patients' hospitalisation [11].

In the Netherlands both physicians and nurses have been trained according to the CanMEDS competency framework [23, 24]. For both health care professionals, the roles of "communicator" and "collaborator" describe that nurses and physicians should be able to communicate and collaborate with each other as well as with family to ensure good patient care, but the ensuing need for role delineation and agreement between these two groups of health care professionals has not been formally described.

Aside from the competency framework, nurses can use an international classification system as a reference for family support in clinical practice. The North American Nursing Diagnoses Association International Classification (NANDA-I), the Nursing Intervention Classification (NIC) and the Nursing Outcome Classification (NOC) describe the role of a nurse in involving and supporting families in detail [25–27]. For example, the nursing diagnosis "interrupted family processes" [25] identifies a change in family relationships and/or functioning and may require nurse interventions such as "promotion family involvement" or "family mobilisation" [26] to achieve outcomes such as "family support during treatment" or "family participation in professional care" [27].

Although guidelines and competency descriptions do exist for working in a family-centered manner, they only address healthcare professionals in general but lack specific role descriptions and distinctions for physicians or nurses [28, 29].

THE STUDY

Aim and objective

The aim of this study is to provide insight into how physicians and nurses view their own roles and each other's roles in communication and collaboration with families in the care of adult patients.

Considering the current challenges in healthcare, PFCC appears to be specifically relevant for elderly adult patients. For that reason, we focused on physicians and nurses working at the University Medical Center Groningen's Department of Internal Medicine, as these professionals primarily deal with frail and elderly adult patients with a clear need to involve family members.

Research question

How do physicians and nurses view their own roles and each other's role in communication and collaboration with families during hospitalisation of an adult patient?

METHODS

Design

A qualitative interpretive interview design was used. For the study design and analysis of the results, the consolidated criteria for reporting qualitative research (COREQ) guidelines were followed (See Appendix 1) [30].

Study framework

Interviews were held using a semi-structured interview guide (see Appendix 2). The research team developed the interview guide based on literature regarding the main concepts of communication and collaboration with family members [11, 18, 21]. In preparation for this list, the interviewer (JMW) obtained insight into the standard operating procedure of communication and collaboration with family members in the participating internal medicine ward. The final interview guide was established based on two pilot interviews.

Setting, participants and recruitment

The study was conducted at the University Medical Center Groningen's Department of Internal Medicine between December 2021 and February 2022. Participating physicians and nurses were recruited from the internal medicine ward where patients were admitted for general internal medicine, geriatrics, as well as infectious diseases. There were no specific inclusion or exclusion criteria for physicians and nurses, except that they had to be employed in the Internal Medicine department of the University Medical Center Groningen. All physicians and nurses in this department were considered eligible to participate in the study.

Purposive sampling was used to obtain the desired range of work experience, professional background, age, and gender among both groups. Eligible physicians and nurses were approached by mail to participate voluntarily, and written information was provided. All approached physicians and nurses were willing to participate and signed an informed consent form after which an interview was scheduled. Recruitment of participants continued until data saturation—the point in data collection when no new issues emerge—had occurred [31]. This point was reached after 14 interviews (seven physicians and seven nurses).

Data collection

A semi-structured interview was used to maintain sufficient focus on the research question while allowing the interviewees space to share reflections, opinions, and experiences in a broader sense. Interviews were conducted online with Microsoft Teams or face to face in a secluded area in the hospital with a minimum chance of interruption. The interviews took approximately 45 minutes and were recorded on a voice recorder, while additional field notes were made. Training and pilot testing prepared the interviewer, JMW, to conduct the interviews, which were held over approximately 2 months. The interviewer did not have established relationships with any of the interviewees. Each interview began with a brief introduction, where the interviewer was introduced as a researcher interested in the interviewees' opinions regarding communication and collaboration with members of the other health care profession regarding their interaction with families of patients in their care.

Data analysis

The analysis started with the transcription of audio recordings immediately after the interviews. Transcripts were returned to participants for comment or correction. After every two transcribed interviews, JMW, MLL, and WP analysed the transcriptions to identify new issues that could be further explored in subsequent interviews.

Data were analysed according to the steps of thematic analysis [32]. After familiarisation with the data, JMW developed initial codes for physicians' and nurses' roles using an inductive approach, and MLL and WP validated them. After analysis of six interviews (three physicians and three nurses), a robust set of 115 codes was developed in the software program Atlas ti. During analysis of the

next six interviews, codes were added and/or modified, ultimately resulting in 136 codes. By the last two interviews, the process of developing codes stopped, saturation was reached, and no new topics were identified in the data. In the next step of thematic analysis, JMW grouped codes to create themes of roles physicians and nurses fulfil in communication and collaboration with each other regarding their interaction with families, which MLL, WP, and ROBG then validated.

Ethical considerations

The ethical committee of the University Medical Center Groningen approved the study protocol (research number 202100640). All methods were in accordance with relevant guidelines and regulations. The participants received information about the study purpose, the process of anonymising data, and the data retention period, and they were informed that they could withdraw their participation at any time. All participants provided written informed consent to participate in the study.

Rigour

Lincoln and Guba [33] describe credibility, transferability, dependability, and confirmability as the starting points when establishing trustworthiness in qualitative research. Credibility concerns the fidelity of the researchers' representation of participants' views [34]. Triangulation—wherein multiple researchers consider the interview transcripts independently of one another—is a method to increase credibility. In this study, all transcripts were analysed independently by at least two researchers. In some cases, where interpretations diverged, a third examiner was asked to consider a transcript. To further enhance credibility, all researchers discussed the interim and final analysis. To sharpen the meaning of the themes, reflection rounds were held among the researchers such that definitive themes could be determined by consensus.

Attention is paid to transferability by describing the interviewees' work environments and professional backgrounds (see Section 'Setting, participants, and recruitment'). These descriptions can be used as a frame of reference to determine the extent to which results can be transferred to another comparable research context.

Regarding dependability, the researchers ensured that the research process was logical, traceable, and clearly documented [34]. The dependability of the research is enhanced by the fact that the researchers followed the consolidated criteria for reporting qualitative research and ensured that the process of coding and analysis was reported in detail (see Section 'Data analysis') [30].

Finally, confirmability is an important criterion for trustworthiness [34]. For confirmability, the researcher's interpretations, findings, and conclusions must be clearly derived from the data. One of the ways to increase confirmability was by including verbatim statements (quotes) from participants in the Findings section (see Section 'Findings'). Confirmability also requires a self-reflective approach of the researcher towards their own preconceived notions that may impact the research. After each interview the researcher made field notes regarding personal emotions, biases, and insights [35].

TABLE 1 Participant characteristics.

	Physicians ($n=7$)	Nurses ($n=7$)
Gender		
Female (number)	4	5
Male (number)	3	2
Age in years (range)	31–52	19–62
Year after Graduation (range)	4–24	0–39

FINDINGS

Participants

Seven physicians and seven nurses were interviewed. Table 1 provides an overview of participant characteristics. These characteristics are described in general to avoid traceability of individual participants.

Roles

Data gathered from the interviews were organised into codes and subsequently code groups. Code groups were interpreted as role views of physicians and nurses in communication and collaboration with families. Two of three code groups represent themes that were shared by physicians and nurses (see Appendix 3). The final themes are described here as physicians and nurses' roles and provide information on how physicians and nurses view their own roles and each other's roles in communicating and collaborating with families. Role descriptions are illustrated by quotes from participants.

Physicians and nurses reported three main roles in communicating and collaborating with family. Both physicians and nurses described "building a relationship" and "information sharing" with families as part of their job

description. The role of "offering support" was particularly described as a nurse's role by both professions.

The following subsections first describes how nurses and physicians view their own roles in communication and collaboration with family. Subsequently, this section describes how physicians and nurses view each other's roles in the same context.

Nurses' roles according to nurses

Building a relationship

Nurses mentioned *building a relationship* of trust with patients and families as an important role in their profession. All nurses mentioned that a nurse, considering their continuous presence in the ward during the whole stay of a patient, is the prime contact person for the family:

> You are the patient's prime contact person. [...] Family must know that they can come to you.
>
> (N6)

Nurses reported that it is their role to ensure that family feels included in the care process (N1,2,6,7). Nurses must pay close attention to patient's family members to get to know them well and build a trusting relationship with them (N1,4,6,7).

Information sharing

Nurses emphasised that providing and receiving information from members of the family of a patient is an important role in their communication and collaboration with families. All nurses reported that their contact with family members occurs primarily during visiting hours and by phone calls:

> I do get regular calls from family where they ask how it goes or how the patient has slept, so you are close to the family.
>
> (N4)

Most contacts involve sharing information about the patient, particularly in response to questions raised by family. Nurses indicated that most family questions are about repeating or clarifying information provided by the physicians during ward rounds to patients. Patients are expected to pass on this information to the family themselves. However, nurses indicated that many patients do not seem to be able to reproduce or remember the information provided properly. Therefore, nurses consider it their role to make sure that the family receives the right information (N 1,2,4–6):

> If family is present at visiting hours, the patient sometimes no longer knows what was been said during ward rounds. They would also like to have information because there is just so much going on with the patient that a lot of information has already been forgotten by the patient when they visit.
>
> (N6)

All nurses reported their role of informing families about their nursing observations during daily care, and addressing practical healthcare issues particularly with a view on the upcoming discharge:

> We know how someone eats, how to help someone to get out of bed, how their mobility is, those kinds of observations. But also, to prepare towards discharge. How discharge will proceed or where someone will go (home, a rehabilitation unit, a short-stay community unit or a nursing home).
>
> (N6)

In their role as prime contact person, all nurses reported receiving both medical and non-medical questions from families, but from their perspective it is not their role to provide medical information to families. They describe their role as intermediary: they pass on medical questions from the family to the physician (N1,4,5,6).

In addition to answering questions and providing information, nurses indicated that obtaining information about the activities of daily living and the social situation of the patient from the family as another part of their role. This practical information helps nurses to conduct daily care that best suits the patient (N2–5,7):

> Family knows how the patient was before admission. We learn how to deal with the patients. This information is not just about the illness. The family may say that patients like to listen to music. This information outside the medical domain can help to make a patient more comfortable.
>
> (N7)

Information about the home situation is also needed to prepare for and arrange a patient's discharge and discuss with family what is needed in this regard (N4,6).

Offer support

Nurses also described offering support to families as a primary nursing role in communication and collaboration with families. Nurses assess families whether medical

and non-medical information is understood or whether some questions or ambiguities remain (N1,2,7). Nurses described it as their role to repeat information provided by physicians in plain language and explain the implications to the patient and family (N1–3,4,6). Moreover, nurses see it as their role to pay close attention to the family, to assess how each member is coping with the situation at that moment. Nurses should be able to recognise when families are overwhelmed and overloaded, and provide appropriate (emotional) support to them (N1,2,4,5–7):

> You must offer support to the family because a lot of things happen when a family member is in the hospital. You must also pay attention to the family, how they deal with the whole situation.
>
> (N6)

Nurses also reported a need to support the family in preparation for discharge of the patient. Nurses need to explain to the family the optimal care process and needs of the patient as well as support of the caregiver after hospitalisation (N4,6):

> A patient once said himself 'I can do everything myself,' but his wife told us, 'That it is not true, I must do everything for him. I'm just overloaded, and something must be done because I cannot do it anymore.
>
> (N4)

Physicians' roles according to physicians

Building a relationship

Physicians also reported building a relationship with families during hospitalisation of an adult patient as one of their main roles. Although physicians see families less frequently than nurses do, they still consider it important to know families themselves and to build a relationship with them. All physicians stated that most communication occurs during a so-called and planned 'family conversation'—a formal exchange of information between the patient, their family, and the physician. Sometimes physicians will start a relationship with the families by meeting them informally during visiting hours (P1,2,4,5). Through these informal meetings, physicians demonstrate their accessibility (P2,4,5), thereby building a relationship for collaboration (P4–6):

> If you have a family conversation and you already know the people because you have spoken to them a few times, then a family conversation is a lot less of a formal encounter.
>
> (P1)

> I think it is important that you are accessible for family, if you stay there in your doctor's office, then it is only when difficulties arise - a physician may appear.
>
> (P5)

Information sharing

Physicians reported sharing information, especially medical information, as the key purpose in their communication with families. This means providing brief information and updates about the health care situation of the patient and answering questions either during visiting hours or by calling families regarding information provided to the patient during ward rounds (P1–5,7). Furthermore, all physicians indicated that during the 'family conversation' they have a formal role of updating family about the patient's medical care:

> Family needs to feel like they know what's happening to the patient and what's going to happen, and we provide that information. I go through the admission process, the reason why someone was admitted at that moment. What has happened since, where are we now, and what we want to do now? And then I also answer any questions the family may have.
>
> (P5)

Physicians' reasons for initiating a formal 'family conversation' were in the event of important diagnostic results, relevant changes in the clinical situation of the patient, and before discharge. All physicians reported that it is their role to keep the family well-informed about the medical process and discuss treatment options. Physicians suggested that well-informed family members can be key partners in the treatment choice that is most appropriate for a patient in a particular situation (P2,3,5,6). Physicians indicated that, depending on the complexity of the situation, their understanding of the patient's situation and the decision-making capacity of the patient, the family may play a guiding role (P1,3,6,7).

Before discharge, physicians provide a summary of what has occurred since the admission and during hospitalisation, and inform families about coordination of care when the patient gets discharged (P3–7):

> To go through everything that has happened during hospitalization So what did we do? Just a few things to explain, to indicate whether there is a follow-up policy and what we do to transfer care to the general practitioner if discharged home.
>
> (P7)

In addition to providing information, physicians must also obtain information from the family about the patient and the home situation. They stated that this information is needed to tailor medical therapy to the needs of the patient and to be able to work towards discharge (P1–7):

> Family can give input about what the patients' quality of life has been thus far, so we (physicians) do the right thing for that particular patient.
>
> (P5)

> In the end we may think that someone will go home, but if the (informal) care situation at home does not allow for that, then you can try it, but those patients are often readmitted quickly and then from a hospital perspective nothing has been solved.
>
> (P4)

Nurses' roles according to physicians

Building a relationship

All physicians reported that a nurse is the most visible person of the health care team to the family during a patient's hospitalisation and therefore has the responsibility of maintaining contact with family. During this contact, nurses should see and listen to the family and build a relationship with them (P2,3,6):

> The nurse is the most important person for the patients and the families. They speak and see them the most. They (families) only see me occasionally, when I pass by, as if descending from my ivory tower. Nurses have the most contact with them, and they must establish trust that any concerns that the family has will be heard.
>
> (P6)

Information sharing

According to physicians, nurses also have a role in information sharing—not only information based on their own nursing observations but also medical information. Whereas nurses indicated that they are not allowed to offer medical information, physicians reported that it is the nurse's role to clarify any ambiguities as quickly as possible; thus, if asked, nurses are allowed and expected to provide medical information (P2,6,7):

> Nurses can state for which problems someone has been admitted and which examinations will follow. And even discuss or give results that they have discussed with us first. Then they can address any uncertainty at an early stage.
>
> (P6)

Physicians reported that the nurse's primary role is to obtain information about the family to establish for them a useful background of the patient and the situation at home. In this regard, physicians noticed that sometimes they expect more in-depth information about the home situation than has been collected by nurses (P2,3,6,7). Although information gathering from family is primarily deemed a nurse's task, many physicians therefore also conduct an interview of the family themselves (P1,4–7):

> On the ward, in principle, the nurse performs an interview of the family. Then it depends a bit on which nurse you talk to if a clear picture of the patient's situation at home has been obtained. Sometimes no one knows exactly how it (home situation) is. Yes, and then you are going to clarify that with a conversation yourself. Then you call the first contact person, or you may speak to them at the bedside, or you may have a formal family conversation scheduled.
>
> (P4)

Physicians stated that the nurse's role during a formal family conversation is to complement the physician's information about the health of the patient with daily observations:

> Nurses can of course complement the physician by describing their observations [...] They can provide additional information that we (physicians) yet do not have.
>
> (P7)

Physicians also described the nurse's role in informing the patient, family, and other health care professionals about discharge, stating that nurses generally have a more clear understanding of what is needed at home than physicians do (P1–6):

> When it comes to discharging a patient, a nurse has a much better overview of what someone can and cannot do themselves.
>
> (P5)

Offer support

Physicians also appreciated the family supporting role of nurses. They reported that nurses have more contact with

families than physicians do and therefore can better assess whether some ambiguities or concerns remain with the family after e.g., a formal family conversation (P5–7):

> I always want to have nurses present at a family conversation, because they will speak to the patient afterwards and then if there are any ambiguities, they can address them.
>
> (P5)

In addition, they believe they have a role to provide suitable (emotional) support to families but believe that this is mainly a role for the nurses. (P1,3,4–7). Nurses are continuously present on the ward and thus have more time and contact with family to support them.

Physicians' roles according to nurses

Building a relationship

All nurses reported that physicians have the role of building a relationship with the patient and family. Nurses indicated that this role of physicians—to establish contact with the family—is fulfilled in different ways. Some physicians walk by spontaneously during visiting hours, while others only make contact at the family's or nurse's request:

> Often the physician says, I will walk by, because that family is always there at three o'clock.
>
> (N1)

Information sharing

Providing families with medical care updates and answering their (medical) questions are part of the physician's role of information sharing according to all nurses:

> The family has a lot of questions, and if nurses can't give the answers, then often a formal talk of the physician with the family will be scheduled [...] where the current (health) situation of the patient will be discussed.
>
> (N1)

Nurses described that it is also the physician's role to receive information from families. Physicians should know the patient and their home situation, so this can be considered when formulating the medical policy for the patient.

DISCUSSION

We explored how physicians and nurses view their own and each other's roles in communication and collaboration with families during hospitalisation of an adult patient. "Building a relationship" and "sharing information" with families were roles that both nurses and physicians share regarding communication and collaboration with families. "Providing support to family" is seen as a nurse-specific role by both professions.

The physicians' roles of "building a relationship" and "sharing information" have been reported earlier but were primarily aimed at providing medical information and mainly focuses on physician–patient relations, not family relations [11, 36]. Medical specialists in the Netherlands are trained according to a Medical Training Framework based on the CanMEDS competency framework [23]. In the Dutch framework physicians' communication is described as "striving for and fostering an empathic relationship with patients, their loved ones, and other (care) professionals to collect and share essential information required for good care" [37]. This description, however, is quite general and does not specify this role of the physician in clinical practice regarding communication and collaboration with a patient's family.

Nurses also have a training program based upon the CanMEDS competency framework with a general description of their role in communication and collaboration with families, where building a relationship and sharing information are recognised [24]. The nurse's role as communicator is to ensure optimal information exchange between the patient and their informal network, and the nurse's role as collaborator is to build a relationship of trust, working together with patients and their relatives based on the principles of shared decision-making, and to support them in self-management [24]. In addition to this competence framework, nurses also have a classification system that provides family-focused diagnosis and interventions, including building a relationship, sharing information, and offering support to families as part of the interventions [25, 26]. These interventions, for example "family support" offer a concise description of the nurse's role [26]. Both physicians and nurses in this study reported that nurses are the prime contact person for families, as they are more available at the patient's bedside than physicians are and thus have the role of supporting families. In line with these findings, the study of Kalocsai et al. [11], based on family perspective, found that the nurse's role was to facilitate the understanding of medical information and to provide emotional support to families through frequent, clear, and empathetic communication throughout the day. Nurses are uniquely positioned in communication and collaboration with families during a patient's hospitalisation [38, 39]. Although this nurse's role seems to be clear in theory, research shows that in daily practice nurses do not always act in a way that supports families [40].

The analysis of the interviews revealed a clear perception of how both professionals view their roles in daily

practice. However, nurses' and physicians' views of each other role in communication and collaboration with families varied and did not always meet each other's expectations. For example, a physician expects a nurse to be well informed about a family situation, but that expectation is not always fulfilled. Furthermore, interviewees reported ambiguity regarding the role of "information sharing." Physicians and nurses have overlapping roles and do not always know what information is provided to the family or obtained from the family by the other professional. Medical and nursing interaction with the family seem to run in parallel, but information sharing between the two disciplines leaves much to be desired. Clearly, knowledge about, and understanding of each other's professional roles are important [41]. Factors that influence the collaboration between nurses and physicians include the quality of their communication; how they coordinate their communication and what information they expect from each other, and whether they actually receive information from each other [42]. Mutual respect and trust in the working relationship between physicians and nurses are also important.

For efficient nurse–physician collaboration each profession must be aware of and respect each other roles, skills, and responsibilities [41]. Both health care professionals have generic descriptions of the role of "communicator" and "collaborator" how to communicate and collaborate with each other as well as with family to ensure good patient care. However, there seems to be a clear need for explicit agreements on how to fulfil these roles in clinical practice with clear assigning of responsibilities.

Strengths and limitations

All participating professionals were from the same hospital department, which limits the transferability of the findings. However, care was taken to remain true to the data and to limit bias from interpretations. To this end, the research process was logical, traceable, and clearly documented, following the consolidated criteria for reporting qualitative research.

This study provides insight into how physicians and nurses view their roles regarding communication and collaboration with families in their daily practice during a patient's hospitalisation, from admission to discharge. There was not a focus on a specific moment or specific conversation during hospitalisation. It can be argued that the context of a family conversation influences the role division of physicians and nurses. For example, in conversations with families and patients about medical results or treatment decisions, physicians have a much more explicit role than nurses. However, this study had the aim to explore generic roles of nurses and physicians regarding communication and collaboration with families during the entire hospital stay and not during specific moments.

Recommendations for practice, education and further research

Role divisions and expectations in communication and collaboration should be clear to introduce families as part of the healthcare team. Physicians and nurses both play a role in communication and collaboration with families; however, there is no clear division of roles between these healthcare professionals. Therefore, further research should explore how these roles can be properly portrayed in practice to ensure optimal communication and collaboration between physician, nurse, patient, and family during hospitalisation of an adult patient.

In this study, the perspectives of physicians and nurses were studied. To conduct interprofessional communication and collaboration, roles, and responsibilities of all involved in the care situation should be clear. Therefore, further research should also explore the perspectives and roles of patients and families in communication and collaboration with the different healthcare professionals.

Communication and collaboration patterns are deeply embedded in professional identity and organisational cultures [42]. The next step in the identification of specific roles of nurses and physicians in communication with family is to integrate this communication into education and practice. Nurses and physicians both have their educational curricula, which should consider to family integration. Furthermore, interprofessional education is needed to learn how physicians and nurses work together as professionals with families.

CONCLUSION

Current changes in society and health care call for an increased awareness of the importance of family involvement during a patient's hospitalisation. Physicians and nurses see a role for themselves and each other in communication and collaboration with patients and their families. However, the division of roles, tasks and expectations thereof are different, overlapping, and unclear. To assign family a role and position during the hospital care process, clarification of the roles of physicians and nurses in this

partnership is necessary. A clear need exists for the operationalization of general role descriptions into more specific and explicit agreements on how to fulfil these roles in clinical practice.

AUTHOR CONTRIBUTIONS

All authors contributed to the study conception and design. Josien Woldring, prepared materials and performed data collection. Josien Woldring, Marie Louise Luttik, and Wolter Paans performed data analysis. Josien Woldring wrote the first draft of the manuscript, and all other authors suggested improvements to subsequent drafts of the manuscript. All authors read and approved the final manuscript.

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CONFLICT OF INTEREST STATEMENT

The authors of the current study have no conflicts of interest to declare.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available in the supplementary material or from the corresponding author upon reasonable request.

ETHICS STATEMENT

Approval was granted by the Ethics Committee of the University Medical Center Groningen (UMCG) in January 2022, research number 202100640. The healthcare professionals received written and oral information about the study before data collection, and informed consent was obtained from all individual participants included in the study. Participants were informed that their identities and the collected data would be kept confidential and that they could withdraw from the study at any time.

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APPENDIX 1

COREQ checklist.

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	P 5
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	Title page
Occupation	3	What was their occupation at the time of the study?	Title page
Gender	4	Was the researcher male or female?	N/A
Experience and training	5	What experience or training did the researcher have?	p6
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	p6
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	p6
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	p 6
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	p5
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	p5
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	p5
Sample size	12	How many participants were in the study?	p5
Non-participation	13	How many people refused to participate or dropped out? Reasons?	p5
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	p6
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	n/a
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	p5
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	p5/6
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	p5/6
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	p6
Field notes	20	Were field notes made during and/or after the inter view or focus group?	p6
Duration	21	What was the duration of the inter views or focus group?	p6
Data saturation	22	Was data saturation discussed?	p6
Transcripts returned	23	Were transcripts returned to participants for comment and/or	p6

Topic	Item No.	Guide Questions/Description	Reported on Page No.
		correction?	
Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data?	p6
Description of the coding tree	25	Did authors provide a description of the coding tree?	seperate file
Derivation of themes	26	Were themes identified in advance or derived from the data?	p6
Software	27	What software, if applicable, was used to manage the data?	p6
Participant checking	28	Did participants provide feedback on the findings?	p6
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	p8
Data and findings consistent	30	Was there consistency between the data presented and the findings?	p8
Clarity of major themes	31	Were major themes clearly presented in the findings?	p8
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	p15

Developed from: Tong et al. [30].

APPENDIX 2

Interview guide.

Topics	Subtopics	Possible opening questions
Communication with families	Experience	What do you think of when I say communication with family?
	Role view	What role does the nurse, physician, patient, and family have in such a communication moment?
	Reflection	How would you like to see the communication and the division of roles in it?
	Circumstances/ Conditions	What is needed to be able to communicate well with family and to have a clear division of roles in this?
Collaboration with families	Experience	What do you think of when I talk about collaborating with family?
	Role view	What role does the nurse, physician, patient, and family have in working together?
	Reflection	How would you like to see the collaboration and the division of roles in it?
	Circumstances/ Conditions	What is needed to be able to work well with family and to have a clear division of roles in this?

APPENDIX 3

Code tree.