

PATIENTS', NURSES', AND PHYSICIANS' PERCEPTIONS OF
THE IMPORTANCE OF SELECTED NURSING ACTIVITIES

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BY
LOURIE JENKINS TRAVIS, BSN, RN

DENTON, TEXAS

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TEXAS WOMAN'S UNIVERSITY
DENTON, TEXAS

Nov. 5, 1991
Date

To the Dean for Graduate Studies and Research:

I am submitting herewith a thesis written by _____
Lourie Jenkins Travis, BSN, RN
entitled Patients', Nurses', and Physicians' Perceptions
of the Importance of Selected Nursing Activities

I have examined the final copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Science, with a major in Nursing.

Rae McNamara
Major Professor

We have read this thesis and
recommend its acceptance:

Lois Haugh
Suzanne Kuri

Accepted:

Robin M. Thompson
Dean for Graduate Studies
and Research

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ABSTRACT

LOURIE JENKINS TRAVIS, BSN, RN

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING
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This study examined 50 patients', 50 nurses', and 38 physicians' prioritization of selected nursing activities. White's (1979) Nursing Activities Checklist was used. Fifty activities were categorized into four areas: physical care, psychological care, implementation of medical care, and discharge planning. Activities were prioritized from 1 to 5 by subjects.

Utilizing the one-way analysis of variance (ANOVA) and subsequent Tukey tests, the three groups of subjects were found to differ significantly in three of four areas. The patient and nurse samples prioritized physical care significantly higher than did the physician sample ($p < .05$). Nurses prioritized psychological care significantly higher than did the patient and physician samples ($p < .05$). Nurses prioritized discharge planning significantly higher than physicians ($p < .05$). Although the patient group prioritized this activity lower than the nurse sample and higher than the physicians, the difference

was not significant. All three groups prioritized medical care at approximately the same level.

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CHAPTER I

INTRODUCTION

In the United States, economic growth and opportunity now depend upon the service industries (Albrecht & Zemke, 1985). Hospitals are service-oriented institutions, and nursing service is often the largest department within a hospital. Numerous hospital surveys have shown widespread criticism of nursing care as a service. M. White (1972) suggested that some of the patient dissatisfaction as well as the frustration of hospital nurses may arise from differing concepts as to which nursing functions are important.

Hospitalized adult patients and professional nurses caring for these patients may differ as to the importance of selected nursing tasks and skills. M. White (1972) proposed that the successful plan of care must coordinate the patient's desires for himself and the nurse's desires for the client. Although a mutual agreement of ideas seems ideal, it is not always feasible. There is some debate as to whom is actually in a better position to affect decisions about care. Etzioni (1964) stated that there is a strong professional conviction that those who perform the service to the client are in a more advantageous position

to judge what is good for the client than the client is. In conflict with this bureaucratic view is the patient-centered ideology of nursing as suggested by Marram (1973) who stated, "the nurse is, or should be, greatly influenced by the evaluations of patients and families" (p. 322). Thornton and Leonard (1964) supported this patient-centered view by stating that if the nurse does not approach the patient in a manner that will induce understanding and cooperation, "then all the time in the world will not be enough to get the desired effects" (p. 122).

The patient in a health care setting behaves in ways that are related to individual perceptions and learning, as does the nurse and physician from their own standpoints. Each has awareness and expectations of the roles of the others, as based on past learning experiences. Their differing methods of socialization can produce vast differences between perceptions of what may be expected in the role of the nurse (Donabedian, 1980). S. King (1962) has observed that "when sickness occurs, the patient adopts a new set of perceptual expectations relative to his own behavior, his obligations toward others, and the kind of behavior they owe him" (p. 210). Each individual certainly has potential for his or her own unique perception of the world. However, groups of individuals in the same role,

having similar learning experiences and similar reinforcements important to their roles, may be more likely to have correspondingly similar expectations and goals than those who have not shared some commonalties of background learning. Although role groups, such as patients, nurses, and physicians, may heavily interact, their expectations of each other can be very dissimilar because of variant social learning activities. Physicians are educated to focus primarily on the physical aspects or disease process, while nursing education focuses heavily on psychosocial aspects of the patient. It is believed that patients, nurses, and physicians have different perceptions of what is important in the nursing role based upon their diverse social learning experiences. It would seem appropriate to compare opinions from patients, nurses, and physicians concerning the prioritization of nursing activities. Thus, efforts could be made to alleviate some of the dissatisfaction which arises in patient evaluation of care by coordinating concepts of the nursing role among groups involved.

Problem of Study

The problem of this study was:

Is there a difference in prioritization of selected areas of nursing tasks among patients, nurses, and physicians?

Justification of the Problem

One of the nurse's ongoing responsibilities in daily work is to make judgments as to what is most essential to accomplish and what is less important to the patient's care. This activity impacts the quality of patient care and the satisfaction level of the client. Donabedian (1980) suggested that patients who are satisfied are more likely to accept and comply to prescribed treatments for care and to seek care again. Vuori (1987) reinforced this belief by asserting that patient satisfaction is required for achieving goals set for health care because it influences the patient's decision to follow recommendations. These critical variables influence numerous factors in a hospital setting, such as patient acceptance of medical regimes, treatments or procedures, and the likelihood of adherence to treatment plans continuing. By increasing the patient's sense of control over care, MacStravic (1988) stated that the patient's level of satisfaction is significantly increased also. Soliciting opinions and information from patients and putting these preferences into practice is crucial in the attempt to give patients some control over their own care.

Patient satisfaction and quality of care go hand in hand. Meleis (1985) stated that "exploration and

validation of nurses' and parents' perceptions, thoughts, and feelings increase the effectiveness of help offered to patients in need of help" (p. 269). Vuori (1987) explained that patient satisfaction is an attribute of quality of care because without it there cannot be good care. He described "quality" as being dependent on culture, age, gender, socioeconomic status, and changes within an individual such as stage of illness or health. Ehrat's (1987) perspective of quality, described as "more perceptual than concrete in its orientation," also suggests a subjective nature in the evaluation of quality. Petersen (1989) stated that the patient's perception can differ from those of the caretaker's in a given situation, but the caretaker must accept the patient's feedback as valid. Acknowledging the perceptual, subjective component of quality may help the nurse change the focus of action from a defensive viewpoint to one of determining how to influence the patient's perceptions in a more positive manner (Petersen, 1989).

Not only patient satisfaction is to be considered but staff satisfaction is also a factor. Levenstein (1985) asserted that nurses are even more likely to be victims of role conflict than are employees in a business environment because nurses function in a setting controlled by

administrative and medical hierarchies. If differences are not identified and addressed, role ambiguity and role conflict may result among groups (Hardy & Hardy, 1988).

M. White (1972) noted that frustration of staff also arises from differing concepts of what is important in working activities. It has been suggested by Bullock (1953) that job satisfaction may rest largely upon outcomes in the achievement of personal objectives as perceived in the employment situation; the giving of quality patient care is ideally one of the nurse's personal objectives.

Two individuals working side by side in different roles often do not understand the activities and the felt responsibilities of the other. Kalisch and Kalisch (1977) explained that the functions and goals of the nurses are not understood by the physicians and that the two groups work side by side throughout their careers without really understanding what the other is about. They further compared nurse-physician communication to the parallel play of toddlers. This is a disturbing observation which might benefit from further comparison of expectations of role activities. There exists a vital need for research on the health care and provider-client systems as related to role stresses, often caused by differences in role expectations (Hardy & Hardy, 1988).

Assumptions

The following assumptions were made for this study:

1. Ordering and prioritizing nursing activities reflects the perception of the nurse's role by the groups of individuals identified, that is to say that those judgments made at that time and under those circumstances are deemed as valid and "true" (M. White, 1972).
2. Congruence of perceptions among patients, nurses, and physicians will decrease the likelihood of role stress and role strain (Hardy & Conway, 1988).
3. Nurses and physicians perceiving role expectations and role performance as congruent will facilitate in the achievement of mutual goals (I. King, 1981).
4. Differences in role expectations and perceptions of nurses and physicians influence patient care.

Research Questions

The answers to the following research questions were sought in this study:

1. Is there a difference among patients, nurses, and physicians in the prioritization of nursing activities?
2. Is there a difference among patients, nurses, and physicians in the prioritization of nursing activities concerning physical care?

3. Is there a difference among patients, nurses, and physicians in the prioritization of nursing activities concerning psychological care?

4. Is there a difference among patients, nurses, and physicians in the prioritization of nursing activities concerning implementation of medical orders?

5. Is there a difference among patients, nurses, and physicians in the prioritization of nursing activities concerning discharge planning?

Definition of Terms

The following terms were defined for the purpose of this study:

1. Patient--an individual under the care of a physician, currently admitted as an in-patient to the hospital that was used for this study.

2. Nurse--an individual licensed by the State Board of Nurse Examiners to practice as a registered nurse or licensed vocational nurse within the state of Texas and presently employed in the hospital that was used for this study.

3. Physician--an individual licensed by the Board of Medical Examiners to practice medicine within the state of Texas and presently practicing in the hospital that was used for this study.

4. Prioritization--the placing of items so that some have precedence in order or rank of importance before others (Barnhart, 1969).

5. Nursing activities--those actions or behaviors which are made by a practicing nurse toward a patient for the benefit of that patient.

a. Physical care--activities in response to physiological care concerning cleanliness, comfort, sleep, and rest; these are reflected in items 2, 3, 4, 5, 6, 8, 9, 11, 13, 14, 17, 18, 20, 21, 26, 27, 32, 33, 34, 35 of the Nursing Activities Checklist (M. White, 1972).

b. Psychological care--activities concerning supportive emotional, spiritual, and diversional care; these are reflected in items 7, 10, 16, 23, 28, 29, 30, 31, 38, 39, 40, 44, 45, 47 of the Nursing Activities Checklist (M. White, 1972).

c. Implementation of medical care--activities including observing, reporting, and carrying out physician's orders; these are reflected in items 1, 12, 15, 19, 24, 42, 43, 46 of the Nursing Activities Checklist (M. White, 1972).

d. Discharge planning--activities concerning teaching and planning for continued care; these are

reflected in items 22, 25, 36, 37, 41, 48, 49, 50 of the Nursing Activities Checklist (M. White, 1972).

Limitations

The following limitations were identified in this study:

1. The sampling methods used for this study limit the generalizability of the findings. A convenience sampling method was used to obtain nurses and physicians samples. A purposive sampling method was used to obtain the patient sample. Convenience samples possess traits which may be extraneous to the study or which may possibly influence or be related to the variables of the research problem (Polit & Hungler, 1987). Purposive sampling involves "handpicking" of subjects, selected by the chosen expert to be representative of the accessible population (Nieswiadomy, 1987).

2. The perceived importance of the nursing activities, not the actual execution of these activities, was studied.

3. Subjects may have provided socially acceptable responses or responded as they thought the researcher wished them to respond.

Summary

This study was designed to investigate and compare perceptions concerning prioritization of nursing activities among patients, nurses, and physicians. There is some debate within the literature as to who is actually in a better position to affect decisions concerning patient care and what is deemed as important for patients. Differences in professional outlook and background are often brought to light regarding nurses and physicians, yet the patient or health care consumer must also have input into care decisions. Donabedian (1980) suggested that satisfied patients are more likely to comply to treatment and seek care again. It is necessary that nurses work hand-in-hand with patients to offer stable, competent patient care. Data obtained from this study may assist nurses in understanding and anticipating expectations of their services and aid in improving future patient care.

CHAPTER II

REVIEW OF THE LITERATURE

Professional health care practice centers on the client, although it aims to promote health for the general society. The accomplishment of this goal in nursing depends upon analyzing nursing care critically and recognizing and effecting the need for appropriate changes (Rheiner, 1983). Within this chapter, four areas will be investigated. These areas include perceptions of the nursing role, comparisons of the perceptions of the role, and the importance of a quality patient/nurse interaction.

Perceptions of the Nursing Role

Each individual's image of a role defines the perception for that person at that time. How an image is defined depends on the individual's experiences and the interpretations of past and current situations. Swansburg (1981) stated that the range of perception is physiological, being a product of the senses, but its limitations are cultural and emotional. He added that to gauge the perceptions of the nursing role, nurses must assess the various perceptual dimensions of individuals and groups.

Nursing actions or activities which define the role of the nurse include what nurses say or do for the benefit of the patient. These activities may be carried out with or without the participation of the client. Orlando (1962) identified two types of nursing activities, which include deliberate actions and automatic actions. Deliberate actions are made in response to ascertaining a particular need that the patient has specified. Automatic actions are decided upon for reasons other than for the patient's immediate need, such as carrying out physicians' orders or administrative functions. Orlando further explained that administrative activities are meant to protect and foster patients' health in general, but may not directly meet patients' specific needs.

A distinction may be made between the intended purpose of aiding a patient in any given nursing activity and the actual outcome that may occur. I. King (1981) has stated that nurses' actions are outcomes of reaction to what is perceived as being presented in a situation. A nurse may act on a perception without validating its accuracy with the patient. There may also be a conflict between the patient and the nurse as to what is prescribed for the patient's best interest.

The role of the nurse is presently in a state of change and expansion. Historically, nurses have been defined by tasks associated with cooking, cleaning, plumbing, and patient care to assist the physician (Maucksch & Miller, 1981). Goals of patient care focused on relief of symptoms and suffering. Few interventions were initiated by nurses; the principle tasks concerned the implementation of physicians' directions (Elms & Morehead, 1977). Caring for the patient or family as a domestic servant was the perception of the role of the nurse by the upper class, while the lower class viewed nursing as "one of the noblest of professions" (Aroskar, 1980, p. 27).

Today, the nursing role has been expanded greatly. An increase in technology has required nurses to learn new skills. Various pumps, hemodynamic monitoring equipment, and computers are but a few of the everyday items in patient care. Wille (cited in Tack, 1987) stated that the nursing process has also become more sophisticated to encompass scientific rationale for planning and evaluating care. Many nurses are now pursuing higher education, performing research, and expanding methods of patient care. The emergence of a scientific body of knowledge can be instrumental in fostering commitment and accountability to patients (Polit & Hungler, 1987).

Many studies have been undertaken in attempts to elicit perceptions of what activities are important for nurses to perform. Research concerning perceptions and images of the nurse from the viewpoint of health care consumers, nurses, and physicians will be presented.

Health Care Consumers' Perceptions of the Nursing Role

There is strong empirical evidence that patients' attitudes toward their nurses and the nurses' behaviors are crucial components of evaluation of health services (Ware, 1978). Nurses must determine what they want their image to be and work toward relaying messages to the health care consumer to convey that image (Swansburg, 1981). To solicit opinions of what the public perceives, surveys have been performed concerning expectations people hold for the nursing role in recent times.

One such study was conducted by senior nursing students (Sisk et al., 1965) at an Ohio hospital. They developed a questionnaire concerning importance of selected nursing activities, based on a review of the literature and guidance from the nursing instructor. Questionnaire statements were analyzed by chi-square for significance of frequencies. Subjects numbered 62 chronically ill, ambulatory patients. A majority of the subjects agreed

that the primary role of the nurse should be to help patients meet physical needs. The highest level of agreement between subjects included patients wanting the nurse to know the important changes in their health conditions and how these affected them, more specifically in understanding the action of medicines and treatments. The next level of agreement showed that subjects wanted explanations of treatments presented to them prior to the actual procedure; they also expected treatments to be performed carefully and correctly. About four-fifths of the subjects wanted nurses to teach them how to maintain an optimum state of health. Subjects also recognized the role of the nurse on the health care team in planning patient care with other department members. Subjects in general expected physical needs to be the nurse's greatest concern, with teaching to be less important, but significant to the role.

In a study attempting to identify patients' satisfaction level in relationship to the care received, Gowan and Morris (1964) interviewed 52 adult post-operative patients. The intercom system was utilized to record patient requests, the times made, and the frequencies. Each patient was interviewed within 24 hours of the time the request was made. Interview questions included forced-

choice and open-ended questions. Results showed that personnel responded immediately to 76% of the requests, while 24% of requests had to be repeated. Of the repeated requests, pain medication was in most demand, comprising 52% of all repeats. The interviews indicated that patients withheld many requests because they believed nursing personnel were too busy, would disapprove of the request, because patients hated to bother the nurse, or because patients thought the requested action might not be good for them. The investigators questioned whether the stated satisfaction with care is actually an indication of the quality of care provided.

In a study presented by Beletz (1974), a small sample of hospitalized patients identified activities of the nurse to be similar to those of the image of the nurse as projected on television. Activities commonly mentioned were taking physicians' orders, giving medications, serving meals, and providing bedpans. Beletz described subjects' image of the nurse as one who has limited function outside of the hospital setting.

In another study by Beletz (1976), 25 people answered an open-ended questionnaire. Frequencies of answers were tallied to find that 17 subjects believed that the image of the nurse on television--that of the sex symbol,

subordinate to the physician, and sometimes lacking in intelligence--was inaccurate. Three subjects believed the image to be accurate and four thought there were some elements of truth in the image. Eighteen of the 25 subjects stated that they would attend a nurse-run group session and 13 subjects stated they would consider a home health care nurse, if needed. Independent actions by the nurse were supported by 17 of the 25 respondents. Sixteen subjects stated that they had gone to a physician for treatment or advice which a nurse could have provided. Beletz summated by stating that conspicuously absent from any responses made were the more cognitive roles as researcher, teacher, planner, administrator, legislator, or provider of primary health care versus secondary care.

A study of 300 consumer respondents was made by Robinson (1978), using a marketing approach, in two shopping areas of a southwestern city. An open-ended questionnaire was utilized. In answer to the question, "What service do you think a nurse should provide?", responses included providing physical care, teaching self-care, explaining doctors' orders, demonstrating ways to care for others, providing information, giving medications, doing physical examinations, offering counseling, helping to establish rights as a patient, and helping to find other

health care resources. The report indicated that consumers generally thought that nurses should confine themselves to traditional services, and that was what nurses were usually observed doing.

Grau (1984) surveyed 411 elderly persons, ranging from 70 to 99 years of age. Surveys were reported in the patients' own words, in essay form, after the patients were asked for their expectations of what a nurse should do. A total of 87% of the respondents was female, with 73% of the total sample living in skilled institutions. One striking aspect of the findings indicated a sharp discrepancy between nursing home and community residents' perceptions of who nurses are and what they should do. Four principal categories were found in the results, emerging in order of importance to respondents. The first area, personal qualities, showed that all of these respondents expected kindness and caring. Community residents appeared to expect little more than a friendly attitude and good manners, while nursing home residents frequently desired a mutual trustful and loving friendship. A full 19% of all respondents also expected a sense of humor. The second category, interpersonal skills, had to do with the nurse's ability to listen, understand, and respond in an appropriate manner. Of the community residents, 66%

provided examples of these skills such as being able to provide desired health and medical information. Many nursing home residents (38%) desired a different sort of information. General knowledge of what is going on in the world was sought. Of particular importance to both groups was the nurse's willingness to listen to reminiscences and to appreciate them. The third category, provision of direct care, included activities of daily living. In both groups, but particularly in the institutionalized subject group, it was suggested that their needs were often not met by the nurse. The most frequent expectation associated with direct care included personal respect, value of the individual's dignity, respect of privacy and rights, and promptness. The fourth and final category contained elements of professionalism. The most mentioned element (35%) was nursing knowledge and skills. The nurse/physician relationship was perceived by 20% of subjects as dependent. Other elements of professionalism, personal appearance and professional integrity, were also mentioned by 27% of respondents. In summary, Grau pointed out that subjects seldom distinguished between the RN, LVN, and the Nursing Assistant; often it was the Nursing Assistant, or the "aid" who had carried out bedside care in nursing homes. In general, both community and nursing home

respondents cited kindness and caring most frequently as an expectation of the nurse.

Another group of health care consumers, patients with cancer, were asked their perceptions of most and least important nursing care behaviors (Larson, 1984). Using the CARE-Q instrument, 57 adult patients hospitalized for treatment in three hospitals in the western United States, were surveyed. It was found that patients ranked as most important a competent clinical "know-how," such as administering shots, managing equipment, knowing when to call the doctor, responding quickly to calls, and giving medications and treatments on time. Prioritized as least important was asking for the name the patient wanted to be called, the nurse's professional appearance, and sitting down to talk with the patient to establish a trusting relationship. Psychosocial skills appeared to become important only after patients' basic "getting well" needs were met.

Another similar study of patients, conducted by Allanach and Golden (1988), utilized a modified Q-sort method of categorizing 50 nursing care behaviors. Subjects consisted of 26 adult patients in a southern United States hospital. The nursing behaviors were identified from past writings addressing the issue of nursing care and were then

categorized into 14 areas. Expectation scores ranged from 2.62 to 3.90 (mean score 3.26), with the area contributing the most desired behaviors being technical quality. This area contained activities such as the ability to give shots and starting an IV (3.90), knowing when to call the doctor (3.90), and appearing to be skillful at work (3.82). This was followed by activities such as taking time to give thorough care (3.64) and being knowledgeable about medicines and being able to answer questions (3.55). The lowest expectancy was found to be concerned with availability, being there when the patients needed the nurse (3.14).

In a national survey of attitudes toward health care made in 1984 by the American Nurses' Association (ANA, 1985), it was found that 92% of the 602 adult respondents believed that nurses should be allowed to increase their areas of responsibility, and 80% believed that health care costs could be lessened if more services were performed by nurses. The survey also found that 88% of the sample thought that nurses are the best source of home care and 87% believed nurses to be currently qualified to serve as information sources on nutrition and other health issues. Between 85% and 96% of the respondents believed that, with specialized training, nurses could prescribe routine

prescription drugs, conduct physical exams, deliver babies, provide home health care, and administer psychotherapy to individuals and families. In general, persons polled thought that nursing responsibilities could and should grow; they further expected to be hearing ideas from nurses about how to help contain the cost of health care in the future.

The literature appears to indicate that the health care consumer expects a variety of services from the nurse. Certain age groups and interest groups have their own special needs and expectations which should be addressed by nurses working in those areas. Generally, the public seems to indicate a desire for comfort, information, and monitoring services from nurses (Robinson, 1978). Whatever services are provided, the public expects competent and thorough care.

Nurses' Perceptions of the Nursing Role

Each profession looks at itself with a critical eye and holds expectations for roles within its area. Nurses have been surveyed to determine what behaviors and activities are important and desirable for the nursing role. One such study was made in 1956 by Gorham (1962), using the critical incident technique to collect

information concerning the specific behaviors of general staff nurses. The majority of subjects was staff nurses, numbering 1,053, from 10 hospitals in the metropolitan Washington, DC area. Also, 738 nursing supervisors were investigated. Respondents were asked to describe incidents of effective and ineffective nursing care to discover what role expectations are held for the nurse in daily hospital care. Results were categorized into five basic areas, with behaviors specific to each. The area most mentioned by staff nurses (39.7%) and supervisors (43.4%) alike was concerned with contributing to medical treatment of patients, such as carrying out medical orders, initiating medical procedures, reporting patients' conditions, and using and checking the operation of equipment. A total of 29% of the staff nurses and 21.7% of the supervisors reported that nurses should be concerned with improving patients' adjustment to hospitalization or illness. Behaviors relative to this role include explaining treatment and conditions, helping to relieve emotional tensions, and teaching self-care. Other categories, such as promoting the patient's comfort and hygiene, arranging management details, and personal characteristics of the nurse, were also mentioned as important, but with less frequency by respondents.

In a study involving five Ohio hospitals, Ciesla, Decker, Gavron, Iacofano, and Kirk (1965) found that 130 nurses caring for chronically ill ambulatory patients thought the most important function of the nurse was to care for the patient's physical needs, agreeing with the statement that physical care and observation procedures were more important than total patient care. A Likert-scale tool consisting of 88 statements of nursing activities drawn from the literature and reviewed by a nursing instructor staff member was utilized to collect data. It was found that nurses believed that the primary role of the nurse was to record and report patients' physical conditions. Body hydration, skin protection, and aiding patients to participate in their care were considered significant. Other primary role behaviors identified were: orienting patients to their environment, following hospital policies, and considering the patients' limitations when planning care. A lack of concern with continuity of care beyond the hospital was found, as well as a reluctance to consult other departments on behalf of the patient. Administrative activities were also considered less important than caring for patients' physical needs.

Approximately 15 years later, a study by Clark and Lenburg (1980) was made in a northeastern metropolitan area and included 31 nurses from medical-surgical units in four general hospitals. Each nurse completed a comprehensive critical incident questionnaire, yielding 82 usable in-depth reports. Based on the data it was found that nurses may be perceived to function as rule-oriented or as knowledge-oriented practitioners. Six distinct roles emerged from analysis of behavioral incidents. Interrater reliability was consistently high when tested for reliability in categorization and interpretation. The most frequently reported roles were "agent of control" and "patient advocate," cited 20 and 19 times, respectively. Agent of control activities were least compatible with a knowledge-oriented frame of reference, while patient advocate was found to be most compatible with this type of role. Monitoring the patient's condition, monitoring physician behavior, informer/advisor, and overseer of tests and treatments were other roles identified from the data. Monitoring the patient's condition was also found to be a role highly compatible with the knowledge orientation, while the remaining roles were found to be less so. The inverse relationship between the occurrence of interpersonal conflict and the ability to use knowledge was

also noted; interpersonal conflict was most evident in unsuccessful role performance when nurses acted as agents of control and monitor of physician behavior. Incidents were further analyzed for categories of behaviors influential to the roles. The category with the highest degree of influence was problem-solving (assessing needs, planning). This was followed by having resources to support actions (recognition, respect, approval) and information exchange (asking questions, receiving answers, being kept informed). These three categories of behavior helped or hindered knowledge-utilization the most, regardless of the role being performed. This study suggested that nurses can learn to implement the specific activities needed to ensure a more full application of professional knowledge in the practice setting.

In a study to identify behaviors which differentiate critical care nurses from general staff nurses, Benner and Kramer (1972) employed Corwin's Role Conception Scale and Kramer's Role Behavior Scale with 162 nurses in special care units. Specifically being tested were the professional and bureaucratic role orientations and levels of integrative behavior of these subjects. Findings showed that the role conception scores between critical care and staff nurses were similar, but critical care nurses scored

higher on integrative behaviors. It was suggested that special care units required more technically-focused rather than expressive actions and thus more conflict between the professional and bureaucratic orientations. Integrative behaviors would be more likely to help reduce role strain for the critical care nurse.

From a similar administrative viewpoint, Taunton and Otteman (1986) studied the staff nurse role conception, or expectations nurses in hospitals hold for their own behaviors in providing services to patients. Staff nurses ($n = 581$) from eight midwestern hospitals responded to a questionnaire of 137 items compiled from responses received from a large number of nurses, administrators, patients, and physicians. The questionnaire was later revamped to a more manageable size by a national panel of nurses. Results showed that data fell into seven categories labeled professional boundaries, job boundaries, direct patient services, authority relationships, autonomy, ethics, and billing and costs. The authors stated that these components represent the filters nurses need to make decisions about what they would or would not do in a day's work. Professional boundaries related to professional organizations, politics, continuing education, research, or volunteer work in community service. Job boundaries

related to coordinating care among disciplines, counseling, or acting as advocate in behalf of a patient. Direct patient services contained behaviors such as delegation or provision of technical procedures, treatments, and activities of daily living. Patient teaching was included in this area, residing on a continuum from being important to being disruptive or omitted in lieu of higher priority patient needs. Authority relationships fell into three clusters including hospital administration, expectations of physicians, and negotiations among nurses and in collective bargaining. Items related to autonomy included expectations suggesting recommendations for specific services, for an alternative physician if asked, explaining patients' medical diagnosis to family members, clarifying public misinformation concerning health issues, informing the public when staffing inadequacies in a hospital jeopardize patient safety, and others. Being cognizant of ethical issues and billing costs were considered less important by nursing respondents. The authors concluded that bureaucratic-professional role conflicts remain potential sources of stress for today's staff nurse; they also stated that past researchers have not reflected the real diversity of expectations among nurses in their roles. From a professional organization's standard of the nursing

role, the American Nurses' Association (1980), in its guidelines for nursing, has stated that the scope of nursing practice encompasses care, cure, and coordination. Ideally, care is a central theme which permeates the cure and coordination activities. Validating the effects of intended care has been an important topic of research for nursing.

Physicians' Perceptions of the Nursing Role

Medicine and nursing have common goals, that of the preservation and restoration of health. In working in a side-by-side relationship, nurses and physicians form opinions and expectations of the other's role. In 1970, Bates described physicians as thinking of themselves as soloists, viewing the nurse as a helper, following orders and carrying out whatever the doctor chooses to delegate. She cited studies in which the nurse was shown to be primarily engaged in technical activities, with failure to extend psychological support. Bates then suggested that the reasons for this constricted nursing role may be due to medical authoritarianism on one hand and nursing's acceptance of dependence, or even deference, on the other. Bates also suggested that nursing's full potential was not being met. She believed that interviewing, physical

examinations, preventative measures, managing certain problems, and providing emotional support and guidance should be included in the expanded role of the nurse. She stated that the cardiologist and the coronary care nurse were perhaps the only successful nurse/physician team which existed because of the knowledge base and protocol arrangements made between doctor and nurse.

In a study of 57 physicians in a semi-rural population area, O'Dell (1974) utilized a Likert-scale questionnaire concerning functions which would constitute an extended role for the nurse under supervision of a physician. A majority of physicians (93%) agreed to nurses expanding their traditional role performance in 11 of the 15 functions listed in the questionnaire. A majority of respondents disagreed on nurses performing patients' complete physical examinations and on interpreting diagnostic findings to patients. Seventy-five percent of the respondents perceived nurses as managing prenatal and postpartum care. Other functions physicians believed nurses could perform included eliciting histories, doing triage, performing certain diagnostic and minor surgical procedures, making house calls, ordering x-rays, diagnosing common colds and sprains, initiating emergency treatments, managing child health supervision, and prescribing

medications for minor symptoms, pain, and sedation. Some physicians made additional suggestions for the extended role.

Kalisch and Kalisch (1977) expressed the belief that nursing is perceived differently by nurses and physicians. According to the authors, nurses believe they make independent contributions to patient care, Physicians view the nursing role as primarily one of completing or assisting with physicians' orders and reporting the patient's progress. Kalisch and Kalisch continued by stating that physicians typically answer that an improvement in nursing care would result in more precise compliance with physicians' orders.

Conflict between nurse practitioners and physicians was explored by Chacko and Wong (1984) in a nationwide study of 361 nurse practitioners who answered four questionnaires measuring perceived role conflict, job satisfaction, and leadership behavior. Practitioners in hospitals reported greater conflict than those in public health and physicians' offices. Potential role difficulties were minimized when the work setting had fewer physicians and nursing personnel. In general, conflict showed a significant negative correlation with satisfaction and with the instrumental leadership style of

the supervisory physician. It was noted by the authors that there was no consensus within the health care field as to the proper definition of the role of nurse practitioner, which adds a dimension of role ambiguity to the study.

It is in medical school that physicians form a primary professional opinion of the nursing role. Webster (1985) interviewed 60 randomly selected medical students in multiple settings, using analytic induction and cross-classification within topical categories, to quantitatively determine trends. Findings showed that during the 4 years in medical school, medical students' perceptions of the nursing role became more broad and diffuse. Information concerning the nursing role was presented briefly in two courses taught by physicians, but the students' recollection of content was minimal. The variety of nursing roles that medical students observed only served to add to their confusion. According to Webster, medical students in their third and fourth years expressed a striking confusion in defining the interface between nursing and medicine. Less than 20% of those medical students were aware that nurses had legitimate roles independent of physicians' orders and expectations.

Webster (1988) again interviewed 60 randomly selected medical students in multiple settings to discover that many

of the findings of earlier studies, citing different value systems, education, social class, and status differences, were corroborated. It was found that third year medical students particularly often resented doing "scut work," such as starting IVs, drawing blood, or chasing down written reports, thought to be nurses' or other health care workers' duties. Medical students often acknowledge that nurses have more experience than they do, but at the same time believe that their own education should accord them the higher status. Webster concluded that medical students' experiences from one clerkship to another and from one institution to another (public and private differing in many respects) are characterized by varying degrees of role overlap and by ambiguous and changing relationships with the nurses.

Comparisons in the Perception of the Nursing Role

Nursing is a classic example of a profession undergoing a dynamic reconsideration of itself and its role in society today (Lum, 1978). As nurses acquire new responsibilities, their accountability becomes a more important issue within the health care system. To address this accountability, role expectations must be defined, although role expectations among role sets may differ.

Rheiner (1983) stated that the person fulfilling a given role must know what activities will acceptably fulfill the responsibilities of the position; therefore, expectations for a role must be illuminated. Comparisons of these expectations will be examined between patients and nurses, among nurses themselves, and between nurses and physicians.

Comparison of Perceptions between Patients and Nurses

Freidson (1960), who has investigated the role of the consumer in the health care setting, indicated that clashes in perspectives between patients and health care providers are expected because these two groups occupy different positions in the social system. His approach implied that patients want to be treated as adults and participate in decisions which affect their care. On the other hand, Etzioni (1964) contended that there is a strong professional conviction that those who perform the service to the client are in a more advantageous position to judge what is good for the client. There may also be role responsibilities involved in giving service of which the receiver is not aware.

Studies have been undertaken to elicit information concerning opinions on what priorities nurses should follow in patient care. An early study by Abdellah and Levine

(1958) was made using a checklist of 50 statements expressing primarily hospital patients' complaints. Approximately 8,000 patients and 12,000 hospital personnel completed the checklist. This provided some clues concerning what patients thought to be important in care; however, the research also included many aspects outside of nursing responsibility. It was found that patients wanted more professional nursing time, but that hours of nonprofessional nursing time did not raise patient satisfaction.

There may be differences in role perceptions dependent upon how perceptions are elicited. Copp (1971) studied 165 nurses and 101 patients to describe the cross expectations of nurses and patients. Surveys and interviews were utilized directly and indirectly to test perceptions between groups. Direct descriptions were tested by means of a respondent questionnaire, Mind-Body Circle Test, and Role and Affect Word Selection; indirect descriptions were made by the Copp Patient-Nurse Projective Cartoon Inventories. Instruments were developed by the investigator and had been tested previously but validity and reliability data were not presented. Perceptions were found to be similar within each group, although there were marked differences between the perceptions elicited from

the direct and indirect methods. Patients described nurses in an impersonal light through a direct forced-choice method. Terms such as "preoccupied medication givers," "concerned record keepers," and "stern supervisors" were chosen. Using cartoon strips to describe the nursing role, patients ascribed a more personal tone with such responses as "reassuring professional" and "controlling teacher-explainer." Using direct techniques, nurses described patients as frightened dependents; whereas using indirect techniques, nurses described patients as having no submissive characteristics. They perceived patients to be complaining, demanding, and protesting. The author voiced a concern that nurses may sometimes plan for the idealized patient instead of the real patient.

M. White (1972) conducted a study in three hospitals in an eastern metropolitan area which matched nurse-patient pairs to determine the congruence of perceptions in the importance of 50 selected nursing activities. There were 100 nurses and 300 patients in the sample (each nurse cared for more than one patient). The Nursing Activities Checklist, having four categories including physical care, psychosocial care, implementation of medical care, and discharge planning, was developed by the researcher in a Likert-scale form. Information concerning validity and

reliability was presented in a later critique study of the tool (M. White, 1979). Patients identified the importance of the nursing activities for themselves, while the nurses identified what was important for the responding patient. A t-test was used to compare nurse-patient disagreement scores. Nurses agreed closely with their patients on the importance of implementing medical care; carrying out doctors' orders was considered most important in both subject groups. Neither patients nor nurses considered discharge planning activities to be an important responsibility for the nurse. The other two areas showed significant differences between patient and nurse perceptions for prioritization. Nurses overemphasized the importance of psychosocial activities but underestimated the importance of personal hygiene and physical comforts, including environmental factors, as compared to patients. The author concluded that instead of speaking globally about meeting patients' needs, nurses should concentrate on activities which may make illness in the hospital a more tolerable experience.

In 1986, Wille (cited in Tack, 1987) replicated M. White's (1972) study using 60 nurse-patient dyads in three hospitals in New England. Findings were similar to M. White's study in that physical activities were ranked

higher by patients than nurses and discharge planning was ranked low by both groups.

Johnson (1987) utilized M. White's (1972) activities checklist and found certain similar results. This study involved 50 pairs of nurses and elderly medical patients at a private southwestern hospital. Pairs of nurses and patients were asked to respond to the particular needs of the patients. Data obtained showed agreement in the areas of physical care and implementing medical care, but showed marked differences in agreement concerning psychosocial and discharge planning areas. Nurses perceived psychosocial needs as important while patients did not; patients perceived discharge planning as very important while nurses saw it as less important.

Another study by Tack (1987), utilizing M. White's (1979) instrument, was made with 112 registered nurses and 81 adult patients in a large teaching hospital in the southwestern United States. These findings indicated a significant difference in the perception of the nurse's role in preparing the patient for discharge; nurses chose this area as the first category of importance while patients chose the area as least important. Both groups ranked Implementing Medical Care as second and Psychosocial Care as third. Nurses ranked Physical Care as fourth and

patients ranked it as first. However, after correcting for ties, only one category, Discharge Planning, had a z-score significant at $p < .05$.

A study by Lauer, Murphy, and Powers (1982) explored patients' and nurses' perceptions of the learning needs of cancer patients. Using a questionnaire developed by the investigator, 33 nurses and 27 oncology patients rated the importance of learning 36 information items, concerning treatment, nutrition, and diagnostic testing. In addition, both groups rated six content areas concerning problematic learning areas, patient knowledge, and patient interest in information. Results indicated that significant differences existed between nurses' and patients' perceptions. Nurses rated the importance of 20 general information items significantly higher than did patients; nurses ranked availability of financial assistance first, while patients ranked this item at 18th. Nurses ranked dealing with feelings as most problematic for patients, while patients ranked this area low in priority. Significant differences were also found between the two groups in what they thought to be most important for the patient to learn.

Other studies concerning teaching and learning needs have found discrepancies in perceptions between patients

and nurses. One such study by Adom and Wright (1982) compared patients' and nurses' perceptions of individual and group teaching modalities on a surgical ophthalmology unit. Three evaluation tools were developed by the investigators; reliability and validity information were not presented. A total of 60 patients and 13 primary nurses was surveyed. Only one-third of patients preferred individual teaching, while nurses indicated a greater preference for individual teaching but selected a combination method as most preferred. Patients differed from nurses in their perception of the amount of time and energy needed for individual teaching. Groups also differed in their opinion about how much information the patient retains from the teaching activity and in how much time should be allotted for questions. A wide discrepancy (43% difference) existed between the groups concerning the learning gained from other patients. The highest area of agreement between patients and nurses (75%) concerned patients gaining reassurance by sharing feelings with other patients.

Tilley, Gregor, and Thiessen (1987) also found incongruent perceptions between patients and nurses concerning the nurse's role in patient education. Thirty-eight matched nurse-patient dyads from two hospitals in

eastern Canada were presented with two sets of questionnaires developed and pilot tested by the investigator; reliability and validity information were not presented. Symbolic interactionist perspective was the theory basis stressing the importance of shared meanings in the definition of a situation. Results showed that patients would prefer a physician to teach them specific information related to their conditions, preferring a more general teaching function for the nurse. Nurses most frequently chose a nurse as the current and most desired teacher for patients. The two groups also differed in the preferred time for teaching in the patient's hospital stay period. Another area of disagreement concerned a tendency among nurses incorrectly to assume that their desires were shared by patients. The authors also noted that the nurses in one hospital appeared to understand their patients better than nurses in the other hospital involved, which may have been due to the organization in the two hospital settings. Results suggested that nurses need to develop a clear definition of their role in patient education and to validate patient desires in this area.

Conflict in perceptions may also occur between nurses and the patient's family members or significant others. This is particularly important with critically ill patients

because it is often the family members who make decisions and preparations concerning the patient's care. In a study by Norris and Grove (1986), selected psychosocial needs of family members of critically ill adult patients were investigated for importance. A pilot study was conducted using Molter's 45 need statements, finally reducing the questionnaire to 30 statements. Content validity and reliability were established. A sample of 20 intensive care nurses and 20 family members participated in this descriptive study. Results showed that family members ranked "to feel there was hope" and "to feel that hospital personnel cared about the patient" most highly. Nurses ranked three of the four highest as dealing with the need for information. The need ranked as fourth by nurses was to feel that hospital personnel cared about the patient. In total, four needs were found to be significantly different in ranking at the .05 level; these related to being called at home for changes in the patient's condition and knowing the prognosis. Three additional needs perceived as very important by the family but not the nurse ($p = .01$) included the family knowing about the type of staff caring for the patient, to feel there was hope, and having questions answered honestly. Nurses appeared to

underestimate the importance of these needs to family members.

There have also been differences in perceptions concerning specific patient care activities such as bathing. Webster, Thompson, Bowman, and Sutton (1988) questioned 22 nurses and 22 medical patients at a large teaching hospital and some significant differences in the areas of patient involvement in bathing, priority of bathing, communication during bathing, patient embarrassment, and satisfaction with bathing. A 20-item questionnaire was designed by the researcher for a comparison of frequencies between the two groups; validity and reliability were not presented. Responses indicated that nurses place more importance on bathing than do patients. Nurses (77%) thought that bathing time should not be up to the nurse, although patients (64%) believed it was the nurse's choice. Patients (73%) were not embarrassed by bathing, while significantly fewer nurses (41%) believed this to be true. Patients had a general overall feeling of satisfaction with bathing in the hospital but only 68% of nurses agreed with this. Authors also noted that a higher rate of "don't know" responses from nurses might indicate nurses' difficulty in generalizing about the opinions of patients.

A study conducted in a postpartum unit in eastern Canada by Morales-Mann (1989) also showed incongruencies between the importance ratings assigned by 50 patients and 25 nurses to nursing activities. Questionnaires were developed by the investigator, based on material found in textbooks. Content validity was established. Nursing activities were classified into teaching activities, physical care activities, and psychosocial care activities. Nurses were also questioned as to the importance assigned to an activity in actual practice as compared to the importance the nurse would like to give an activity in an ideal setting. Significant differences between patients and nurses were found in 10 of 17 items, especially concerning seven teaching activities. These activities were ranked much higher by patients than by nurses. Physical comfort measures and psychosocial activities involving adjustment and expression of feelings concerning the new child were also ranked high by patients. Nurses wanted to spend more time with physical care, including comfort measures, and with psychosocial aspects. Results of this study implied that the performed role of the nurse may not be congruent with the nurse's perceived role.

Donabedian (1980) has pointed out that there may be significant differences in the perceptions of health care

providers and patients as to what quality care is and to what extent it is provided. The literature has provided several instances of these differences. Incongruities also may exist between and among nurses in this area.

Comparisons of Perceptions of the Nursing Role Among Nurses

There appears to be very little research comparing perceptions among nurses as to what the role of the nurse should be as related to patient care. It may be assumed by some researchers that nurses tend to think alike as a unit, as opposed to patient or physician groups. Nursing's current state of transition into a more autonomous profession may particularly warrant such studies to find out if nurses, indeed, agree on what role activities are important in patient care. Weiss (1983), in a study involving consumers', nurses', and physicians' opinions of the nursing role and its overlap with the medical role, found that within the nursing subgroup studied, nurses could not identify one single behavior unique to nursing. This was also found to be the case with consumers and physicians, leading to the conclusion that there is a continued public image and self-image of nursing as an extender of functions performed by the physicians.

Studies have been made in the area of intrarole conflict in the fields of job satisfaction and role transformation of the new nursing graduate. Innumerable studies from various standpoints, such as psychological, sociological, industrial relations, administrative, as well as nursing, have been done in the field of job satisfaction. Also, Kramer and Schmalenberg (1979) have studied the unrealistic expectations of nursing graduates specifically, revealing that when there is incongruity between values and behaviors of the school subculture and the work situation, there is role deprivation that leads to conflict and lowered job satisfaction. Although these issues are crucial to nursing, they do not specifically address a comparison of nursing role activities oriented toward patient care, but encompass a wider job environment including such factors as staff spirit, relationships between supervisors and staff, cooperation among staff members, and transition from academy to the working world.

Wanous (1980) explained that some people become dissatisfied with their work because inflated expectations of the rewards associated with work do not match the rewards given. Wanous has hypothesized that the more and better the information given to the individual, the less inflated and more realistic will be the individual's

expectation of the job, which will result in more positive attitudes. Establishing role expectations for nurses, as agreed upon by nurses in the field, may lead to more realistic and positive attitudes for new and old employees alike.

Comparisons of Perceptions between Nurses and Physicians

Opinions concerning role differences has long been an issue between staff nurses and physicians in their hospital relations. While they carefully present an image of harmony to the public, these health care providers often conceal a deep level of misunderstanding, resentment, and anger (Sheard, 1980). Kalisch and Kalisch (1977) have reiterated this several times in saying that nurses and physicians work side by side, seldom understanding the work or responsibilities of the other. When two occupations work closely but structure their work differently, their conceptions and methods show significant divergence; yet each group naively expects the other to look upon work as they perceive it (Sheard, 1980).

Sheard (1980) has outlined six basic differences in work dimensions between nurses and physicians which may contribute greatly to the structure of conflict. The first concerns a sense of time; nurses tend to have an hourly,

strictly structured sense of time, while physicians tend to think in more enduring terms encompassing a patient's entire course of illness and history. A second source of conflict is the sense of resources available to each group. Nurses have a "scarcity view" (Sheard, 1980) of hospital resources because resources are often limited and difficult to obtain. Physicians tend to think of the hospital as offering nearly a limitless pool of resources for diagnosing and treatment. A third difference is based on the unit of analysis. This author stated that the physician requires a holistic approach to the diseased body and that nurses use a particulate unit of analysis, focusing on completion of scheduled tasks. Work assignment areas are the fourth area of concern; nurses are assigned by room number (geographically) and physicians deal with patients by case assignments. Another area revolves around types of rewards; physicians are paid a salary or fee for services, while nurses receive an hourly wage. The final difference noted concerns a sense of mastery. Sheard suggested that physicians appear to have a strong sense of mastery over their work, while the nurse tends to have a weak one because of a constant involvement in strict routine, shift assignments, a functional division of labor, and the hourly wage. A solution to the differences was

offered in the application of primary nursing, organizing nursing in much the same manner as medicine. This would allow for more time to undertake problem-solving by the nurse.

Shortell (cited in Kalisch & Kalisch, 1977) in 1974 compared the views of 117 physicians and 66 patients who were asked to rank 41 job categories. According to Kalisch and Kalisch, only one large variation was found between the two groups in this study and that was for nursing. Patients ranked nursing 19th while physicians ranked nursing 27th. Patients did rank nursing higher than certain medical specialties, such as dermatology and podiatry. However, physicians, who work closely with nurses, ranked the nursing profession in the lower levels of importance.

A study was undertaken by Weiss (1983) to determine whether a series of systematic dialogue sessions among consumers, nurses, and physicians would result in consensus as to what areas are unique to the role of the nurse and what role activities are shared by nurses and physicians. Seventy-two nurses, consumers, and physicians met monthly for 20 months in small groups to discuss health issues in practice. Perceived areas of role differentiation were identified through verbatim recordings and a Likert-type

instrument. There were no unique activities which emerged just for the nursing role, but 82% of behaviors and responsibilities were found to be overlapping, equal areas for nurses and physicians. The nursing subgroup supported a more equal assumption of responsibility between nurses and doctors. Nurses disagreed with physicians' predominance in always assuming responsibility for a patient's plan of care, writing orders for the plan, and in admission and discharge responsibilities. Overall findings suggested that the normative nurse lacks a strong identification with a particular domain of unique skills, resulting in a "blue collar mentality" that may hinder any attempt to function as a colleague with physicians who have a strong sense of identity.

Another study was conducted by Temkin-Greener (1983) to identify nurses' and physicians' ideas of a "team." Interviews were made with six nurses and six physicians, all heads of departments. Everyone basically agreed with the definition of a team; however, physicians viewed teamwork as a nursing concept only. Nurses viewed medicine as accepting of interprofessional teamwork only when it was imposed from an outside agency. This supports Bates' (1970) statement that physicians tend to think of themselves as soloists.

Kalisch and Kalisch (1977) stated that physicians have long insisted on maintaining the dominant role in health care. Physicians regard other health care professionals as serving a role primarily to assist them in the "captain of the ship" role rather than functioning in a health care team working together to serve the patients. Physicians appear to assume that health care workers are completing delegated tasks and functions which the physician could perform but does not for reasons concerning inefficient use of time and money. According to Kalisch and Kalisch, the nurse has continued to accept this position. This leads to Bates' (1970) statement that nurses may have accepted a dependent position in health care with deference. It remains that nursing is primarily dominated by women and medicine dominated by men. According to Freudenberg and North (1985), deference has traditionally been approved for women, indicating that silence, persistent smiling, and apologizing are ways of avoiding confrontation. These methods may be used by nurses when dealing with physicians.

Masson (1985) compared the nurse/physician roles by saying that medicine is based on the use of tools, while nursing is based on the use of self. She has envisioned a continuum characterized by an attitude toward life on one end that centers on utilizing the ability to focus, divide

and change, and problem-solve ("masculine") and an attitude of acceptance, awareness of unity of all life, nurturance, and a readiness for relationships ("feminine") on the other. Although these qualities are interwoven into people of both genders, the author identified nursing as being more feminine and medicine as being more masculine on this continuum. Masson also stated that physicians focus on the diseased part or system and tend to "rule out" areas of concern, while nurses are more likely to look at the diseased part in context of the whole person. This is in contrast to Sheard's (1980) opinion, which is that the doctor takes a holistic view of the patient and the nurse is limited more to thinking in specific units related to tasks. Masson also made the point that modern medicine is grounded in physical and life sciences; nursing relies more heavily on humanities and social sciences. For this reason, nursing is also more culturally bound than is medicine.

Another possible source of tension between nurses and physicians involves the management of information to patients and/or family members. Traditionally, nurses were taught to preserve the physician's exclusive right to relay medical information; however, today, nurses are taught that it is part of their professional obligation to keep the

patient informed (Mathews, 1983). Mathews has said that the prevailing thought in nursing is that the patient has a right to information in order to make informed decisions about treatment options and to make adjustments in life. The author disclosed some important factors which bear on this issue, including professional ideas concerning what information to reveal, the relationship between hierarchal status, and the control of information and who owns the information. These issues appear to be an increasing source of conflict between nurses and physicians.

Moniaci (1988) cited reasons for conflict between nurses and physicians as basic gender set, differing levels of education, role conflict, and economic disparity. In a study using M. White's (1972) Nursing Activities Checklist, Moniaci asked 147 licensed nurses and 75 physicians in a large private hospital to rank nursing activities. She found that the role of the nurse is perceived differently between the two groups. Nurses ranked discharge planning significantly higher than physicians ($p = .01$), also ranking physical and psychological care higher. Both groups ranked implementing physicians' orders as the highest category. Differences were also found between licensed vocational nurses and registered nurses and between physicians and resident physicians. Resident

physicians ranked discharge planning as the most important nursing activity.

The changing role of nursing leads to a less distinct boundary between nursing and medicine. When two people have related responsibilities with ill-defined boundaries, the potential for conflict increases (T. White, 1985). Role expectations and role clarity are challenged by change. As long as groups work side by side with similar values and goals but differing backgrounds, there will be some degree of conflict between the groups.

The Importance of a Quality Patient/Nurse Relationship

Several differences and conflicts in the perception of what a nurse does or should do in daily patient care activities have been found. In order to effect positive changes in patients' health care status, the nurse-patient interaction must promote consensus and mutual goal attainment between those involved (Kasch, 1986). The nurse/patient relationship is the basis for many theories within nursing, and is therefore thought to be of utmost importance to nursing.

The term "patient" relays a contractual agreement to elicit supportive skills for the maintenance, promotion, and restoration of the person in need (Bottoroff & D'Cruz,

1984). This arrangement is what distinguishes the individual consumer as being the focal point of the practicing nurse. The very notion of a patient is not viewed in a solitary context, but in an interactive notion involving interpersonal and social encounters, interconnecting roles, and a health care or health maintenance setting. In the hospital setting, the patient may have a contractual agreement with the institution or the physician, the nurse-patient relationship being secondary to this agreement. Yet, as Mathews (1983) stressed, nurses are the most constant persons in the patient environment. A sound relationship between the nurse and patient may expedite the patient's progress toward goals being met and give the patient an overall feeling of excellence in care.

Peplau (1952) developed an interpersonal theory of therapeutic relations with patients, based on the belief that individuals have an innate drive toward health. She stated that the nurse and the patient are both objects of scrutiny in a relationship, but the patient should be the focus of the time spent relating. Four phases bring the relationship to light: (a) orientation, in which the nurse explains the nature and purpose of the relationship and each person's role and responsibilities;

(b) identification, in which the patient identifies the problems to be dealt with; (c) exploitation, when patient problems and underlying needs are investigated; and (d) resolution, at which time events in the relationship and the growth occurring in the exploitation phase are evaluated by the patient and nurse. Peplau spoke of the relationships as being goal-directed, primarily motivated by the patient's need to be free of anxiety. Within this framework, nurses use themselves therapeutically to help patients guide and control anxiety. A quality relationship between patient and nurse may keep anxiety within a "mild" range where awareness and attention may be heightened. Peplau added that "a measure of security is provided in the 'thereness' of the nurse . . . listening to what is said and responding" (p. 133).

Mauksch and Tagliacozzo (1959) undertook an exploratory study to identify the patient's point of view of the patient's role. Subjects included 86 patients with cardiovascular and gastrointestinal disease in a large teaching hospital in the Midwest. Structured interviews were analyzed with a detailed coding guide developed by the investigators; findings were reported as frequencies and percentages. Results showed that patients' efforts are directed toward recovery, with a major concern for

successful adaptation and acceptance within the hospital. The most often cited expectation of patients was to have a prompt response and reduction of emotional strain from the nurse. The authors stated that because patients generally are not competent to judge the skill and technical knowledge of the professional, "interest" in the patient is an indirect demonstration of competence. Kindness is often a symbol of safety and caring.

Often, and for various reasons, patients do not adequately express their needs. Tagliacozzo (1965) conducted an exploratory study of 60 nurse-patient contacts in a large hospital in the Midwest to observe how adequately patients' verbal and nonverbal behaviors expressed their concerns and needs for nursing assistance. Patient interviews were made immediately after routine care episodes. Findings showed that 98% of the needs were not expressed or fully expressed to the nurse caring for the patient. In 11 instances, the patients expressed their need in part, asking for concrete items such as a glass of water or an adjustment in bed. As the concrete needs were met, other more personal needs emerged as the patients became familiar and comfortable with the nurse. Patients needed to establish some degree of confidence in the relationship before their needs were presented and met.

Initial patient behavior may not be a reliable basis for assessing needs and concerns. Patients and nurses are essentially strangers to each other in the initial relationship, yet patients are expected to trust their care to the nurse on the basis of the nurse's position. In our culture, individuals often hesitate to reveal intimate needs until they have established a sense of trust with the other person involved. In addition, some patients may not be aware of what assistance is actually needed (Tack, 1987). As nurses carry out their tasks with patients, the continuity and personal nature of the interactions provide a basis for entering into relationships characterized by intimacy and comfort (Bottoroff & D'Cruz, 1984). If the patient views the nurse as someone who can be trusted and is willing to communicate and assist, the patient can feel free to clarify and elaborate concerns. I. King (1981) stated that it is the ongoing process of perception and communication which sets the stage for nursing as a cooperative and therapeutic endeavor.

Patients frequently express a desire for more personal contact with the nurse (Chapman, 1977). Patients respond to the strains of illness and the unique experience of hospitalization, often desiring more personal attention and contact than they receive during their adjustments to

hospitalization. The concept of time is significant in nursing because it is a 24-hour, 7-days-a-week service, and the nurse is continually responsible while on duty. The sustained and continuous contacts in nursing are characterized by quality nursing care, and hopefully, by a quality relationship between patient and nurse.

There is strong, empirical evidence that patients' evaluations of health care services weigh heavily upon attitudes toward their health care providers and the providers' behaviors (Ware, 1978). For this reason, institutions rely on nursing service as a crucial component in the public's view of care within the institution. And the very basis of nursing activity is the nurse-patient relationship; mutual participation of patient and provider is central to several theories in nursing.

In all nursing encounters, nursing activities have to do with the quality of a patient's living and dying (Bottoroff & D'Cruz, 1984). Understanding and reducing the stresses, strains, and anxieties of patient experiences can facilitate and sustain attitudes between both the patient and nurse in their road to a quality interaction.

Summary

Perceptions of the nursing role were presented from the health care consumers' point of view and from nurses'

and physicians' perspectives. Views vary as to what a nurse does or should do, depending on the needs of the group being questioned. Studies comparing patients' and nurses' perceptions and comparing nurses' and physicians' viewpoints were then presented. Several differences and conflicts in perceived roles of the nurse and prioritization of nursing activities were found between groups. The importance of some consensus or agreement of nursing role activities was related in a discussion of a quality nurse/patient relationship and collaboration between nurses and physicians.

CHAPTER III

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

A nonexperimental, comparative research design was employed for this study. Comparative research is designed to compare intact groups on a dependent variable; the researcher is not able to manipulate the independent variable (Nieswiadomy, 1987). A survey was carried out among three groups--patients, nurses, and physicians--to identify and compare the similarities and differences of perceptions in prioritizing the importance of specific nursing activities. More specifically, the variables investigated included areas of physical care, psychological care, implementation of medical care, and discharge planning.

Setting

A 380-bed hospital in a large metropolitan area in the southwestern United States was the setting for the data collection. The institution houses 280 beds, with 244 medical-surgical care beds and is a full-service facility accredited by the Joint Commission for the Accreditation of

Hospitals Organization. There were 467 RNs and 156 LVNs employed at this hospital at the time of the study.

Patients completed questionnaires in their rooms; such distractions as television and visitors were limited or curtailed whenever possible. Nurses completing the questionnaires were asked to do so in a quiet place within their departments, without conversing among themselves. Physicians completed the surveys in the place of their choice, although questionnaires were distributed in the mail room in the medical records department. The researcher was not immediately present in any of these settings while the subjects completed the surveys.

Population and Sample

The target population groups for this study were: (a) adult patients currently hospitalized, (b) nurses currently working in the hospital, and (c) physicians currently working with hospitalized patients. Purposive sampling was used to obtain patient subjects; a convenience sampling method was utilized to obtain the nurse and physician subjects. The accessible population groups for this study were obtained from the hospital described in the section concerning the setting. Eligible subjects were approached individually and invited to participate. Those subjects

who agreed to and participate and complete and return usable questionnaires comprised the sample group.

The patient subjects were selected from the medical-surgical and intensive care units of the selected hospital. Head nurses on the units suggested eligible subjects. Patients were asked voluntarily to participate at the specified time of data collection. The criteria for patient selection included the following:

1. 18 years of age or older.
2. Able to read and write English.
3. Oriented to person, place, and time.

4. Not experiencing a crisis or trauma such that answering a survey would be deemed as disturbing to the patient's psychological or physiological status; head nurses, the patients' assigned nurses, or physicians made this judgment.

5. Admitted to the hospital for at least 24 hours.

The nursing population consisted of the registered nurses and licensed vocational nurses on the medical-surgical and critical care units of the selected hospital. All nurses on these units were eligible and participation was voluntary. There were some differences between RNs and LVNs working on units not using telemetry, particularly concerning tasks such as assessment duties and intravenous

administration of drugs. These differences were less noted in the critical care areas, where nurses are certified by the hospital for such procedures.

The physician population comprised all attending physicians currently practicing at the selected hospital. All physicians at this institution were licensed medical doctors.

It was hoped that at least 50 subjects would complete usable surveys in each group. Data were gathered over a 5-week period of time.

Protection of Human Subjects

The study involved adult clients completing an anonymous survey questionnaire. Participation in the study was voluntary, with minimal risks involved. This study was classified as a Category I study according to the Federal Regulation for Protection of Human Rights (Appendix A). Agency permission for conducting the research was obtained in writing prior to implementing the study (Appendix B). Permission to conduct the study was obtained from the Texas Woman's University Graduate School (Appendix C). Along with the questionnaire, each subject also received a cover letter explaining the purpose of the study (Appendix D). The following steps ensured the protection of each individual's human rights involved with this study:

1. Permission from the hospital administration was obtained.
2. Voluntary subject consent was implied by completion and return of the questionnaire.
3. Data were to be reported only as group data.
4. A different color of paper was the only differentiating element used to separate the three groups' questionnaires; there were no other codes assigned to surveys.
5. Subject anonymity was assured by asking subjects to refrain from placing their names on the questionnaires.
6. The researcher's telephone number accompanied each survey packet to ensure that any question might be answered, in the case that the researcher was not directly available.

Instrument

The Nursing Activities Checklist (Appendix E) developed by M. White (1979) was distributed to patients, nurses, and physicians at the identified hospital. Permission to use the instrument was obtained (Appendix F). The content, format, and response categories for each group surveyed remained the same for each instrument except for changes in pronouns to fit the subject. For example, on

the instrument to be given to patients, item number 10 stated: "Allow me to make decisions about my own care." On the version that was given to nurses and physicians, item number 10 stated: "Allow patients to make decisions about their own care."

The instrument consists of 50 nursing activities, each categorized into one of four broad areas:

1. Physical care--activities in response to physiological care concerning cleanliness, comfort, sleep, and rest (M. White, 1979).
2. Psychological care--activities concerning supportive emotional, spiritual, and diversional care (M. White, 1979).
3. Implementation of medical care--activities including observing, reporting, and carrying out physicians' orders (M. White, 1979).
4. Discharge planning--activities concerning teaching and planning for continued care (M. White, 1979).

Responses were indicated by circling the letters chosen as appropriate for each activity listed. Choices for each activity varied from not important to extremely Important. Each response was assigned a number from 0 to 4, with 0 being not important and 4 being extremely important. The physical activities subscale contains 20

items, with possible scores ranging from 0 to 80. There are 14 psychosocial items, with possible scores ranging from 0 to 56. Both the implementation of medical care and the discharge planning subscales contain eight items each, with possible scores of 0 to 32. A score for each question and a score for each of the four categories can then be obtained from the completed instruments.

The original tool had an additional choice of does not apply but it was given the same value (0) as the not important choice. Wille (cited in Tack, 1987) recommended this choice be deleted from the tool. The analysis reported no benefit from having it included, and it was not deemed beneficial to this study. The original instrument was used to compare what a specific nurse and a specific patient found to be of priority in their situation, as opposed to the use of the tool to gather information among groups, as was done in the present study.

Items in the instrument were derived from a review of literature, statements from nursing leaders and professional organizations, interviews with patients and nurses, and the original researcher's experience. The four basic areas of categorization were pulled from the original list of 74 activities which were first submitted to nurse practitioners, doctoral students, nursing faculty members,

and former patients. From this, a checklist of 56 items was compiled which adequately represented each of the four categories. At this point, the checklist was piloted with hospital staff and patients. The final revision was made by 12 graduate students selected on the basis of clinical nursing competency; thus, the instrument was found to have content validity. The resulting tool contains 50 items (M. White, 1979).

Internal consistency reliability has been established using Cronbach's Alpha. The reliability score for the instrument in general was found to be .96. For each of the four categories, the following reliability coefficients have been obtained: Physical care = .92; Psychological care = .89; Implementing medical orders = .84; and Discharge planning = .89.

Demographic data sheets (Appendix G) were developed by the investigator to obtain information to describe the composition of the sample. Each of the sample groups was asked age, gender, and educational background. In addition, patients were asked about previous hospitalizations. For nurses, years of experience and highest level of nursing education were also requested. Physicians were asked specialty area and years of experience.

Data Collection

After obtaining the necessary approvals, the head nurses of the involved units were verbally contacted and presented preliminary information at a head nurses' meeting. A questionnaire packet was then presented to each head nurse. Staff nurses on each qualifying unit were subsequently informed of the study and given the opportunity to participate. This was accomplished in a group meeting after nursing reports were exchanged at the time of shift change (7 a.m. and 3 p.m.). A questionnaire packet, including the Nursing Activities Checklist, a demographic information sheet, a cover letter, and an envelope for returning the information, was given to each nurse interested in participating. Any concerns or questions were addressed at this time. The researcher did not remain with subjects as they completed questionnaires; subjects were instructed to place completed surveys in a collection box designated for completed surveys, one of which was left on each unit. Subjects were encouraged to complete the surveys promptly, but also had the option to complete them at their convenience. The researcher returned daily to collect the questionnaires.

With the aid of the head nurses, the investigator selected appropriate patients for subjects. The researcher

approached each appropriate patient in his or her hospital room during daytime hours (8 a.m. to 6 p.m.), explained the study, addressed any questions or concerns, and distributed a questionnaire packet to each willing subject. A telephone number was listed with each survey packet for further information. The researcher explained to each patient that she would step outside of the room while the questionnaire was completed and would return in 15 minutes (or at an agreed upon time) to collect the questionnaire and demographic data sheet. Completed questionnaires and demographic data sheets were placed into a large collection envelope with other completed surveys before the researcher left each subject's room.

Data collection occurred over a 5-week period. The investigator circulated through each participating unit as many times as needed to contact nurses and patients who might have been unavailable at the initial contact sessions. There was a box designated on each unit for the placement of completed forms. The investigator was not immediately present when subjects completed the questionnaires.

For physicians, a questionnaire packet was left in the physicians' mail boxes, which were located in the medical records room at the hospital. A collection box was left in

this room and on each unit of the hospital for completed forms.

Treatment of Data

Frequencies and percentages were computed on demographic variables used to describe the subject groups. Because each question on the Nursing Activities Checklist has been categorized into one of four areas, a mean category score was computed for each area. An analysis of differences among the patients' sample, the nurses' sample, and the physicians' sample was determined by utilizing analysis of variance (ANOVA). The level of significance was set at .05. Subsequent to obtaining a significant F-ratio, the Tukey test was also used to make comparisons between means in order to pinpoint exactly where (between what groups) the significant effect was located.

CHAPTER IV

ANALYSIS OF DATA

A nonexperimental, comparative study was conducted to determine 50 patients', 50 nurses', and 38 physicians' perceptions of the importance of selected nursing activities. This was accomplished by having a purposive sample of patient subjects and convenience samples of nurse and physician subjects complete a 50-item Nursing Activity Checklist (M. White, 1979) to measure the importance of each nursing activity within four specific categories. The importance of each category of nursing care was analyzed among the three groups of subjects. Demographic statistics were also collected by researcher-developed tools. Data were collected on adult medical and surgical patients, licensed medical and surgical nurses, and licensed medical doctors at a 380-bed hospital in a large metropolitan area of the southwestern United States. In this chapter, the samples are described and an analysis of findings is presented.

Description of the Sample

There were 52 questionnaires distributed to patients with 50 (96%) returned as completed. Fifty-four

questionnaires were distributed to nurses, with 50 (93%) returned as complete. Of the 180 questionnaires distributed to physicians, 38 (21%) were returned completed.

Figure 1, Figure 2, and Figure 3 describe the demographic variable of age for the three samples of subjects utilized in this investigation. The major trend of interest here is that the physicians represent the youngest age group of the three groups sampled. The nurses who participated occupy the mid-range, with the patient population definitively the most mature of the subjects who were sampled.

The next characteristic of the samples to be described is the distribution of males versus females across the three groups. Figure 4 clearly points to the skewed distribution on the male side for the physicians sampled in this study. However, if this were to be considered a potentially confounding variable, Figure 5 demonstrates the inverse problem with the participating nurses. Reference to Figure 6 completes the gender picture for this investigation and shows roughly a 70/30 proportion favoring males within the patient population.

Figure 7 offers a profile of the amount of professional experience of the two groups of subjects. It

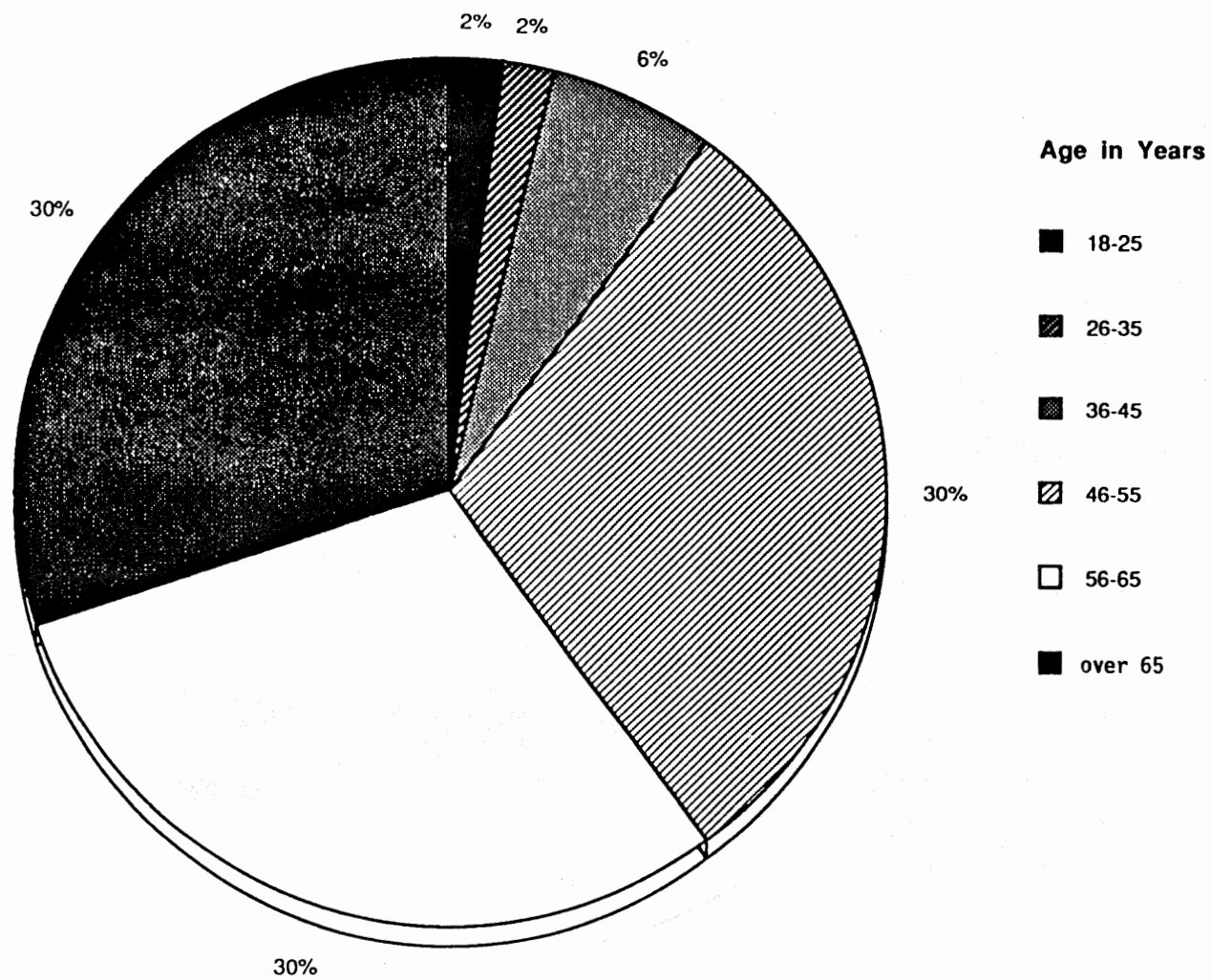


Figure 1. Age distribution of patients.

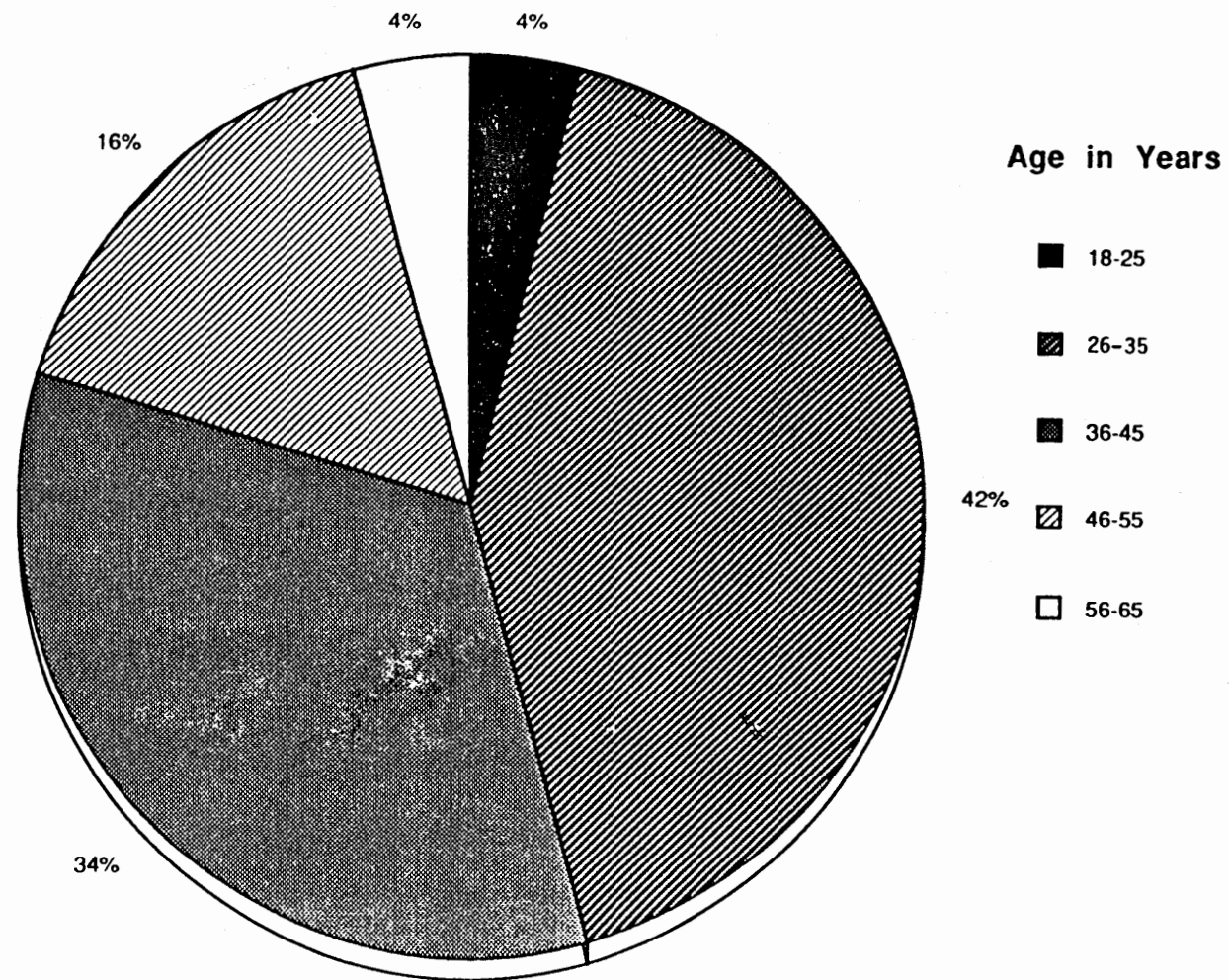


Figure 2. Age distribution of nurses.

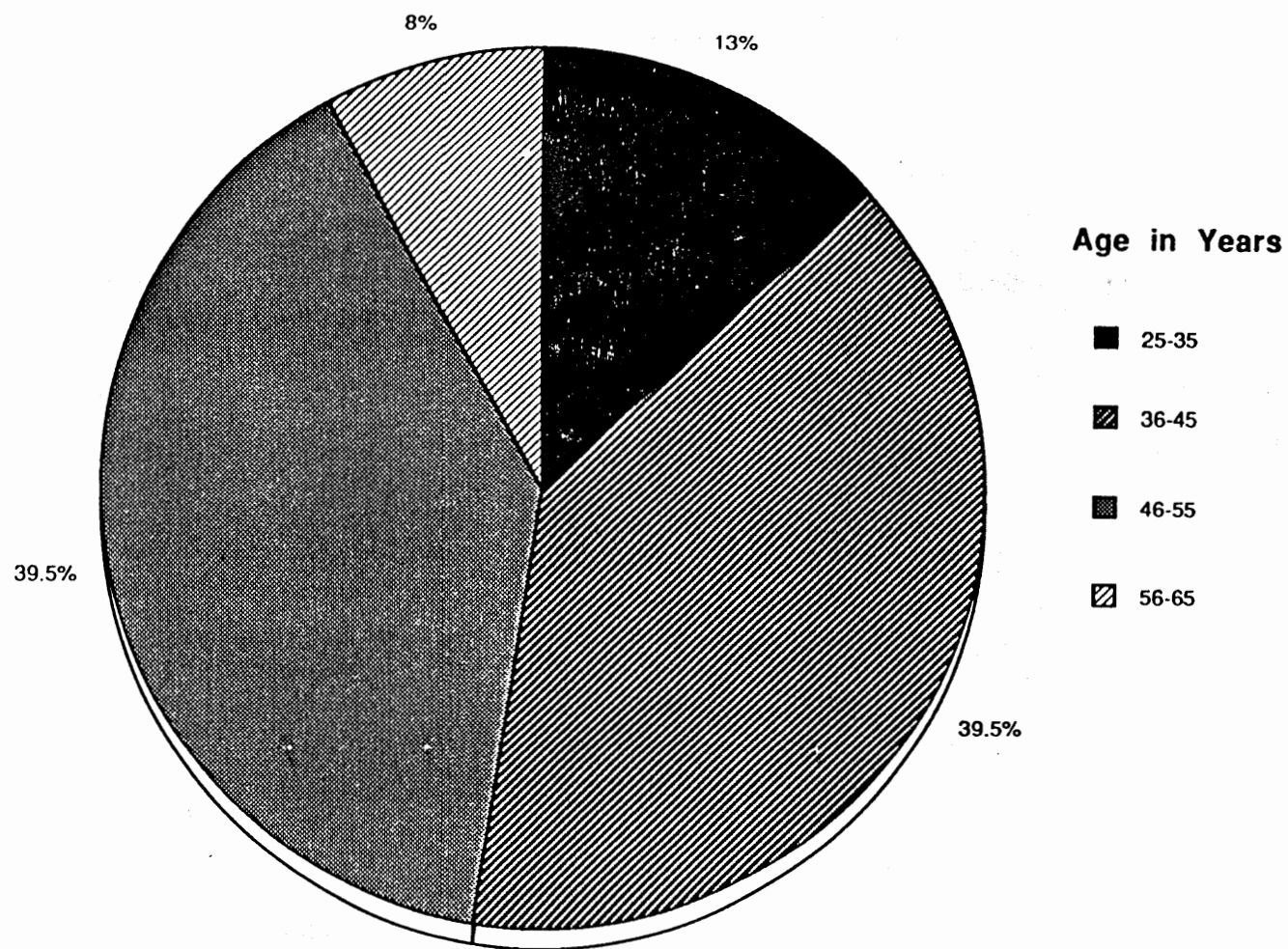


Figure 3. Age distribution of physicians.

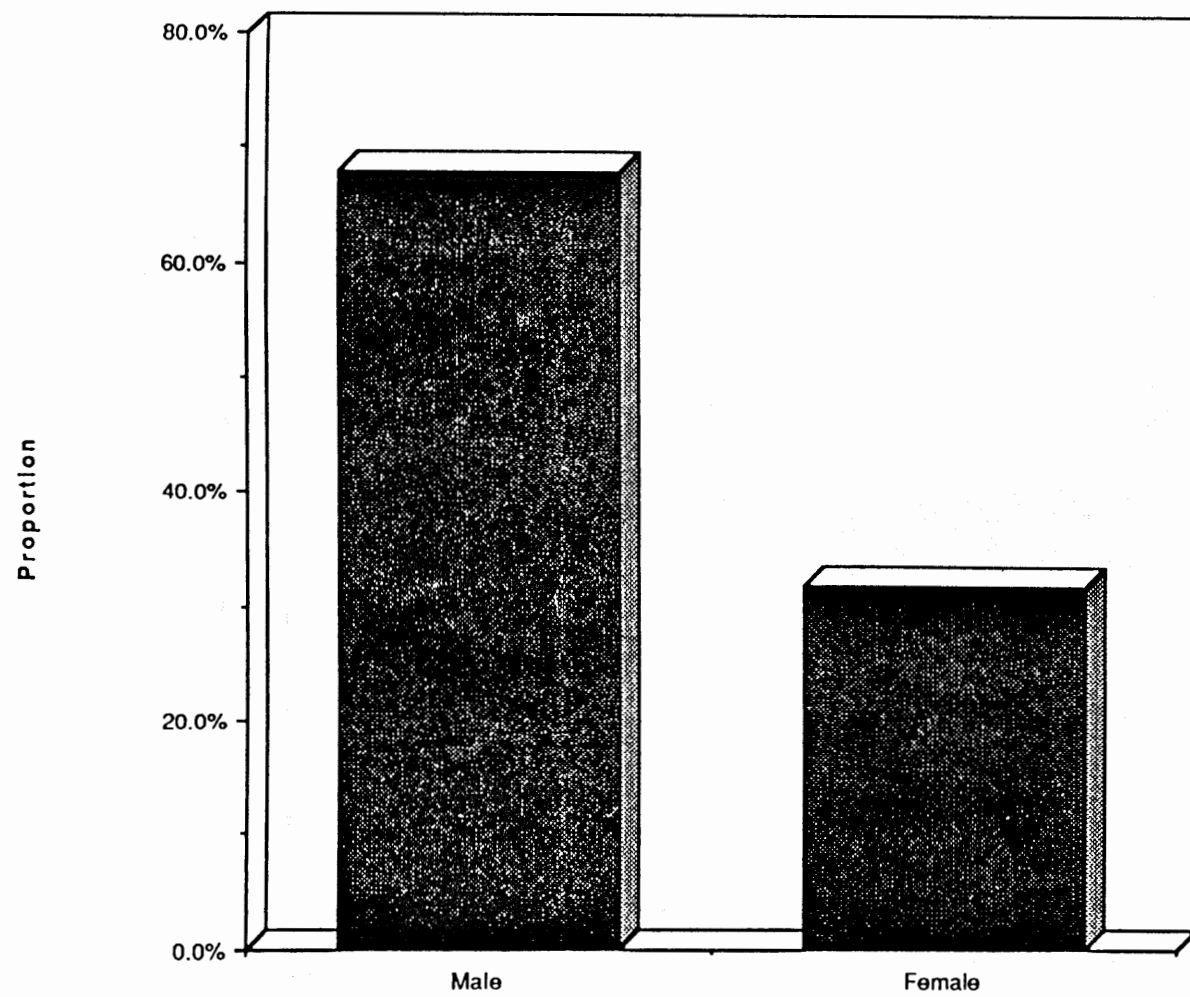


Figure 4. Patients' gender distribution.

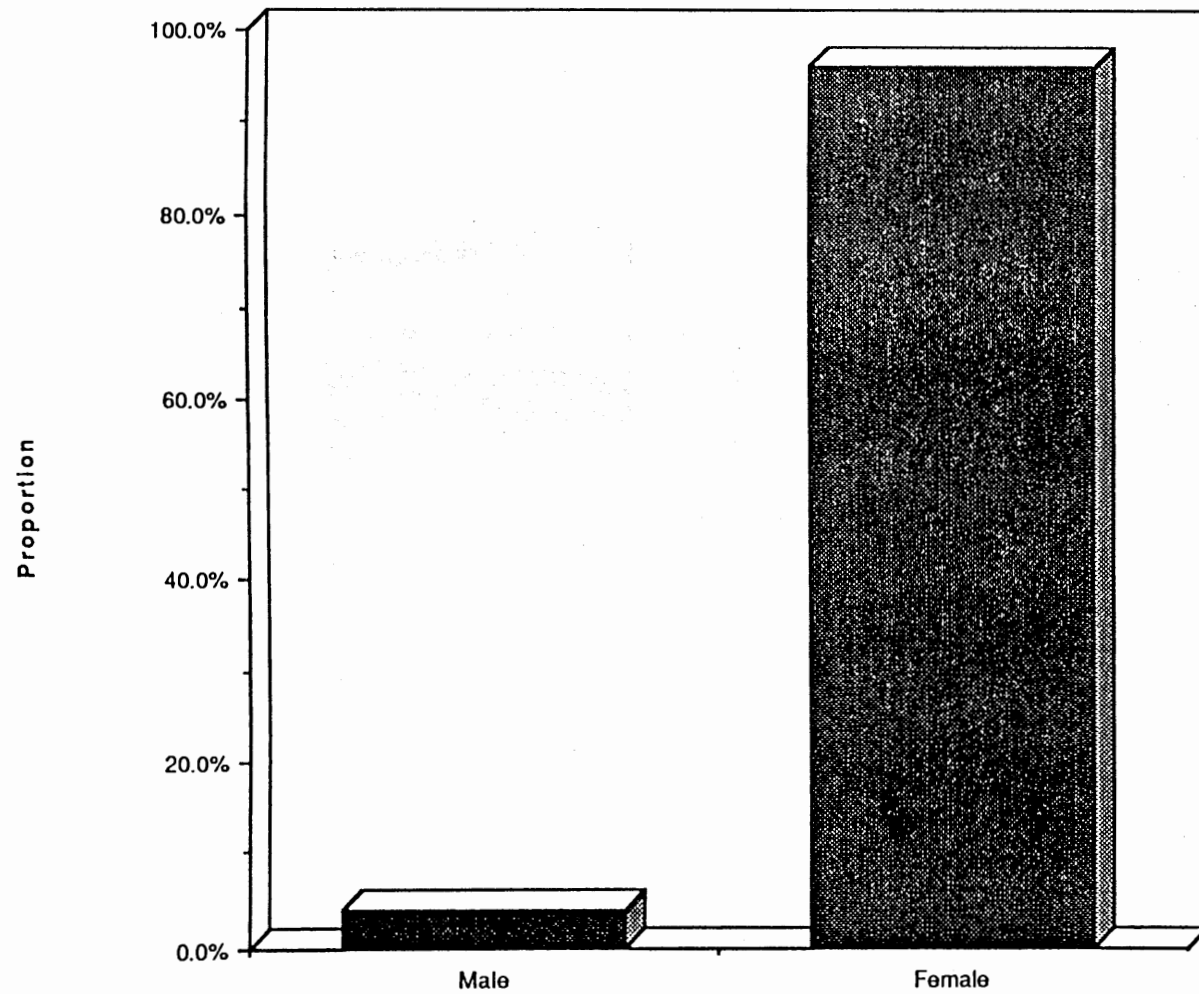


Figure 5. Nurses' gender distribution.

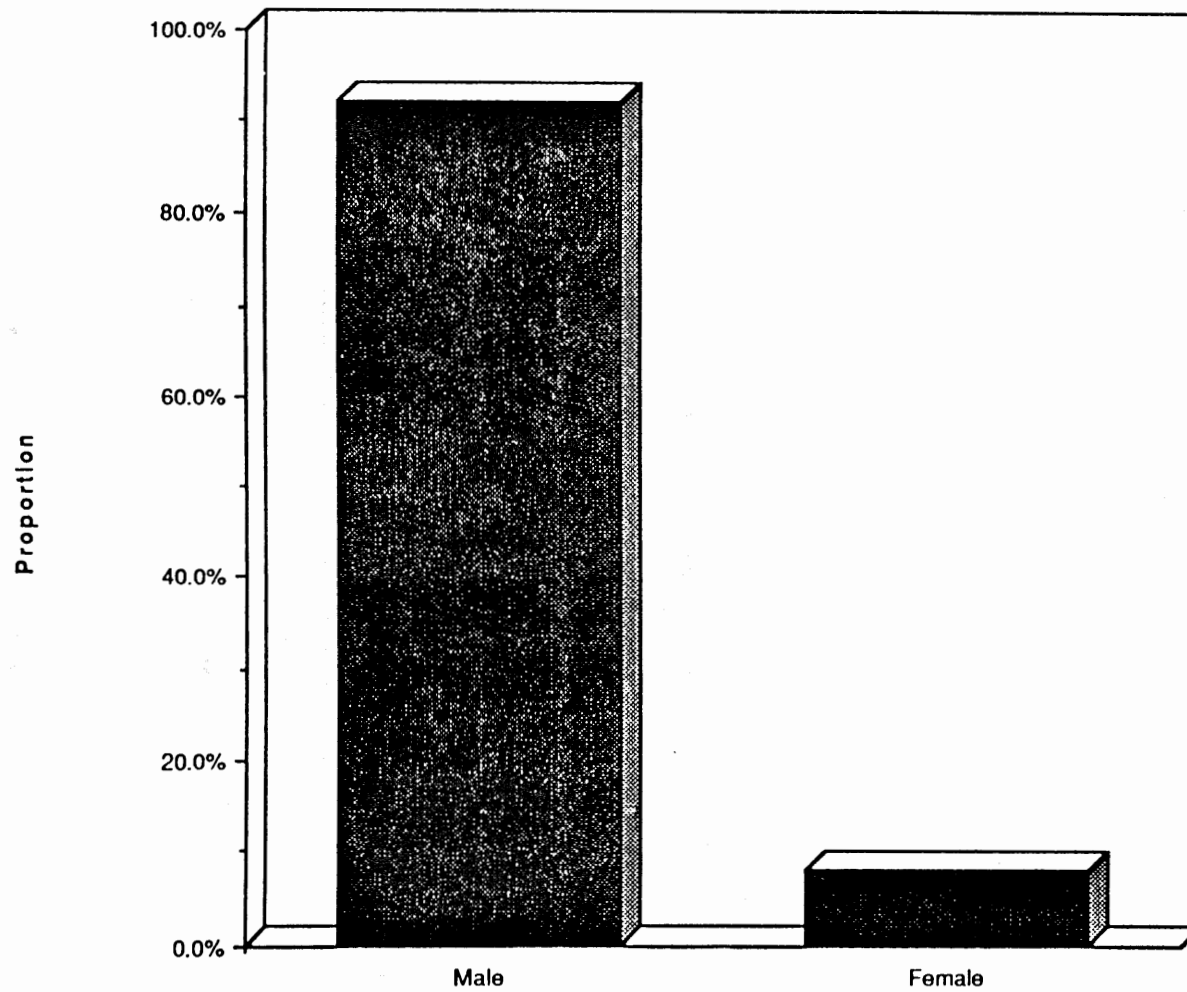


Figure 6. Physicians' gender distribution.

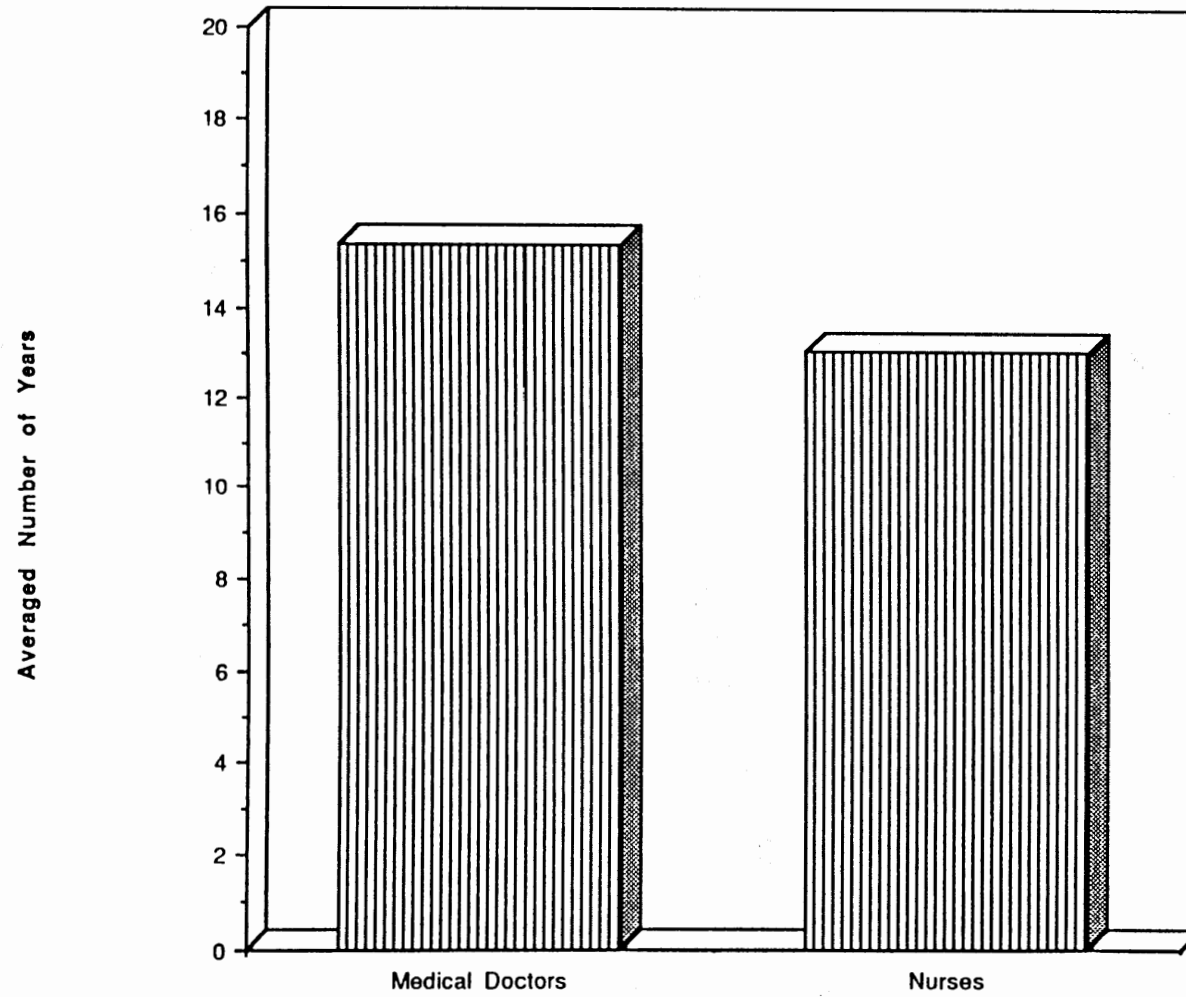


Figure 7. Professional experience for physicians and nurses.

is worth noting that both physicians and nurses who responded were mature professionals, with an average exceeding 12 years in practice for both groups. This attests to one aspect of the integrity of the data collected as it is clearly not influenced by inexperience.

As can be seen, Figure 8 shows the differentiation of specialty area for participating physicians. It may be noted that a 60-40 split in favor of the medical over surgical specialties is evident in this particular sample.

Two final categories of demographics to be addressed here are the educational level of the sample of participating nurses and patients (Figure 9 and Figure 10), and the frequency of previous hospitalizations for the patient sample (Figure 11).

As can be seen from Figure 9, close to 50% of the participating nurses hold a baccalaureate degree. Diploma nurses, as well as those holding associate and master's degrees, each occupy approximately 10% of the sample obtained. From these data it would appear that approximately 80% of the nurses were registered nurses, with 20% being vocational nurses.

Figure 10 depicts a large proportion of the patient sample with at least some college education, if not a

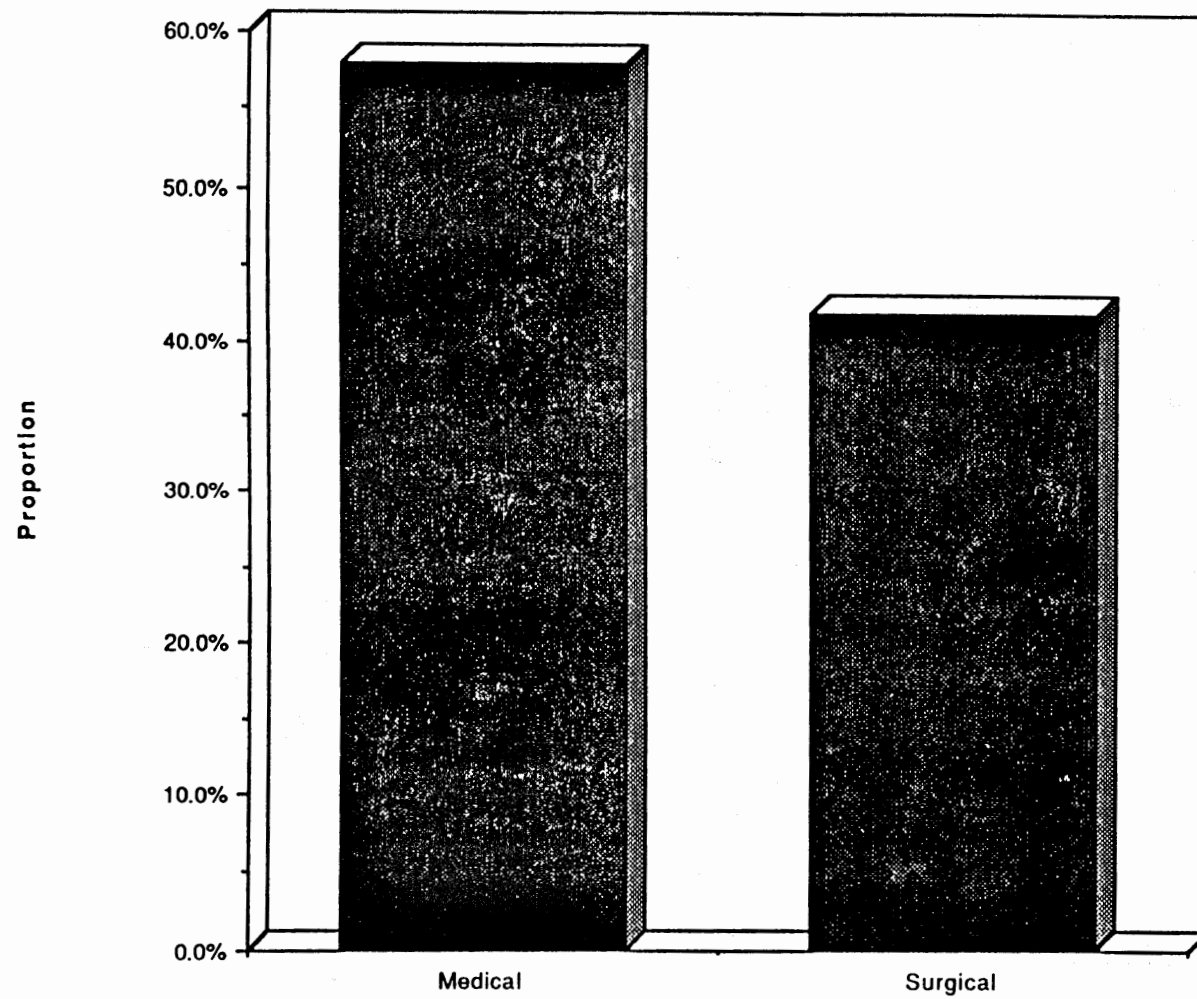


Figure 8. Specialty area for physicians.

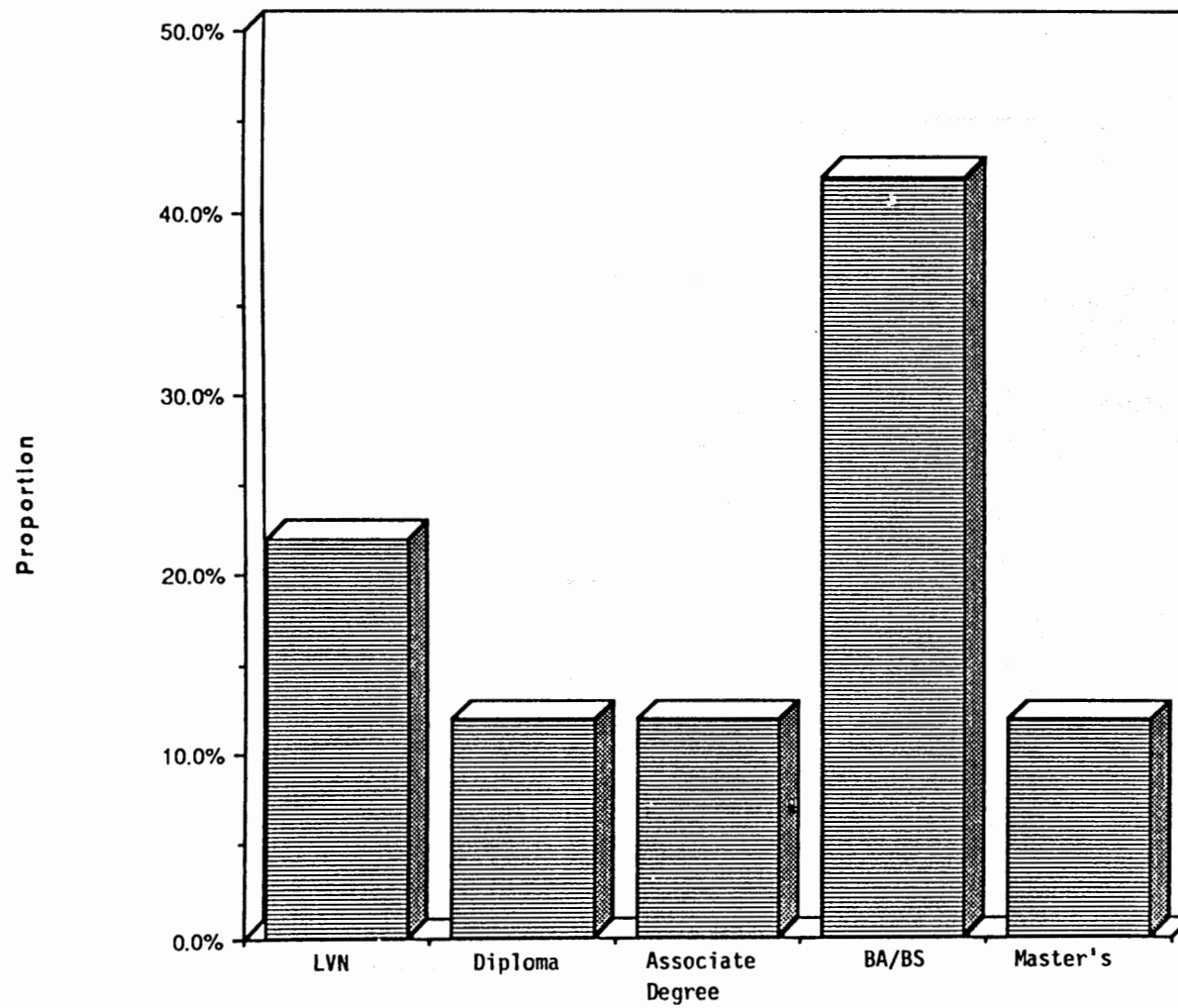


Figure 9. Educational background of nurses.

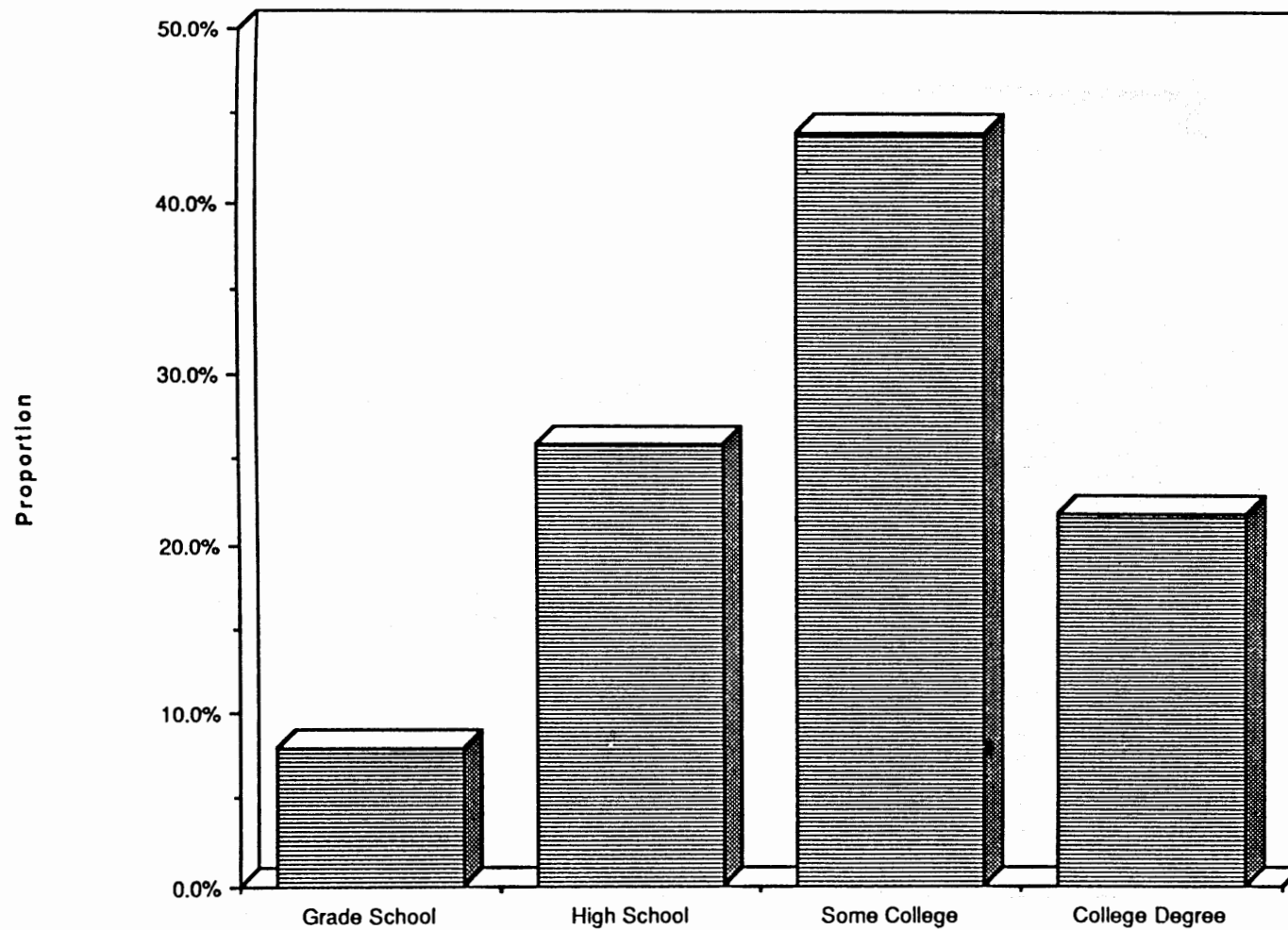


Figure 10. Educational background of patients.

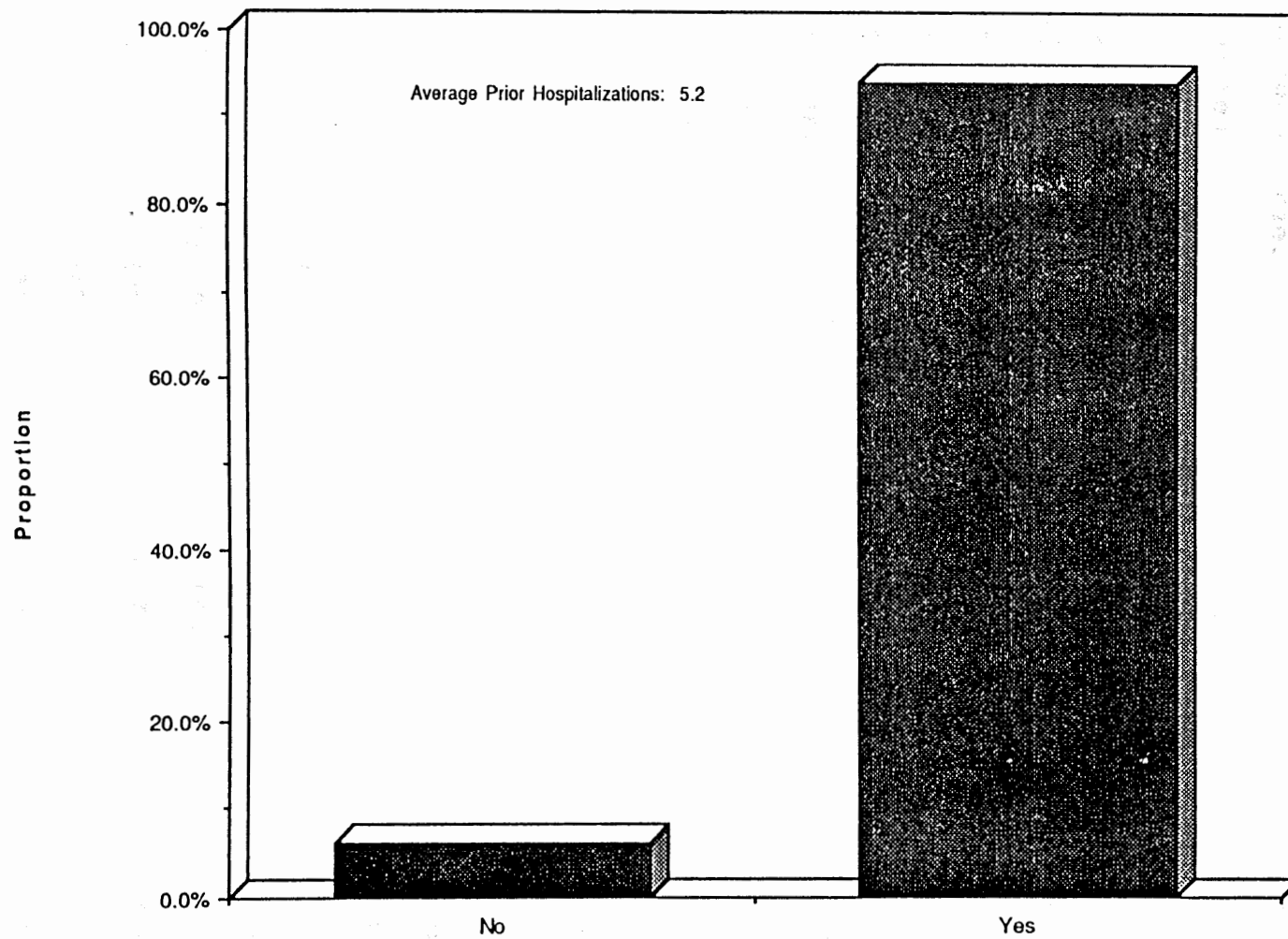


Figure 11. Previous hospitalization of patients.

college degree. Specifically, about 65% of this sample reported education beyond a high school diploma.

The final demographic variable of interest is shown in Figure 11. Here it is clearly evident that the majority of patients (over 90% of the sample) was well acquainted with the concept of being hospitalized. This is viewed in a very positive light, given that the more experience the patient has had, the more relevant should be the answers on the questionnaire. The overall average number of prior hospitalizations was computed to be approximately five. However, inspection of the actual data matrix for this variable reveals that the actual range of the number of prior hospitalizations is from 1 to 12.

Findings

The purpose of this study was to determine if there were differences in prioritization of the importance of selected nursing activities among patients, nurses, and physicians. Each nursing activity was categorized into one of four groups; however, this was not evident to subjects completing the questionnaire. The four categories are: physical care, with 20 items; psychological care, with 14 items; medical care, with 8 items; and preparation for discharge, with 8 items. The importance to each group of selected activities was determined for each of the three

groups of subjects. The Nursing Activities Checklist (White, 1979) was completed by 50 patient respondents, 50 nurse respondents, and 38 physician respondents. The activities listed were the same on each checklist, modifying only the pronouns in order for the activities to make sense to the group responding.

As described previously, the results of the questionnaire were subjected to a one-way analysis of variance (ANOVA). A total of five such ANOVAs were executed, one for each of the four components of the Activities Checklist and one across collapsed components.

The first research question for the study was: Is there a difference among patients, nurses, and physicians in the prioritization of nursing activities? An overall ANOVA was conducted to address the question. This specifically involved collapsing the matrices across all components of the questionnaire. The purpose of this was to determine if the investigation generated an overall statistically significant effect among groups which was independent of the separate components of the tool (the four subsections). Results of this analysis revealed an F -ratio of 4.27 ($df = 2, 135$, $p < .05$). Thus, it can be stated that there exists a significant difference in the prioritization of selected areas of nursing tasks among

patients, nurses, and physicians. The largest difference (.27) between the average perceived importance of all nursing activities was found between nurses ($\bar{x} = 3.60$) and physicians ($\bar{x} = 3.33$).

Data will not be presented to answer the four research questions concerning physical care, psychological care, medical care, and discharge planning. Figure 12 and Figure 13 offer alternative pictures of the averaged results which were separately subjected to the ANOVA regimen. The analysis will start at the far left of each of the graphs and move progressively to the right.

The averaged component scores for physical care were found to contain a significant between-group effect ($F = 5.59$, $df = 2,135$, $p < .01$). Subsequent Tukey analysis of means demonstrated that both the patient sample and the nurse sample were significantly different from the physician sample ($p < .05$). This finding can be verified visually by inspecting both Figure 12 and Figure 13. Notice that in both representations, nurses and patients report a higher perception of the importance of physical care than do physicians. Specifically, the average score of nurses (3.25), as well as the average score of the patients (3.28), was significantly higher than the average score of the physicians (2.95). The task eliciting the

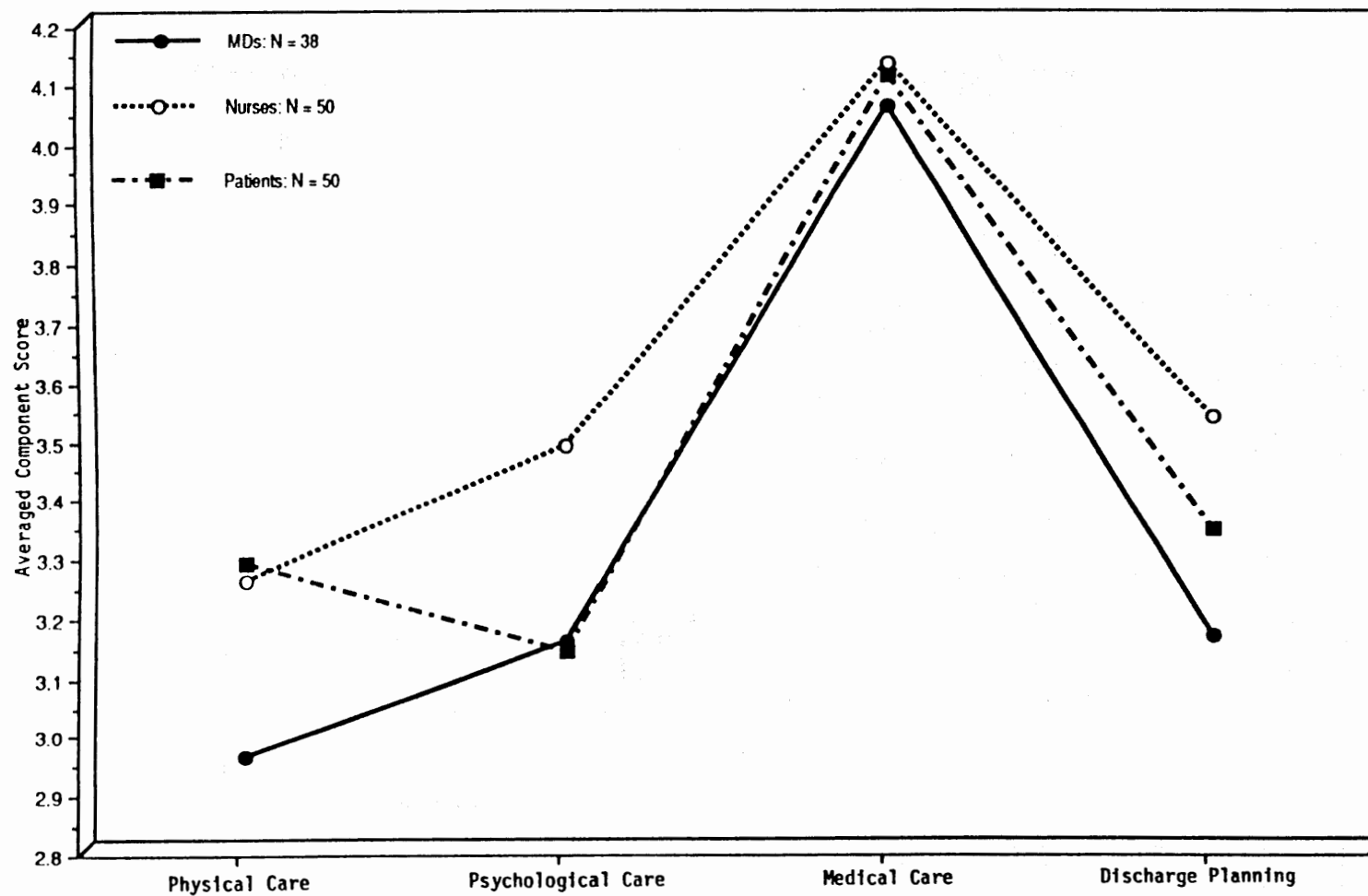


Figure 12. Line graph of patients', nurses' and physicians' prioritization of nursing activities.

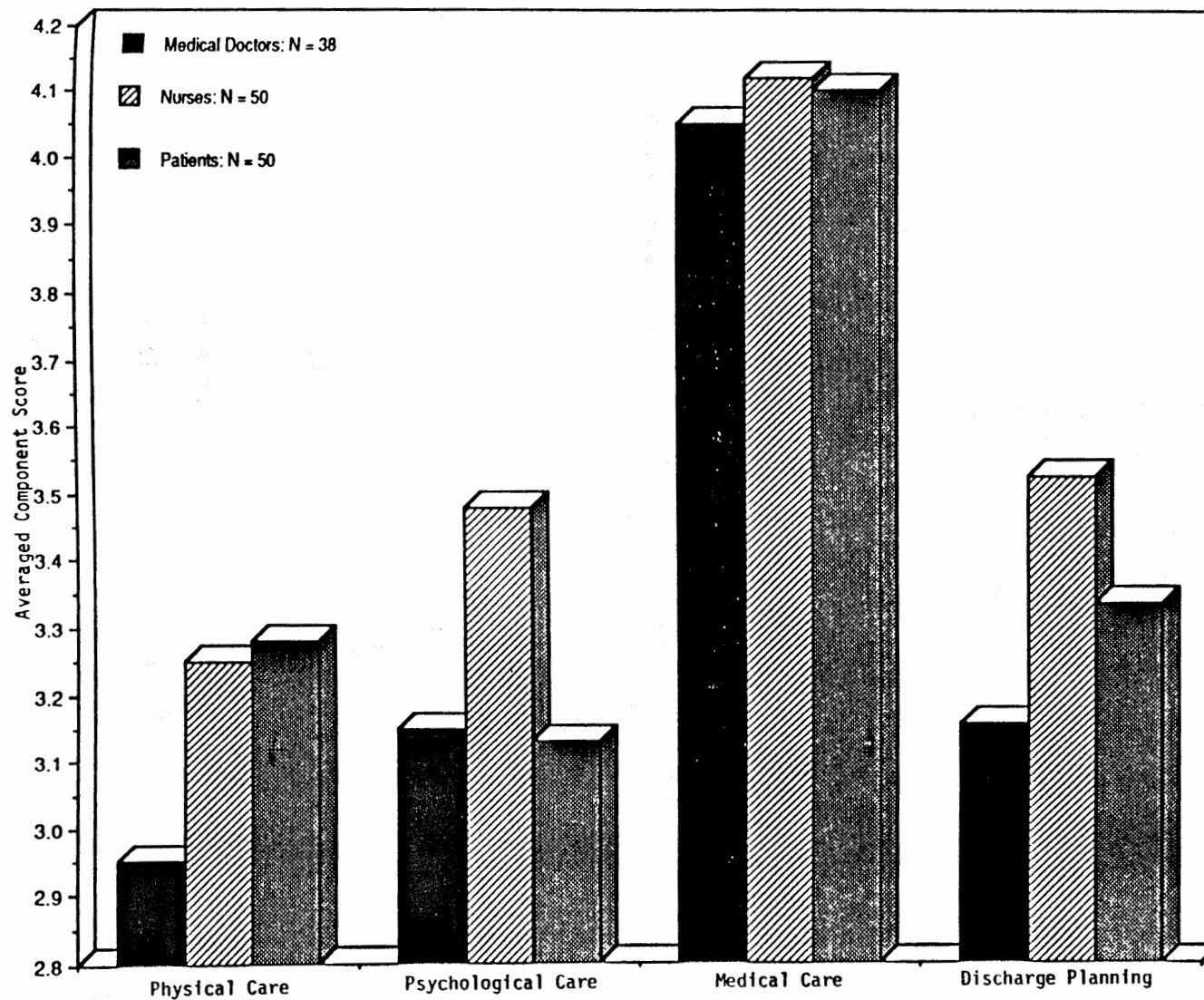


Figure 13. Histogram of patients', nurses,' and physicians' prioritization of nursing activities.

lowest score ($\bar{x} = 1.97$) from physicians was a physical activity concerning making the patient comfortable through the delivery of a back rub.

The next component, psychological care, also was found to be significantly different between groups ($F = 6.30$, $df = 2,135$, $p < .01$). However, subsequent Tukey probe analysis revealed that with this component, it was the physicians and patients who clustered together, with nurses differing. Specifically, nurses view psychological care (3.48) as more important than either the doctors or the patients (3.15; 3.13). This difference in importance is significantly lower in doctors and patients ($p < .05$) when compared to the answers submitted by the group of nurses. One particular psychological activity, "plan some diversion or recreation for the patient," ranked as the very lowest for both patients ($\bar{x} = 1.84$) and nurses ($\bar{x} = 2.34$) and second lowest of all activities for the physician sample ($\bar{x} = 2.08$).

Moving across to medical care, it is clear from Figure 12 and Figure 13 that all three groups considered this to be the most important activity. All three groups averaged above 4.0, demonstrating the sensitivity of the testing instrument (i.e., the questionnaire). Analysis of variance revealed no significant difference among the three groups

on this variable ($F = 0.30$, $df = 2,135$, $p > .05$). The patient and physician samples chose the same medical activity as highest of all in priority; the task was "carrying out the doctor's orders," with patients' mean score of 4.62 and physicians' mean score of 4.76. Nurses ranked the medical activity, "notice and report changes in patient's condition," as highest ($\bar{x} = 4.80$), while physicians prioritized this as second in importance of all activities.

Analysis of the final component, discharge planning, again revealed overall significance ($F = 3.60$, $df = 2,135$, $p = < .05$). Subsequent Tukey analysis revealed that the primary effect was the difference in importance ratings between nurses and doctors. Specifically, nurses viewed this activity the most important (3.53), followed by the patients (3.34), with the lowest rating of importance reported by the physicians (3.16). However, statistical significance was only obtained on the difference between the nurse and physician groups ($p < .05$). Patients ($\bar{x} = 4.12$), nurses ($\bar{x} = 4.32$), and physicians ($\bar{x} = 3.79$) all ranked "teach the patient about medications to take at home" as the most important of the discharge planning activities.

Table 1 summarizes the Tukey post-hoc analysis. Overall, physicians ranked all activity groups as less important than did patients or nurses except in the area of

Table 1

Tukey Post-hoc Analysis of Differences Among Patients', Nurses', and Physicians' Perceptions of the Importance of Selected Nursing Activities

Group	Means	Difference scores	Critical difference	p value
<u>All</u>				
Patient/nurse	3.46/3.60	-.14	.23	> .05
Patient/physician	3.46/3.33	.13	.23	> .05
Nurse/physician	3.60/3.33	.27	.23	< .05*
<u>Physical care</u>				
Patient/nurse	3.28/3.25	.03	.24	> .05
Patient/physician	3.28/2.95	.33	.24	< .05*
Nurse/physician	3.25/2.95	.30	.24	< .05*
<u>Psychological care</u>				
Patient/nurse	3.13/3.48	-.35	.26	< .05*
Patient/physician	3.13/3.15	.02	.26	> .05
Nurse/physician	3.48/3.15	.33	.26	< .05*
<u>Medical care</u>				
Patient/nurse	4.10/4.12	-.02	.22	> .05
Patient/physician	4.10/4.05	.05	.22	> .05
Nurse/physician	4.12/4.05	.07	.22	> .05
<u>Discharge planning</u>				
Patient/nurse	3.34/3.53	-.19	.30	> .05
Patient/physician	3.34/3.16	.18	.30	> .05
Nurse/physician	3.53/3.16	.37	.30	< .05*

* Denotes statistical significance.

psychological care. Patients and physicians ranked this area similarly, with doctors ($\bar{x} = 3.15$) perceiving it as slightly more important than patients ($\bar{x} = 3.13$). Patients ranked physical care to be slightly more important ($\bar{x} = 3.28$) than did nurses ($\bar{x} = 3.25$), otherwise nurses ranked overall more importance to activities. The largest difference was found between nurses ($\bar{x} = 3.53$) and physicians ($\bar{x} = 3.16$) in the area of discharge planning.

Summary of the Findings

In this nonexperimental, comparative study, the 50-item Nursing Activities Checklist (M. White, 1979) was administered to 50 patient, 50 nurse, and 38 physician respondents to determine if there were differences in prioritization of selected nursing activities among the three groups. The checklist was categorized into four areas pertaining to nursing care: physical care, psychosocial care, implementation of medical care, and preparation for discharge. Utilizing the one-way analysis of variance and subsequent Tukey tests, four of the five stated research questions pertaining to comparison of the overall questionnaire and the four categorizes within the questionnaire were found to have highly significant differences. The following results were found:

1. There was a statistically significant difference between patients' and physicians' perceptions of the importance of physical care nursing activities ($p < .05$). Patients ranked physical care activities more highly than did physicians.

2. There was a statistically significant difference between nurses' and physicians' perceptions of the importance of physical care nursing activities ($p < .05$). Nurses ranked physical care activities more highly than did physicians.

3. There was a statistically significant difference between nurses' and patients' perceptions of the importance of psychological care nursing activities ($p < .05$). Nurses ranked psychological activities more highly than did patients.

4. There was a statistically significant difference between nurses' and physicians' perceptions of the importance of psychological care activities ($p < .05$). Nurses ranked psychological care activities more highly than did physicians.

5. There was a statistically significant difference between nurses' and physicians' perceptions of the importance of discharge planning activities ($p < .05$).

Nurses ranked discharge planning more highly than did physicians.

6. Physicians ranked all categories lower than did nurses.

7. Physicians ranked all categories except psychological care activities lower than did patients.

8. Nurses ranked all categories except physical care activities higher than did patients.

9. The largest difference (.27) between the average perceived importance of all nursing activities was found between nurses ($\bar{x} = 3.60$) and physicians ($\bar{x} = 3.33$).

10. The largest difference (.37) within any of the four categories of nursing activities was found between nurses' ($\bar{x} = 3.53$) and physicians' ($\bar{x} = 3.16$) perceptions of the importance of discharge planning.

CHAPTER V

SUMMARY OF THE STUDY

The purpose of this study was to determine if differences existed among patients', nurses', and physicians' perceptions of the importance of selected nursing activities. Questionnaires were utilized in collecting data from participants. This chapter offers a general summary of the study, discussion of findings, conclusions and implications, and recommendations for further study.

Summary

A nonexperimental, comparative design was utilized in determining areas of agreement and disagreement in perceptions of the importance of selected nursing activities among patients, nurses, and physicians. Samples were obtained from a 380-bed hospital in a large metropolitan area of the southwestern United States. Data were collected from the three groups by use of The Nursing Activities Checklist developed by M. White (1979). The questionnaire consisted of 50 nursing activity items, each of which fits into one of four categories: physical care, psychological care, implementation of medical care, and

discharge planning. Participants in this study included 50 adult medical and surgical patients, 50 licensed nurses, and 38 physicians who voluntarily completed and returned a self-administered questionnaire and an investigator-designed demographic information sheet.

Percentages were computed on demographic variables. The patient sample ranged in age from 18 years to above 65 years, with a majority (90%) falling in a group from 46 to greater than 65 years of age. Approximately 70% of the patient sample was male and 30% female. About 65% of these patients reported at least some college education, if not a college degree. Over 90% of the patient sample had been hospitalized previously, with an average of 5.2 prior hospitalizations.

The nurse sample was represented in age with a majority (76%) being 26 through 45 years of age. Sixteen percent were ages 46 through 55, with the remaining being equally distributed in groups younger than 26 and older than 55. Approximately 95% of the nursing sample was female. Close to 50% of the nurses held a baccalaureate degree, 20% were vocational nurses, and there was almost an equal remaining distribution among associate degree, diploma degree, and master's prepared nurses. The nursing

sample reported an average of approximately 13 years of professional experience.

The majority (79%) of the physician sample was in the 35 through 55 year old group. Thirteen percent were ages 25 through 35 years and the remaining 8% were in a range of 56 through 65. Approximately 90% of the physician sample was male. A slight majority (60%) was reported as having a medical specialty, with the remaining 40% reporting a surgical specialty. There was an average of approximately 15 years of professional experience among physicians.

Five research questions were generated for this study. Five analysis of variances (ANOVA) were utilized to analyze differences among the patient, nurse, and physician groups for the overall questionnaire and the four categorizes within the questionnaire. Subsequent Tukey tests were then applied to pinpoint exactly where the significant effects were located. In the area of physical care, patient and nurse samples clustered together and were significantly different ($p < .05$) from the physician sample. In the psychological care component, patients and physicians clustered together, leaving the nurses with a significantly different outlook ($p < .05$). Discharge planning revealed a significant difference ($p < .05$) between the nurse and

doctor groups, with patients being in a mid-range group. Medical care, however, was the one in which all three sample groups were statistically close in their perceptions. Physicians ranked all four categories on the questionnaire lower in importance than did nurses. Physicians also ranked all categories except psychological care activities lower than did patients. The largest overall difference (0.27) in samples was found to be between nurses' ($\bar{x} = 3.60$) and physicians' ($\bar{x} = 3.33$) perceptions. The largest difference (0.37) within any of the four categories was found between nurses' ($\bar{x} = 3.53$) and physicians' ($\bar{x} = 3.16$) perceptions of the importance of discharge planning activities.

Discussion of Findings

The findings indicated that the role of the nurse is perceived differently among patients, nurses, and physicians. Of the four categories within the questionnaire, three were found to have significant differences ($p = .05$) between groups, as will be discussed. There appear to be two issues in discussing the findings: firstly, the agreement (or lack of) between group perceptions, and secondly, the level of importance given to each category.

In discussing the physical care category, patients and nurses in the present study clustered together, perceiving this area to be significantly more important than did the doctors. Interestingly, both the nurses and the physicians perceived physical care tasks to be the lowest in importance of the four categories of nursing activities. This contrasts with Moniaci's (1988) study, also utilizing the Nursing Activities Checklist (M. White, 1979), which did show a significant difference ($p = .05$) between nurses' and physicians' perceptions of physical care tasks; however, those doctors ranked that category as second in importance while nurses in that study ranked physical care tasks as fourth or last in importance.

In discussing the differences of perception between nurses and physicians in both studies, particularly in the physical care area, there may have been some confusion on the part of the respondents as to what a "nurse" really is (whether a registered nurse, a vocational nurse, a nursing technician, or a nursing assistant) and whether the nurse must actually perform the task or whether the nurse is just responsible for seeing that the task is implemented. Respondents may be thinking in terms of either "importance to the patient" or in terms of "importance to be carried out by the nurse." This may be of particular relevance to

physical care tasks, such as giving baths and presenting bedpans, because these activities are usually the first type of duties delegated down the hierarchial ladder to another individual. Moniaci (1988) stated that such activities may be identified as "menial" by the nurse. It is very likely perceived this way also by physicians who may be somewhat confused concerning the hierarchial arrangement of nurses and "who does what."

Another point which may influence perceptions between nurses and physicians is gender-set. Approximately 95% of nurses in the present study were female, while approximately 90% of physicians were male. Moniaci (1988) noted that gender-set is a primary reason for conflict between nurses and physicians because, within the traditional American society, males have been inundated with the concept of power and control while females have been known as the "weaker sex." The skew of subjects' gender may have effected perceptions, in general, between nurses and physicians.

Patients and nurses in the present study perceived the importance of physical care tasks very closely. In looking at other studies comparing patients and nurses, Johnson's (1987) study showed similarly that there was close agreement between groups, both ranking physical care

highly. Also, two studies done concurrently by nursing students, Sisk et al. (1965) and Ciesla et al. (1965) revealed that patients and nurses both agreed that the primary role of the nurse was to help the patient meet physical needs. However, M. White's (1972) study, using the Nursing Activities Checklist, showed that patients and nurses disagreed in the realm of physical care, with patients ranking it significantly more highly. Tack's (1987) study, also utilizing this checklist, revealed a disagreement, with patients prioritizing physical care as the highest in importance and nurses ranking it last of the four categories.

There is some disagreement between studies as to whether physical care is actually more or less important than the other activities questioned. This may reflect some confusion in the individual's perception of a "nurse" and whether or not the nurse needs actually to implement a task or be responsible for its implementation, as previously mentioned. However, as a whole, patients do perceive tasks in the physical care area to be very important to them. The nurse has historically been associated with physical tasks and care (Mauchsich & Miller, 1981) and this image continues to follow nursing.

In the area of psychological care, the present investigation revealed that patients and physicians clustered together, with nurses believing this area to be significantly higher in importance than the other two groups. Nurses ranked psychological care as third in importance, while patients prioritized this area in fourth place. Moniaci (1988) found that nurses ranked psychological care as third in importance and doctors ranked it as fourth or last. M. White (1972) also showed conforming results in that nurses perceived significantly higher differences in the importance of psychological care compared to patients. In Larson's (1984) Q-sort study of cancer patients ranking of nursing care behaviors, psychosocial skills appeared to become important only after patients' basic "getting well" needs were met. The general trend in these studies appears to be that nurses hold psychological activities to be more important than do the doctors or patients.

Wille (cited in Tack, 1987) contended that an emphasis in current nursing school curricula on the highly technical and psychosocial aspects of care may contribute to this effect and also to a de-emphasis on the value of physical care. Part of the curricula in today's schools of nursing include such theories as Peplau's (1952) interpersonal

theory of therapeutic relations, various role theories and coping theories, and other information aimed at the psychosocial aspects of nursing care. Many nurses may be aware that a therapeutic relationship "should" be established as part of an optimum plan; however, patients need varying amounts of time to establish a trustful relationship in order to be receptive to psychological interventions. Interestingly, Tack (1987) found no differences between groups in the ranking of psychological care activities, with both patients and nurses ranking this area as third of the four categories.

The greatest amount of conflict in perceptions between groups and among the different studies lies in the area of discharge planning. The present investigation revealed a significant difference between nurses and doctors, with the patient group responses falling mid-range. M. White (1972) and Wille (cited in Tack, 1987) both found discharge preparation to have the lowest priority among patients and nurses. On the other hand, Tack (1987) found a large difference between patients and nurses in that nurses ranked discharge planning first while patients ranked it fourth or last of the categories. Moniaci (1988) revealed that nurses and physicians differed significantly, with nurses ranking discharge planning as second and doctors

ranking it as third on the scale of four. All of these studies utilized the same questionnaire and resulted in various findings. The general trend appears to be that nurses find preparation for discharge to be overall more relevant to their responsibilities than do doctors or patients. This may be partly due to the transition toward earlier hospital discharge and short-stay observation designations which have resulted from financial limitations and constraints placed by governmental and other large business organizations. Because earlier discharging is a trend of only the past few years and discharge planning is probably the "newest" addition to nursing tasks of the four categories named, it is not surprising that some confusion and difference of opinion surrounds the issue. Wille (cited in Tack, 1987) noted that the nursing process has become more sophisticated to encompass scientific rationale for planning and evaluating care. Nursing schools are now incorporating discharge planning into the nursing process. Patient education and preparation for discharge are issues which are becoming the cornerstone of efficient and effective patient care (Tack, 1987). It could be possible that patients and even physicians do not realize that preparation for discharge has become a nursing responsibility.

The area of implementation of medical care is the one area in which there lies a close agreement between patients, nurses, and physicians. This area was chosen as the most important by all groups in this investigation. M. White (1972), Wille (cited in Tack, 1987), and Moniaci (1988) also found nurses and doctors in agreement that items within the medical care category were important, listed as number one. Tack (1987) found agreement here, with medical care taking second place in importance of the four categories. Interestingly, nurses in the present study, the Tack (1987) study, and the Moniaci (1988) study ranked "notice and report changes in the patient's condition" as the most highly ranked activity of the 50 presented.

In summary, it may be noted that patients, nurses, and physicians come from different frames of reference. In answering the questionnaires, there may have been different interpretations of the phrase "what is important," that is, there may have been subtle differences in the meaning of the phrase. Some may take this to mean that which should be important to a patient, or that which is in the best interest of quality care, or perhaps that which is most important for patients within a certain time frame or within certain other constraints. Coming from different

reference points, patients, nurses, and physicians bring with them varying background information based on their educational emphasis and experience which may influence their ideas of "what is important."

Conclusions and Implications

Based on the findings of this study, the following conclusions were drawn:

1. Nurses have not thoroughly accomplished the task of relaying to the public or to physicians the specific skills and services specialized to the nursing profession.
2. Implementation of medical activities continues to reign as the most important area of nursing practice.
3. It appears that nursing may be meeting the needs of the profession with less emphasis on the desires of society.

The implications for nursing that may be drawn from the findings of this study are the following:

1. Nurses need to purposefully communicate their practices, especially involving discharge planning and awareness of psychosocial problems in patients. It appears that physicians do not recognize discharge planning as a nursing activity and responsibility. It is commonly thought that people do not actually know what another's responsibilities are until they have "been in their shoes"

or have been enlightened in some way. Nurses have a need to market their skills and abilities in a positive manner to form a more solid basis for accountability of time and quality practice. This may also include clarifying to the public the practitioners' levels of skills and professional content of service and knowledge.

2. Patients come to the hospital for such things as pain relief, treatments, medications, and observations in relation to their health conditions and expect, first and utmost, to have these activities taken care of. Therefore, nurses should continue to place great emphasis on carrying out medical activities.

3. Nursing needs to reconcile meeting professional and societal priorities.

Recommendations for Further Study

The following recommendations are made:

1. The study should be repeated using a similar updated instrument which might include more autonomous nursing activities, activities which are provided outside of the hospital, and which might differentiate more specifically between nursing activities which the nurse should be responsible for and those which the nurse should implement directly.

2. The study should be repeated using a larger sample size and a random sampling technique.

3. The study could be enhanced by identifying on patient questionnaires as to whether activities were actually implemented. A focus could then be made on those activities that were ranked highly but not carried out.

4. A meta analysis of many studies using similar questionnaires and interviews concerning the perceptions of health care consumers, nurses, and physicians would be useful to gain information on a more generalizable level.

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APPENDIX A

Human Subjects Research Review Committee
Exemption Form

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING

PROSPECTUS FOR THESIS/DISSERTATION/PROFESSIONAL PAPER

This prospectus proposed by: LOURIE JENKINS TRAVIS

_____ and entitled:

PATIENTS', NURSES', AND PHYSICIANS' PERCEPTIONS OF
THE IMPORTANCE OF SELECTED NURSING ACTIVITIES

Has been read and approved by the member of (his/hers)
Research Committee.

This research is (check one):

XX Is exempt from Human Subjects Review Committee
review because ANONYMOUS QUESTIONNAIRES WILL BE USED
TO GATHER THE DATA.

_____ Requires Human Subjects Review Committee review
because _____

Research Committee:

Chairperson, _____

Member, _____

Member, _____

Date: NOVEMBER 30, 1990

Dallas Campus XX Denton Campus _____ Houston Campus _____

APPENDIX B

Graduate School Permission to Conduct Study

TEXAS WOMAN'S UNIVERSITY
DENTON DALLAS HOUSTON
THE GRADUATE SCHOOL

P.O. Box 22479, Denton, Texas 76204 817/898-3400, 800-338-5255



March 26, 1991

Ms. Lourie Jenkins Travis
104 W. Lavender Lane
Arlington, TX 76010

Dear Ms. Travis:

I have received and approved the Prospectus for your research project. Best wishes to you in the research and writing of your project.

Sincerely yours,

Leslie M Thompson

Leslie M. Thompson
Dean for Graduate Studies
and Research

dl

cc Dr. Rose Nieswiadomy
Dr. Carolyn Gunning

APPENDIX C
Agency Permission Form

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE

GRANTS TO LOURIE JENKINS TRAVIS

a student enrolled in a program of nursing leading to a Master's Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem.

Patients', Nurses', and Physicians' Perceptions of the Importance of Selected Nursing Activities

The conditions mutually agreed upon are as follows:

1. The agency (may) (may not) be identified in the final report.
2. The names of consultative or administrative personnel in the agency (may) (may not) be identified in the final report.
3. The agency (wants) (does not want) a conference with the student when the report is completed.
4. Other:

12-6-90	
Date	Signature of Agency Personnel
<u>Louie Jenkins Travis</u>	<u>Rose M. Jenkins</u>
Signature of Student	Signature of Faculty Advisor

- * Fill out & sign 3 copies to be distributed:
Original: Student, 1st copy: Agency
2nd copy: TWU School of Nursing

APPENDIX D

Cover Letters to Subjects

Graduate Nursing Student
Texas Woman's University
Parkland Campus
Dallas, Texas 75207

February 22, 1991

Dear Patient:

I am a graduate student at Texas Women's University pursuing a Master's of Science degree in Nursing. I am also a Registered Nurse in the Cardiac Care Unit at Arlington Hospital. For partial fulfillment of my degree, I am conducting a research study entitled "Patients', Nurses', and Physicians' Perceptions of the Importance of Selected Nursing Activities." The purpose of this letter is to request your assistance in this study.

The enclosed questionnaire will assist in identifying nursing activities which you may or may not perceive to be important. This questionnaire will take approximately 10 minutes to complete. All responses will remain anonymous. Therefore, you are asked to refrain from placing your name or any other identifying information on the questionnaires. Return of the questionnaire will be considered as your consent to participate in the study.

Participation in this study is voluntary. There are no risks, costs, or personal benefits to you if you participate or do not participate in this study. Your care will not be influenced by your participation or nonparticipating in the study. If you are willing to participate, please fill out the questionnaires and place them in the designated envelope. I will pick up the completed packet at a designated time. If you do not wish to participate, simply discard the packet.

The packet includes two questionnaire sheets. One questionnaire lists nursing activities which you rank in varying degrees of importance. The second questionnaire asks your age group, gender, highest education level, and if you have been a patient in the hospital before.

If you have any questions regarding this study, do not hesitate to contact me at one of the telephone numbers listed above. Study results will also be available through

these numbers by October 1991. Thank you for your time.
Your participation is very much appreciated.

Sincerely,

Lourie Travis
Graduate Nursing Student
Texas Woman's University
Parkland Campus
Dallas, Texas 75207

February 22, 1991

Dear Nurse:

I am a graduate student at Texas Women's University pursuing a Master's of Science degree in Nursing. I am also a Registered Nurse in the Cardiac Care Unit at Arlington Hospital. For partial fulfillment of my degree, I am conducting a research study entitled "Patients', Nurses', and Physicians' Perceptions of the Importance of Selected Nursing Activities." The purpose of this letter is to request your assistance in this study.

The enclosed questionnaire will assist in identifying nursing activities which you may or may not perceive to be important. This questionnaire will take approximately 10 minutes to complete. All responses will remain anonymous. Therefore, you are asked to refrain from placing your name or any other identifying information on the questionnaires. Return of the questionnaires will be considered as your consent to participate in the study.

Participation in this study is voluntary. There are no risks, costs, or personal benefits to you if you participate or do not participate in this study. Your job will not be influenced by your participation or nonparticipating in the study. If you are willing to participate, please fill out the questionnaires and place them in the designated envelope. A collection box will be left on your unit labeled "Nursing Activities Research" for completed questionnaires. If you do not wish to participate, simply discard the packet.

The packet includes two questionnaire sheets. One questionnaire lists nursing activities which you rank in varying degrees of importance. The second questionnaire asks your age group, gender, highest level of education in nursing, and years of experience in nursing.

If you have any questions regarding this study, do not hesitate to contact me at one of the telephone numbers listed above. Study results will also be available through

these numbers by October 1991. Thank you for your time.
Your participation is very much appreciated.

Sincerely,

Lourie Travis

Graduate Nursing Student
Texas Woman's University
Parkland Campus
Dallas, Texas 75207

February 22, 1991

Dear Physician:

I am a graduate student at Texas Women's University pursuing a Master's of Science degree in Nursing. I am also a Registered Nurse in the Cardiac Care Unit at this hospital. For partial fulfillment of my degree, I am conducting a research study entitled "Patients', Nurses', and Physicians' Perceptions of the Importance of Selected Nursing Activities." The purpose of this letter is to request your assistance in this study.

The enclosed questionnaire will assist in identifying nursing activities which you may or may not perceive to be important. This questionnaire will take approximately 10 minutes to complete. All responses will remain anonymous. Therefore, you are asked to refrain from placing your name or any other identifying information on the questionnaires. Return of the questionnaire will be considered as your consent to participate in the study.

Participation in this study is voluntary. There are no risks, costs, or personal benefits to you if you participate or do not participate in this study. If you are willing to participate, please fill out the questionnaires and place them in the designated envelope within the packet. There are collection boxes labeled "Nursing Activities Research" in the medical records room and on each medical-surgical unit.

The packet includes two questionnaire sheets. One questionnaire lists nursing activities which you rank in varying degrees of importance. The second questionnaire asks your age group, gender, specialty, and years experience as a practicing physician.

If you have any questions regarding this study, do not hesitate to contact me at one of the telephone numbers listed above. Study results will also be available through these numbers by October 1991. Thank you for your time. Your participation is very much appreciated.

Sincerely,

Lourie Travis, RN

APPENDIX E

Nursing Activities Checklist

The Nursing Activities Checklist is a copyrighted instrument. Information regarding this instrument may be obtained from:

American Journal of Nursing Co.
555 West 57th Street
New York, NY 10019
Phone: 212-582-8820

APPENDIX F

Permission to Use Instrument



April 10, 1990

Lourie Jenkins Travis
104 W. Lavender
Arlington, TX 76010

Dear Ms. Travis:

Thank you for your letter of April 5, 1990 requesting permission to utilize a learning instrument by Dr. Marguerite White in your thesis.

You have permission to utilize the tool in your thesis providing you use the following credit line:


Copyright 1972 The American Journal of Nursing Company. From Nursing Research, January/February, Vol. 21, No. 1. Used with permission. All rights reserved.

Should you plan to publish your research in the future, please inform us so that formal permission applications can be filed.

Thank you for your cooperation.

GOOD LUCK!

Sincerely,


Gloria Gay
Permissions Coordinator

APPENDIX G
Demographic Data Sheets

DEMOGRAPHIC DATA

PATIENTS

1. Age: ☐ 18-25
 ☐ 26-35
 ☐ 36-45
 ☐ 46-55
 ☐ 56-65
 ☐ Over 65
2. Sex: ☐ Female
 ☐ Male
3. Education: (Check your highest level)
- ☐ Grade school
 ☐ High school
 ☐ Some college
 ☐ College graduate
4. Have You Ever Been in the Hospital Before?
- ☐ No
 ☐ Yes
 If yes, how many times? _____

DEMOGRAPHIC DATA

NURSES

1. Age: ☐ 18-25
 ☐ 26-35
 ☐ 36-45
 ☐ 46-55
 ☐ 56-65
 ☐ Over 65
2. Sex: ☐ Female
 ☐ Male
3. Highest Level of Nursing Education:
 ☐ LVN
 ☐ Diploma degree
 ☐ Associate degree
 ☐ Baccalaureate degree
 ☐ Master's degree
4. Years Experience in Nursing: _____

DEMOGRAPHIC DATA

PHYSICIANS

1. Age: ☐ 25-35
 ☐ 36-45
 ☐ 46-55
 ☐ 56-65
 ☐ Over 65
2. Sex: ☐ Female
 ☐ Male
3. Specialty Area:
 ☐ Medical
 ☐ Surgical
4. Number of Years as a Practicing Physician: _____