

MEDICAL-SURGICAL NURSES' AND PHYSICIANS' PERCEPTIONS
REGARDING WHO SHOULD INITIATE SELECTED
PATIENT CARE ACTIVITIES

A THESIS
SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR
THE DEGREE OF MASTER OF SCIENCE
IN THE GRADUATE SCHOOL OF THE
TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING

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MAY 1990
DENTON, TEXAS

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ACKNOWLEDGMENTS

I would like to thank all my committee members, Dr. Rose Marie Nieswiadomy, Dr. Sue Goad, and Dr. Shirley Ziegler, for their help and expertise in the writing of this thesis.

I would like to give special thanks to Dr. Nieswiadomy, my thesis chairperson, for all the help and support she has given me, not just on my thesis, but throughout my 2 years in graduate school. She has always gone that extra mile to help me reach my goals. She is a credit to her professions, both nursing and education, and I hope that I can live up to the standards she sets in both.

Also, a special thanks goes to Dr. Ziegler for her help with the statistics for this study. Her computer expertise and knowledge, as well as her willingness to take the time to work with me on analyzing my data, were very much appreciated and were invaluable in the writing of Chapters IV and V.

Appreciation also goes to David for all the love and support he gave to me during the last few months I was working on this project. It meant so much to me to have his encouragement during that time.

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ABSTRACT

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MAY 1990

A nonexperimental, comparative study was designed to determine nurses' and physicians' perceptions of the independent role of the nurse, specifically in relation to 10 patient care activities. The conceptual framework used to direct this study was Biddle and Thomas' (1979) role theory.

A researcher designed questionnaire was used to collect the data concerning who presently writes the order and who should write the order to initiate 10 patient care activities. Nurses and physicians differed significantly ($p < .05$) on who should write the order to: determine the frequency of vital signs, change diet orders, repeat abnormal laboratory tests, and start oxygen. Additionally, nurses indicated they should be allowed to write orders for 8 of the 10 activities that they presently do not order. The physicians indicated a change should be made for only 2

of the 10 activities (ordering an eggcrate mattress and ordering soft restraints).

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CHAPTER I

INTRODUCTION

Nursing has been evolving and changing for centuries. Nurses have responded to the dramatic technological and scientific advances of the 20th century by accelerating their efforts to improve the quality of nursing practice, and, thus, health care delivery (Neaves, 1989). Part of their efforts toward improving nursing practice have been directed toward achieving recognition as members of an autonomous profession. However, before nursing can be recognized as an autonomous profession it must fully develop the attitudes and skills attendant to professional practice among rank and file nurses (Neaves, 1989).

The literature indicates that while a significant number of nurses are progressing toward the responsible independent practice of nursing, an even larger number are not (Neaves, 1989). Furthermore, many physicians and hospital administrators persist in their view of nurses as unquestioning followers of doctors' orders. These attitudes are in direct conflict with those of nursing leaders who are trying to gain recognition of the profession as "independent and different from medical

science . . . under the control of nurses and defined and practiced independently" (Gamer, 1979, p. 109).

According to Gamer (1979), nursing is different from medical science and should be practiced independently. The difficulty arises in trying to decide which nursing activities should be guided by nursing decisions and which should be directed by medical decisions. The clarification and delineation of independent nursing activities will take study and discussion between members of both professions.

Problem of the Study

The problem of this study was to compare nurses' and physicians' report of (a) who presently writes the order and (b) who should write the order to initiate 10 selected patient care activities in the agencies where they practice. In addition, the study compared nurses' perceptions of who presently writes the order versus who should write the order for the 10 selected patient care activities. Also, the study compared physicians' perceptions of who presently writes the order versus who should write the order for the 10 selected patient care activities.

Justification

Descriptive words such as "autonomous" and "independent" can be found in many articles describing the changing role of the nurse. Autonomy is defined as being self-governed; independent means being free from the control of others (Flexner, 1983). Traditionally, it has been difficult for nurses to be free from the control of others because the tasks they carried out were ordered by physicians (Bille & Wright, 1987; Darbyshire, 1987). More recently, nurses have come to the realization that there are many activities that nurses are capable of carrying out (by virtue of their education and experience) that do not fall under the jurisdiction of physicians (Smoyak, 1987). In response to this discovery, nurses are formulating more nursing diagnoses, and research is being done to develop nursing theories that will direct interventions for these diagnoses.

The National Joint Practice Commission (cited in Smoyak, 1987) has defined joint practice as "nurses and physicians collaborating as colleagues to provide patient care. It is a conscious review of the work to be done, how it will be allocated, and what skills are involved" (p. 37). Although the Joint Practice Commission recognized that a review was needed, the members did not, themselves,

set out to allocate specific roles and duties for each profession. To delineate which actions will be under the direction of nursing and which will be directed by the medical profession, members of both professions will need to collaborate in their practices.

Weiss (1983) reported on a study of role differentiation between nurses and physicians that was carried out in San Francisco in the early 1980s. The study was designed to determine whether a series of systematic dialogue sessions among nurses, consumers, and physicians would result in consensus regarding (a) unique areas of nursing practice as differentiated from medical practice, and (b) areas of common practice shared by both professions (Weiss, 1983). Twenty-two major professional responsibilities were identified, reflecting major areas of responsibility under which more specific health behaviors might fall. The participants in the study were asked to rate each of the 22 items for both physicians and nurses, indicating the degree to which the participant believed that the two different professions should each exercise the responsibilities reflected in the items. Seven items contributed most dramatically to the variance in the total sample's perceptions of nurse responsibility and physician responsibility. These included: writing orders to guide

the consumer's plan of care, pronouncing people dead, and determining an appropriate plan of care for the consumer. Weiss concluded that there is a twofold problem: (a) lack of clarity within the nursing profession regarding the competencies specific to the discipline of nursing, and (b) a continuing public image of nursing as a mere extender of functions performed by the physician.

Both professions, nursing and medicine, would benefit from a clarification of roles. This clarification of roles would help solve the problems identified by both Smoyak (1987) and Weiss (1983).

Further study into the overlapping areas of practice is clearly indicated. A study of the role perceptions and practices of both physicians and nurses is needed.

Conceptual Framework

Several reasons may exist for the lack of progress nurses are making toward a responsible independent practice. First, nurses may have difficulty in determining what activities are considered in their scope of practice. Second, physicians may be reluctant to relinquish any of the decision-making power to the nurse. This research will use role theory as a framework within which to examine nurses' and physicians' perceptions of the independent role

of the nurse in making the decision to initiate selected patient care activities.

Biddle and Thomas (1979) have defined role as a set of prescriptions that define the desired behavior of a position. Furthermore, one person's role is partially dependent upon the roles of related others in the social context. These authors further stated that role expectations are held by particularized or generalized others for the appropriate behavior that "ought" to be exhibited by the persons holding a given role. Biddle and Thomas also described an activity known as role description. The description of a role is free from value judgments. Both the individual's cognitions and perceptions of what a role consists of in terms of functions, obligations, position, and rights are included in role description.

In discussing role descriptions and expectations, Biddle and Thomas stated that consensus is important. Consensus is defined by Biddle and Thomas (1979) as the amount of agreement on a specific topic. When consensus on appropriate behaviors is not reached, or when the expectations associated with the position are incompatible with that of another person, role conflict is said to result (Biddle & Thomas, 1979). The source of the

conflicting expectations may be from within the person himself, from his role partners, society at large, or any combination of these. Regardless of the source, a general proposition about role conflict is that when it brings about enough strain in the actor to preclude his adequate role performance, he seeks to resolve it.

According to LaRocco (1978), role conflict occurs in a situation in which two or more sets of expectations operate. The usual result is some degree of tension and anxiety. The perception of how the nurse is permitted to enact the nurse role that he or she has conceptualized will determine the amount of role conflict experienced by the nurse. A similar concept, intrarole conflict, has been identified by Davies (1974). According to Davies, intrarole conflict is defined as the discrepancy between the activities and decisions in which the nurse expects to participate and expectations of that participation by the physician.

If the physicians and nurses disagree on what the nurse should be able to do, then role conflict would be in evidence. Also, according to LaRocco's (1978) definition, one would assume role conflict would be in evidence if the nurses themselves did not agree on what activities they can initiate. It may also be postulated that without

resolution of the role conflict, the transition of the nursing role towards one of autonomy and independence will continue to be a slow and arduous process.

Assumptions

1. Role conflict occurs in a situation where two or more sets of expectations operate.

2. The nurses and physicians had knowledge and understanding of the 10 patient care activities that were studied.

3. Nurses were aware of the policies in the agencies where they practice, for each of the 10 patient care activities.

4. Physicians were aware of the policies in the agencies where they practice, for each of the 10 patient care activities.

Hypotheses

This study tested the following hypotheses:

1. Among the nurses and physicians surveyed, there is a difference between the nurses' and physicians' reports of who presently writes the order to initiate 10 selected patient care activities:

- A. Apply an eggcrate mattress on a patient's bed.
- B. Determine the frequency of vital signs.

- C. Give nonprescription medications.
- D. Apply soft restraints on a patient.
- E. Make diet changes.
- F. Order repeat lab tests when abnormal values are found.
- G. Start oxygen on a patient.
- H. Write a do not resuscitate order.
- I. Suction a patient.
- J. Declare a patient dead.

2. Among the nurses and physicians surveyed, there is a difference between the nurses' and physicians' reports of who should write the order to initiate 10 selected patient care activities:

- A. Apply an eggcrate mattress on a patient's bed.
- B. Determine the frequency of vital signs.
- C. Give nonprescription medications.
- D. Apply soft restraints on a patient.
- E. Make diet changes.
- F. Order repeat lab tests when abnormal values are found.
- G. Start oxygen on a patient.
- H. Write a do not resuscitate order.
- I. Suction a patient.
- J. Declare a patient dead.

Definition of Terms

The following terms were defined for this study:

1. Nurse--any nurse as evidenced by his or her name being on the list of the Board of Nurse Examiners and who has listed medical/surgical as his or her clinical area.
2. Physician--as identified by the nurse subjects in this study and who practice on the units where the nurse subjects practice.
3. Write an order to initiate a patient care activity--writes an order on the chart for the purpose of carrying out any of the 10 patient care activities.
4. Ten selected patient care activities--
 - A. Apply an egg crate mattress on a patient's bed--
apply a foam covering on a bed as a protective device to prevent skin breakdown.
 - B. Determine the frequency of vital signs--
determine how often blood pressure, temperature, pulse, and respirations are taken on a patient, i.e., every 4 hours, 8 hours, etc.

- C. Give nonprescription medications--
administer any medication such as Tylenol, Maalox, Milk of Magnesia that can be obtained legally without a physician's order.
- D. Apply soft restraints on a patient--
apply foam and/or cloth pads with attached ties applied to wrists and ankles for the purpose of preventing falls/self harm.
- E. Make diet changes--
order a change in the consistency of food, i.e., liquid to soft or regular to mechanical soft; not to include calorie restrictions/salt restrictions.
- F. Order repeat lab tests when abnormal values are found--
reorder lab tests when any laboratory findings of urine, stool, or blood samples fall outside the range listed as normal.
- G. Start oxygen on a patient--
administer oxygen either by nasal cannula or mask on a patient not previously on oxygen.
- H. Write a do not resuscitate order--
withhold mechanical chest compressions,

artificial respirations, and/or emergency drugs and electric shock on a patient with a terminal illness when he or she experiences respiratory or cardiac arrest.

I. Suction a patient--

removal of secretions by mechanical means from the mouth, throat, nares, or tracheostomy with the use of plastic catheters and suction machine.

J. Declare a patient dead--

determine the cessation of life (no heart beat, respiration, or blood pressure)
(Hospital Law Manual, 1982). Does not include determination of cause of death.

5. The person who presently writes the order--

information on nurses' and physicians' reports of who presently writes the order was obtained from nurses' and physicians' self-report responses on the study questionnaire.

6. The person who should write the order--information

on nurses' and physicians' reports of who should write the order was obtained from nurses' and physicians' self-report responses on the study questionnaire.

Limitations

The following limitations were identified for this study:

1. A random sampling technique was employed, but only 45% of the nurse sample returned questionnaires and only 9% of the questionnaires intended for physicians were returned.

2. The method of obtaining physician subjects for the survey was through network sampling and, thus, a biased sample may have been obtained.

3. The subjects surveyed may have had differing definitions and knowledge of the 10 patient care activities.

4. There was no control over subject characteristics, such as length of employment at the agency, age, years of work experience, or education.

5. The setting in which the subjects completed the questionnaires was not controlled.

Summary

Previous studies on the different roles of nurses and physicians have failed to include specific patient care activities and, instead, have focused on major categories of roles, such as decision-making and planning care. Because nursing and medicine have overlapping areas of

practice, both disciplines should be involved in delineating areas of practice. This study sought the opinions of both physicians and nurses in an attempt to more clearly identify areas of independent practice for nurses.

CHAPTER II

REVIEW OF LITERATURE

In this study of the independent role of the nurse as perceived by nurses and physicians, four primary areas of literature were reviewed. The first area examines the evolving role of the nurse. Secondly, the sources of conflict between nurses and physicians are explored. The third area covers the current issue of collaboration between nurses and physicians. Finally, selected patient care activities are discussed, in which the roles of nursing and medicine may overlap.

The Evolving Role of the Nurse

In order to fully understand the dynamics being studied in this research concerning the decision of who should order selected patient care activities, it is necessary to first look at the evolving role of the nurse, historically. A look at where nursing began and its close relationship with medicine will help the reader understand the roots of the present conflict in defining nursing's present role in the health care system.

In the early 1900s the role delineations between nurses and physicians were very unclear. At that time

there were no antibiotics, tranquilizers, or surgery, and physicians could do little more than "nurse" their patients (Smoyak, 1987). Elms and Morehead (1977) agreed that at the turn of the century medical treatment relied less on science than experience and that medicine was not a lot different than nursing. The delineation of the roles of physicians and nurses became clearer as the gap between the educational levels widened. As medical education improved and degrees were required, nursing went into what Smoyak (1987) described as the "dark ages." The reasons for this are complex but many agree that male dominance was the key in holding back nursing, a field containing mostly women (Darbyshire, 1987; Smoyak, 1987).

The first nursing schools established in the early 1900s were all hospital-based. According to Elms and Morehead (1977), nurses principally implemented physicians' orders and initiated few interventions on their own. Aroskar (1980) has pointed out that even as late as the 1930s many hospitals employed no paid nursing instructors and provided little formal education for the students. Nursing education remained entirely dependent on the kind and quality of medical services provided in the hospital for teaching purposes (Aroskar, 1980). The problem of the gap in education has continued into the present.

As a result of World Wars I and II, science and medical experimentation provided higher levels of sophistication in treating patients. Increasing levels of technology required nurses to learn more technical skills. As a direct result, nursing care became more sophisticated (Moniaci, 1988). Nurses began using scientific rationale for planning and evaluating care, in addition to nurturing and caring for the patients (Wille, cited in Moniaci, 1988).

In the 1960s the discord between medicine and nursing became a public issue (Smoyak, 1987). A call was made for the realignment of roles, and three national conferences took place to discuss the issues of practice and health care delivery. As a result, the National Joint Practice Commission was formed. Unfortunately, after a period of time the American Medical Association withdrew its support from the commission and it was dissolved (Smoyak, 1987). The formation and subsequent dissolution of the commission did, however, stimulate a much more public debate on joint practice and collaboration among medicine and nursing.

Sources of Role Conflict

The literature identifies many reasons for the conflict between nurses and physicians. The most prevalent reason cited is gender role-set. Until recently, the

traditional pattern was that almost all physicians were male and almost all nurses were female (Moniaci, 1988). Many have identified the role of the nurse as a nurturer and caregiver (Freudenberger & North, 1985; Masson, 1985), while the physicians have been viewed in the more masculine role of problem-solver.

The predominant pattern of interaction between nurses and physicians has been cited by Kalisch and Kalisch (1972) as one of dominance on the part of the physician and deference on the part of the nurse. The male physician has seen his role as independent, and the thought of consulting a nurse makes a physician feel threatened (Moniaci, 1988). Independence and the clinical freedom to make decisions, according to Moniaci (1988), have been highly valued by physicians. However, the advent of the multidisciplinary team concept has meant that now nurses not only expect, but insist upon, being consulted and involved in decisions regarding patient care. Darbyshire (1987) has stated that while most physicians have tried to adapt, the notion still persists among some that team work is merely a group of people doing what the physicians say should be done.

Kalisch and Kalisch (1977) concurred with this idea by stating that physicians regard other health care professionals as primarily serving them in their so-called

"captain of the ship" role rather than as team members working side by side to serve the patients. The physician makes the assumption that other health care workers are carrying out delegated functions or tasks which the physician could perform, but does not because it would be an inefficient and overly expensive use of the physician's time. According to these authors, the nurse has continued to accept that position.

Moniaci (1988) cited two reasons for conflict between nurses and physicians. The first is that physicians do not understand the functions and goals of the nurses; the second is that the nurses lack insight into the scope of the physician's responsibilities. Furthermore, she reported conflict that stems from the fact that medical and nursing students have not studied together, nor have they learned information regarding each other's profession.

In a study done by Webster (1985) with 60 medical students, it was found that over the 4 years of medical school, students' perceptions of the physician's role vis-a-vis the patient and the health care team became more specific, while their perception of the nurse's role became more vague and diffuse. The most striking finding reported by Webster was among the 3rd and 4th year students. They had difficulty defining the nurse's role relative to their

own role. The majority expressed confusion in defining the interface between nursing and medicine. Fewer than 20% of the 3rd and 4th year students exhibited an awareness that nurses had legitimate roles that were independent of physician's orders and expectations (Webster, 1985).

Webster discussed several possible reasons why medical students had such a "poor" view of nursing's role, including the fact that nurses and medical students have extremely limited interaction. Another reason proposed was that medical students resented having to do "scut work" such as changing dressings or drawing blood samples that they felt was nurse's work, and they directed their resentment toward the nurses. Webster (1985) concluded that,

to improve the relationship between physicians and nurses, major changes must be made in the kinds of work that are valued in society. As long as fields that have been stereotypically male, highly technological and illness oriented are held in higher esteem than those that have been typically female, focusing on long-term care, quality of life, and health maintenance, there is little reason to foresee major changes in interprofessional relationships, except on an individual basis. (p. 317)

Bates (1970) also discussed the sources of conflict and misunderstanding between nurses and physicians. This author stated that a specific area of misunderstanding has been the increased emphasis nurses have placed on the psychological aspects of patient care. Bates indicated

that physicians believe that nurses have moved too far in that direction and that they are now quietly ignoring the patient's physical needs. On the other hand, nurses believe that physicians have forgotten about the patient as a person (Bates, 1970). Physicians focus on diseases and are not usually concerned with personal and social influences in relation to those diseases. Bates reported that many physicians are comfortable with and more skilled at meeting their patients' needs for drugs and for diagnostic or therapeutic technologies than they are at providing a trusting relationship and skilled understanding.

Education is another factor discussed in the literature concerning the conflict between nurses and physicians. According to Moniaci (1988), the differences in education can account for the lack of communication among nurses and physicians. The problem with education is two-fold. First, there is an obvious gap in the levels of education that are necessary to enter each profession. A physician invests many years in formal education before beginning to practice; whereas a nurse may practice nursing with a minimal investment in formal education (Moniaci, 1988). Secondly, the focus of study for physicians and nurses is different. Physicians are concerned with

curative aspects of health care, while nurses focus more on caring (Darbyshire, 1987; Smoyak, 1987).

Even the push in nursing for higher levels of education may not solve the problem. Kalisch and Kalisch (1977) noted that physicians stated they did not value higher education for nurses because they had not seen the improved care which is supposed to result from additional education. All of these factors contribute to the lack of clearly defined roles in nursing (Darbyshire, 1987).

Collaboration Between Medicine and Nursing

Numerous articles and papers have been written in recent years addressing the controversy in distinguishing the roles of nursing and medicine in health care today. Most of the authors agree that many, if not all, of the problems could be allayed through collaboration (Bille & Wright, 1987; Fagin, 1987; Michelson, 1988).

Baggs and Schmitt (1988) defined collaboration as nurses and physicians cooperatively working together, sharing responsibility for solving problems, and making decisions to formulate and carry out plans for patient care. Concurring with this definition, Michelson (1988) stated that nurses and physicians would share more explicitly in every aspect of the overall management of the

patient, including the privileges, responsibilities, and rewards, both professionally and financially. Michelson further stated that this requires nurses and physicians working as colleagues.

Collegiality, as stated by England (1986), implies a relationship that epitomizes collaboration. The author further stated that it connotes equality, mutuality, rights, privileges, and power--qualities that enhance human productivity. England went on to state that even though medicine has become more and more dependent on other professions to be effective, there is resistance to this change on the part of the physicians. Independence and the clinical freedom to make decisions, as stated earlier, are highly valued by physicians. Yet, according to Darbyshire (1987), this position of almost complete autonomy has become increasingly unrealistic.

Milburn (1986) agreed that collegiality is necessary for collaboration. She has described collaboration as nurses and physicians jointly communicating about health care. It is more than just an exchange of words, but rather discussions of health care as information is gathered and decisions are made. Collaboration, according to Steele (cited in Milburn, 1985), occurs when the

physician relinquishes the role of leader and the nurse that of follower. .

McKay (1983) agreed that communication is important in the nurse/physician relationship, but took a different view of joint practice and autonomy for nursing and medicine.

McKay (1983) stated that,

the perspective of autonomy of professionals in organization can no longer be limited to the traditional definition of independent decision making in accordance with one's training but must acknowledge interdependence in decision making with intraprofessional peers and interprofessional colleagues. (p. 26)

Professional autonomy according to McKay is both independent, interdependent, and practice-related.

Decision-making is based on a complex body of knowledge and skill. The redefinition of professional autonomy to include independent and interdependent practice-related decision-making acknowledges the changing role of the professional (McKay, 1983). However, in sharing full and equal voice in making patient care decisions, health care professionals also share a full and equal responsibility for those decisions. Given the reality that nurses are among those being held responsible for decision outcomes, it is most appropriate that they be included in making the decision (McKay, 1983).

Davis (1974) studied intrarole conflict in relation to job satisfaction in nurses on a psychiatric unit. Davis reported a significant difference between nurses' and physicians' expectations of appropriate functions for nurses when they were asked how much involvement nurses should have in certain aspects of care. High intrarole conflict was found but, according to Davis, it was not associated with lower job satisfaction.

A study by Weiss (1983) examined physicians' and nurses' views of their role and what areas of responsibility each had. The whole group, including the nursing subgroup, did not identify a single behavior as being uniquely nursing. Nurses defined the professional responsibility of diagnosing a narrow range of common diseases as being the physicians' domain while the physician and consumer groups considered it to be an area of common practice.

A survey commissioned by the American Nurses' Association in 1985 reported that the general public believes that nurses are trained to play a larger role in providing health care services than they are presently allowed to do (American Nurses' Association, 1985a). Fingerhut/Granados Opinion Research Company of Washington, DC, conducted a survey of 602 adults which included racial,

gender, and regional groups in proportion to their distribution in the national population. The survey results showed that 68% of the respondents believed that nurses should be playing a larger role in health care than they are presently allowed to do. Eighty-four percent favored health plans reimbursing nurses directly as a method to control costs, and 83% of those who responded expected to hear ideas from nurses about ways nurses could expand their current responsibilities (American Nurses' Association, 1985a).

In a second survey, reported by the American Nurses' Association (1985a), 151 professionals in television, radio, and the print media were interviewed. These people considered to be opinion leaders responded positively to the statements that: "with the high cost of medical care, it would be a good idea to let nurses increase their areas of responsibility [and] if more services were performed by nurses, medical costs could be lowered" (p. 5).

McKay (1983) has stated that each participant in collaborative practice is responsible for and should be held accountable for his or her actions. This author noted that the nurse must have the knowledge to observe intelligently and act or intervene efficiently in order for collaboration to be effective. Traditionally, physicians

have always assumed final responsibility for patient care. They have routinely made all the decisions because they were held accountable for anything that happened or failed to happen to the patient. According to McKay, the nurse and the physician must each be held legally accountable for appropriate practice and care of the patient within the system of collaboration.

Selected Patient Care Activities

Ten activities carried out by nurses were chosen for examination in this study. The literature has shown that there is some controversy concerning who should be responsible for writing the order for initiating 6 of the 10 activities. A review of the literature on the other four activities revealed no information or no controversy concerning who should order the activities. These four activities are: (a) applying an eggcrate mattress, (b) making diet changes, (c) writing repeat laboratory orders, and (d) suctioning a patient. The six areas where some controversy was found are: (a) determining frequency of vital signs, (b) giving nonprescription medications, (c) applying soft restraints, (d) starting oxygen, (f) writing a do not resuscitate order, and (g) declaring a patient dead.

Vital Signs

The hospital staff is under obligation to monitor all patients. Hospital liability for the negligent monitoring of a patient's condition by its employees, such as nursing personnel, is imposed on a vicarious basis (Hospital Law Manual, 1986). If a patient's condition shows signs of worsening, the nurse is charged with taking some positive action, the least of which includes monitoring the patient more frequently (Hospital Law Manual, 1986).

With respect to how often vital signs are taken, according to the Hospital Law Manual (1986) a nurse is under legal obligation to take them as often as the physician deems necessary. She is also charged with the responsibility of taking them more frequently if the patient's condition warrants it. Currently, she is not allowed to take them less frequently than what the physician has ordered.

One of the problems that arises from this system is frequently cited in sleep studies of hospitalized patients. Several studies cite the interruption of sleep for vital signs as being one of the major causes of sleep deprivation in hospitalized patients (Brewer, 1985; Goodmate, 1985; Webster & Thompson, 1986). This is not to say that these studies advocate not awakening patients for vital signs.

What they do advocate is that nurses should make their own decisions as to when to wake up their patients (Brewer, 1985; Webster & Thompson, 1986). Brewer (1985), for example, proposed that the nurse be able to take vital signs when she is giving medications or when the lab is drawing blood instead of on a set every 4 or 6 hours. Webster and Thompson (1986) stated that nurses are in a privileged position to ensure that each patient is in an optimum state to receive sufficient sleep and that the nurse should be allowed to manipulate the environmental factors that affect the patient's well-being. They further stated that it may be beneficial at times for nurses to "selectively decide not to do something, i.e. an early morning blood pressure recording. . ." (p. 455).

Nonprescription Medications

Stilwell (1988) has divided medications into three categories: (a) dressings and lotions, (b) over-the-counter or "nonprescription medications," and (c) "prescription only" medications. This author's argument for nurses to be allowed to prescribe "prescription only" medications centers around nurse practitioners and will not be addressed in this study. Stilwell does, however, set forth an argument that general nurses should be allowed to

decide when to use lotions and dressings as well as when to give the patient nonprescription medications.

Stilwell (1988) stated that because dressing wounds is a traditional nursing task, nurses have an adequate knowledge of what should be used. She proposed that if nurses are not allowed to decide which dressings and lotions to use, the patient's quality of care may suffer. It may take the nurse some time to contact the physician to get an order for a dressing change. The same argument is true for nonprescription medications. The patient may wait unnecessarily for the nurse to locate the physician and obtain an order.

Another argument Stilwell (1988) has presented in support of giving nurses the right to write prescriptions for "over-the-counter" drugs concerns the cost factor. There are some medications that can be obtained either with or without a prescription and those people entitled to free prescription medications need that written prescription to get those medications at no cost.

The whole question of whether nurses should be allowed to prescribe ignores the fact that nurses often give medications or write orders that the physician later signs (Stilwell, 1988). The real question, according to Stilwell, is not whether nurses are able to prescribe

medications, but should they be given the legal right to do what they are, in many instances, already doing.

Stilwell's arguments are supported in the results of a survey commissioned by the ANA (1985a). The survey of 602 adults was conducted by Fingerhut/Granados Opinion Research Company of Washington, DC. The results showed that people trust nurses to do more (ANA, 1985a). The survey showed that 68% of those surveyed believe that nurses are trained to play a larger role in providing health care services than they are presently allowed to do. Included in this, between 85-96% of the poll's respondents believe that, with specialized training, nurses would be qualified in such areas as prescribing routine prescription drugs, conducting physical examinations, and many other activities (ANA, 1985a). Although the respondents mention specialized training for nurses concerning the prescribing of medications, the survey does illustrate the public's willingness to trust nurses in this area.

Soft Restraints

In a study on perceptions patients and nurses have about physical restraints, Strumpf and Evans (1988) found that in 19 of 20 cases where restraints had been applied, a nurse rather than a physician had made the initial determination that restraints were needed. Mention of the

need for restraints was found in the physician's progress notes in only one case, suggesting almost sole nursing responsibility for this practice. Even so, the policy in many hospitals still requires that a physician order restraints before the nurse can apply them.

Horsley (1987) discussed a case where a nurse was found legally liable for not applying restraints on a patient. The case cited involved a nurse who informed a physician that a patient was disoriented and wandering in the hall. The physician told the nurse to just return the patient to his room if he got up again. Subsequently, the patient fell and fractured his pelvis. The family successfully sued the hospital and the court found that the nurse should have been more persistent in getting an order for sedation or restraints from the physician. According to the court, if the physician continued to refuse, the nurse should have gone through the chain of command, to the chief of staff if necessary, to protect the patient (Horsley, 1987).

The Hospital Law Manual (1987) also addressed this issue. It stated that the hospital is obligated to provide devices designed to prevent injury to patients who are in a weakened condition. In addition, it stated that hospitals are under a general obligation to monitor all patients

regularly and that this monitoring usually falls under the jurisdiction of the nursing personnel. The Hospital Law Manual (1986) also cited another legal case where a New York hospital was found liable when the staff, knowing that the patient required close supervision, failed to move him to a secure room, restrain him, or have someone watch him continuously. It is clear that nurses have the professional and legal responsibility to protect their patients from harm.

Oxygen Administration

According to the Hospital Law Manual (1984), the administration of oxygen is the responsibility of and under the sole jurisdiction of the physician. In a 1979 case, the court recognized that under certain circumstances a nurse may exercise independent judgment in the administration of medication pursuant to a physician's order. However, this decision has not generally been applied to oxygen administered.

A nurse was found negligent in a case in New York where she administered 6 liters of oxygen to a patient for whom the physician had only ordered 4 liters (Hospital Law Manual, 1984). The hospital contended that the treatment actually given by the nurse conformed to the then accepted standard of care relating to the concentration of oxygen.

The court concluded that in such cases the nurses are not authorized to determine for themselves what is a proper course of medical treatment (Hospital Law Manual, 1985). The court further stated that nurses may not invade the area of the physician's competence and authority by overruling his or her orders.

Do Not Resuscitate

The issue of the right to die has been gaining wide public attention. More and more people are looking at using living wills and other legal means to ensure that they will be able to die without extraordinary means and lifesaving methods being employed to keep them alive. According to Ott (1986), "the decision not to attempt cardiopulmonary resuscitation (CPR) is clearly as important a decision, in terms of patient welfare, as is the decision to undertake resuscitation" (p. 25).

Traditionally, Do Not Resuscitate (DNR) orders have been written by the physician. The Hospital Law Manual (1987) states that DNR orders are an appropriate part of medical practice. Yarling and McElmurry (1983) have contended that although a physician is the person who should determine that a patient's condition warrants a DNR order, the writing of a DNR order should be regarded as an overlapping function of medicine and nursing, which may be

performed either by the physician or the nurse, depending upon the situation. It is inconsistent to believe that the nurse who bears the responsibility of life and death when initiating CPR is not responsible enough to write the DNR order when the patient has made it clear to the nurse that resuscitation efforts are not wanted (Yarling & McElmurry, 1983). All participants in the decision must be viewed as having valuable contributions to make (Martin & Redland, 1988). Martin and Redland (1988) cited nurses' increasing professionalization as one of the reasons why the nurses' role in determining treatment is an important one. Yarling and McElmurry (1983) have stated that the nurse of the 1980s has emphasized patient autonomy in decision-making and the role of the nurse includes acting as a patient advocate.

The American Nurses' Association (1985b) Code for Nurses states that each nurse has an obligation to be knowledgeable about the moral and legal rights of all clients and to protect and support those rights. Perhaps the most compelling reason for nurses to be involved in DNR decisions is that the nurse is the one professional who is in close and continuous contact with the patient and, thus, is better able to help the patient articulate his or her wishes or to speak on behalf of the incapacitated patient

(Martin & Redland, 1988). Anderson (1988) concurred, stating that the special nurse/patient relationship makes nurses invaluable when there is a deadlock between the physician and the family on a DNR decision. Farber et al. (1986) contended that if the patient has expressed his wishes concerning DNR, the nurse should then participate in the DNR decisions.

Ott (1986) has stated that because of the frequent and ongoing interaction between the patient and the nurse, the discussion about the DNR situation often takes place first between these two individuals. It is common for the patient to tell the nurse that he or she does not wish to continue treatment and wants to be allowed to die. However, Yarling and McElmurry (1983) stated that because of the historical domination of nursing by the medical profession, the nurse is not free to act on her professional commitment to the patient and that the patient would be better served by a balance of power on this issue.

If nurses were given the power to write DNR orders, would they make the same decisions as physicians would, in the same situations? Farber et al. (1986) illustrated the difference in nurses' and physicians' views on when to implement cardiopulmonary resuscitation. Using questionnaires containing clinical vignettes of patients

with varying diagnoses, Farber et al. (1986) looked at when the nurses and physicians would initiate CPR. They found that the nurses were more likely than the physicians to initiate CPR for patients who suffered mental retardation, those admitted from a nursing home, and those related to a staff physician. Farber et al. (1986) concluded that the findings argue for a policy on written code orders that permit nurses, physicians, and the patient or family to discuss the options.

Another area of controversy between physicians and nurses is the issue of "slow codes." A "slow code" occurs when a physician wants to issue a DNR order, but he or she is unable to get the family to agree. Nurses are then expected to take their time responding, if a patient arrests (Anderson, 1988). Anderson conducted a national survey in which 1 nurse in 4 reported that she participated in a "slow code" the previous year. He also found that 6 survey respondents in 10 participated in resuscitation efforts they considered senseless or hopeless during the previous year.

Pronouncement of Death

The nurse's role with the dying patient has been brought to the public's attention with legislation passed in New Jersey in 1983. The New Jersey legislature passed a

law allowing registered professional nurses to pronounce death in homes, residences, and long-term care facilities (Reinhard & Aughenbaugh, 1985). The argument proposed by Reinhard and Aughenbaugh for allowing nurses to declare death in homes and long-term facilities is a social one.

Reinhard and Aughenbaugh stated that the nurses often have spent more time with the patient and their families than the physician and the nurse is usually present when the patient dies. They further stated that in most states, a body cannot be released to the funeral home until the death certificate has been signed by a physician. Therefore, families must wait, sometimes for hours, for their attending physician to arrive and sign the certificate. Nurses can eliminate this wait, thereby preventing the families of the deceased of having to wait to have the body moved (Reinhard & Aughenbaugh, 1985).

Similarly, legislation was proposed in Texas in 1989 to give registered nurses the authority to determine death in accordance with their facilities' policies (Texas Nurses Association, 1989b). The proposal stated that those policies would have to have been developed and approved by the facilities' nursing and medical staffs. The Texas Nurses' Association (1989a) asserted that existing laws requiring death to be determined only by a physician create

situations that interfere with the patient's right to a dignified death.

The legislative bill died in committee in both the House and Senate (Texas Nurses' Association, 1989c). The legislation, which would have permitted registered nurses to determine death, encountered a number of technical problems, according to the Texas Nurses' Association (1989c), one of which was a request by the Texas Hospital Association that the bill not include hospitals. A decision was made not to pursue the legislation this session because of the concerns about limiting the scope of practice to certain practice sites.

The social benefit of nursing being able to pronounce death does not address the issue of nurses' knowledge or ability to declare death. The Hospital Law Manual (1982) stated the traditional definition of death as "the cessation of respiration, heartbeat, and certain indications of central nervous system activity, i.e., failure to respond to pain and pupils that are dilated and do not react to light" (p. 31). Determining the presence or absence of vital signs is a fundamental nursing skill (Reinhard & Aughenbaugh, 1985). In fact, nurses have been pronouncing death for many years, for example, each time a nurse calls a physician to tell him or her that the

patient has expired and asks the physician to come pronounce the patient dead. Reinhard and Aughenbaugh (1985) proposed that all states legitimize nurses' authority in this area.

Summary

In this literature review of the independent role of the nurse, four areas were examined. The first area examined the historical evolution of nursing. Nursing has moved from being under the direct supervision of medicine, where nurses merely followed orders or were handmaidens to physicians, to a more sophisticated profession responsible for planing and evaluating care in addition to nurturing and caring for patients.

The evolution of nursing has produced a conflict between nursing and medicine, which is well documented in the literature. The sources of conflict identified include: gender-role set where the male physician dominates the subservient female nurse, physicians and nurses lack of insight into the others function and goals, the different emphasis the two professions place on certain aspects of care, and the different educational levels between the two groups.

The third area of literature review examined collaboration between medicine and nursing. Most authors

agreed that collaboration is the key to solving the conflicts between medicine and nursing. Collaborative practice should include a sharing of the decision making and responsibilities inherent in caring for patients.

Finally, the literature was examined for areas of conflict concerning who writes the order for 10 selected patient care activities. The literature revealed no conflict for four of the activities. These included: ordering an eggcrate mattress, making diet changes, ordering repeat laboratory tests, and suctioning a patient.

The literature revealed controversy on the other six activities: determining the frequency of vital signs, ordering nonprescription medications, ordering soft restraints, ordering oxygen, writing a DNR order, and declaring a patient dead. The controversy concerned who should be able to write the order for the activities--nurses, physicians, or both. Most of the arguments in favor of nurses being able to write orders for these activities centered around the fact that in many instances, nurses are already initiating these activities and then later obtaining a physician's order to back them up.

CHAPTER III

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

A nonexperimental, comparative design was used to conduct this research. According to Nieswiadomy (1987), comparative studies are those that examine the differences between intact groups on some dependent variable of interest. The difference in comparative studies and experimental studies lies in the researcher's ability to manipulate the independent variable (Nieswiadomy, 1987). In comparative studies such as this, there is no manipulation of the independent variable. A comparison of the difference between the groups is made and the researcher attempts to discover the possible reasons for this difference by isolating some personal or environmental independent variable that has already been in existence. A survey carried out through mailed questionnaires was used to collect the data.

Polit and Hungler (1987) used the term survey to designate any research activity in which the investigator gathers data from a portion of a population for the purpose of examining the characteristics, opinions, or intentions of that population. Surveys are designed to obtain

information from populations regarding the prevalence, distribution, and interrelations of variables within these populations (Polit & Hungler, 1987). In this study mailed questionnaires were used to collect data on physicians' and nurses' reports concerning the decision to initiate selected patient care activities.

Setting

The study was conducted in the southwestern United States. A mailed questionnaire was sent to nurses whose names were on a list of the State Board of Nurse Examiners. They were asked to distribute two more questionnaires to physicians who practice on the units where the nurses work. The actual setting for completion of the questionnaires was the location chosen by each subject.

Population and Sample

The target population was all nurses and physicians currently practicing in medical/surgical settings in hospitals. The accessible population of nurses was those whose names were on a list obtained from the State Board of Nurse Examiners. The list contained the names of all registered nurses in the state of Texas who worked full-time in hospitals and who listed medical/surgical as their clinical area of practice. The list contained a total of

10,365 names. The accessible physician population was those physicians who have patients on the units where the nurse subjects practiced. A systematic random sample of 200 nurses was chosen from the list by choosing every 52nd name. The nurses were asked to give the questionnaires to two physicians they worked with in an attempt to obtain a similar size sample of physicians. The actual study sample consisted of those nurses and physicians who returned the questionnaires. There were 85 nurse and 34 physician questionnaires returned.

Protection of Human Subjects

This research project received exemption from review by the Human Subjects Review Committee (Appendix A). The study was classified as Category I research because data collection involved the use of anonymous questionnaires. After receiving permission to conduct the study from the Graduate School of Texas Woman's University (Appendix B), data collection began. The questionnaires were mailed to nurses whose names were obtained from a list that was purchased from the Texas State Board of Nurse Examiners. A cover letter (Appendix C) accompanied the questionnaires informing the subjects of the purpose of the study. Subjects were also informed that there were no known risks and a possible benefit of the study would be to help more

clearly define a nurses' and physicians' perceptions of the role of the nurse. The questionnaires were not coded or marked in any way to ensure anonymity of the participants. The following statement appeared at the top of the questionnaires: COMPLETION AND RETURN OF THIS QUESTIONNAIRE WILL BE CONSTRUED AS YOUR INFORMED CONSENT TO ACT AS A SUBJECT IN THIS STUDY.

Instruments

A self-report questionnaire (Appendix D) was used to collect the data. The first half of the questionnaire covered the demographic data. The second half covered 10 patient care activities.

The demographic questions concerned age, years of experience, area of practice, gender, ethnic background, and profession of each respondent. This information was used to describe the sample.

The second part of the questionnaire covered selected patient care activities. A review of the literature revealed 10 key patient care activities, carried out on most medical/surgical floors in hospitals, in which there is some degree of confusion or controversy as to who should order the activities. Current health care journals were examined and reviewed in selection of these patient care activities to establish content validity for the

questionnaire. In order to minimize any confusion over what the researcher meant by each activity listed on the questionnaire, a list of definitions of the activities was included in the packets.

Prior to mailing, the questionnaire was tested for readability, length of time for completion, and clarity of items. Ten nurse colleagues of the researcher were asked to complete the questionnaire and to give one other questionnaire to a physician they worked with. The nurse colleagues were asked to collect the questionnaires from the physicians, and to return all questionnaires to the researcher. Envelopes were provided so that each respondent could seal his or her own questionnaire after it was completed, to insure anonymity. No problems were encountered; therefore, the questionnaire was used in its original form.

Data Collection

After permission was obtained from the Graduate School of Texas Woman's University, data collection began. The researcher mailed a survey packet to each of the selected 200 nurse subjects.

The packet included three complete questionnaires, one for the nurse and two others that the nurse was asked to distribute to physicians who practiced in their agencies.

Each of the questionnaires had four pages. Page 1 was the cover letter explaining the risks, purposes, and benefits of the study as well as introducing the researcher. Page 2 contained demographic questions used in describing the sample. Page 3 was a list of definitions of each of the patient care activities in order to provide the participants with a clear understanding of each activity. Page 4 contained a list of the 10 patient care activities with a space to mark who presently writes the order and who should write the order for the activity. Each packet also contained three stamped, addressed envelopes for return of the questionnaire. The respondents were asked to return their questionnaires within 10 days of receiving them.

If less than 30 questionnaires were returned for each group, a follow-up postcard was to be sent 3 weeks after the initial mailing. This follow-up mailing was not necessary.

Treatment of the Data

The questionnaires produced five types of data. The first was the demographic data which were used to describe the sample. Frequency distributions in each category of age, education, gender, years of experience, ethnic background, area of practice, and profession were compiled.

The other four categories of data obtained were:

(a) who the nurse respondents said presently writes the order to initiate the 10 patient care activities, (b) who the nurse respondents said should write the order to initiate the 10 patient care activities, (c) who the physician respondents said presently writes the order to initiate the 10 patient care activities, and (d) who the physician respondents said should write the order to initiate the 10 patient care activities. Frequency and percentages of responses were plotted for each category separately. In addition to this, a chi square test was used to compare responses in a and c, and b and d. Also, the number of changes between a and b, and c and d was compared, using descriptive statistics.

CHAPTER IV

ANALYSIS OF DATA

This chapter presents the findings of the study. First the sample is described and then the data are presented in relation to the hypotheses and subproblems of the study. Data for each of the activities are presented separately.

Description of the Sample

Two hundred questionnaire packets were mailed to a random sample of nurses who listed medical/surgical as their area of practice with the Texas State Board of Nurse Examiners. The questionnaires were mailed in August of 1989 and completed questionnaires were received by the investigator through September.

The study sample consisted of 85 nurses and 34 physicians whose completed questionnaires were received by the investigator. Ten packets were returned with no forwarding address. Of the other 190 packets, 85 nurse questionnaires were returned, which is a 45% return rate. The percentage of physicians who returned the questionnaires cannot be calculated because there is no way of knowing how many of the nurses actually distributed the questionnaires to the doctors with whom they worked.

Of the 400 physician questionnaires mailed out, 34 (9%) were returned.

Demographic data on the subjects were obtained from responses to the seven demographic questions and will be addressed separately for the two groups. The data for the physician sample are presented in Table 1 and the nurse sample data are found in Table 2.

The data indicated that 97% or 33 of the physicians were MDs. There were 32 males and 2 females in the sample. Almost 90% of the subjects were over 31 years of age.

Variation existed in the years of experience listed by the respondents. Over half had less than 10 years of experience. A large majority of the physicians (91.2%) listed their ethnic background as Caucasian. Of those remaining, 5.9% were Hispanic and 1 person listed "other."

Half of the physician respondents listed medical as their area of practice. The second largest group (29.4%) listed surgical as their area of practice.

Of the 85 nurses who responded, 78 (91.8%) were females and 7 (8.2%) were males. There was a wide distribution in their ages and a wide distribution in their years of experience. The majority of the nurses (72.9%) listed Caucasian as their ethnic background. The other largest ethnic group represented in the sample was the

Table 1

Demographic Data on Physician Sample

Variable	Number	Percent
<u>Education</u>		
M.D.	33	97.1
D.O.	1	2.9
<u>Gender</u>		
Male	32	95.0
Female	2	5.0
<u>Ethnic Background</u>		
Caucasian	31	91.1
Hispanic	2	6.0
Other	1	2.9
<u>Age</u>		
20-30	4	11.8
31-40	17	50.0
41-50	7	20.6
51-60	5	14.7
> 60	1	2.9
<u>Years of Experience</u>		
0-5	11	32.4
6-10	7	20.6
11-15	8	23.5
16-20	2	5.9
21-25	3	8.8
> 25	3	8.8
<u>Area of Practice</u>		
Medical	17	50.0
Surgical	10	29.0
Other	7	21.0

N = 34.

Table 2
Demographic Data on Nurse Sample

Variable	Number	Percent
<u>Education</u>		
Diploma	18	21.2
Associate degree	28	32.9
Bachelor's degree	36	42.4
Other	3	3.4
<u>Gender</u>		
Male	7	8.2
Female	78	91.8
<u>Ethnic Background</u>		
Caucasian	62	72.9
Hispanic	5	5.9
Black	4	4.7
Asian	10	11.8
Other	4	4.7
<u>Age</u>		
20-30	17	20.0
31-40	38	44.7
41-50	22	25.9
51-60	7	8.2
> 60	1	1.2
<u>Years of Experience</u>		
0-5	16	18.8
6-10	25	29.4
11-15	18	21.2
16-20	12	14.1
21-25	7	8.2
> 25	7	8.2
<u>Area of Practice</u>		
Medical	26	30.5
Surgical	17	20.0
ICU	14	16.5
Other	28	33.0

N = 85.

Asian population (11.8%). The educational levels of the nurses also varied, with each category well represented. Those who listed "other" were either working on or had obtained a master's degree in nursing and one stated she was a nurse practitioner.

The nurses reported many different areas of practice. The largest group checked the "other" category. They listed areas such as rehabilitation and the emergency room. The second largest group checked medical as their area of practice.

Presentation of the Findings

Hypotheses

Hypothesis 1 (A-J) stated: Among the nurses and physicians surveyed, there is a difference between the nurses' and physicians' reports of who presently writes the order to initiate 10 selected patient care activities (A-J). The physicians consistently reported that physicians write the orders for the activities. The nurses' responses were more varied. For a breakdown of the responses for each of the 10 activities, see Table 3.

Table 3

Comparison of Nurses' and Physicians' Reports of Who
Presently Writes the Order for 10 Selected
Patient Care Activities

A. Order an eggcrate mattress.

<u>Response</u>	<u>Respondent</u>	
	<u>Nurse</u> (<u>N</u> = 85)	<u>Physician</u> (<u>N</u> = 33)
Physician	59 (64.4%)	29 (87.8%)
Nurse	4 (4.7%)	0 (0.0%)
Either	22 (25.9%)	4 (12.2%)

Chi-square = 6.68, df = 2, p = .10

B. Determine frequency of vital signs.

<u>Response</u>	<u>Respondent</u>	
	<u>Nurse</u> (<u>N</u> = 84)	<u>Physician</u> (<u>N</u> = 33)
Physician	61 (72.6%)	30 (90.9%)
Nurse	1 (1.2%)	1 (3.0%)
Either	22 (26.2%)	2 (6.1%)

Chi-square = 6.17, df = 2, p = .05

C. Order nonprescription medications.

<u>Response</u>	<u>Respondent</u>	
	<u>Nurse</u> (<u>N</u> = 84)	<u>Physician</u> (<u>N</u> = 33)
Physician	79 (94.0%)	33 (100.0%)
Nurse	1 (1.2%)	0 (0.0%)
Either	4 (4.8%)	0 (0.0%)

Chi-square = 2.05, df = 2, p = .39

(table continues)

D. Order soft restraints.

<u>Response</u>	<u>Respondent</u>	
	<u>Nurse</u> (<u>N</u> = 85)	<u>Physician</u> (<u>N</u> = 33)
Physician	59 (64.4%)	27 (81.8%)
Nurse	6 (7.1%)	1 (3.0%)
Either	20 (23.5%)	5 (15.2%)

Chi-square = 2.6, df = 2, p = .10

E. Change diet order.

<u>Response</u>	<u>Respondent</u>	
	<u>Nurse</u> (<u>N</u> = 85)	<u>Physician</u> (<u>N</u> = 33)
Physician	73 (85.9%)	33 (100.0%)
Nurse	1 (1.1%)	0 (0.0%)
Either	11 (13.0%)	0 (0.0%)

Chi-square = 5.19, df = 2, p = .07

F. Order repeat lab tests.

<u>Response</u>	<u>Respondent</u>	
	<u>Nurse</u> (<u>N</u> = 85)	<u>Physician</u> (<u>N</u> = 33)
Physician	77 (90.6%)	30 (90.9%)
Nurse	2 (2.4%)	0 (0.0%)
Either	6 (7.0%)	3 (9.1%)

Chi-square = 0.91, df = 2, p = .64

(table continues)

G. Order oxygen.

<u>Response</u>	<u>Respondent</u>	
	<u>Nurse</u> (<u>N</u> = 85)	<u>Physician</u> (<u>N</u> = 33)
Physician	71 (83.5%)	30 (90.9%)
Nurse	2 (2.4%)	1 (3.0%)
Either	12 (14.1%)	2 (6.1%)

Chi-square = 1.49, df = 2, p = .47

H. Write do not resuscitate order.

<u>Response</u>	<u>Respondent</u>	
	<u>Nurse</u> (<u>N</u> = 85)	<u>Physician</u> (<u>N</u> = 33)
Physician	85 (100.0%)	32 (96.9%)
Nurse	0 (0.0%)	1 (3.1%)
Either	0 (0.0%)	0 (0.0%)

Chi-square = 2.59, df = 2, p = .11

I. Perform suctioning.

<u>Response</u>	<u>Respondent</u>	
	<u>Nurse</u> (<u>N</u> = 85)	<u>Physician</u> (<u>N</u> = 32)
Physician	59 (64.4%)	19 (59.3%)
Nurse	5 (5.8%)	2 (6.2%)
Either	21 (25.8%)	11 (34.5%)

Chi-square = 1.15, df = 2, p = .56

(table continues)

J. Declare death.

<u>Response</u>	<u>Respondent</u>	
	<u>Nurse</u> (<u>N</u> = 85)	<u>Physician</u> (<u>N</u> = 33)
Physician	85 (100.0%)	31 (93.9%)
Nurse	0 (0.0%)	0 (0.0%)
Either	0 (0.0%)	2 (6.1%)

Chi-square = 5.24, df = 2, p = .02

A chi-square was computed for each of the 10 patient care activities. According to Munro, Visintainer, and Page (1986), a generally agreed upon rule is that expected frequencies in any cell should be at least 5, if the df are greater than 1. The chi-square is valid as long as no more than 20% of the expected frequencies are less than 5. For Hypothesis 1 (A-J), the test assumptions were violated for all activities except two (ordering soft restraints and suctioning). Therefore, caution should be exercised when interpreting the results of this hypothesis. The only significant chi-square values were found for the activity of determining the frequency of vital signs (chi-square = 6.17; df = 2, p = .05) and the declaration of death (chi-square = 5.24, df = 2, p = .02). More nurses than physicians reported that either nurses or physicians write the order to determine the frequency of vital signs. On the other hand, more physicians than nurses reported that

either nurses or physicians presently declare death. Therefore, only Hypothesis 1B and 1J were supported.

Hypothesis 2 (A-J) stated: Among the nurses and physicians surveyed, there is a difference between the nurses' and physicians' reports of who should write the order to initiate the 10 selected patient care activities. The data are presented in Table 4. The responses concerning who should perform activities were distributed more evenly in the six cells of the data when they were prepared for the chi-square analysis. Data for two of the activities (DNR and declaration of death) did not meet the requirements of the test.

There were four activities that had especially large differences in the reports from the two groups. Of the 33 physicians who responded, 23 (69.7%) indicated that only physicians should write the order to determine the frequency of vital signs; while only 16 (19%) of the 84 nurses agreed that only physicians should write the order. The majority of the nurses (58 or 69.2%) responded that either physicians or nurses should be able to write the order. The chi-square value was 25.98, with a df = 2 and a p value of $< .001$. Therefore, Hypothesis 2B was supported.

Another area of disagreement was in the reports of who should make diet changes. The majority of the physicians

(20 of 34 or 58.8%) responded that ordering diet changes should be a physician's decision compared to 51 (60%) of the nurses who responded that either nurses or physicians should be able to make that decision (chi-square = 11.33, $df = 2$, $p = .004$). Hypothesis 2E was also supported.

A similar difference was found in the area of ordering repeat lab tests. Twenty-six of the 34 physicians (76.5%) reported that lab tests should only be ordered by the physician. Over half (46 or 54.8%) of the nurses indicated that this should be ordered by either nurses or physicians (chi-square = 15.17, $df = 2$, $p = .001$). Therefore, Hypothesis 2F was supported.

The final activity that showed a marked difference in the two groups' responses was the starting of oxygen on a patient. Only 20 (23.8%) of the 84 nurses checked that it should only be a physician's order, while 21 (61.7%) of the 34 physicians responded that it should be their decision (chi-square = 15.4, $df = 2$, $p = .001$). Hypothesis 2G was supported.

A distinction found between the two groups was their report of which activities should be exclusively determined by nurses. There were more nurses than physicians who indicated that there were some activities that were exclusively nursing. One activity that a large number of

nurses reported should be exclusively under the realm of the nurse was the ordering of an eggcrate mattress. Of the 84 nurses, 24 (28.6%) of them marked this as a nursing function (Table 4).

Table 4

Comparison of Nurses' and Physicians' Reports of Who Should Write the Order for 10 Selected Patient Care Activities

A. Order an eggcrate mattress.

<u>Response</u>	<u>Respondent</u>			
	<u>Nurse</u> (<u>N</u> = 84)		<u>Physician</u> (<u>N</u> = 34)	
Physician	5	5.9%	3	8.9%
Nurse	24	28.6%	5	14.7%
Either	55	65.5%	26	76.4%

Chi-square = 2.61, df = 2, p = .27

B. Determine frequency of vital signs.

<u>Response</u>	<u>Respondent</u>			
	<u>Nurse</u> (<u>N</u> = 84)		<u>Physician</u> (<u>N</u> = 34)	
Physician	16	19.0%	23	69.7%
Nurse	10	11.8%	1	2.9%
Either	58	69.2%	10	27.4%

Chi-square = 25.98, df = 2, p = < .001

(table continues)

C. Order nonprescription medications.

<u>Response</u>	<u>Respondent</u>	
	<u>Nurse</u> (<u>N</u> = 85)	<u>Physician</u> (<u>N</u> = 34)
Physician	41 48.3%	19 56.0%
Nurse	2 2.2%	1 2.9%
Either	42 49.5%	14 41.1%

Chi-square = .67, df = 2, p = .72

D. Order soft restraints.

<u>Response</u>	<u>Respondent</u>	
	<u>Nurse</u> (<u>N</u> = 84)	<u>Physician</u> (<u>N</u> = 34)
Physician	8 9.4%	7 20.6%
Nurse	17 20.0%	4 11.8%
Either	59 70.7%	23 67.6%

Chi-square = 3.33, df = 2, p = .18

E. Change diet order.

<u>Response</u>	<u>Respondent</u>	
	<u>Nurse</u> (<u>N</u> = 85)	<u>Physician</u> (<u>N</u> = 34)
Physician	23 27.0%	20 58.8%
Nurse	11 13.0%	1 2.9%
Either	51 60.0%	13 38.3%

Chi-square = 11.33, df = 2, p = .004

F. Order repeat lab tests.

<u>Response</u>	<u>Respondent</u>			
	<u>Nurse</u> (<u>N</u> = 84)		<u>Physician</u> (<u>N</u> = 34)	
Physician	31	37.0%	26	76.5%
Nurse	7	8.2%	1	2.9%
Either	46	54.8%	7	20.6%

Chi-square = 15.17, df = 2, p = .001

G. Order oxygen.

<u>Response</u>	<u>Respondent</u>			
	<u>Nurse</u> (<u>N</u> = 84)		<u>Physician</u> (<u>N</u> = 34)	
Physician	20	23.8%	21	61.7%
Nurse	6	7.0%	1	2.9%
Either	58	69.2%	12	35.4%

Chi-square = 15.40, df = 2, p = .001

H. Write do not resuscitate order.

<u>Response</u>	<u>Respondent</u>			
	<u>Nurse</u> (<u>N</u> = 84)		<u>Physician</u> (<u>N</u> = 34)	
Physician	78	92.9%	33	97.1%
Nurse	0	0.0%	1	2.9%
Either	6	7.1%	0	0.0%

Chi-square = 4.94, df = 2, p = .08

(table continues)

I. Perform suctioning.

<u>Response</u>	<u>Respondent</u>	
	<u>Nurse</u> (<u>N</u> = 85)	<u>Physician</u> (<u>N</u> = 34)
Physician	8 9.1%	4 11.8%
Nurse	12 14.1%	5 14.7%
Either	65 76.8%	25 73.5%

Chi-square = .17, df = 2, p = .92

J. Declare death.

<u>Response</u>	<u>Respondent</u>	
	<u>Nurse</u> (<u>N</u> = 85)	<u>Physician</u> (<u>N</u> = 34)
Physician	66 77.6%	28 82.4%
Nurse	1 1.2%	0 0.0%
Either	18 21.2%	6 17.6%

Chi-square = .62, df = 2, p = .73

A subproblem of this study was to compare nurses' perceptions of who presently writes the order versus who should write the order for the 10 selected activities. Many nurses reported that they should be able to write orders for more of the activities than is presently being allowed. The number of discrepancies between who presently writes and who should write the orders, and the rank ordering of these discrepancies are found in Table 5.

The activity for which the greatest discrepancy was noted concerned the application of an eggcrate mattresses. Of the 59 nurses who responded that physicians presently

Table 5

Rank Ordering of the Discrepancies in the Nurses' Reports
of Who Presently Writes the Order and Who Should Write
the Order for 10 Selected Patient Care Activities

Activity	Total number of changes	Rank
Order an eggcrate mattress	58	1
Order soft restraints	57	2
Order oxygen	55	3
Perform suctioning	53	4
Change diet orders	51	5
Determine frequency of vital signs	48	6
Order repeat lab tests	47	7
Order nonprescription medications	43	8
Declare death	19	9
Write DNR order	6	10

write the order, 35 (59.3%) indicated that either nurses or physicians should write the order and 19 (32.2%) checked that nurses alone should write the order (Table 6). A total of 58 (69%) of the nurses changed their choices

when responding to who should write the order in comparison to who presently writes the order.

Table 6

Nurses' Reports of Who Presently Writes the Order versus Who Should Write the Order for 10 Selected Patient Care Activities

A. Order an eggcrate mattress.

<u>Who presently writes the order</u>	<u>Who should write the order</u>			Total
	Physician	Nurse	Either	
Physician	5	19	35	59
Nurse	0	2	1	3
Either	0	3	19	22

B. Determine frequency of vital signs.

<u>Who presently writes the order</u>	<u>Who should write the order</u>			Total
	Physician	Nurse	Either	
Physician	15	9	37	61
Nurse	1	0	0	1
Either	0	1	20	21

C. Order nonprescription medications.

<u>Who presently writes the order</u>	<u>Who should write the order</u>			Total
	Physician	Nurse	Either	
Physician	38	2	39	79
Nurse	1	0	0	1
Either	1	0	3	4

(table continues)

D. Order soft restraints.

<u>Who presently writes the order</u>	<u>Who should write the order</u>			Total
	Physician	Nurse	Either	
Physician	7	13	39	59
Nurse	1	2	2	5
Either	0	2	18	20

E. Change diet orders.

<u>Who presently writes the order</u>	<u>Who should write the order</u>			Total
	Physician	Nurse	Either	
Physician	23	9	41	73
Nurse	0	1	0	1
Either	0	1	10	11

F. Order repeat laboratory tests.

<u>Who presently writes the order</u>	<u>Who should write the order</u>			Total
	Physician	Nurse	Either	
Physician	30	6	40	76
Nurse	1	1	1	2
Either	0	0	6	6

G. Order oxygen.

<u>Who presently writes the order</u>	<u>Who should write the order</u>			Total
	Physician	Nurse	Either	
Physician	18	5	47	70
Nurse	1	0	1	2
Either	1	1	10	12

(table continues)

H. Write Do Not Resuscitate order.

<u>Who presently writes the order</u>	<u>Who should write the order</u>			Total
	Physician	Nurse	Either	
Physician	78	0	6	84
Nurse	0	0	0	0
Either	0	0	0	0

I. Perform suctioning.

<u>Who presently writes the order</u>	<u>Who should write the order</u>			Total
	Physician	Nurse	Either	
Physician	8	9	42	59
Nurse	0	3	2	5
Either	0	0	21	21

J. Declare death.

<u>Who presently writes the order</u>	<u>Who should write the order</u>			Total
	Physician	Nurse	Either	
Physician	66	1	18	85
Nurse	0	0	0	0
Either	0	0	0	0

The activity that ranked second for the most discrepancies was the ordering of soft restraints. A total of 56 nurses selected different choices in response to who should write the order for soft restraints versus who presently writes the order. Fifty-nine (70.2%) of 84 nurses reported that physicians presently write these orders and of those, 39 (66.1%) indicated that either

physician or nurses should write these orders and 13 (22%) checked that only nurses should write these orders. Two nurses indicated that either the doctor or the nurse presently writes the order, but only the nurse should write the order. In contrast, two nurses reported that only the nurse presently writes the order, but that either the doctor or nurse should write the order.

Another activity where a discrepancy was noted concerned the ordering of oxygen. Forty-seven of the 70 nurses who reported that physicians presently write this order, indicated that either group should be able to write the order for this activity. Five nurses indicated this was an activity that should be ordered only by nurses. Three other respondents changed their choice when responding to who should write the order in comparison to who presently writes the order. One respondent changed from "nurse" to "physician," one respondent changed from "either" to physician, and one changed from "either" to "nurse." Thus, a total of 55 (64.7%) nurses indicated a change in who should write this order.

Suctioning was the activity with the fourth highest number of discrepancies noted. Of the 59 nurses who reported that the physicians write the order for this activity, 42 (71.2%) indicated that this should be either a

physician or a nurse's order. In addition, 9 (15.2%) others checked that this should be a nursing order exclusively. Two respondents changed their choice from "nurse" to "either." Thus, a total of 53 (62.4%) of the 85 nurses made changes in their choice of the person who should write the order in comparison to who presently writes the order.

The activity with the least number of discrepancies noted was the DNR activity. Only 6 (7.1%) nurses made a different choice when listing who should write the DNR order. These nurses indicated that either the physician or the nurse should be able to write this order. In summary, there were 8 of 10 activities that more than 50% of the nurses indicated should be ordered by nurses, that are not presently ordered by nurses.

An additional subproblem of the study compared physicians' perceptions of who presently writes the order in comparison to who should write the order for the 10 selected activities. Although not as many discrepancies were observed for this group as in the nurses' group, there were some changes noted. The greatest number of discrepancies in the physicians' choices was in the area of ordering eggcrate mattresses (Table 7). Of the 29 physicians who responded that physicians presently write

the order, 22 (75.9%) indicated that either physicians or nurses should be able to write these orders (Table 8).

The second highest number of discrepancies for the physicians was again the same as for the nurses in ordering soft restraints. Of the 27 physicians who reported that physicians presently write this order, 18 (66.7%) checked that either nurses or physicians should write the order.

One activity that showed no difference when comparing the physicians' choice was the DNR activity. All of the physicians who responded to this item (33 or 100%) reported that physicians presently write this order and should write the order for this activity. Also 27 (87.1%) of the 31 physicians who responded that physicians presently declare death, reported that only physicians should do this. Table 7 presents the rank ordering of the number of discrepancies noted for each activity and Table 8 presents the data on the specific choices for the 10 selected patient care activities. In summary, there were only 2 of the 10 activities that the majority of the physicians indicated should be changed from only physicians ordering them to allowing nurses or physicians to order them.

Table 7

Rank Ordering of the Number of Discrepancies in the
Physicians' Reports of Who Presently Writes the
Order and Who Should Write the Order for
10 Selected Patient Care Activities

Activity	Total number of changes	Rank
Order an eggcrate mattress	22	1
Order soft restraints	20	2
Suctioning	16	3
Change diet orders	14	4
Order nonprescription medications	13	5
Order oxygen	10	6
Determine frequency of vital signs	8	7
Order repeat lab tests	7	8
Declare death	4	9
Write DNR order	0	10

Table 8

Physician's Reports of Who Presently Writes the Order
versus Who Should Write the Order for 10 Selected
Patient Care Activities

A. Order an eggcrate mattress.

<u>Who presently writes the order</u>	<u>Who should write the order</u>			Total
	Physician	Nurse	Either	
Physician	3	4	22	29
Nurse	0	0	0	0
Either	0	0	4	4

B. Determine frequency of vital signs.

<u>Who presently writes the order</u>	<u>Who should write the order</u>			Total
	Physician	Nurse	Either	
Physician	22	0	8	30
Nurse	0	1	0	1
Either	0	0	2	2

C. Order nonprescription medications.

<u>Who presently writes the order</u>	<u>Who should write the order</u>			Total
	Physician	Nurse	Either	
Physician	19	1	13	33
Nurse	0	0	0	0
Either	0	0	0	0

(table continues)

D. Order soft restraints.

<u>Who presently writes the order</u>	<u>Who should write the order</u>			Total
	Physician	Nurse	Either	
Physician	7	2	18	27
Nurse	0	1	0	1
Either	0	0	5	5

E. Change diet orders.

<u>Who presently writes the order</u>	<u>Who should write the order</u>			Total
	Physician	Nurse	Either	
Physician	19	1	13	33
Nurse	0	0	0	0
Either	0	0	0	0

F. Order repeat lab tests.

<u>Who presently writes the order</u>	<u>Who should write the order</u>			Total
	Physician	Nurse	Either	
Physician	24	1	5	30
Nurse	0	0	0	0
Either	1	0	2	3

G. Order oxygen.

<u>Who presently writes the order</u>	<u>Who should write the order</u>			Total
	Physician	Nurse	Either	
Physician	20	0	10	30
Nurse	0	1	0	1
Either	0	0	2	2

(table continues)

H. Write Do Not Resuscitate order.

<u>Who presently writes the order</u>	<u>Who should write the order</u>			Total
	Physician	Nurse	Either	
Physician	32	0	0	32
Nurse	0	1	0	1
Either	0	0	0	0

I. Perform suctioning.

<u>Who presently writes the order</u>	<u>Who should write the order</u>			Total
	Physician	Nurse	Either	
Physician	4	1	14	19
Nurse	0	2	0	2
Either	0	1	10	11

J. Declare death.

<u>Who presently writes the order</u>	<u>Who should write the order</u>			Total
	Physician	Nurse	Either	
Physician	27	0	4	31
Nurse	0	0	0	0
Either	0	0	2	2

Additional Findings

The questionnaire was designed to be answered with checkmarks. No essay answers were required. However, many of the questionnaires came back with written comments. The compilation of these comments are found in Table 9.

Table 9

Compilation of Written Comments

Physicians' Comments

- Nurses determine the frequency of vital signs on a prn basis.
- Nurses should have the freedom to increase the frequency of vital signs, but not decrease them.
- Nurses should be able to give non-prescription medications if categories of safe patients are established, i.e., not patients with organ failure, etc.
- Nurses should start only 2 liters of oxygen.

Nurses' Comments

- Nurse practitioners can do more than staff nurses.
 - In ICU we initiate the activity or make suggestions, then get the doctor's order.
 - Nurses can start oxygen in an emergency.
 - In my institution the nurse initiates and writes verbal orders for some of the activities but the physician later signs the order. In other words, a nurse may write the order initially (from the nurse's initiative), but it is always written as a verbal order.
 - RN and MD should write the DNR together.
 - RN initiates, but has to get an MD's order for the insurance company to pay for eggcrate mattress, non-prescription meds, soft restraints, lab tests.
 - Applying soft restraints, making diet changes, repeating lab tests, and starting oxygen are frequently done by nurses prior to or without receiving an order.
 - RN should start oxygen if a prompt MD response is not obtained.
-

Summary of Findings

The summary of findings is as follows:

1. The nurse respondents were predominantly 20-50 years old, Caucasian females, with less than 20 years experience in nursing. The majority (50%) had been in nursing for 6-15 years and 41.9% had Bachelor's degrees.
2. The physician population was predominantly Caucasian, male, MDs, 30-50 years old, with less than 15 years experience in their field.
3. For Hypothesis 1B, more nurses than physicians reported that either nurses or physicians write the order to determine the frequency of vital signs (chi-square = 6.17, df = 2, p = .05). Therefore Hypothesis 1B was supported.
4. For Hypothesis 1J, more physicians than nurses repeated that either nurses or physicians presently declare death (chi-square = 5.24, df = 2, p = .02). Therefore, Hypothesis 1J was supported.
5. For Hypothesis 2B, more nurses than physicians reported that either nurses or physicians should be able to determine the frequency of vital signs (chi-square = 25.98, df = 2, p = < .001). Therefore, Hypothesis 2B was supported.

6. For Hypothesis 2E, more nurses than physicians reported that either nurses or physicians should be able to change diet orders (chi-square = 11.33, df = 2, p = .004). Therefore, Hypothesis 2E was supported.

7. For Hypothesis 2F, more nurses than physicians reported that either nurses or physicians should be able to order repeat lab tests (chi-square = 15.17, df = 2, p = .001). Therefore, Hypothesis 2F was supported.

8. For Hypothesis 2G, more nurses and physicians reported that either nurses or physicians should be able to order oxygen (chi-square = 15.40, df = 2, p = .001). Therefore, Hypothesis 2G was supported.

9. The majority of the nurses identified 8 of the 10 activities that they presently do not order that they indicated they should be able to order. These included: ordering an eggcrate mattress, determining the frequency of vital signs, ordering nonprescription medications, ordering soft restraints, making diet changes, ordering repeat laboratory tests, ordering oxygen, and performing suctioning.

10. The majority of the physicians identified only 2 of the 10 activities that the nurses presently do not order that the physicians indicated nurses should be able

to order. These were: ordering an eggcrate mattress and ordering soft restraints.

CHAPTER V

SUMMARY OF THE STUDY

This chapter contains the summary of the study. The findings are discussed and conclusions and implications are presented. Finally, recommendations for further research are considered.

Summary

This nonexperimental, comparative study was designed to determine nurses' and physicians' perceptions of the independent role of the nurse, specifically in relation to 10 selected patient care activities. The accessible population of nurses consisted of nurses who listed medical/surgical as their area of practice when applying for licensure with the Texas State Board of Nurse Examiners. The accessible physician population was composed of physicians who practiced in the hospitals where the nurse respondents were employed. Questionnaires were sent to a random sample of 200 nurses. These nurses were each sent two additional questionnaires and were asked to distribute these to two physicians who practiced in the agencies where the nurses were employed. A total of 85 (45%) nurse and 34 (9%) physician questionnaires was returned by mail to the investigator.

The conceptual framework for this study was based on Biddle and Thomas' (1979) role theory. A questionnaire was developed to examine nurses' and physicians' expectations for the role of the nurse. Thus, a determination could be made concerning possible role conflict. The questionnaire contained seven demographic questions which were used for obtaining background information on the sample. The respondents were then asked to indicate who presently writes and who should write the order to initiate 10 selected patient care activities.

Comparisons were made to determine if there were differences in the nurses' and physicians' responses concerning who presently writes the order and also who should write the order for the activities. In addition, the number of discrepancies in the choice of who presently writes the order in comparison to who should write the order for the activities was determined for both the nurses and physicians in the sample.

There were differences found in all four areas addressed in the problem of the study, but to varying degrees. The least disagreement was found between the two groups in regard to who presently writes the order for the activities. For the most part, the nurses and physicians agreed that physicians presently write the orders

initiating the 10 activities. The greatest difference found between the two groups was in the area of of who should write the order to initiate the 10 patient care activities. The nurses, more so than the physicians, identified activities they believed should be initiated by either nurses or physicians. The activities where the greatest difference was found concerned determining the frequency of vital signs, ordering repeat laboratory tests, and starting oxygen on a patient.

Discrepancies were noted between who presently writes the order and who should write the order for the 10 patient care activities. The most discrepancies for both groups were noted in the ordering of an eggcrate mattress and ordering soft restraints. Many physicians and nurses indicated that nurses should be able to order these, while presently only physicians are allowed to write the order. The two groups also were similar when considering the activities where the least number of changes were made: ordering DNR and declaring death. They agreed that physicians presently order these activities and they should be ordering them.

Discussion of the Findings

The findings of this study indicate that there is disagreement among and between nurses and physicians

concerning the independent role of the nurse. Therefore, role conflict may exist for many nurses. Not only may there be role conflict because of disagreement between nurses and physicians, but role conflict may also exist because nurses do not agree among themselves concerning what activities are independent nursing functions. To a lesser degree some of the physicians may be experiencing role conflict. They disagreed among themselves and with nurses concerning some of the activities. It appears that some doctors may experience difficulty in accepting the independent role of the nurse.

Role conflict is said to occur when two or more sets of expectations are operating at the same time (LaRocca, 1978). This appears to exist for many subjects in the sample. The results of role conflict according to LaRocca (1978), is tension and anxiety. Tension and anxiety produced in this situation can prevent nursing from moving toward an autonomous profession. Collaboration is needed between nursing and medicine concerning the evaluation and possible redefinition of the nursing role. Before this can be done, however, it will be necessary for the nursing profession to examine itself. Nurses need to reach agreement on the role they wish to take on before they can negotiate with the physician.

Each of the 10 activities will be addressed separately when comparing the study data to information found in the literature. Those activities for which no discussion or controversy was found in the literature will be addressed first, followed by those activities where controversy exists in the literature concerning who should have the authority to initiate these activities.

No information was found in the literature concerning a controversy for four of the activities. These activities are: ordering an eggcrate mattress, ordering diet changes, ordering repeat laboratory lab tests, and suctioning a patient.

Eggcrate Mattress

Literature was not found addressing the issue of who does or should apply eggcrate mattresses. However, this was one of the activities found to have the greatest number of differences between who the two groups reported presently write the order and who should write the order. The two groups basically agreed that physicians presently write the order, but that either one should be able to write the order. This raises the question: Why do nurses not order eggcrate mattresses, if the physicians and nurses agree they should? This may be linked to the historical role of the nurse and the tradition of

subservience cited by Kalisch and Kalisch (1977). Since the physicians have always ordered them, they continue to order them. Or, as suggested by one of the comments written on one of the questionnaires, it may be the problem of getting insurance companies to pay for things that nurses order.

Diet Changes

The literature also did not identify a controversy in the area of ordering diet changes. In this area there was again a large difference in the number of times nurses responded that physicians presently write the order in comparison to their response that nurses should also be able to write this order. A smaller number of physicians indicated a change in who writes the order versus who should write the order, but approximately 42.4% of them indicated that nurses should be ordering diet changes. The issue of third party reimbursement does not apply in this case, so another answer must be sought as to why nurses are not making diet changes. Again, traditional roles probably play a part in this area. Physicians have always been the ones responsible for ordering a patient's diet.

Repeat Laboratory Tests

The literature does not address this issue, but the findings of this study document some difference in nurses' and physicians' views on this activity. Both groups agree that physicians presently write these orders and the majority of the physicians reported that physicians should write the order. However, 64.3% of the nurses responded that this should be a function of either nurses or physicians. It is possible that more physicians and nurses would say that it could be a decision made by either group if there was more support from insurance companies for nursing orders.

Suctioning

This was one of the activities where both groups showed differences between who they report presently writes the order and who should write the order. The majority of the nurses and physicians agreed that suctioning should be ordered by either group. This is probably why nothing was found in the literature as far as controversy on this issue. More than any other activity in the study, the two groups were in agreement on the issue of suctioning. However, as one respondent wrote, it may take a physician's order to get the third-party reimbursement for the supplies.

Information about six of the activities was found in the literature. These activities were: determining the frequency of vital signs, ordering non-prescription medications, ordering soft restraints, ordering oxygen, write DNR order, and declare death.

Vital Signs

The disagreement found between the two groups in this study is comparable to what was found in the review of the literature concerning vital signs. An overwhelming majority of the nurses reported that nurses alone or either nurses or physicians should be able to order the frequency of vital signs. On the other hand, two-thirds of the physicians indicated this should be a physician's decision only. One physician's written comment suggested that nurses should be able to take vital signs more frequently, but not less frequently. This is consistent with what the Hospital Law Manual (1986) stated is legal. This may be the crux of the problem. Nurses are charged with taking vital signs more frequently if the patient's condition warrants it, but they are not credited with the ability to determine when vital signs need to be taken less frequently. The nurses in this study obviously agreed that nurses should be in a position to manipulate the environmental factors that affect their patient's

well-being. The monitoring of vital signs is definitely something that can contribute to a patient's well-being, whether it be to take them more often in an emergency or to take them less often to insure that the patient receives a good night's sleep.

Nonprescription Medications

Both groups were divided on the issue of nonprescription medications. They agreed that physicians presently order nonprescription medications, but neither group had a majority of responses indicating that it should be either the physicians' or the nurses' decision. The two groups were almost equally divided between saying that it is a physician's decision and saying that either physicians or nurses should be able to decide. This activity is very indicative of role conflict among the nurses due to the differing sets of expectations within the groups.

This activity also had the most comments written in by the respondents, which might help identify why this is a controversial issue. One physician proposed that guidelines be set up restricting the types of patients for which nurses could write orders. A nurse explained in a comment that only nurse practitioners should be allowed to write prescriptions, suggesting the need for higher education before expanding the role of the nurse.

Stilwell's (1988) division of medications touched on this issue. She proposed a category of "prescription only" medications that only nurse practitioners could give. The nurses' comments that they frequently carry out some of these activities and later obtain a physician's order, also supports Stilwell's argument that nurses be given the legal right to do what they are, in many instances, already doing.

Application of Soft Restraints

The findings on this issue are interesting because it is the one activity that a portion of both nurses and physicians responded should be an exclusive nursing decision. The majority of subjects in the two groups did agree that either nurses or physicians should write the order for soft restraints, but the portion that responded that it should be a nursing decision only was greater for this activity than any other. It appears that resistance to nurses writing this order would not be great by physicians. The findings in this study support those of Strumpf and Evans (1988) whose study found the decision to apply soft restraints almost a sole nursing responsibility. Because both groups indicated that the physicians write the order for restraints, it may be that hospital policies where they practice require a physician's order for this

activity. It may also be the result of insurance company requirements for reimbursement purposes.

Ordering Oxygen

According to the Hospital Law Manual (1984), the administration of oxygen is under the sole jurisdiction of the physician. A surprising finding from this study was that 12 nurses and 2 physicians responded that presently nurses or physicians may order oxygen. The comments written in that nurses should be allowed to order oxygen in an emergency may explain this. It may be acceptable to their hospital policies that nurses start oxygen in intensive care units or in cardiac arrest situations. This may also explain why 12 of the physicians responded that either nurses or physicians should be allowed to order oxygen. The majority of the nurses indicated that they should also be able to make this decision. However, the nurse's role is still unclear and undefined in this area and needs to be clarified.

Do Not Resuscitate

This was the activity where the most agreement between the two groups was found. Both agreed that physicians presently write and should write DNR orders. This is probably linked to the tradition that this has always been

the physician's decision. Unfortunately, the real controversy identified by both Yarling and McElmurry (1983) and Martin and Redland (1988), concerning who should participate in the DNR decision, was not really addressed in this questionnaire. Instead of asking who writes/should write the order for DNR, it may have been more helpful to ask who should participate in the decision. What is really surprising in light of the review of literature and the other findings in this study, is that six nurses and one physician indicated that nurses should be able to write a DNR order.

Declaration of Death

The findings from this study indicated that the majority of the physicians and nurses reported that not only do physicians presently make this decision, but they should be making this decision. This is contrary to what was found in the literature. Legislation has been passed in New Jersey and has been proposed in other states (including Texas) that nurses be able to declare death. According to Reinhard and Aughenbaugh (1985), nurses have been declaring death every time they call a physician to pronounce a patient dead. One of the comments on one of the questionnaires stated that the law mandated who could declare death. This may be why neither group responded

that nurses should be able to declare death. The legal restraint may have influenced their answers.

Conclusions and Implications

The following conclusions have been made based on the findings of this study:

1. Nurses and physicians have a similar perception of the present role of the nurse concerning selected patient care activities, but they disagree on what this role should be.

2. Because many nurses perceive that they should be able to order many patient care activities that are currently being ordered by physicians, role conflict may exist for many nurses.

3. Nurses may need assistance in dealing with the role conflict indicated by the study results.

The following implications are based on the conclusions of the study:

1. Institutions need to be made more aware that many nurses have role conflict. This conflict may influence retention of nurses.

2. The health care system needs to consider changing hospital policies concerning these activities in order to reduce the nurses' role conflict.

3. The legal system needs to consider changing the laws governing those activities which nurses are qualified to regulate, in order to reduce the nurses' role conflict.

Recommendations for Further Study

Based on the findings in this study, the following recommendations for further study are offered:

1. The study should be replicated using a larger physician sample size and expanded to nurses in other settings.
2. An exploratory study should be undertaken to examine the specific reasons given by nurses and physicians for the nurse's role in determining various patient care activities.
3. A study should be undertaken to examine how the legal system and third party payment affect/restrict nursing activities.
4. Further study into the sources and solutions for role conflict between nurses and physicians should be done.
5. A study should be undertaken to actually measure the amount of role conflict experienced by nurses.

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APPENDIX A

Human Subjects Review Committee Form

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING

PROSPECTUS FOR THESIS/DISSERTATION/PROFESSIONAL PAPER

This prospectus proposed by: Rosemarie R. Rayl

_____ and entitled:

Decision to Initiate Selected Patient Care Activities:
Nursing Decision Versus Physician Decision

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 it is classified as Category I research.

_____ Requires Human Subjects Review Committee review
because _____

Research Committee:

Chairperson, Roxanne M. Nequigadony

Member, Susan Good

Member, Shirley M. Fiegler

Date: July 6, 1989

Dallas Campus x Denton Campus _____ Houston Campus _____

APPENDIX B

Graduate School Permission Letter

TEXAS WOMAN'S UNIVERSITY
 DENTON DALLAS HOUSTON
 THE GRADUATE SCHOOL
 P.O. Box 22479, Denton, Texas 76204 817/896-3400, 800-338-5255



August 28, 1989

Ms. Rosemarie R. Rayl
 4228 W. Pioneer Dr., #1074
 Irving, TX 75061

Dear Ms. Rayl:

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. Helen Bush

APPENDIX C

Cover Letters to Nurses and Physicians

Dear Nurse:

Hello, my name is Rosemarie Rayl. I am a graduate nursing student at Texas Woman's University in Dallas. I am conducting a study as part of the requirements for completion of a graduate degree in nursing. The purpose of the study is to examine nurses' and physicians' perceptions of the independent role of the nurse.

Your name has been selected from a list of medical/surgical nurses whose names were on a list of the State Board of Nurse Examiners. You are being asked to complete the enclosed questionnaire and return it in the pre-addressed stamped envelope provided. I am also asking the nurses who participate in this study to give two other questionnaires to physicians they work with. Physicians may not be as interested as nurses are in this study. Therefore, in order to ensure an adequate sample size of physicians, I am asking that you give questionnaires to two physicians. Both nurses and physicians are being asked to participate in this study because of the overlapping areas of practice between the professions.

There are no foreseeable risks involved in participating in this study, and participation is voluntary. By participating in this study, you will be

helping to define more clearly nurses' and physicians' perceptions of the role of the nurse.

Before completing the questionnaire, please review the enclosed list of definitions for the 10 selected patient care activities chosen for this study. The 10 patient care activities that you are being asked to consider have been selected because there is some controversy in the literature as to who should write the order to initiate them. After reviewing the list of definitions, fill out the accompanying questionnaire which should take no more than 10 minutes. For each of the listed 10 patient care items you will be asked to indicate who presently writes the order in the institution where you practice now and, in your opinion, who should write the order.

If you would like to participate in this study, please complete the questionnaire and mail it in the enclosed envelope within 10 days of receiving it. If you have any questions about the study, please contact me at the address on the return envelope or call me collect at (214) 790-7172. If you would like to receive the results of this study, you may send a postcard or letter separately to the address on the return envelope.

Your participation is greatly appreciated. Thank you
for your time and attention.

Sincerely,

Rosemarie Rayl, R.N., B.S.N.

Dear Physician:

Hello, my name is Rosemarie Rayl. I am a graduate nursing student at Texas Woman's University in Dallas. I am conducting a study as part of the requirements for completion of a graduate degree in nursing. The purpose of the study is to examine nurses' and physicians' perceptions of the independent role of the nurse.

You have been given a questionnaire by a nurse who works on a unit where you practice. You and the nurse are both being asked to complete and return the questionnaires provided. I am sending questionnaires to physicians as well as nurses because of the overlapping areas of practice between both professions. Your input on the role of the nurse is very valuable in helping the nursing profession more clearly define its area of practice. There are no foreseeable risks involved in participating in this study, and participation is voluntary.

The questionnaires are not marked or coded in any way and your responses will remain completely anonymous. Before completing the questionnaire, please review the enclosed list of definitions for the 10 selected patient care activities chosen for this study. The 10 patient care activities that you are being asked to consider have been selected because there is some controversy in the

literature as to who should write the order to initiate them. After reviewing the list of definitions, fill out the accompanying questionnaire which should take no more than 10 minutes. For each of the listed 10 patient care items you will be asked to indicate who presently writes the order in the institution where you practice now and, in your opinion, who should write the order.

If you would like to participate in this study, please complete the questionnaire and mail it in the enclosed envelope within 10 days of receiving it. If you have any questions about the study, please contact me at the address on the return envelope or call me collect at (214) 790-7172. If you would like to receive the results of this study, you may send a postcard or letter separately to the address on the return envelope.

Your participation is greatly appreciated. Thank you for your time and attention.

Sincerely,

Rosemarie Rayl, R.N., B.S.N.

APPENDIX D
Questionnaire

COMPLETION AND RETURN OF THIS QUESTIONNAIRE WILL BE
CONSTRUED AS YOUR INFORMED CONSENT TO ACT AS A SUBJECT
IN THIS STUDY.

Demographic Data

Please check the category that applies to you:

1. Age:

- ☐ 20-30
- ☐ 31-40
- ☐ 41-50
- ☐ 51-60
- ☐ > 60

2. Years of experience as a practicing nurse/physician:

- ☐ 0-5
- ☐ 6-10
- ☐ 11-15
- ☐ 16-20
- ☐ 21-25
- ☐ > 25

3. Area of current practice, i.e., medical, surgical, ICU, rehabilitation, etc. Please specify:

4. Gender:

- ☐ male
- ☐ female

5. Ethnic background:

- ☐ Caucasian
- ☐ Hispanic
- ☐ Black
- ☐ Asian
- ☐ other _____

6. Profession:

- ☐ nurse
- ☐ physician

7. Educational Background:

If you are a nurse, please answer the following:

- ☐ diploma
- ☐ Associate degree
- ☐ Bachelor's degree
- ☐ other _____

If you are a physician, please answer the following:

_____ M.D.

_____ D.O.

_____ other _____

Description of Selected Patient Care Activities

1. Application of an eggcrate mattress--putting a foam covering on a bed as a protective device to prevent skin breakdown.
2. Frequency of vital signs--determine how often blood pressure, temperature, pulse, and respirations are taken on a patient, i.e., every 4 hours, 8 hours, etc.
3. Nonprescription medications--any medication such as Tylenol, Maalox, Milk of Magnesia that can be obtained legally without a physician's order.
4. Soft restraints--foam and/or cloth pads with attached ties applied to wrists and ankles for the purpose of preventing falls/self harm.
5. Change diet orders--change the consistency of food, i.e., liquid to soft or regular to mechanical soft; not to include calorie restrictions/salt restrictions.
6. Abnormal lab values--any laboratory findings of urine, stool, or blood samples that fall outside the range listed as normal in each institution where those surveyed practice.
7. Start oxygen--administration of oxygen either by nasal cannula or mask on a patient not previously on oxygen.
8. Do not resuscitate--withholding mechanical chest compressions, artificial respirations, and/or emergency drugs and electric shock on a patient with a terminal illness when they experience respiratory or cardiac arrest.
9. Suction a patient--removal of secretions by mechanical means from the mouth, throat, nares, or thracheostomy with the use of plastic catheters and suction machine.
10. Declare a patient dead--determine the cessation of life, no heart beat, respiration, or blood pressure. Does not include determination of cause of death.

COMPLETION AND RETURN OF THIS QUESTIONNAIRE WILL BE CONSTRUED AS YOUR INFORMED CONSENT TO ACT AS A SUBJECT IN THIS STUDY.

Questionnaire Concerning Patient Care Activities

For each of the 10 patient care activities listed below, please answer each question by placing a check mark in the appropriate box.

- A. In your institution, who writes the order to initiate each patient care activity? (physician, nurse, either physician or nurse)
- B. In your opinion, who should write the order to initiate each patient care activity? (physician, nurse, either physician or nurse)

A. Person who writes
the order to:

B. Person who should
write the order to:

Physician	Nurse	Either		Physician	Nurse	Either
			1. Apply an eggcrate mattress on a patient's bed.			
			2. Determine the frequency of vital signs.			
			3. Give nonprescription medications.			
			4. Apply soft restraints on a patient.			
			5. Make diet changes.			
			6. Order repeat lab tests when abnormal values are found.			
			7. Start oxygen on a patient.			
			8. Write a do not resuscitate order.			
			9. Suction a patient.			
			10. Declare a patient dead.			