



Original Article

Interpersonal Communication among Critical Care Nurses: an Ethnographic Study

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Article History:

Received: 31 Aug. 2018

Accepted: 13 Jan. 2019

ePublished: 1 Mar. 2020

Keywords:

Personal, Communications, Ethnography, Critical care, Nurses

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yahoo.com**ABSTRACT****Introduction:** Interpersonal communication in critical care units is one of the most important factors due to complicated and critical conditions of patients. Nurses' confrontation with ethical distresses and conflict resolution techniques are often influenced by the culture governing these units. This study aimed to explore interpersonal communication culture among critical care nurses.**Methods:** A focused ethnographic approach was used to conduct study in Iran. The research method was based on the research evolutionary cycle model recommended by Spradley (1980). Data were collected over six months through purposeful sampling and semi structured interviews (n=18) and participation observation (n=43). The data were obtained over six months of observation and interview with participants. Data analysis was done by Spradley method and was interpreted to discover the meaning units from the obtained themes. MAXQDA10 was used to manage data.**Results:** Five major domains of observations and high-level consensus were extracted in this study, including grouping, work-life interaction, professionalism, organizational atmosphere and experience.**Conclusion:** Development of interpersonal communication culture is influenced by various factors. Besides, the working models and nurses' use of workspace are indispensable components of effective communication at workplace. The findings of this study can be helpful in determining appropriate strategies and practices to resolve communication problems among nurses by specifying challenges, thereby leading to proper communication among nurses, promoting this communication and finally providing high quality and more effective care.**Citation:** Mahvar T, Mohammadi N, Seyedfatemi N, Vedadhir. Interpersonal communication among critical care nurses: an ethnographic study. J Caring Sci 2020; 9 (1): 57-64. doi:10.34172/jcs.2020.009**Introduction**

The word communication is derived from the Latin word 'communis' which means common. The definition underscores the fact that unless a common understanding results from the exchange of information, there is no communication. Communication can be defined as the process of transmitting information and common understanding from one person to another.^{1,2}

Communication may be intentional or unintentional, may involve conventional or unconventional signals, may take linguistic or non-linguistic forms, and may occur through spoken or other modes.³ This act of making common and known is carried out through exchange of thoughts and ideas. The exchange of thoughts and ideas can be accomplished by gestures, signs, signals, speech or writing. Basically, communication is sharing information, whether in writing or orally.²

Communication is also a key factor in team activities and facilitates the provision of health services.^{1,4}

Therefore, communication is of great importance in health sciences in general and nursing profession in particular. One of the major activities of nurses is to communicate. Appropriate communication can enhance

the worklife of nurses by increasing their satisfaction with professional communication and reducing conflicts among colleagues.² Communication problems are one of the most important factors involved in interpersonal conflicts among nurses, which can lead to medical errors, poor cooperation and provision of low quality care.⁵ This communication can be up or down the hierarchy (vertical level) or with other nurses (horizontal level).³

Communication is always a challenging issue in both vertical and horizontal levels, because nursing profession requires teamwork to provide the patients with healthcare. Horizontal level of communication is also called interpersonal communication. Appropriate interpersonal communication among nurses promotes healthcare in patients.

A research study has shown that inappropriate interpersonal communication can cause negative reactions such as unilateral judgment, blaming the other party, resentment and annoyance, anger, deliberate opposition, territorial threat, over-expectation, disruption, insult, unfairness, jealousy, contemplation and escape from work.³ These negative outcomes, which are caused following conflicting interpersonal communication, can in turn, expose the nurses to job stress.⁴ In addition, job stress and high physical and

mental exhaustion in nurses bring about conflict, intense transfer and vulnerability in professional communications, reduce healthcare quality and finally cause dissatisfaction and job abandonment.³ Novice nurses have been reported to experience injustice and oppression on the part of nursing authorities due to inappropriate interpersonal communications, thereby reducing their work quality.⁶

Interpersonal communication skill is one of the most important abilities of nurses.⁵ Although interpersonal communication is crucial in all levels and areas of nursing profession, interpersonal communication among critical care nurses is even more significant, because it is more challenging and causes high tension and high workload in these areas. Dougherty et al., reported that based on the analyses of American Association of Critical Care Nurses, 53% of critical care nurses declared that they were not being supported by their colleagues and 33% of them had experienced poor and unfair interaction with their peers.⁷ Poor interpersonal communication among nurses is a problem. However it is not often identified or reported or more often gets poorly reported.⁸

Cooperation and interpersonal communication with colleagues are often dependent on a desirable working culture. A healthy work culture provides more cooperation by the personnel, reduces job abandonment and provides high quality care in nurses.⁹ It helps to increase learning atmosphere and job satisfaction, reduce job stress and finally promote effective cooperation.¹⁰ To identify the factors inhibiting positive communication, it is necessary to understand the nurses' interpersonal communication to determine the factors involved in developing and nurturing positive nurse-to-nurse communication (critical). This can help nurses to create and maintain a healthy working culture.¹¹ Working models, interpersonal communication between nurses and the use of the workplace are inseparable components of effective communication at workplace. Historical and social interpretation and explanation as well as sex factors that affect the behaviors and communication in nurses are of high significance.¹² Therefore, the culture governing the nurses' interpersonal communication and conflict resolution techniques influence the management of critical care units and quality of patient care.⁵

Every cultural nursing area has its own unique behavioral models, values and rules. Therefore, each nursing area has its own characteristics, which are a part of the unique culture of area. Nurses who are in a unique specific area should behave based on the culture codes and rules.¹³ However, factors such as religious beliefs, education, verbal and non-verbal communication skills, close cooperation with colleagues, work experience, self-confidence, welcoming criticism, being advocate and negative feelings to workplace impact on the interpersonal communication process. Undoubtedly, there still are certain hidden and unknown layers of culture in nurses' interpersonal communication which need more cultural studies to be clarified. In professions

such as nursing that deal with human phenomena, it is imperative to employ qualitative research approaches that attempt to describe and interpret human phenomena that are not quantifiable in quantitative ways. The purpose of this study is to explore the interpersonal communication culture among critical care nurses.

Materials and methods

This study is a focused ethnographic research, which focused on three elements of the interpersonal communication culture among critical care nurses, including place, structure and communication.¹⁴

Descriptive ethnographic approach is used in this study. The study ethically approved [IR.IUMS. REC. 1395.9321199006 (2017 April 17)] by the Research Ethical Committee of Iran University of Medical Sciences. After receiving ethics approval and necessary permissions obtained from Kermanshah university of Medical sciences, the researcher started to introduction and collect data. At Kermanshah University of Medical Sciences, the researcher was referred to the university security department and submitted a report of the research plan to the department, with the consent of the research project being issued.

The study was conducted in the critical care unit of a teaching hospital affiliated to Kermanshah University of Medical Sciences. This unit has 12 active beds and every nurse is responsible for taking care of two patients. The work shifts of nurses are fixed in morning shifts and in rotation (morning, evening and night shifts). Nurses with more work experience normally work on the morning shift. Nurses were from different religions, different work experience in nursing and in critical care unit and from diverse ethnic and language backgrounds, Nurse assistants under supervision of registered nurses were normally responsible to provide the fundamental nursing care (such as changing position and washing) in this unit and registered nurses provide specific and complex nursing care. According to the critical care unit's rule, new staff and nurses train for one month in the morning shifts by the nurse manager or an experienced nurse. After appraisal of the new staff, they could commence their job responsibility. Visiting time of patients is very strict in the unit. Nurses should attend in the unit approximately half an hour before handover and changing shifts. Nurse Manager or in-charge nurses allocate the nurses based on their competence and patients' critical status. In-charge nurses also allocate nursing staff in the monthly timetables.

Observation and interview were used as data collection method to collect the required data in a period of six months from July 2107 to December 2017. Data collection process was started with the presence of the principal researcher in the unit. The principal researcher (T.M) used a selective and purposeful direct observation method to collect data of interpersonal communication among nurses and took field notes of ideas and events in different conditions. Observations were conducted in

different shifts (morning, evening and night duty) and the average time of observations was 185 minutes. After the formal entry into each special care unit, data collection was started, using participatory observation and identification of subjects contributing to the field interview. At first, observations were generally conducted, which lasted 40 hours for 1 month. In this regard, sector routines, working relationships, and environment were identified. View from the start of the section. Then the purposeful observation was continued with the aim of understanding relations, interactions, behaviors, verbal and non-verbal communication, and so on. With the official start of the data collection process, the researcher had 27 job shifts in the intensive care unit, which included 13 shifts in the morning, 10 shifts in the evening and 4 shifts in the night.

In this study, the focus was on collecting data on the three elements of the place, the structure of the intensive care unit and the nurses present and their activities.

The researcher was observing the intensive care unit, nurses and their activities, s/he tried to participate in the activity of the nurses. The extent of the participation of the researcher at the beginning of the visit was almost minimal and the researcher was more likely to observe the activities and events. But over time, with the trust of the nurses and sometimes other groups attending the department, such as physicians, physiotherapists, laboratory staff, etc., the extent of the researcher's activity and participation increased. The researcher's participation was so great that, while observing the nurses' interactions and activities, this partnership did not create a gap in the care of the patients, and the researcher took all of his collaborative actions to observe ethical considerations and prevent the patients from getting harmed. He constantly supervised the nurse responsible for each bed and head nurse.

It should be noted that participation in all nursing interventions was carried out with the presence and consent and supervision of participation.

During the data collection process, if the principal researcher needed complimentary data to make a situation clear, a face-to-face in-depth interview was conducted by the recruited participants after obtaining an informed consent form. The participants were selected by a purposive sampling method. The interviews were conducted with eight participants and interview durations lasted from 30 minutes up to 45 minutes. The place to talk with nurses was usually in the rest room or at the station. Occasionally, these conversations took place at the bedside of the patients and in shorter time .

The appointment was made by appointment and prior notice, and the participants were invited to participate in the course. Using the tape recorder to record the interview was granted permission and satisfaction. Data collection was continued until data saturation was reached. The potential participants were nurses with bachelor and master degree in nursing, working in the critical care unit. The nurses' work experience varied from newly-employed nurses to nurses with more than

20 years' work experience who were working as clinical nurse, shift in-charge nurse, infection control nurse, nurse educator, and nurse manager. Semi-structured in-depth interviews were conducted with participants to make an opportunity for them to express their experience of interpersonal communication. To strengthen the methodology and credibility of the data, the data were collected from various sources such as: observation, formal and informal interviews, and document review, presence in the research environment and continuous observation, long-term thinking, drowning in the data, and integration of notes. Reliability is achieved when another researcher is able to achieve similar results using researcher perspectives, raw data and analytical documents. For this purpose, in the field and documentation, the text of the interviews and analysis of all of them together, the expression of rethinking, the views and experiences of the researcher, the control of the findings by the participants of the study and reflection and control of the data with the members of the research team. In this study, data collection and data analysis were conducted concurrently, using domain analysis method proposed by Spradley.¹⁵ It should be noted that MAXQDA-10 software (VERBI GmbH, Germany) was used to manage data.

Results

Five major domains were extracted in the process of data analysis, including grouping, work-life interaction, professionalism, organizational atmosphere and experience (Table 1).

Grouping

Grouping was the first major domain which emerged in the study in the process of observation and interview with the participants. The study findings showed that nurses tended to become members of a specific group based on their commonalities and received the support of their group. Also membership in a group provided them with a sense of security, satisfaction and peace. In each group, usually one person was in-charge of the group and guided the group toward its objectives. In addition to the workplace, the grouping existed outside the workplace. The commonalities and factors creating groups vary, and every person may be the member of several groups simultaneously. Their commonalities may involve factors such as gender, religion, interests, employment type, work experience and age. For example, an interviewee stated:

"Here there is a kind of team leader ...usually two people become leaders in two groups and nurses become their members..... Usually one group is aggressive and another group tries to proceed gently, i.e. classification of nurses. Of Course, there is also a group of nurses spending their after graduation service, which is not very important....but these two major groups I am talking about....one of them is compromising and another one uses power and aggression.... However, I do not prefer aggression.... I prefer to join the group that is gentle and tries to talk over the problems....of course, not very much, but I am a member".(I4)

Table 1. Major domains extracted from observation and high level codes

Domains	Sub-domains	Primary codes
Grouping	Out of unit grouping	Out of unit communication outcomes The sense of sincerity in communication out of unit, out of section Doing common activities Get rid of the clauses
	Inside unit grouping	Advantages of the group on individual demand Grouping outcomes Support by members of the group The diversity of groups based on the shared interests and interests of the members
Work-life interaction	Personal characteristics	Everyday routine Inactivity Monotonous life Fatigue Reduced self-care power Penetration of work stress into personal life Interference in personal life Personal problems involved in work Behavioral similarity of men to women
	Cultural atmosphere governing communication	Female leadership Family culture Style of dressing Accent Not counting the nomads
Professionalism	Professional communication	Horizontal communication Vertical communication Interactive collaboration between nurses Impact of nurses' generation change on relationship conflicts Change behavior with change of responsibility
	Non-professional communication	Need to have a supporter Privacy Human relations Respect Fake pride Lack of transparency in speaking Sense of superiority owing to work experience
Organizational atmosphere	Physical space	Quiet environment Closed space Dark tunnel Quiet in terms of human voice Busy in terms of machine noise Unit appearance effects
	Working environment	Positive feeling about the unit Negative feeling about the unit
Experience	Work experience	Staff's adaptability to experience Importance of experience in critical care unit Failure to transfer experience to colleague Considering experience by less-experienced personnel Diminished culture of mutual respect over time
	Experience in informal communications out of unit grouping	Bitter experience of friendship Hurt feeling Fear of making friends again Risk of losing job Abuse

More experienced nurses added *"newly arrived personnel are being trained by one of the morning shift personnel. The groups were also completely separated during work and rest"*.(I4)

In the following, an observation of the researcher is *unit had been divided into two sections, half of the personnel were up the ward and the other half was down the ward. I preferred to go up the ward because I knew the personnel there"* (O10).

Work-life interaction

Another domain extracted in this study was work-life domain. The interpersonal communication of nurses was formed based on the interaction of their work and personal life. The results of this study showed there was an interaction between the nurses' working conditions and communication at workplace and their personal life. The effect of working conditions such as tiredness, daily routines and work stresses affected the nurses' personal

life. Compliance or non-compliance with conflicts in the Workplace or life influences the nurses' communications. Non-compliance with conflicts can result in specific problems at work such as increased absence from work, reduced efficiency, motivation, reduced job satisfaction, job abandonment, etc., which in turn causes communication conflicts in the workplace and life. Nurses may also go through behavioral changes depending on their gender. For example, women's sense of leadership in life as a result of their leadership at workplace and men's behavioral similarity to women in critical care units, because of the greater number of female nurses and effect of their behavioral features on men, and even cultural effects in their communication such as underestimating local subcultures and people's appearance indicate the effects of work-life interaction. The following text is taken from interviews with nurses in this regard.

"The women believe they will become some kind of leader because the work environment here makes you manage many types of work. This will certainly affect the personal life....you know the result of every behavior. After a while, you gain experience in predicting the result of every behavior... you will certainly adopt that behavior at home.... In terms of personality, men do not often backbite in our culture.... But men here are different from the men outside here.... For example, the behavior of the boys doing their after graduation service changes a lot after about a year compared to when they first came here.....they change.....they become similar to women.... There are four women on each shift here. We have one male nurse. How much does he want to be alone? After a while, he has to talk with the women and more in their interaction with their attitudes and behavior, which certainly affects their behavior over time" (I10)

In an interview with a male nurse with 10 years of work experience working in the night shift, he said: *"I tried not to let my job affect my life ... but couldn't. I had a problem in my personal life ... The family is not happy with my working hours and I have to spend night shifting at work, so I'm going to make some changes, but unfortunately, our work is a bit too hard ... you're just getting tired. It does not give you the power you need for yourself and your family"*. (I7)

Professionalism

Professionalism is another domain extracted in this study. The critical care nurses experienced professional and non-professional communication, which sometimes interfered with each other. Professional communication included horizontal relations (peers) and vertical relations (high ranking managers). Non-professional communication was based on the needs, human relations, common personal characteristics, reactions and previous experience of the nurses. Each of these relations had in turn many positive and negative aspects which could directly or indirectly affect the nurses' communications. In the following, an example of interaction of professional and non-professional communication among nurses is presented.

"About 8:00 am when I entered the unit, I heard a lot of noise, the night shift superintendent and one of the Young nurses of

the same shift were talking with the matron. Apparently the cartridge of a drug used for the patient had been lost. The young nurse was responsible for it. The nurse director said angrily, I will not support you anymore, you have been careless several times, and the young nurse blamed the shift superintendent and said she had to take the empty cartridge. The shift in-charge and nurse director were in the same front and said, you are responsible for all the work of your patient based on the routine of the unit, and you have been previously warned about it in other cases. Now, there is no other choice but reporting the lost cartridge to the nursing office. The young nurse told indifferently "report it, this is what you always do". It is always the same... and she left there.... The shift superintendent said you see how rude she is.... Please do not put her in my shift....she makes me crazy until morning, and the matron said I have to punish her, I have no other choice."(O21)

Organizational atmosphere

The fourth major domain extracted in this study was organizational atmosphere. Organizational atmosphere of the critical care unit is a significant factor involved in the quality of nurses' interpersonal communications. The findings of this study showed the quality of physical space of critical care units such as closed environment and reduction of human voice and mechanical machines noise as well as working space such as positive and negative feelings of nurses about their workplace affect their interpersonal communication. For instance, one of the participants stated:

" Nurses pay more attention to work. This is the positive point of this unit, in my idea. But this can also be negative because we are not friends and we just work here. I feel I enter a formal environment when I enter the unit and I put away some of my moralities, and when I quit here, I feel I am free from a series of limitations and have entered a quiet environment. Out of here, I feel more peace....most of the time, because our work environment is very stressful, and we are not close friends really....this is a stressful environment for us. When we enter this environment, we feel this stress more. When we quit here, we feel free". (O17)

In the following, an observation of the researcher is presented:

"The place was located in the basement of the hospital. It had a dark and light. It was a distraction. It took a few minutes to go to the main space of the section. The walls of the gray part of the cream were bright. The curtains of the unit of the patients were bright gray and, more interestingly, some of the curtains were drawn, and from the nurses' posts, it was not seen at all and the patient's unit space. The overall atmosphere was not pleasant, and it gave me a feeling of heaviness, leanness and weakness". (O9)

Experience

Experience is a term frequently heard in conversations between nurses. Their experience involves whatever skills and knowledge they have acquired during years of working, as well as, the experience from their informal communication on memories about different subjects in a specific period. Both types of experiences affect their interpersonal communication. For example, the effect of work experience can be clearly seen in the interaction

Between experienced and novice personnel, and both sides state instances of compatibility and incompatibility related to work experience. Moreover, negative or positive experiences of informal communication in the past affect the present and future communication of nurses. One of the participants stated that:

"I don't like to be a close friend with anyone. My bad history of friendship has made me not seek another experience of that sort again. That is to say, I don't know many of them and they don't know me, either. For this reason, I don't like to communicate with them and have another bitter experience, because it was very hard for me. Both in terms of the feeling I had and the fear that I could have lost my job....she had told bad things about me, and bad things happened to me. They went so far as investigating to see whether I was right or that person was right. She was even going to be punished for what she had done, and she was transferred from critical care unit to another ward. But it was not enough for me. She left this unit, but she left that difficult and bad experience for me. I always feel bad about it".(I15)

In one of my hours in the morning shift I saw that:

" A novice nurse who had just begun work in the intensive care unit for only one month, telephoned the patient's condition to the doctor, speaking loudly and seemed to want to do his best. Ask the doctor to give more accurate and more information. The nurse sat close to him and was sitting at the station, and provided with cool information without looking at her. A clinical nurse with a history of 12 years in front of him And on the other side of the station, he checked the opiate's wardrobe and repeatedly looked back at him, so that ... do not get so scared ... we heard ... everyone heard. ... How much did you get this planet.... do not give ... do not be afraid..... The designer's nurse sometimes looked at her and raised her voice ... it seemed that she could the photographer wants to treat the experienced nurse and show his protest".(O23)

Discussion

Interpersonal communication issue is one of the most common causes of conflict in critical care units and leads to failure to meet or respond to a colleague's request for information. It also causes non-professional behaviors of nurses such as lack of mutual respect.¹⁶ Effective interpersonal communication can help nurses in provision of high quality care and preserving the capital. The studies have reported effective communication provides a significant increase in the quality of care; improves effective treatments and care plans; enhances satisfaction of patients and health professionals; and increases retention rate of nurses. In addition, effective interpersonal communication improves health professionals performance and coordination; increases shared responsibility and creativity;¹⁷ reduces days of hospitalization; reduces unnecessary administrative visits; and prevents medical errors.^{18,19} Although interpersonal communication is complicated and vital in a stressful working environment, communication conflicts may arise and have impacts on decisions made by health nurses under intense time pressure.

The findings of this study showed critical care nurses were attached to certain inward and outward groups based on commonalities among group members. There are many commonalities impact on nurses' attachment to a certain group including gender, religion, interests, employment type, work experience and age. According to exclusive type of commonalities, a certain group establishes and support by the group members. Studies have shown that nurses' gender plays a role in their grouping and commonalities. Also, men and women use different methods for communication and conflict resolution. Men are more inclined than women to make use of compromising methods.²⁰ Further, cultural differences are involved in nurses' interpersonal communications, and evidence shows that Asians are less interested in expressing their feelings about disagreements.²¹ However, some studies have reported that most Iranian nurses working in critical care units tend to talk to settle their disagreements.²²

Professional communications (horizontal and vertical) occur in critical care units based on the needs, privacy, human relations, reactions, work experience and personal characteristics. These communications affect the cooperation and efficiency of nurses. Research has shown that poor communication is a significant problem in critical care units, and occurs quite frequently. Poor communication often leads to errors following poor cooperation and conflict among nurses. Conflicts can only be resolved by communication. Therefore, interpersonal communication skill is an important ability for the nurses and their leaders.^{5,32}

On the other hand, good communication can increase nurses' satisfaction with inter-professional communications and reduce conflicts among the colleagues. It also increases the nurses' retention in the nursing profession and to some extent provide the healthcare system with required nursing force. Some studies have reported improved communication among nurses and nursing managers, transitional leadership style of managers, extrovert personality trait and attractive organizational structures of the ,which support the competency and capability of nurses, group independence and integrity and university graduates, improve interpersonal communication in nurses and nursing managers, thereby enhancing job satisfaction, maintaining the nurses and preventing frequent transfer.²³ Some studies have reported that nurses with poor experience in nurse-to-nurse reactions face problems in asking questions and seeking strategies from other nurses, so the possibility of committing errors in patient care is increased.⁷ When there is poor communication and cooperation among nurses in the unit, it will be difficult for the newly-employed nurse to work, and workplace will become unsafe.²⁴

Negative reactions, threats, prior negative experiences and illogical and unfair behavior with nurses regarding the errors and unsafe work environment play a role in making and repeating medical errors. Cooperation,

communication skills, making effective decisions and correct diagnoses make the nurses' work valuable and Promote the patient care and health care system.²⁵

Creation and maintenance of physically healthy work environments and identification of factors inhibiting positive communication among nurses improve communications.¹¹ Close communication among nurses creates an atmosphere for good cooperative communication. Promotion of professional communication enhances learning and job satisfaction, reduces job stress in nurses and finally promotes cooperation among them.¹⁰ On the other hand, conflict in nursing profession, especially among critical care nurses induces negative feelings conventionally, reduces concentration and causes disappointment and enmity.

This negative feeling can be transferred to the private environment of nurses and cause problems.²⁶ Studies have shown that negative reactions following conflicting events, one-sided judgment of finding the other party guilty, resentment shown as annoyance and anger, intentional disagreement, territorial threat, over-expectation, disobedience, insult, unfairness, jealousy, humiliation and escape from work are negative strategies that are formed following conflicts among nurses.

Another phenomenon that nurses face is job stress. Studies have reported too much job stress and physical and mental exhaustion in nurses, which results in conflict and too much transfer, vulnerability in professional communication, reduced quality of care, dissatisfaction and job abandonment in nurses.^{3,27}

The results of this study showed that work experience and experience in informal communication such as risk of losing the job or friendship experience affected the interpersonal communication in nurses. Accordingly, studies have shown that communication can be influenced by factors such as work experience, education, tendencies and personal beliefs of the nurses, and differences and similarities in this regard may cause damage and hostility or improve the communication.^{7,28}

Understanding and knowledge of conflicts in critical care nurses is associated with two major sources of interpersonal behaviors and care-related behaviors. Interpersonal behaviors include personal hostility, suspicion and distrust, communicative and collaborative gaps and absence of useful meetings inside the unit. The care-related conflicts include lack of psychological support, non-optimal decision-making process, suppression of symptoms and signs of conflict and ignoring them.²⁹ Nurses' failure to achieve independence, communicative gaps and lack of nursing authority are factors that cause conflicts in critical care units.

Moreover, changes in treatment plans due to rotating shifts of nurses increase the risk of conflicts.^{30,31}

Conclusion

Interpersonal communication in nursing is a dynamic, integrated, regular and inevitable process with unique

and multidimensional characteristics that come along with patience, which is dependent on observing the boundaries and scientific, communicative and managerial principles. Effective positive nurse-to-nurse communication is a key to developing a healthy working environment and it is essential to improve the patients' health. This positive communication is established when healthy and safe working environments are created and maintained. Moreover, knowledge and perception of the nurses of their communication in various dimensions help them to reduce and resolve potential and actual problems. As result it guarantees the quality of professional services provided to the patients. In addition, effective positive communication can considerably help nurses to, reduce job abandonment and improve the error reporting rate.

The findings of this study can be helpful in determining appropriate strategies and practices to resolve communicative problems, to create positive communication, promote this communication and provide high quality and more effective healthcare among nurses. However the study finding is limited to the research study setting.

Acknowledgments

This paper was taken from a PhD research project, which was financially supported by Iran University of Medical Sciences. We thank all the participants that participated in the study and support in carrying out this research.

Ethical issues

None to be declared.

Conflict of interest

The authors declare no conflict of interest in this study.

Research Highlights

What is the current knowledge?

Clarify the challenges in nurses' fear communication and enables effective and culturally compatible strategies; can be the basis for corrective interventions.

What is new here?

This study is one of the few studies that has investigated the relationship between nurses with ethnographic lens and multi-ethnographic lens.

Author's contributions

Four authors have collaborated in the form of PhD student, supervisor and advisor professors. Conception and design, Acquisition of data, Analysis and interpretation of data, Drafting the article, Review of article and find approval : TM, NM, NS and AV.

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