Perceptions of Nurses and Doctors Relative to Nurse Clinical Decision Making Authority

By

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ABSTRACT

TITLE: Perceptions of Nurses and Doctors Relative to Nurse Clinical Decision Making Authority

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This study compared perceptions of 42 nurses and doctors of the current and ideal status of the decision-making authority of registered nurses. Each nurse and doctor was asked to rank 25 aspects of practice, in two contexts, using the Authority in Nursing Roles Inventory (ANRI) (Katzman, 1989). The items in the ANRI describe various aspects of nursing practice.

The results of the study indicate nurses and doctors both think nurses should have more clinical decision making authority. The overall difference score for nurses ($p<.05$) showed a positive shift away from zero indicating a statistically significant difference from their perceived current practice and what their perceived ideal practice should be. The overall difference score for the doctors ($p<.01$) showed a positive shift away from zero indicating a statistically significant difference from their current perception of nurse decision making authority and what they perceive the ideal should be. The overall mean difference for the nurses and doctors went in a positive direction from zero and was statistically significant which suggests a desire for change in the direction of increasing nurses' decision making authority.

Oversight of doctors orders and patient teaching are activities done routinely by nursing. The scores of the doctors and the nurses indicate agreement that nurses continue

and expand these functions. This suggests that the doctors are comfortable with what nurses already do and that nurses want to maintain these important areas as aspects of their practice.

Contributing to health care policy and patient management planning have not traditionally been within the realm of nursing. The nurses scores indicate that they feel their functions should be expanded into these areas. While not statistically significant for these aspects of practice the doctors scores suggested that they are satisfied with the nurses decision making authority in these areas.

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Chapter 1

Introduction and Problem Statement

Traditionally, care planning and decision making for patient care has been done within a hierarchical system with the doctor giving orders to be implemented by the nurse. The doctor is essentially absent from the area where patient care is being delivered and must be contacted for patient problems or for requests for alterations to the orders. This decision making model is inefficient, expensive and can have an adverse effect on patient care, patient outcome and length of stay in the hospital (Alpert, 1992; Fagin, 1992; Knaus, 1986; Mechanic, 1982; Weis, 1983).

The hierarchical system for decision making fails because of lack of shared care planning and shared decision making between medicine and nursing. In the hierarchical system the patient has the medical plan of treatment operating in isolation from other care providers trying to accomplish the care and treatment necessary for their diagnosis and treatment. There is another plan of care at work within the hierarchical system and that is the nursing care plan. The two care plans operate in isolation from one another with no communication of issues and no awareness of shared goals. The nursing care plan includes the assessment and daily plan for care but also incorporates patient education, psychosocial issues, family issues and discharge planning. The medical plan of care focuses on assessment diagnosis and treatment.

Communication within the hierarchical system is done through doctors orders, progress notes and nurses' flow charting. This forces the doctor to micro-manage the patient's episode of care. Nursing must interpret the orders and implement them within

that interpretation and often in isolation because of doctor unavailability. Misinterpretations, misunderstanding and errors occur and can cause costly delays and potential harm to the patient (Alpert, 1992; Fagin, 1992).

The patient is ultimately the one that pays the price for the system's inefficiency. The price to the patient is not strictly the final bill. The price also includes the increased risk incurred by the patient through delays in treatment, missed treatments, duplication of treatments, extra days in the hospital, delayed rehabilitation and return to normal daily life with an attendant loss of wages.

The institutional delays for one patient may create a cascade of delays for other patients waiting for services and contribute to higher overall costs. The increased costs for the institution are passed on to the consumers and their third party payers. Third party payers are holding hospitals accountable for these costs by not reimbursing for duplicate tests, treatments or extra days in the hospital that fall outside the maximum required length of stay for the diagnosis. These must be absorbed by the institution and passed on to the consumer through higher prices. Hospital revenue controlled by preset reimbursement will not cover the cost of non-reimbursed services, treatments and extra hospital days.

The literature suggests that one solution is a formal collaborative decision making model for doctors and nurses. Collaboration is the coming together of different disciplines with a common focus. The result of collaboration is synergism - the combined effect of joint action being more effective than the action of any single individual (Alpert, 1992; Chavigny, 1988; Fagin, 1992).

Collaborative decision making is founded on mutual trust between nursing and medicine and respect for each other's expertise with the patient and his/her well being as the focal point. This applies to the activities of care planning, care conferences, setting of shared long range goals and joint care plans with respect for the particular issues of both specialties.

A key point is the need for a shared understanding between nursing and medicine, that nurses must have autonomous decision making authority within and related to carrying out the jointly established plan of care. Examples could include but are not limited to, deferring of surgery if a patients' stress test is abnormal, starting IV's, changing inappropriate diets or changes in medication dosage and route (Mechanic, 1982; Makadon, 1985).

Despite significant documentation that collaborative practice improves patient outcomes and decreases costs by decreasing hospital days (Alpert, 1992; Knaus, 1986; McLain, 1988), most hospitals do not utilize this type of model. We can no longer afford to deliver patient care using inefficient wasteful systems. Research done in this area is primarily found in the nursing literature. The focus of much of this work has been an examination of the power or lack of power nurses have in effecting changes in their roles and functions especially related to their roles with doctors (Katzman, 1989; Weiss, 1983). Others have looked at collaborative practice as a critical theory and the positive effect it has on patient outcomes and cost containment (Fagin, 1992; Knaus, 1986; McLain, 1988; Alpert, 1992; NJPC Position Paper, 1974).

With the development of the "Authority in Nursing Roles Inventory" (ANRI), Dr. Katzman (1989) got to the core of the issue of collaboration. That being the attitudes and perceptions of both nurses and doctors relative to the function and scope of nursing's role in clinical decision making. The purpose of the ANRI is to identify and measure conflict areas between nurses and doctors. Through analysis of ANRI results, barriers to and opportunities for success can be defined for collaborative practice.

The purpose of this study is to illustrate for doctors and nurses, what their perceptions are toward nurse clinical decision making authority (Katzman, 1989; McLain, 1988; Fagin, 1992). The results of the ANRI analysis in combination with evidence from the literature could be presented to support a proposal for education and re-alignment of attitudes towards implementation of a collaborative practice model.

Chapter 2

Review of the Literature

Much of the current research has examined the power or lack of power that nurses have in implementing changes in their roles and functions especially in their roles with the doctors with whom they work (Katzman, 1989; Weis, 1983; Keddy, 1986). This work has provided important insight into the problem by defining the lack of power nurses have in their relationships and decision making with doctors. What the literature provided was a perspective on the complex problem of health care delivery in an acute care setting and the suggestion of a solution to the problem of communication and quality health care delivery in acute care settings; the collaborative practice mode.

Nurses' decision making authority is critical for a collaborative practice model to be effective. This project will evaluate the perceptions of nurse clinical decision making authority. This will be achieved through measurement and analysis of the ANRI perception scores.

Fagin (1992) was able to illustrate the benefits of collaborative practice models when she and her co-researchers compared morbidity and mortality rates from several qualitative and descriptive studies. Fagin, et al., looked at collaborative practice models and their outcomes. What was described in several cases was significantly lower morbidity and mortality rates on units that had collaborative practice models. Also noted was improvement in patient satisfaction and a sense of having been well cared for.

At Beth Israel, Alpert (1992) reported from their collaborative practice model pilot unit, that patients had faster rehabilitation and return to normal function than on

other similar surgical units. They compared patient outcomes within specific diagnosis related groups based on patients' progress and functional status from admission to discharge and found significantly shorter hospital stays and shorter rehabilitation periods. They attributed their results to the collaborative practice model on 7 North because of the shared planning and implementation of care between nurses and doctors.

Knaus (1986) concluded that differences in death rate reflected specifically on important differences in effectiveness of patient care planning and delivery. They compared actual death rates to predicted death rates among 13 hospitals' Intensive Care Units and 5030 patients and their outcomes. Variations in patient conditions were controlled through the standardized application of the APACHE II scoring system. Technical capability was evaluated and found to be comparable among the 13 hospitals reviewed. They noted that the hospitals with higher death rates did not have high levels of interaction between nurses and doctors while those hospitals with lower than expected death rates had high levels of interaction and collaboration between nurses and doctors.

The hospitals with lower death rates tended to also have well established care protocols, a senior charge nurse on each shift, a primary nursing model, administrative supports, and a full time nursing director. These factors may also have contributed to the lower mortality rates.

Other investigators have examined collaborative practice as a critical theory in relation to patient outcomes and the direct effect it has on cost containment (McLain, 1988; NJPC Position Paper 1974).

Hospital costs and patient outcomes are closely related. How the patient does and what their outcomes are affect the length of stay. If all treatments go well, if the there are no systems delays or systems errors, the length of stay is a predetermined length based on diagnosis. If there are complications the length of stay will increase. This is to be expected. But increased length of stay due to poor communication between nurses and doctors is not acceptable.

The collaborative decision making model in contrast to the hierarchical model, has been shown to be more efficient and promotes better patient care, patient outcomes and decreased length of stay (Alpert, 1992; Fagin, 1992; Knaus, 1976; Mechanic, 1982). The hierarchical system in which the doctor has the formal authority and is largely absent from the patient care setting is increasingly ineffective in the climate of today's hospital in which patient stays are half of the average length of stay in the early 70's. This is important to note because it illustrates the radical change in focus for acute care delivery. Patients enter the hospital sicker and are in the hospital fewer days. Coupling this with offering more services in a shorter period of time with fewer personnel has increased the responsibilities of the nurses to coordinate and make decisions regarding patient care in the doctors absence (Mechanic, 1982; Stein, 1990).

The value of the collaborative decision making model has been recognized and generally accepted by nurses and doctors for patient care delivery in high acuity units [Acuity is a term that combines patient types, severity of condition and care unit volume as related to the nurse patient ratio (Phillips, 1992)]. Examples of these high acuity units are, Emergency Departments, Intensive Critical Care Units or Labor and Delivery

Departments. The nurses in critical or urgent care settings make critical clinical decisions and are supported by the doctors in these areas. This phenomenon occurs because the needs of the patients are of a sufficiently critical nature that the traditional barriers to autonomous nurse decision making , i.e. the medical hierarchy, are superseded by the demands of the patients' condition. High acuity patient care areas lend themselves to higher levels of collaborative practice. Within this context autonomous decision making by nurses is a critical adjunct to the shared decision making between nurses and doctors (Knaus, 1986; Fagin, 1992). The doctors that work with nurses in these areas not only accept autonomous decision making by nurses, they expect it.

The need for a collaborative decision making model on lower acuity units is also critical. Today patients on lower acuity units are sicker and more like critical care patients than not. These lower acuity care units are where the majority of time is spent by the patient during the episode of care. Doctors make rounds on their patients once or twice during a twenty four hour period. Patients are sicker and less stable therefore orders written once a day are not sufficient to meet the potentially unstable and frequently changing needs of the patient.

The amount of time doctors are on the low acuity units and with their patients is minimal when compared to the minute by minute, hour by hour contact nurses have with their patients (Alpert, McLain, Fagin). The combination of the traditional medical decision making hierarchy and system processes for the communication and implementation of doctors' orders creates a situation that can and often does lead to orders being written in error, missed or interpreted incorrectly due in part to the small amount of

time the nurse and doctor are in contact. The doctor writes orders, the nurse may or may not be present, because of workload constraints and so does not have an opportunity to get clarification while the doctor is on the unit. This can be especially problematic if the doctor and nurse have no shared understanding of treatment and care plans for the patient.

Collaborative practice would improve this communication between nurses and doctors because all plans of care are established in joint care conferences. Collaborative care planning and decision making has been shown to improve morbidity and mortality rates (Knaus, 1986; Fagin, 1992), by decreasing errors in communication and eliminating duplication.

Nurses traditionally have had the authority to monitor doctor's orders for correctness and appropriateness. In addition nurses have taken the lead in patient education. However nurses also need the authority to act on matters within their sphere of competence. Changing inappropriate special diets; modifying medication when indicated, including dosage and mode of administration; rescheduling strenuous diagnosis procedures as indicated by patients' condition; changing surgical dressings if needed; deciding on the frequency of vital-signs monitoring; inserting catheters for patients unable to void; and contributing to decisions on the appropriate time and place for hospital discharge are just a few examples of judgements nurses are qualified and competent to make. In many cases, if these judgements are not made in a timely fashion the result is inconvenience, discomfort and injury to the patient and diminished productivity for both doctors and nurses (Mechanic, 1982; Makadon, 1985).

To set the stage for implementation of a collaborative practice model it is essential that each institution make an initial assessment of a representative sample of the players who will be implementing collaborative practice. The assessment would help target issues and show the need for training. The results could provide focus for the planning of systems changes like multi-disciplinary rounds and protocols needed to support collaborative practice and also for training sessions to promote team building for everyone involved in implementation of a collaborative practice model.

The instrument selected for this project is the "Authority in Nursing Roles Inventory" (Katzman, 1989). The ANRI measures the perception of the respondent in two contexts, current and ideal. When results are analyzed, areas of conflict between respondents can be identified. The contrast between current perceptions and ideal perceptions would focus on discrepancies not only between nurses and doctors but also from within nursing as a group (Katzman, 1989). For example one could conceptually evaluate where to start by sorting aspects of practice into the following categories:

High current/high ideal: Suggests current and ideal are congruent.

High current/low ideal: Suggests that the current is higher than the ideal should be.

Low current/low ideal: Suggests the status quo is congruent with no desire for change.

Low current/high ideal: Suggests the current and ideal are incongruent with desire to change.

The hospital as an institution or a unit within the institution could use the ANRI to evaluate attitudes before and after implementation of a collaborative practice mode. The ANRI could be used to measure effectiveness of educational interventions aimed at re-aligning attitudes with collaborative practice goals.

This study was done to illustrate for doctors and nurses, what their perceptions are toward nurses' decision making authority (Katzman,1989; McLain, 1988; Fagin, 1992). Evidence from the literature and the results of the ANRI analysis could be presented as a package to hospital administrators, faculty and staff. No matter what the findings the message is clearly a challenge to the collective group to strive for collaborative practice to improve patient outcomes while decreasing costs (Knaus, 1986; Alpert, 1992; Fagin, 1992; Katzman, 1989). The first step is to examine perceptions and attitudes as real barriers to successful implementation of collaborative practice. The information gleaned from these questions could provide insight into the current perceptions of nurses and doctors relative to nurse decision making authority. For example, if the overall current scores are low and the overall ideal scores are high this relationship would show disagreement with current level of nurse decision making authority with agreement that a general increase of their authority is desirable. This would mean congruence exists between perceived low current decision making authority and perceived high ideal decision making authority which indicates a desire for change in the direction of increasing nurse decision making authority.

Research Questions

1a. Overall do nurses want more decision making authority than they currently have?

1b. Do nurses want more decision making authority over specific aspects of their practice?

2a. Overall do doctors want nurses to have more decision making authority than they currently have?

2b. Do doctors want nurses to have more decision making authority over specific aspects of nursing practice?

3. Are there aspects of nursing practice where nurses and doctors agree nurses should have more decision making authority?

Chapter 3

Methods

Research Design

This research was a descriptive, correlational study. The author explored the interrelationship between the perceptions of nurses and doctors related to nurses' clinical decision making authority in current and ideal contexts.

Subjects and Setting

The subjects for this study were registered nurses and doctors randomly selected from a large northwest regional teaching hospital. Nurse subjects were randomly selected from three general care units characterized by lower acuity patients: an adult medical unit, a post-partum/gyn unit and an adult surgical unit. The doctors were randomly selected from their specialty department rosters. For the purposes of filling out the questionnaire the doctors were instructed to think only of the unit to which their subspecialty most frequently admits patients.

Of the 100 RN's selected, 15 returned the survey making the response rate 15%. Over half of the nurses who returned their survey were 35 years of age or older, the majority were female and nearly all were college educated. Most nurses had 5 or more years of experience and over half had greater than 10 years of experience (see Table 1).

Of the 100 surveys sent to doctors 27 were returned giving a response rate of 27%. Most of the doctors were over the age of 35 and well over half were male. Most of the doctors had 5 years or more of experience and over half had greater than 10 years of experience (see Table 1).

The nurses were younger than the doctors and mostly female while the doctors were older and mostly male. A majority of both the nurses and the doctors had 10 years or more of experience (see Table 1).

Table 1.
Subjects

		N	RN (%)	N	MD (%)
Age	25-34	7	(46.66)	4	(14.81)
	35-49	6	(40.00)	17	(63.00)
	>50	2	(13.33)	6	(22.22)
Gender	Female	14	(93.33)	9	(33.33)
	Male	1	(06.66)	18	(66.66)
Academic preparation: RNs	Hospital diploma	1	(06.66)		
	Asst. degree	2	(13.33)		
	Bachelors degree	11	(73.33)		
	Masters degree	1	(06.66)		
Years since graduation	30 > years	2	(13.33)	3	(11.11)
	20-29 years	1	(06.66)	5	(19.01)
	10-19 years	5	(48.14)	13	(33.33)
	05-09 years	6	(15.01)	4	(40.00)
	01-04 years	1	(06.66)	2	(07.39)
Specialty	Medical unit	4	(26.00)		
	Surgical unit	5	(33.00)		
	Post-partum unit	6	(40.00)		
	Family practice			5	(18.00)
	Surgery			5	(18.00)
	OB/Gyn			15	(55.55)
	Orthopedics			2	(07.00)

Instrument

The instrument used for this project is a self administered questionnaire, the "Authority in Nursing Roles Inventory" (ANRI). The ANRI was used by permission of Elaine Menter Katzman PhD, RN, who developed it in 1985. The instrument measures the respondents' current and ideal perception of decision making authority relative to aspects of nursing practice (1989).

The 56 item instrument consists of three sections; one section contains six demographic items, a second contains 25 items measuring the perceptions of the respondent to the "current" state of clinical decision making for nurses, a third section contains 25 items measuring the perceptions of the respondents to the "ideal" state of clinical decision making for nurses for the 25 aspects of practice. These last two sections are identical except for the time reference and relate to a variety of aspects of practice such as professional roles, functions and behaviors. Hereafter the first section will be referred to as current and the second section will be referred to as ideal.

The response mode for each aspect of practice is a five point Likert Scale, ranging from strongly agree to strongly disagree. Total scores can be calculated separately by summary item scores for current and ideal. Thus each subject receives two scores each with a potential range from 25-125. High scores on the current scale indicate a perceived high current level of nurses' clinical decision making authority. High scores on the ideal scale indicate a perception that nurses should have a high level of authority.

The instrument has been evaluated for reliability and validity. The content validity was established by a panel of expert faculty and nursing practitioners who came to

consensus on the 25 items (1989). The reliability testing of the ANRI, using coefficient alpha to test for internal consistency, was 0.90 for the current scale and 0.93 for the ideal scale. Over a two month period, the test-retest estimates were 0.82 and 0.81 for current and ideal scales, respectively The sample groups were 99 nurses and 44 doctors (1989).

The construct validity for the ANRI was tested by the known groups technique. In this procedure it was expected that nurses' and doctors' scores on both ANRI scales would differ significantly, particularly on the ideal scale. The Dr. Katzman reported construct validity for the ANRI in that, in this sample, nurses as a group showed significant greater agreement with both current and ideal nursing authority than did the doctors ($F=4.97$, $p<.0001$ for current; $F=13.76$, $p<.0001$ for ideal), (Katzman, 1989).

Procedures

Stake Holders

The Associate Hospital Administrator for the Division of Nursing gave her approval for the study to be conducted.

Personal contact was made by the author with the chair of the medical board and the chair of each service, the chief residents of each service and the nurse mangers of the clinical care units that were involved. The purpose of these contacts was to obtain approval to survey their personnel, to acquaint them with the project, its purpose and to answer any questions about the instrument or the project. This knowledge assisted them to become a resource to their peers and subordinates who may have had questions regarding the questionnaire and the project in general. Approval was obtained from all departments selected for inclusion in the study.

Upon obtaining approval from the subjects' managers, rosters of staff nurses, faculty and resident doctors were obtained from their departments. Each individual was numbered and randomly selected using a random numbers table. The names of the subjects were kept in a data log with their assigned code numbers by profession and clinical area. The subjects' number and specialty code appeared on the questionnaire. There were two mailings two weeks apart. The second mailing was to be a reminder to those who had not responded. The data log was used to track returned surveys and response rates by profession and area codes, not by individual respondent. The names of the subjects were retained through the second mailing. After the second mailing and cut off date the names of the respondents were destroyed.

A cover letter and a questionnaire were sent to each subject (see Appendix A and B). The cover letter explained the purpose of the project and had a few instructions for filling out the instrument, the demographics portions of the questionnaire and the procedure for returning the questionnaire to the author.

Chapter 4

Analysis and Findings

Research question 1a.: Overall do nurses want more decision making authority than they currently have? To address this question and question 2a., a series of difference scores were generated. First difference scores were calculated for each item by subtracting the subject's current score from his/her ideal score. The difference scores for each of the 25 items were added and an overall mean difference score was obtained for each subject. The possible difference score range was -4 to +4, with positive values meaning the nurses want more clinical decision making authority than they currently have and with values of zero meaning nurses have as much authority as they want. A negative value means the nurses have more authority than they feel is ideal. The difference between these scores and zero was tested with a paired t-test. As illustrated at the bottom of Table 2, overall the nurses want more clinical decision making authority than they currently have. The mean difference score was .419 which was statistically significantly different than zero (t=3.544, df=14, p=.0032).

Research question 1b.: Do nurses want more decision making authority over specific aspects of their practice? This question was answered by comparing the subjects' current score with the ideal score for each aspect of practice. As with the overall difference scores, positive scores mean the nurses want more clinical decision making authority in that area of practice. The closer the scores are to zero, the more congruence there is between current and ideal practice. The findings suggest a trend toward the nurses wanting more authority. For 20 of the 25 aspects of practice the nurses want more

authority than they currently have. For three of the areas nurses want less and for two they want no change in their level of authority (see Table 2). However when evaluated with a paired t-test the differences between their current and ideal scores was statistically significant ($p \geq .05$) for only ten of the 25 aspects of practice. The nurses want more authority related to nine of the ten of the aspects of practice and less authority for one aspect of practice. The nine aspects of practice with positive scores are: contributing to patient management plan decisions, contributing to development of health policy, clarification of orders, teaching health promotion, teaching illness prevention, teaching patients how to cope with chronic illness, support community health nurses' development of programs, questioning inappropriate orders and nurses set their own nursing standards. In the area of pain management they want less authority than they currently have (see Table 2).

Table 2.

Ranked Difference Scores for RN's

Aspect of practice	Mean Current Score	Mean Ideal Score	Mean Diff. Score	SD	*t**
21) Contribute to pt. mgmt. plan	2.46	4.53	2.06	1.624	4.92**
03) Contribute to health policy	2.87	4.20	1.33	1.23	4.18**
04) Clarify orders	3.50	4.57	1.07	1.14	3.51**
11) Teach health promotion	3.80	4.80	1.00	1.07	3.62**
09) Teach illness prevention	3.87	4.80	0.93	0.88	4.09**
12) Teach pt.'s how to cope with chronic illness	3.73	4.60	0.87	1.36	2.47**
25) Support comm. hlth. nurses' plan programs	4.07	4.87	0.80	0.94	3.29**
14) Initiate self care education	4.20	4.80	0.60	1.06	2.20
19) Decide freq. of vital signs	3.20	3.73	0.53	0.99	2.09
05) Question inapprop. orders	4.47	4.93	0.47	0.64	2.82*
18) Nurses determine nursing care required	4.33	4.80	0.47	0.64	2.82*
06) Nurses set care standards	4.33	4.73	0.40	0.83	1.87
20) Primary role as asst. to the doctor	3.73	4.13	0.40	1.55	1.00
24) Nurses are accountable for nursing care	4.40	4.80	0.40	0.91	1.70
02) Initiate change of inappropriate diet	3.47	3.80	0.33	.098	1.32
22) Question inappropriate prescriptions	4.67	5.00	0.33	0.62	2.09

Note: (*p<.05; **p<.01; ***<.0001)

(table continues)

Aspect of practice	Mean Current Score	Mean Ideal Score	Mean Diff. Score	SD	*t**
23) Dominant role in pt.'s transition home	4.33	4.60	0.27	0.80	1.29
15) Primary role is to assess pt. responses	4.07	4.33	0.27	1.28	0.80
16) Nurses do many things not under MD orders	4.40	4.60	0.20	1.21	0.64
17) Nurses initiate dressing changes	3.20	3.27	0.07	0.79	0.32
01) Nurses question unclear orders	4.93	4.93	0.00	.038	0.00
10) Nurses modify med. orders per pt. condition	2.60	2.60	0.00	1.20	0.00
07) Initiate physical assessment	4.47	4.40	-0.06	1.10	0.24
08) Nurses answer pt.'s questions	4.20	4.13	-0.06	1.10	0.24
13) Nurses make decisions re: pain management	3.87	2.93	-0.93	1.49	2.23*
Overall			0.42	0.46	3.54**

Note: (*p<.05; **p<.01; ***<.0001)

Research question 2a.: Overall do doctors want nurses to have more decision making authority than they currently have? The analysis of research questions 2 a and b was conducted in the same way as question 1. Overall the doctors do want nurses to have more authority than they currently have. The mean difference score .20 was significantly different from zero (t=2.889, df=26, p=0.0077).

Research question 2b.: Do doctors want nurse to have more decision making authority over specific aspects of nursing practice? For 17 of the aspects of practice the doctors want nurses to have more authority than they currently have. However when

evaluated with a paired t-test the differences between their current and ideal score was statistically significant ($p \leq .05$) for only seven of the aspects of practice. Six of the seven aspects of practice with statistical significance showed the doctors want nurses to have more authority than they currently have. One aspect of practice showed statistical significance that the doctors want nurses to have less authority than they currently have (see Table 3). The six aspects of practice with positive scores are: Clarification of doctors order, teaching illness prevention, teaching health promotion, question inappropriate orders, teach patients how to cope with chronic illness and questioning unclear orders. In the area of pain management the doctors want the nurses to have less authority than they currently have (see Table 3).

Table 3.

Ranked Difference Scores for MD's

Aspect of practice	Mean Current Score	Mean Ideal Score	Mean Diff. Score	SD	*t**
4) Clarify orders	2.96	4.08	1.12	1.11	5.14***
9) Teach illness prevention	3.66	4.59	0.92	1.07	4.49***
11) Teach health promotion	3.93	4.63	0.70	1.10	3.34**
5) Question inappropriate orders	4.19	4.78	0.59	0.80	3.86**
12) Teach pts. how to cope with chronic illness	3.93	4.56	0.59	1.01	3.05**
20) Primary role as asst. to the MD's	4.04	4.44	0.40	0.75	2.83
21) Contribute to pt. mgmt. plan	2.63	3.04	0.41	1.28	1.66
22) Question inapprop. prescriptions	4.22	4.59	0.37	1.33	1.44
1) Question unclear orders	4.48	4.82	0.33	0.62	2.79*
14) Initiate self care education	4.26	4.56	0.30	1.24	1.25
19) Decide freq. of vital signs	2.59	2.89	0.30	1.27	1.22
2) Initiate change of inappropriate diet	2.78	3.00	0.22	1.45	0.80
8) Nurses answer pt.'s questions	4.11	4.33	0.22	1.45	0.80
25) Support comm. hlth. nurses' plan programs	3.89	4.11	0.22	1.31	0.88
17) Nurses initiate dressing changes	3.22	3.37	0.15	0.95	0.81
24) Nurses are accountable for nursing care	4.41	4.56	0.15	1.13	0.68
23) Dominant role in pt.'s transition home	4.19	4.30	0.11	0.89	0.65

*p<.05; **p<.01; ***<.0001

(table continues)

Aspect of practice	Mean Current Score	Mean Ideal Score	Mean Diff. Score	SD	*t**
3) Contrib. to health policy	2.70	2.70	0.00	1.71	0.00
6) Nurses set own standards	4.44	4.52	-0.07	0.73	0.53
10) Nurses modify med. orders per pt. condition	2.48	2.41	-0.07	0.83	0.47
18) Nurses determine nursing care	3.84	3.70	-0.11	1.53	0.38
16) Nurses do many things not under MD orders	4.26	4.07	-0.19	1.18	0.82
7) Initiate physical assessment	4.15	3.89	-0.27	1.04	1.32
15) Primary role is to assess pt. responses	3.77	3.31	-0.46	1.42	1.66
13) Make decisions re: pain management	3.26	2.52	-0.74	1.38	2.80**
Overall			0.20	0.37	2.89**

*p<.05; **p<.01; ***<.0001

Research question 3: Are there aspects of nursing practice where nurses and doctors agree nurses should have more decision making authority? This question was answered by compiling a list of the aspects of care for which the scores were statistically significant for the nurses and doctors. Then the lists were compared for areas of agreement. The nurses had nine scores with statistical significance and the doctors had seven. The nurses and doctors were in agreement on five of these aspects of practice: clarification of doctors orders, teaching health promotion, teaching illness prevention, questioning inappropriate orders and teaching patients how to cope with chronic illness.

In the area of pain management the nurses and doctors agree that nurses should have less authority than they currently have.

An analysis of variance was initially planned to look at differences between care units. However an ANOVA was not conducted because the sample size was too small.

Chapter 5

Discussion

The overall meaning of the findings is that nurses and doctors feel that nurses should have more decision making authority for some aspects of practice and not for others. Significant movement toward an increase in nurse decision making authority for doctors, was directed toward an expansion of traditional, well established aspects of practice in which nurses have always functioned: oversight of doctors' orders and patient education. The nurses want to expand beyond their usual practice and contribute to health policy development and patient management decisions.

Managed care will enable nursing authority to expand into these areas. The tools used to facilitate managed care are multidisciplinary collaboration and autonomous nursing authority to make decisions e.g. care map, critical path creation, and case management. The doctors support expansion of nurse authority in their traditional areas. Nurses want to expand their authority into less traditional areas. This expansion of authority is already happening within the context of managed care and nurses' key role as case managers.

A good vehicle for increasing nursing authority might be the development of care maps and critical paths in one or more of the aspects of practice identified by both the nurses and doctors. The process used in the development of care maps and critical paths is a collaborative and multidisciplinary activity. The five areas nurses and doctors agree on are key points necessary for collaboration needed for care map and critical path

development and joint case management of patients based on a shared care and management plan which is what comprises the care map.

Success with an increased authority in nurses' more traditional aspects of practice could later be extended to less traditional aspects of practice where nurse want increased authority, e.g., Item 3 "Nurses should contribute to health policy development", and Item 21 "Nurses should contribute to the patient management plan". In the instance of patient management, case managers are already making this contribution. Although the doctors scores suggest they are satisfied with the current level of nurse contribution to health policy development, patient management plans, and deciding appropriate nursing care, the reality is the expansion of nursing's role to include these activities is occurring with the role of the case manager. Case managers are nurses who, with doctors, dieticians, physical therapists and other appropriate professionals develop care maps for specific diagnosis related groups. Care map development is the development of health policy at the most basic level and nurses are doing this work in collaborative, multidisciplinary groups. Surveillance of orders and patient education are two aspects of care maps. Variance tracking and outcomes monitoring are major pieces built into the process of patient case management through care maps and entails surveillance of not only orders for accuracy and appropriateness but also management plan compliance. Patient education is critical in a care map in which the patient is moved quickly through the acute care setting out to home care. The nurse case manager is responsible for overseeing that the appropriate information and services are provided to the patient and family by the appropriate expert.

These aspects of care are critical to appropriate and timely delivery of services to patients while containing costs and insuring a smooth transition out of the acute care setting. These are in a shared context which is the care map, jointly created by nurses, doctors and other allied health care providers.

The numbers of areas of agreement is an indication that there is hope for growth and collaboration between nursing and medicine now and in the future. There were numerous aspects of practice for which the scores for the nurses and doctors showed substantial agreement supporting nurses authority: Nurses should set their own standards, nurses should initiate assessments, nurses should answer patients' questions regarding their condition, nurses should initiate patient self care education, nurses do many things not under doctors orders, nurses should change dressings as needed, nurses should determine what nursing care is needed for the patient, nurses should question inaccurate prescriptions, nurses play a significant role in the patient's transition home and nurses should evaluate nursing care.

The scores of Item 13 "Nurses should make decisions independent of the doctors re: pain management" seemed inconsistent with the literature and clinical experience. The scores for the nurses and doctors indicated that they both want nurses to have less authority over this aspect of practice than they currently have. Upon closer examination of the wording of the item, it was felt that the use of the word "independent" changed the context sufficiently enough that neither the nurses nor the doctors felt comfortable with decision making that was not shared. Thus it appears that this item is unreliable and the findings relative to this item should be questioned.

Of interest is one aspect of care for which doctors, but not nurses, wanted nurses to increase authority. For Item 1 "Nurses question unclear orders", the doctors scores indicated acknowledgment of this activity currently by nurses but also showed desire for this activity to increase. Whereas the nurses scores indicated they already have high functioning in this area. The difference could be that the doctors are unclear what nurses do when clarifying orders or feel nurses are not doing enough questioning, nurses may need to examine this activity to see if they are clear and consistent with the doctors when questioning unclear orders.

The main limitations of the study was the small sample size: 15 nurses out of 100, and 27 doctors out of 100 surveyed. However, the nurses appeared representative of the nurses in their institution, who are mainly experienced and college educated. The doctors may not be representative of the doctors in their institution. The group tended to be older and had been practicing longer than the nurses and so would not expect them to want an increase in nurse authority. They however indicated positive movement in the direction of increasing nurse authority. Thus, if the sample were more representative the group might tend to want more of an increase in nurse authority.

Factors that may have contributed to the low response rate are as follows: a sustained period of unusually high census and short staffing, a strike by the support staff, contract negotiations during which the career ladder program was eliminated, with discussion regarding elimination of the bachelor degree differential and curtailment of education dollars. These factors affected morale and may have contributed to the low response rate from the nursing staff.

Furthermore, the results of this study were similar to those in Dr. Katzman's study (1989). Seven of the nine areas identified by the nurses in the Katzman study were also identified in this study. Although Katzman did not test the difference between the current and ideal scores for their doctor group, four of the five areas identified by the doctors in Katzman's study were identified by the doctors in this study.

Implications for Practice and Research

Based on what was found, the author recommends that University Hospital should create a multidisciplinary group looking at collaborative practice and the current role nurse decision making has in the system. This includes bedside decision making as well as case management and discharge planning activities.

Common areas between nursing and medicine were identified by both groups in which nursing authority currently is appropriate and should also be expanded. These findings could be used to define common goals that were comfortable for the two groups within those aspects of practice. If nurses and doctors could grow familiar and thus more comfortable for the two groups within the agreed upon aspects of practice, then the scope of nurse decision making authority might expand into less traditional aspects of practice or areas where nurses are ready.

The results need to be presented to the multidisciplinary group to put the information out in a forum and stimulate discussion. This discussion would energize the group to select an aspect of practice in which to expand nurse authority and thus nursing's contribution. This could lead to defining innovative ways to strategize options for intervention taking advantage of the current evolution in nursing's role in case

management. One of this group's first charges should be to ask the question: If we, nurses and doctors, agree that nurses should have expanded authority, what does it look like, what should it look like, has it happened in some areas and not others and if not, why not? Specifically: Evaluate where are we, how are we doing and where could we expand? A starting point is the examination of the role of the case managers. They are making major contributions to patient management decision making and their activities support the health policy of managed care. These activities are currently a reality of everyday practice.

Conclusion

The importance of the findings is to add to the knowledge of our understanding of nurse decision making authority and the current understanding nurses and doctors have of that authority and it's relationship to care delivery. The contrast of the perceptions enlightens understanding of this relationship and understanding of current perceptions operating within that relationship.

Movement into our uncertain future with sicker patients and fewer resources to care for them requires that we examine all our systems. This includes the most fundamental of system, that being the way in which care, therapy and planning are ordered and administered to patients at the bed side. The change is upon all of us in health care. The question is no longer "if" but "when" and the answer is "now".

References

Alpert, H. B., Goldman, L. D., Killroy, C. M., & Pike, A. W. (1992). 7 Gryzmish: Toward an understanding of collaboration. Nursing Clinics of North America, 27, 47-59.

Chavigny, K. H. (1988). Coalition building between medicine and nursing. Nursing Economics, 6, 179-183.

Fagin, C. M. (1992). Collaboration between nurses and physicians: No longer a choice. Academic Medicine, 67, 295-303.

Katzman, E. (1989). Nurses' and physicians' perceptions of nursing authority. Journal of Professional Nursing, 5, 208-214.

Keddy, B., Jones Gillis, M., Jacobs, P., Burton, H., & Rogers, M. (1986). "The doctor-nurse relationship: An historical perspective. Journal of Advanced Nursing, 11, 745-753.

Knaus, W. A., Draper, E. A., Wagner, D. P., & Zimmerman, J. E. (1986). An evaluation of outcomes from intensive care in major medical centers. Annals of Internal Medicine, 104, 410-418.

McLain, B. R. (1988). Collaborative practice: A critical theory perspective. Research in Nursing & Health, 11, 391-398.

Makadon, H. J., & Gibbons, M. P. (1985). Nurses and physicians: Prospects for collaboration. Annals of Internal Medicine, 103, 134-136.

Mechanic, D., & Aiken, L. H. (1982). Cooperative agenda for medicine and Nursing. New England Journal of Medicine, 307, 747-750.

National Joint Practice Commission. (1974). National Joint Practice Commission position paper on collaborative practice. Chicago, IL: Nealy Printing Company.

Phillips, C.Y., Castor, A., Prescott, P.A., & Soeken, K. (1992). Nursing intensity: Going beyond patient classification. Journal of Nursing Administration, 22, 46-52.

Stein, L. I., Watts, D. T., & Howell, T. (1990). The doctor-nurse game revisited. New England Journal of Medicine, 322, 546-549.

Weis, S., & Remen, N. (1983). Self-limiting patterns of nursing behavior within a tripartite context involving consumers and physicians. Western Journal of Nursing Research, 5, 77-89.

Appendix A

Cover Letters

To: Insert Name of Doctor Respondent CC

From: Barbara Bernardi, Graduate Student, OHSU School of Nursing

Re: Research Project

You are invited to participate in this project. The results of this investigation will help lay the groundwork for establishing Collaborative Practice as a standard for collegial working relationship between Nursing and Medicine at University Hospital.

The purpose of this research project is to examine the perceptions of nurse and doctors at University Hospital, relative to nurse clinical decision making authority.

The identities of the respondents will not be associated or published with the results. The record of respondent names will be retained through the second mailing and then will be destroyed.

When filling out the survey please think in terms of the care unit to which your subspecialty admits most of its patients.

Please read the instructions on the front of the survey. After completing the survey fold it with the return address showing, staple and return to me through the campus mail system.

Thank you for participating in this project.

(appendix continues)

To: Insert Name of Nurse Respondent CU

From: Barbara Bernardi, Graduate Student, OHSU School of Nursing

Re: Research Project

You are invited to participate in this project. The results of this investigation will help lay the groundwork for establishing Collaborative Practice as a standard for collegial working relationship between Nursing and Medicine at University Hospital.

The purpose of this research project is to examine the perceptions of nurse and doctors at University Hospital, relative to nurse clinical decision making authority.

The identities of the respondents will not be associated or published with the results. The record of respondent names will be retained through the second mailing and then will be destroyed.

When filling out the survey please think in terms of your primary care unit.

Please read the instructions on the front of the survey. After completing the survey fold it with the return address showing, staple and return to me through the campus mail system.

Thank you for participating in this project.

Appendix B
Questionnaire

General Instructions

Please complete every item in this questionnaire as accurately as you possibly can. It is important that all questions be answered.

The questionnaire is divided into two sections. The first concerns your beliefs about what registered professional nurses do. The second concerns your beliefs about what they should do professionally.

A. This first set of questions deals with your perception of the current status of nurses. Please check the responses that most closely parallel your view.

	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
1. Nurses question doctors whose "orders" for patients are unclear.					
2. Nurses change patients' inappropriate special diets.					
3. Nurses have as much say as doctors in making decisions about health care policies.					
4. Nurses feel free to call doctors at home to clarify medication prescriptions.					
5. Nurses question doctors whose "orders" appear inappropriate.					
6. Nurses decide what constitutes appropriate standards of nursing care.					
7. Nurses initiate physical assessments of their patients.					
8. Nurses answer patients' questions about treatment regimens prescribed by their doctor.					
9. Nurses decide what to teach people about how to prevent illness.					
10. Nurses modify prescribed medication, including dosage and method of administration, when indicated by patients' condition.					

Please turn the page

(appendix continues)

	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
11. Nurses teach people the principles of health promotion.					
12. Nurses decide on how to help patients cope with chronic illness.					
13. Nurses make decisions about pain management for their patients.					
14. Nurses initiate teaching patients how to care for themselves upon recuperating from illness or surgery.					
15. Nurses assess peoples' responses to actual or potential health problems.					
16. Nurses do many things for patients that are not under a doctor's directions.					
17. Nurses make decisions independent of the doctor about changing surgical dressings.					
18. Nurses determine the nursing care given to patients.					
19. Nurses decide on the frequency of taking patient blood pressures and temperatures.					
20. The nurse's role is primarily as assistant to the doctor.					
21. Nurses have as much say as doctors in patient care decisions.					
22. Nurses question doctors who have prescribed a medication inaccurately.					
23. Nurses play a dominant role in the transition of patients from hospital to home.					
24. Nurses are accountable for evaluating the nursing care given to patients.					
25. Nurses in community health settings plan programs to protect the health of populations at risk.					

Please turn the page

(appendix continues)

B. The second set of questions deals with your perceptions of what the status of nurses <u>should be</u>. Please check the responses that most clearly parallels your views.

	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
1. Nurses should question doctors whose "orders" for patient care are unclear.					
2. Nurses should change patients' inappropriate special diets.					
3. Nurses should have equal decision-making power with doctors in determining health care policies.					
4. Nurses should call doctors at home to clarify medication prescriptions.					
5. Nurses should decide what constitutes appropriate standards of nursing care.					
6. Nurses should decide when and how to perform physical assessments of their patients.					
7. Nurses should question doctors whose "orders" appear inappropriate.					
8. Nurses should answer patients' questions about the treatment regimens prescribed by their doctor.					
9. Nurses should initiate teaching people about illness prevention.					
10. Nurses should modify prescribed medications when indicated by a patient's condition, including dosage and method of administration.					
11. Nurses should teach people the principles of health promotion.					
12. Nurses should make decisions on how to help patients cope with chronic illness.					
13. Nurses should make decision independent of doctors about pain management.					

Please turn the page (appendix continues)

	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
14. Nurses should initiate teaching patients how to care for themselves upon recuperating from illness or surgery.					
15. A nurse's primary role should be assessing peoples' responses to actual or potential health problems.					
16. Nurses should provide care to patients beyond what is "ordered" by a doctor.					
17. Nurses should make decisions independent of the doctor about changing surgical dressings.					
18. Nurses should determine the nursing care given to patients.					
19. Nurses should decide on the frequency of taking patient blood pressures and temperature.					
20. The nurse's role should be primarily as assistant to the doctor.					
21. Nurses should have more say in patient care decisions than they now have.					
22. A nurse should question a doctor who has prescribed a medication inaccurately.					
23. Nurses should play a dominant role in the transition of patients from hospital to home.					
24. Nurses should be accountable for evaluating the nursing care given to patients.					
25. Nurses in community health settings should plan programs to protect the health of populations at risk.					

Please turn the page

(appendix continues)

C. Please answer the following:

1. What is your age? 20-24___
   25-29___
   30-34___
   35-39___
   40-49___
   50-54___
   55-59___
   60-64___
   65-69___

2. What is your gender? Female ___
   Male ____

3. What is your speciality area? _____

4. When did you graduate from medical school? _____

Thank you for participating in this survey.
Fold the survey with the return address showing, staple closed and return through the Campus Mail System.

Please complete and return the survey by September 11, 1995

Return survey to: **Barbara Bernardi**
UHN 58.

cc

Please turn the page (appendix continues)

C. Please answer the following:

1. What is your age? 20-24___
25-29___
30-34___
35-39___
40-49___
50-54___
55-59___
60-64___
65-69___

2. What is your gender? Female ___
Male ____

3. What is your speciality area? _____

4. When did you graduate from your primary training?_____

5. What is your highest level of preparation: Associate Degree____
Hospital Diploma____
Bachelors Degree____
Masters Degree_____

Thank you for participating in this survey.
Fold the survey with the return address showing, staple closed and return through the Campus Mail System.

Please complete and return the survey by September 11, 1995.

Return survey to: **Barbara Bernadi**
UHN 58.

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