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Roodbol, Petrie

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Summary

The following thesis evaluates the study of nurses and physicians on how they divide their work responsibilities and also makes recommendations for new ways to structurally rearrange work tasks. This thesis also suggests the way to implement new functions or professions, which are necessary to divide the line between the nurse and physician domain. The above topics are currently being discussed and are relevant to the issues facing the Dutch health care system. The theoretical framework utilized is Abbott's vision (1988) of the System of Professions: an Essay on the Division of Expert Labour which contains a mix of comparative historical analyses and current evaluation. The theory is assembled within an analytical model which looks at professions from the viewpoint of their jurisdictions, the tasks they do, the expert knowledge needed for those tasks, and how competitive forces internally and externally work to change both the jurisdictions and their tasks. Abbott substantiates his paradigm based on narratives, a research approach that reviews the historical context and the contingencies. Throughout this underlying study the two narratives are described. The first narrative is a historical analysis of the relation between physicians and nurses (chapter 3), and the second deals directly with the way the nurse practitioner (NP) position was implemented in the Netherlands, as a nurse (RN) with traditional medical tasks (chapter 4 and 5).

Historical analysis

The development of nursing as a profession at the end of the 19th century was influenced by social changes, Napoleonic wars, industrialisation and the "reveal" movement. Up until that time female labour for a salary was strictly forbidden. Soon a domain conflict arose.

Physicians considered the rise of nurses as competition with medicine and attempted to gain control over their work by making nursing part of their profession. In their attempt to try and subject nurses to their standards, physicians were assisted by the laws that were currently in place. The WUG (1854) forbade anyone, including nurses, from the practice of medicine by non-physicians. This law ultimately created a hindrance to move medical procedures to nurses. Although physicians were not exactly pleased by the rise of nursing, it was tolerated because of the revolutionary development of medicine and the need for capable helpers.

New procedures, which are done by physicians, such as taking a temperature, blood pressure measurement, giving injections, oxygen saturation measurement, or dialysis, are eventually delegated to the nursing domain once the risks of a procedure are well known and technology has simplified the task. Medical procedures done by nurses are ruled by judgement and jurisprudence in a so called "extended arm construction." The physician is responsible for the indication and correctly formulated orders. The nurse is responsible for correct execution of physician orders. During the execution the physician has to be on location to interfere when needed. The extended arm construction results in two opposing views, on one hand the nurse evolves more as an assistant to the physician and on the other it induces a need for independence and a search to acquire their own identity. Nurses desire to have their own demarcated autonomous domain with procedures and expertise of their own.

In the early seventies, similar to the USA, nurses in our country began a process of professionalization. The distinguished mark of this process is a struggle for the improvement in quality of care, and a transition towards autonomy; independent judgement, and acting based on social scientific knowledge and methods. Traditionally, basic nursing care is made problematic so there is a need for special expertise.

Considering the effort towards their own professional identity, it is not surprising that between 1970 and 1990 a large number of reports and recommendations about the character of nurses

have appeared. For the first time in history the nursing domain is formalized. In 1978 the Central Advisory Board for National Health Care describes the professional tasks of nurses as follows:

- Tasks for the continuing observation and assistance of the patient while on duty;
- Tasks for nursing and care of their patients;
- Tasks ordered by physicians within their medical domain referring the diagnostic and therapeutic activities of physicians.

The report highlights the point of view that nurses are required to do procedures related to the execution of physician orders, but allows nurses to have their independent domain, as well as a recognized profession.

During the late seventies and early eighties, there was a change in the conflict between physicians and nurses. The change resulted in the implementation of primary nursing as an organizational model, which was utilized to divide work among nurses. Physicians eventually loosened their dominant position on the wards and both professions withdrew into themselves and separated from each other more and more. As a result of this, both professions now have their own records, protocols and developments without any common interactions.

The implementation of the NP

The Nurse Practitioner (NP) was implemented in the Netherlands at the end of 1997. The implementation was originally meant to be an answer to several human resource problems: a shortage of physicians, the need for continuity and coordination between patients and healthcare workers, and the lack of career possibilities for nurses.

There has been no struggle, and the implementation of the NP role has been virtually noiseless. Physicians are responsible to precept and supervise “their” own NP’s, and the NP’s are dependent on the physicians for their training. The physician must give the responsibility for care of his patients to the NP, and in return the NP is restricted in her independence to NP functions. In fact the NP is a part of medical science, strengthened by a lack of legislation. Why give nurses the initiative to take over medical tasks of the professional groups which have dominated them for ages? Which factors are influencing?

With the help of cross-sectional descriptive research, along with a combination of quantitative and qualitative elements, the first question was developed and asks, what the NP’s real contribution to the medical care of patients is? The sample size consisted all the 35 NP’s of our country of that moment, 25 junior doctors, 20 clinical nurse specialists and 15 nurses (n=95). With the help of a so called multi-moment observation method every person was observed during 4,5 hours. Each activity was notified at random with the average of every five minutes. In total 5130 activities are observed.

The content of the study evaluated a selected group of somatically ill patients, in which the NP appears to be capable of providing the same contributions to the medical care of patients as the junior doctor in the role of ward physician, and during surgery in the outpatient department. The time contribution of NP’s toward direct medical care of patients on the wards is the same amount as the time spent by nurses (RNs), and even higher than the time spent by junior doctors. The NP takes care of more patients and spends more time with each patient than the junior doctor. In the outpatient department, the contribution in time to the direct medical care for patients is as high as the junior doctor and the clinical nurse specialist. However in that setting, the NP sees fewer patients than the junior doctor and requires twice as much time for each patient intervention.

The percentage of time spent in communication with patients is significantly higher than the junior doctor and RN and the focus of the communication for the NP and patient interaction is

on self-management. Junior doctors are very willing to attend to patients, but not spontaneously; as they require a question from the patient to initiate an interaction.

It appears that the continuity of patient care is better guaranteed with a NP than with a junior doctor or RN. It also appears that a NP needs less supervision than a junior doctor as well as needs less time for education.

Internal forces which influence the structural division of tasks appear to be the difference in strategies pertaining to ways of identifying management, in regard to acceptance, estimation and expectations. I was able to deduce this from the data collected for research, which looked at the effect by NPs on the organisation and effectiveness of care. The research study was an explorative study in two parts, a survey with a 74% response (n=106), and a qualitative comparative case study. There was a selection from the responses of 12 cases from different regions. For each case the NP, the medical specialist, the nursing manager and a nurse who were involved, were interviewed. Each NP was observed during ten hours.

Nurses experienced group deprivation regarding physicians. Physicians attributed a positive effect to the NP on the social identity of nurses. Unfortunately nurses themselves do see this and do not accept the NP as part of their professional group. While the NP position was developed to combine medical with nursing tasks, it appeared that the dissention among nurses was mainly related to the experience impoverishment within their work environment as a result of the implementation of the NP role. Nurses seem to be intimidated by a new professional group which subordinates them.

The NP role in itself appears to be evenly integrated in both the nursing and medical profession. When the nursing profession does not adopt the NP role and the NP's perception of their role appears unchanged from the RN role, than there is a high probability that the NP will assimilate more toward the medical profession and ultimately create a sort of self-fulfilling prophecy for nurses. Currently the NP seems to lean more toward medical culture rather than the nursing culture, most obviously symbolized by the wearing of the medical uniform. The NP seems to be more interested in increasing their identity by individual social mobility, and with more support from the nursing profession, there is a chance for social competition that may ultimately favour the nursing profession. However there is little chance that physicians will recognize the NP role in its full value to their profession. This is demonstrated in certain behaviours by the medical profession, such as contradictions in the acceptance of the NP role and barely speaking of the work that the NP does. The development of the NP is restricted by contradictory expectations. On one hand the NP must be a nurse, but on the other, they are not accepted by nurses. Conversely, the NP functions as well as the junior doctor, and demonstrates similar qualities in their profession as in the role of the junior doctor.

Although the government has attempted structural rearrangement of tasks, it is yet to be successful within the practice setting. Physicians delegate tasks to NP's but remain owners of the tasks. The doctors delegate well defined patient categories to NPs, that encompass distinguished marks like "treatment by protocol" and sometimes also with an emphasis on need for attendance, careful planning, coordination, or specific motor skills. Frequently delegated patient categories to NPs include oncology, chronically ill, heart failure, post partum care and pre and postoperative care for thorax surgery and neonates.

Like the specialized RN, the NP has to do frequently request medical procedures which have been simplified with the help of the technique and by research, above all in acute pain management. Patients with simple or non-complicated trauma's who are relegated to the

emergency department are often helped by an NP instead of a general physician or family doctor. Patient selection is the main mechanism for legitimate delegation of tasks, as well as additional education, treatment protocols, supervision and separation of diagnostic and treatment regimen. Motivation of physicians for this role is primarily derived from the low status of the labour pool and because of the willingness to offer nurses a new career perspective.

The tasks that NPs want to take over from physicians are not flashy and actually appear to be a bit rudimentary. Rather, the NPs seem to aspire more to a career perspective and to become independent in function, along with improved continuity and quality of care. In order to accomplish this, they are willing to do basic medical tasks. There appears to be a paradox, because the NP seems to gain her autonomy by becoming more dependent on the physician, rather than the function of the RN, who has struggled since the seventies for professionalization and independence from the physician. Legitimizing the taking over of medical tasks by nurses is realized by the acceptance of a function as a NP. Motivation is realized by the endeavour for quality and continuity of patient care but above all by their own ambition for independent functions and career perspective. This theory is not always synonymous with an increase in salary, but more importantly to increase the social identity of the NP role.

The current discussion about structural rearrangement of tasks has been stimulated by the Government and the HBO. RNs want to have their HBO Masters Degree in Advanced Nursing Practice, which requires them to be a NP and to work in a new position. The NP's are supported by management and physicians within the organization to realize their interests, and in return a solution for the shortage of physicians appears to be an advantageous by-product. For government, the rearrangement of tasks arises from the expected shortage of physicians, although this theory does not appear to be an argument in practice for either the management or physicians. The interest of nurses is decisive.

How does one characterize clearly the domain of nurses and physicians? Traditionally the nurses' labour can be characterized with care, and the physician with cure. Nurses primarily focus on problems related to disease, fundamental vital functioning and the treatment or care. Physicians focus on the healthcare problem itself; with the perspective on cure. With that in mind the starting point for nurses is the consequences of illness and for the physician, it is the illness itself. However the consequences of illness, the focus for daily vital functioning is to restrict the disease by treating the disease itself. The nurse executes a part of the treatment prescribed by the physician, for example administration of a medication, and therefore the treatment of diseases can not be considered without consequence to the treatment. The aim of a treatment is to cure the patient or to restrict the consequences. The consequences of the treatment regimen are an issue for the physicians' attention as well. One must consider if the remedy is worse than the disease? Based on the WGBO (the law of the medical treatment agreement, 1995), the physician must give the patient clear and concise information about their disease, the proposed treatment plan and the risks and consequences associated with the treatment regimen. Although the starting point for nursing and physicians are different, in theory there is an overlap in the work that they do. Regardless of the nurses' pursuit for their own demarcated autonomous domain, the traditional borders between the work of nurses and physicians remain blurred. The frequently needed medical procedures for the cure of patients are eventually simplified and ultimately delegated to nurses.

In Africa lives a species of bird called honey guide ("Indicator indicator") which works in cooperation with a small animal called the honey badger ("Melivora capensis"). They both love honey. The bird knows where to find the honey, but is not capable of digging it out. The honey

badger is a very good digger but is not skilled in locating the honey. When the honey badger enters the territory of the honey guide, the bird makes a special noise that leads the way to the honey. The honey badger begins digging and eventually they both enjoy the honey that they love so much (Attenborough, 1999).

The nurse is capable to function as the guide and as an observer the nurse is capable of spotting healthcare problems. The physician is adept at uncovering the healthcare problem. Together they work in unison to treat the patient. Some guides are capable of digging a bit as well, like the NP. However some problems are too complicated, so a physician is needed for diagnosis and intervention. Ultimately, they work together to help the patient.

To create harmony between the domain of physicians and the nurses, it is imperative that they start by communicating with each other on both a strategic and operational level. Both professions are separated from each other and each follows his own course. There is no continuity or overlap of work tasks regarding the patients care. It is possible to improve the situation by demonstrating the dependency of both professionals, but physicians and nurses are restrained from communicating with each other about the organization of healthcare because of the two divided domains. When in reality there is only one domain and that is the domain of the patient.

Currently, the NP role functions with traditional medical tasks, like physical assessment, but was developed with a nursing point of view. The discrimination of professions by tasks is very difficult. The context of these tasks seems to be a better alternative.

Based on the study there are two main problems with the implementation rearrangement of tasks. First of all there is a big difference between what the government views the professions functions to be and what actually happens in the practice setting. Regardless of the governments' concern for the impending shortage of physicians, the NPs desire for their own career objectives appears to stimulate the rearrangement of tasks. In this cases neither medical specialists, nurses, nor managers feel responsible for the staffing problems of physicians, and even though tasks associated with the physician role may be structurally rearranged and delegated, the physician still remains the owner of the task. It appears that the NP does not work to change their domain or try to gain ownership of the tasks, nor do they try to integrate the delegated tasks into their professional realm.

Secondly we must ask the question of whether or not we need the rearrangement of tasks on a large scale. Physicians and nurses do not desire to perform work tasks that compliment the other profession, and both professions continue to forge ahead with their own independent goals. Along the way the work is strictly divided into the two realms. NP's appear to be used by physicians for RN tasks. One must ask themselves if there really is a shortage in the capacity of physicians. Is it possible that the productivity would increase if there was better utilization of each profession? There is a need for discussion to examine these concepts and determine what the best route to take is. Rearrangement of tasks implies a formal job description of both professions. If tasks are to be divided but strict separation of tasks is nearly impossible, than one must consider if trying to resolve this dilemma will worsen the current situation.

One of the conclusions of this study is that the domain of physicians and nurses should not be strictly separated. A new function which borders on both the nursing and physician domains would in essence encompass tasks from both of the domains. The NP role is located a bit more on the medical domain than the RN domain. That is primarily because of the goal in creating NP functions was to provide a solution for the shortage of physicians. It appears that the NP in the role of ward physician, or in the outpatient clinic during surgery, is capable of providing care for

a selected group of patients as effectively as the junior doctor. Therefore an improvement in the continuity of care can be realized with the participation of a NP. It appears to be certain that the problem with the physician shortage can be solved by utilizing NPs. Utilization of NP's can offer even more. Physicians and nurses need to communicate with each other. The NP can act as a catalyst to enhance that communication. The NP is expertly suited to bridge the gap between nurses and physicians.

The rise of the NP role might be the very thing to restore the relationship between nurses and physicians, with the understanding that a number of conditions will be fulfilled:

- The nursing profession must adopt the NP concept
- The NP role must have the approval of the medical profession
- Not rearrangement of current tasks, but instead the division of patient categories
- It is important to take caution in the reorganization of patient categories to either medical or nursing exclusively. From many perspectives both disciplines are capable of improving the care and cure of patients in collaboration with each other. However there is an overlap between the two professions
- The defining and rearrangement of tasks must be done at a theoretical level
- Job description of the NP on a national level.

The results of this study make clear that exploration for a clear and concise demarcated domain for both physicians and nurses will end a long-lasting conflict and the lack of communication between the two professions.

Since physicians and nurses have had a long standing domain dispute, it might be best if there appeared to be a willing o'-the- wisps and a domain for both professions. The attempt by medicine to take over nursing was a stumbling run that caused the nursing endeavour to autonomy. By closing the borders or by levying tolls on one another's profession, only causes the professions to isolate and withdraw, and ultimately separate more and more. However, the lines are not rigid. They are song lines. Like a song that very slowly transforms, each line into the next, very subtle, but prescribed by the context. Only optimum collaboration will make the healthcare healthy.

Abbots paradigm is upheld by the first narrative. Professions are interdependent, competitive systems struggling for jurisdictions of their tasks and their domains. In the second narrative there is no competition between the two professions. The implementation of the NP role, a nurse with traditional medical tasks, has been virtually noiseless. May be it is too early to analyse this case with Abbott's model. Alternatively there is a possibility for division and amalgamation. A part of the nursing professions is seceding and merges with the medical professions. Amalgamation and division are by Abbott well-known mechanism.

A new, not yet written supplemented to Abbots vision strategy may be an other possibility. First the NP infiltrates in the medical domain and continues with the jurisdiction of the domain. So far there is no indication for such a strategy.