ABSTRACT

Previous research has suggested that critical care nurses’ close and prolonged contact with patients places them in a unique position of improving patient outcomes and reducing the demand on critical care beds by detecting subtle signs of deterioration in a timely manner and identifying patient progression and readiness for less intensive care. Nonetheless, nurses rarely take decisions about patients’ treatment modalities on their own, and constantly need to seek advice or authorisation. Indeed, several studies suggested that one of the most frequent decisions taken by nurses during clinical practice is that of referring to medical, nursing or other health care practitioners. However, there is very limited research around the factors related to, and the actual process of, such referring. In view of this gap in the literature, the purpose of this study was to explore and explain the process of referring in the context of an intensive care unit by means of a substantive theory derived from the data. The principal research question was: What are the factors associated with critical care nurses’ decisions to seek help from medical practitioners?

The study took place in a general intensive care unit in a state hospital in a Mediterranean island nation. Data generation and analysis took place concurrently and iteratively, and were guided by the dimensional analysis approach to grounded theory. Data collection involved: (1) twenty hours of preliminary non participant observation; (2) fifty hours of participant observation and informal interviewing; (3) fifteen hours of formal semi-structured interviews with ten critical care nurses working in this unit selected by means of purposive and theoretical sampling; (4) two 2-hour focus group sessions aimed at enhancing theoretical sufficiency and verification of the emerging substantive theory. The analytical process was characterised by a series of inductive-deductive cycles, during which increasingly conceptual labels were attached to data segments. Working hypotheses and theoretical memos were used to interrogate the data and look for positive and negative evidence for the inductively derived labels.

The findings suggest that nurses’ decisions to seek help from doctors are complex and frequently mediated by individual or organisational factors which are unrelated to the actual clinical situation, such as experience, assertiveness and willingness to take risk. They involve nurses weighing up several occasionally conflicting motivators, including a desire to act with some degree of independence; attempting to prevent personal and professional risk; and being constantly mindful of their asymmetrical decision making power relative to doctors. A central consideration is that of balancing their moral obligation to safeguard critically ill patients’ interests with their duty to respect medical practitioners’ preferences. Subsequently, nurses find themselves in a position of dual agency as they need to concurrently act as an agent to two different principals, namely the medical practitioner and the patient, a situation which is potentially morally distressing.

The emergent substantive theory underscores the significance of the nurse’s role in acting on behalf of the patient in a scenario of significant patient vulnerability; the factors that enhance, mediate and potentially suppress this advocacy role; and the interrelatedness of nurses’ relationship with doctors and their effectiveness in safeguarding critically ill patients’ interests. Subsequently, the study should provide valuable insight into the type of leadership and education that is required to assist nurses in placing patients’ interest at the forefront of their actions and interactions, while fostering collaboration within multidisciplinary teams.
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<th>Definition</th>
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<tr>
<td>A</td>
<td>Answer</td>
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<tr>
<td>ABGs</td>
<td>Arterial blood gases</td>
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<tr>
<td>BiPAP</td>
<td>Bi-level positive airway pressure</td>
</tr>
<tr>
<td>CPAP</td>
<td>Continuous positive airway pressure</td>
</tr>
<tr>
<td>CPR</td>
<td>Cardiopulmonary resuscitation</td>
</tr>
<tr>
<td>CVP</td>
<td>Central venous pressure</td>
</tr>
<tr>
<td>FiO₂</td>
<td>Fraction of inspired oxygen (delivered by a mechanical ventilator)</td>
</tr>
<tr>
<td>ICU</td>
<td>Intensive care unit</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>pCO₂</td>
<td>Partial pressure of carbon dioxide</td>
</tr>
<tr>
<td>pO₂</td>
<td>Partial pressure of oxygen</td>
</tr>
<tr>
<td>Q</td>
<td>Question</td>
</tr>
<tr>
<td>RCN</td>
<td>Royal College of Nursing</td>
</tr>
<tr>
<td>SSC</td>
<td>State Services Commission (New Zealand)</td>
</tr>
<tr>
<td>SIMV</td>
<td>Synchronised intermittent mandatory ventilation</td>
</tr>
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<td>UK</td>
<td>United Kingdom</td>
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ACKNOWLEDGEMENTS

I would like to express my heartfelt thanks to my supervisors, Professor Julie (Jools) Scholes and Dr Maria Cassar, for their time, patience, support and guidance. I feel privileged to have worked with them, not only because their expert feedback managed to bring out the best in me, but especially because they fostered my academic growth throughout this research journey.

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I can never thank my wife, Roberta, enough for being such a loving companion through the ups and downs of this project and beyond. She helped in all sorts of ways, kept our family going despite my PhD-related absence and is a constant source of encouragement. I am also indebted to my children, Matthew and Martina, for being so patient with their father and for constantly asking “how is it going?”

And finally…Deo Gratias!
DECLARATION

I declare that the research contained in this thesis, unless otherwise formally indicated within the text, is the original work of the author. The thesis has not been previously submitted to this or any other university for a degree, and does not incorporate any material already submitted for a degree.

Signed: ___________________________

Dated: ____________________________
Chapter 1

INTRODUCTION

1.1 THESIS MOTIVATION

In my years as a fulltime critical care nurse, I felt that caring for critically ill patients and their relatives crucially involved communicating with other members of the healthcare team about cues I would have detected in relation to the patient’s progress. I felt that it was my duty to participate in decisions affecting the patients I was caring for, even when an opportunity to do so was not explicitly made available. This involvement in decisions about the patient was driven not only by the associated professional satisfaction, but especially by my role of working closely with critically ill patients, who, more often than not, are unable to voice their own concerns. I believed, and still do, that nurses’ contribution to decisions about critically ill patients has the potential to significantly help their recovery.

Yet, in my experience, not all my colleagues were as enthusiastic about taking a proactive role in decisions about their patients’ treatment modalities; rather, some nurses preferred to wait for doctors’ instructions and only gave their input when they were specifically asked to do so by the doctors. These observations drew my attention to question why this might be the case. I became interested in learning about other critical care nurses’ experiences and perceptions related to the process of referral within the local\(^1\) critical care context. I began to wonder what factors my colleagues took into consideration prior to seeking help from doctors and whether there were different extents to which they were prepared to speak up on behalf of their patients. What factors would help or hinder nurses’ participation in patient-related decisions, and which strategies, if any, did they adopt to enhance their participation in clinical decisions?

As a clinician and an educator, I am fascinated by the diversity of roles played by nurses in critical care areas. These vary from operating sophisticated equipment – such as electronic devices which enable accurate and continuous haemodynamic monitoring or the provision

\(^1\) Throughout this thesis, he terms “local” and “this country” refer to the country in which the study was carried out (refer to Section 1.3.1).
of ventilatory support – to preventing and treating iatrogenic complications; and from preparing and administering highly dangerous medications to informing, educating and supporting critically ill patients and their families. Critical care nurses attempt to reduce patient suffering while being responsive to their need for life support interventions, and communicate all these complex dynamics succinctly to colleagues (Chase, 1995; Burn & Higgs, 2000; Brilli et al., 2001; Woodrow, 2012). Yet, throughout my professional experience I became increasingly conscious of the fine balance that exists between the technological and the human elements in the critical care setting. Reading about former critical care patients’ experiences made me aware of the potentially dehumanising effects of technology on patients. On reflection, this appears to have somewhat shifted some of my perspectives about critical care. While the high-tech environment initially lured me to this speciality of nursing, in later years I became increasingly interested in the social and non-technological aspects of the critical care environment. Subsequently, my research interests began to focus on decision making and inter-professional communication within critical care settings. Early reading around these areas highlighted an unexpected connection between the two: I discovered that nurses’ decisions to communicate with, and seek help from, other health professionals actually constituted one of their most frequent clinical decisions, but very little was known about the factors affecting this important decision. Indeed, while decision making in nursing in general and in critical care nursing in particular has been the subject of various research studies in the past three decades, there is very limited research attempting to explore and explain critical care nurses’ decisions to seek help from doctors, particularly when they identify the need for changes in their patients’ treatment modalities.

These different considerations prompted me to explore nurse to doctor referral in the context of a local critical care unit, with particular reference to treatment modality changes for their patients. The following was, therefore, set out as a preliminary research question: “What are the factors related to critical care nurses’ decisions to refer to doctors when they want treatment modality changes for their patients?” In the context of this study:

- The terms referring, referral and making referrals are defined as the process whereby nurses communicate with other health professionals to seek information, advice or authorisation about various aspects of patient management or to...

---

2 An overview of extant research around this area is provided in the next chapter.
participate in clinical decisions. These terms are used interchangeably with seeking help.

- The term treatment modalities refers to a wide range of therapeutic interventions which critically ill patients receive during their stay in an intensive care unit (ICU). A change in treatment modalities refers to an augmentation or reduction of the intensity of any of these interventions. Examples of such “changes in treatment modalities” include increasing the levels of sedation and other medications; weaning\(^3\) of inotropic\(^4\) and ventilatory support; and discharge from a critical care unit.

Participant observation and interviews with nurses working in a local ICU (Section 1.3) were undertaken to capture nurses’ processes of referral in real time and in the dynamic world of clinical practice. By placing me beside these nurses during their practice, these methods enabled me to see the interactions they were involved in, and to listen to their interpretation of these experiences and how that shaped their actions and the meaning they attributed to them. The research study was guided by the dimensional analysis approach to generating grounded theory (Schatzman, 1991; Kools, McCarthy, Durham, & Robrecht, 1996; Bowers & Schatzman, 2009)\(^5\).

This chapter started by stating my personal and professional motivations for embarking on this study, presenting a preliminary research question driven by these motivations, and declaring my perspectives about the subject. This was done in an effort to enhance reflexivity by being transparent about my views and values in relation to the research area. The chapter proceeds by underscoring the significance of conducting research about nurses’ decisions to seek help from doctors, with a particular emphasis on the potential impact of this decision on patient outcomes.

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\(^3\) In critical care, the term weaning is often used with reference to the reduction in the support provided by a mechanical ventilator or a decrease in the amount of drug being administered to a patient.

\(^4\) Inotropes are drugs with a positive inotropic effect, i.e. drugs which enhance the contraction of heart muscle, and are particularly useful for patients in shock, acute cardiac conditions and other critically ill patients (Branfield, 2012).

\(^5\) The research design and its underlying epistemological assumptions are discussed in detail in Chapter 3 and 4.
1.2 SIGNIFICANCE OF THE STUDY

Research into clinical reasoning and decision making provides a better understanding of the way practitioners think and decide, thereby serving as a means of enhancing the education and training of students and subsequently improving patient outcomes (Jenks, 1993; Boyt Schell, Unsworth, & Schell, 2008). More specifically, the relevance of carrying out research about critical care nurses’ decisions around referral is explicated by the points below:

i. Critical care nurses’ crucial role in improving patient outcomes is well documented (Taylor, 1996; Ball & Cox, 2003; Ball & McElligot, 2003; Royal College of Nursing (RCN), 2003; Page, 2004; Estabrooks, Midodzi, Cummings, Ricker, & Giovannetti, 2005; Gunnarsdottir, Clarke, Rafferty, & Nutbeam, 2009; Tait, 2010; Thompson, Aitken, Doran, & Dowding, 2013). The seminal work of Patricia Benner and her colleagues underscored the manner in which experienced nurses are able to detect patient trajectories, both in terms of recognising subtle signs of deterioration in a timely manner and by identifying patient progression and readiness for less intensive care (Benner, 1984; Benner, Tanner, & Chesla, 1996; Benner, Hooper-Kyriakidis, & Stannard, 1999). Skilled critical care nursing, therefore, has the potential to improve patient outcomes, not least because it is the nurse who, by far, spends most time with the critically ill patient (Burn & Higgs, 2000; RCN, 2003; Ball & Cox, 2003; Page, 2004; American Association of Critical Care Nurses, 2005) and performs most of the assessment, evaluation and care in critical care units (Brilli et al., 2001; American Association of Critical Care Nurses, 2005). In particular, critical care nurses can help their patients, and indirectly the organisation they work for, by strategic and timely reduction of sedation (Randen & Bjork, 2010; Bjork & Hamilton, 2011), mechanical ventilatory support (Rose, Nelson, Johnston, & Presneill, 2008; Rose et al., 2011b; Lavelle & Dowling, 2011), and other treatment modalities which require intensive care (Bucknall, 2000; Bucknall, 2003). This leads to earlier transfer of patients to less intensive settings which subsequently reduces their length of stay with its associated complications, and relieves part of the ever increasing demand for critical care beds (Ahern & Philpot, 2002; RCN, 2003). However, since these decisions are traditionally within the domain of medicine, nurses often need to consult and get some form of

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6 The relevance and timeliness of the present study is also made evident through the gaps in the literature presented in the next chapter (Section 2.3).
authorisation and/or reassurance from a member of the medical profession before implementing such changes (Lavelle & Dowling, 2011; Villa, Manara, & Palese, 2012), even in units in which nurses’ actions are guided by clinical guidelines or protocols (Burn & Higgs, 2000; Hancock & Easen, 2006; Randen & Bjork, 2010; Kydonaki, 2010; O'Leary & Mhaolrunaigh, 2012; Marshall, West, & Aitken, 2013). Subsequently, referring is a particularly important and timely research topic because, while it is evidently a very frequent decision in clinical nursing practice (see Section 2.3), very little is known about the actual process of seeking help and the factors associated with this decision.

ii. Benner (1984, p. 94) had stressed the value of nurses’ recognition and documentation of significant changes in a patient’s condition and their presentation of “a firm, convincing case to the physician”. White (2003) concurs, arguing that nurses’ salient decisions, including those about eliciting cues from the patient, reporting them to and discussing them with physicians, and subsequently improving patient outcomes, distinguish nurses from technical or ancillary staff. Also, there is increasing evidence about critical care nurses’ potential to identify, interrupt and correct medical error (Henneman & Gawlinski, 2004; Rothschild et al., 2005; American Association of Critical Care Nurses, 2005; Balas, Scott, & Rogers, 2006; Henneman, Blank, Gawlinski, & Henneman, 2006; Henneman et al., 2010). However, concerns have been raised on nurses’ ability to promptly and accurately identify signs of physiological deterioration and to seek medical help in a timely manner (Daffern, Lee, Hillman, Bishop, & Bauman, 1994; McQuillan et al., 1998; Cioffi, 2000; Harrison, Jacques, Kilborn, & McLaws, 2005; Cooper et al., 2010; Buykx et al., 2012; Scholes et al., 2012). In view of the increasing emphasis on “rescuing” patients from the complications of care during hospitalisation (Clarke & Aiken, 2003; Department of Health and Human Services, 2007; Thompson et al., 2008; Matthew, 2010; Jones, Bottle, & Griffith, 2011), the process of critical care nurses’ referral to ICU doctors in order to implement timely changes or corrections in treatment modalities is an increasingly important research area. Indeed, patient safety is partly dependent on nurses’ ability to determine when to take action, including seeking assistance from other health care providers. This makes the decision about whether and at which point to seek medical help an important nursing decision in its own right (Gillespie & Paterson, 2009).
iii. Earlier research has consistently indicated that collaboration and good quality communication between doctors and nurses is associated with improved patient outcomes (Knaus, Draper, Wagner, & Zimmerman, 1986; Baggs, 1989; Mitchell, Armstrong, Simpson, & Lentz, 1989; Baggs & Ryan, 1990; Baggs, Ryan, Phelps, Richeson, & Johnson, 1992; Baggs et al., 1999; Wheelan, Burchill, & Tilin, 2003; Estabrooks et al., 2005b), and with enhanced professional satisfaction which results in better retention of nurses in the critical care setting (Baggs & Ryan, 1990; Baggs et al., 1997; Wheelan et al., 2003; Hayes et al., 2006; Seago, 2006; Stein-Parbury & Liaschenko, 2007; Gunnarsdottir et al., 2009; Haller, Honor, Slesinger, Singh, & Platz, 2010). Conversely, poor nurse-physician communication and collaboration has been linked with medication errors and other negative effects on patients (American Association of Critical Care Nurses, 2005; Larson, 2011); and with increased stress, anxiety and thoughts about seeking alternative employment among nurses (Hamric & Blackhall, 2007; Papathanassoglou et al., 2012; Karanikola et al., 2013). What is not entirely known is how collaborative decision making can be facilitated, which is particularly timely to explore in view of the ongoing and worldwide shortage of critical care nurses (Cortes, 2004; Hayes et al., 2006; Kingma, 2007; Iliopoulou & While, 2010). Furthermore, help seeking behaviour is known to enhance teams’ problem solving capacity and improve their strategic decision making and performance (Janss, Rispens, Segers, & Jehn, 2012), but interprofessional collaboration in critical care, where higher levels of perceived proximity and collaborative decision making between nurses and physicians occur (Taylor, 1996; Chaboyer & Patterson, 2001; Manias & Street, 2001a; Manias & Street, 2001b), requires additional research.

iv. Despite their potentially central role in improving patient outcomes, research has suggested that critical care nurses are not always adequately involved in decisions about their patients’ treatment modalities (Kennard et al., 1996; Miller, 2001; Coombs, 2003; Hancock & Easen, 2006; Brand, 2006; Villa et al., 2012). This is particularly evident from recent studies suggesting that nurses’ input in hospital ward rounds is often inadequate or absent (Carroll, Iedema, & Kerridge, 2008; Parissopoulos, Timmins, & Daly, 2013). It is, therefore, timely to investigate the skills, characteristics and conditions which enhance and hinder critical care nurses’ participation in decisions about critically ill patients’ treatment modalities.
v. Research has repeatedly suggested that general and critical care nurses prefer to seek clinical information from human sources, rather than from text-based or electronic ones (Thompson, Cullum, McCaughan, Sheldon, & Raynor, 2004; Pravikoff, Tanner, & Pierce, 2005; Estabrooks, Chong, Brigidear, & Profetto-McGrath, 2005; Kosteniuk, D'Arcy, Stewart, & Smith, 2006; Marshall, West, & Aitken, 2011; O'Leary & Mhaolrunaigh, 2012; Marshall et al., 2013). Furthermore, recent simulation research among nursing students (Cooper et al., 2010), midwives (Scholes et al., 2012) and rural hospital nurses (Endacott et al., 2012) indicates a reliance on support from doctors in the management of rapidly deteriorating patients because of a perceived or actual inability or unwillingness to cater for such situations independently. Accordingly, it is particularly relevant to explore the factors associated with critical care nurses’ decisions to seek such help from their medical and nursing colleagues, particularly because several nurses perceive discussion with physicians and senior colleagues as a source of support, information and learning (Estabrooks et al., 2005a).

vi. By exploring which actions critical care nurses can implement independently and what they need to refer and/or delegate to other health care professionals, this study attempted to provide a contemporary view of critical care nursing practice in the context of a local public hospital setting. This should make the impact of nursing on the welfare of critically ill patients more explicit thereby helping “to disentangle the specific contribution of the nurse to the shared decision making process” which characterises critical care practice (McCaughan, 2002, p. 96). The latter point is particularly relevant in view of the “de-facto boundary-blurring” (Allen, 1997, p. 511) characterising medical and nursing work, which often renders nurses’ input in improving patient outcomes all but invisible (Allen, 1997; Pilcher, 2009). Subsequently, studying nurses’ decision making is considered as the means through which the input of nursing to the production of health can be evaluated (Lauri et al., 2001; Baxter & Rideout, 2006). This includes nurses’ ability of articulating their clinical reasoning to inform other health providers about the patient’s condition (Burn & Higgs, 2000), and their decisions about which aspect of their extensive information about the patient is medically relevant (Gamarnikow, 1991 cited in Allen, 1997). Indeed, it has been pointed out that an analysis of the nature and procedures of clinicians’ decisions and actions constitutes “a very useful approach to describing professional practice” (Eraut, 2005, p. 259).
1.3 THE CONTEXT

1.3.1 Research setting

This study took place in a 20-bedded general intensive care unit admitting adult critically ill patients with all types of conditions, except cardiothoracic surgery. The unit is made up of an 8-bedded section and a 12-bedded section facing each other with a corridor in between. There is no specific distinction between the types of patients allocated to each area, except that all the five single-bedded rooms of the unit are located in the 12-bedded area. This unit is located in a public general hospital in a Mediterranean island nation, and received its first patients in November, 2007 (Anon, 2007).

In this unit, each patient is allocated to the care of a specific nurse, although frequently nurses have to take care of two patients simultaneously due to staff shortages and increased admissions. Most of the eighty nurses working in this unit work on a fixed roster, which includes day and night shifts lasting twelve hours. Nurses are grouped in four different teams (called shifts), each of which has a leader. Two nurse managers run the unit on a day to day basis and are normally only minimally involved in direct patient care. A small number of nurses exclusively work day or night duties while another small number of nurses work on a part-time basis. All nurses working in this unit are registered as first-level (state registered) nurses with the local Council for Nurses and Midwives\(^7\). Since 2009 a practice development nurse facilitates the induction of newly recruited nurses and coordinates the research and educational activities for nurses working in the unit, while maintaining regular bedside clinical duties (Ministry of Health, the Elderly and Community Care, 2008).

Six consultant anaesthetists take turns in assuming the overall responsibility of the unit for one week each. They are normally present in the morning and early afternoon and occasionally during ward rounds taking place later during the day. During their absence, at least one anaesthetist at resident specialist level\(^8\) is present in the unit at all times. Other persons working at this ICU include a number of physiotherapists, technicians, nursing

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\(^7\) Formerly known as the Nursing and Midwifery Board, the Council for Nurses and Midwives is the regulatory body for the nursing and midwifery professions in this country, as stipulated by the Health Care Professions Act of 2003 (Ministry for Justice and Home Affairs, 2012).  

\(^8\) Formerly known as senior registrars, resident specialists form a rank in the medical hierarchy just below that of a consultant.
aides, health auxiliaries and a ward clerk. Other specific contextual issues about the research setting will be provided in the relevant sections of Chapter 5.

The professional relationship between doctors and nurses in this country is somewhat characterised by the historically rooted prestige of the former and the traditionally subservient role of the latter (Cassar, 1964; Savona Ventura, 1999). In the eyes of many, both within and outside healthcare organisations, medicine and nursing are not considered equal; rather, doctors are perceived to be more knowledgeable and powerful, particularly those in a consultant grade. These perceived and actual differences were only partly reduced by the move of nurse education to a university setting in the late 1980s (Faculty of Health Sciences, 2012). In the context of critical care, however, personal observation suggests that the disparity between nurses and doctors is somewhat less than that in other areas, mainly because of two factors. First, the proportion of critical care nurses who hold an undergraduate or a master’s degree tends to be higher than that in other areas. Secondly, nurses providing their services in a specialised setting, such as critical care, are frequently considered to work in an area of technical eminence.

1.3.2 Researcher’s academic and professional background

I am a Maltese male in my mid-thirties. I started my nursing studies at the University of Malta in 1996. During my undergraduate nursing education and training, I became particularly interested in the critical care setting, and looked forward to eventually working in that setting as a qualified nurse, mostly because I feel that it is a privilege to be able to assist critically ill patients and their relatives. In fact, after graduation, I chose to start working as a staff nurse in the intensive care unit of a publicly funded general hospital in August 2000. I worked in this unit on a full time basis until April 2006, following which I moved to full time employment in nursing administration and education. However, I kept working staff nurse duties at the unit on an occasional basis, not exceeding a half-day duty per week, as I wanted to keep in touch with my preferred clinical area. In February 2008, I joined the University of Malta as an assistant lecturer in the Department of Nursing. One of my duties involves coordinating and lecturing in the critical care nursing modules for undergraduate nursing students.

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9 I eventually suspended my clinical duties upon starting to collect data as part of this study.
My previous experience in research is limited to two quantitative studies (using a survey design) in areas related to health promotion as part of my bachelor’s degree in nursing and my master’s degree in public health. As such, this is my first experience in a qualitative research project and in the use of participant observation and interviews as data collection methods. Nonetheless, my clinical and academic experience of critical care nursing has undoubtedly helped to sensitise me to this research area (as discussed in more detail in Section 3.4 of Chapter 3). Likewise, my familiarity with the research setting and its members was helpful in gaining access to the research setting, and especially in building a researcher-participant rapport which is considered beneficial in facilitating the process of constructing knowledge about a selected research area in collaboration with persons who are directly involved in it (Mruck & Mey, 2007).

Nevertheless, it was also important to ensure that my personal experiences and views do not foreclose the generation of rich data from the participants (Charmaz, 2009), making it essential to reflexively manage any preconceived ideas. In this regard, this introductory chapter opened by clearly expounding my own views about the social process being investigated and proceeded by giving information about my academic and professional background. Furthermore, throughout data collection and analysis, reflexive reactions to the data were documented distinctly from the actual data, while self-scrutiny of research decisions took place throughout the research project. Further details about the use of reflexivity throughout this project are provided in several parts of this thesis, especially in Section 3.6.2 and Chapter 7.

1.4 THESIS STRUCTURE

Having made “a priori knowledge and values explicit” (Cutcliffe, 2003, p. 138) in this opening chapter, Chapter 2 situates this research project in the methodological and empirical landscape of the decision making literature. Different genres of decision making research are presented with a reflective commentary on which approaches were considered most suitable to address the purpose of the present study. The next chapter also updates and expands the research question by reflecting on what is known and unknown about referral, and on early data collected and analysed in the present study.
In Chapter 3 I reflect on my ontological, epistemological and theoretical assumptions and the way they influenced the present study, and then discuss grounded theory methodology and dimensional analysis in relation to their applicability to this research project. The strategies utilised for enhancing and maintaining theoretical sensitivity are then described followed by an overview of the methodological decisions underpinning data collection and their rationale in the context of grounded theory principles. The chapter ends with a detailed discussion of the strategies employed to ensure methodological rigour, including the reflexive stance adopted during data collection and analysis.

Chapter 4 explains and illustrates the research design and dimensional analysis procedures adopted in this study. The sampling strategy, the measures used to ensure theoretical sufficiency and the methods used to generate and analyse data are described in the context of the essential features characterising the dimensional analysis approach to generating grounded theory. The process is illustrated with data excerpts, different types of memos used during data collection and analysis, and reference to the relevant literature. This chapter also includes a reflective commentary on the advantages and disadvantages of my role as an insider researcher; my relationship with the participants and its potential impact on the trustworthiness of the data; the way in which theory was generated from the data; the use of the literature in various stages of the project; and my relational ethic governing the various stages of the study.

Chapter 5 presents the principal factors related to critical care nurses’ decisions to seek help from doctors, and proposes a substantive theoretical explanation derived from the analysis of these findings. To ensure that the latter is “grounded” in the data, verbatim excerpts from observation field notes, interview transcripts and focus group conversations are interspersed throughout the presentation of the findings. The chapter is divided into three main sections. First, a discussion is provided about nurses’ motivations for seeking help from doctors and the strategies used during the process of such referring. Second, to gauge a better understanding of the process, it was also considered important to explore critical care nurses’ reasons for not seeking help from doctors. Finally, to depict a more complete picture of referral as a social interactive phenomenon, the third section presents participants’ decisions about who to seek help from.

The aim of Chapter 6 is to engage the theoretical explanation of the data with the literature. It theoretically compares and contrasts the emergent substantive theory with
relevant formal theories and with other empirical research in the substantive area. The chapter also proposes theoretical links between the findings of the present study and earlier work, and highlights the original contribution out of this research.

Chapter 7 sums up this thesis and its contribution to knowledge. It also presents my reflections about the limitations and strengths of this study, as well as my own learning throughout the research project. This chapter also proposes several implications for further research and for nurse education, practice and management, arising from the present study in the context of the rationale for studying referral presented in the present chapter.

This thesis makes extensive use of footnotes as a methodological, theoretical and reflexive device for supplementing the main text with additional contextual comments close to, but without hindering, the principal discourse. Using footnotes was partly motivated by the advice of one of the founders of grounded theory about footnoting the literature in order to “integrate the generated theory into the existing literature through the use of footnotes...[thereby] carefully weaving the theory into its place in the literature” (Glaser, 1978, p. 137). More specifically, footnotes are used throughout the thesis for the following purposes:

- Cross-referencing other sections and/or chapters of the thesis which elaborate the point being made;
- Providing standard definitions of technical and methodological terms;
- Presenting operational definition of terms as used in the present thesis;
- Clarifying or delivering examples of the issue being discussed without interrupting the flow of the main argument;
- Comparing and contrasting findings of the present study with those from other research;
- Reflectively comparing and contrasting the application of conceptual terms in the present thesis with their use in the literature.
1.5 CONCLUSION

This chapter has identified referring as an important nursing decision with a considerable impact on the outcomes of critically ill patients. It underscored the significance of carrying out research around critical care nurses’ decisions to seek help from doctors, particularly in the context of enhancing patient safety. The reflexive stance adopted throughout this study was introduced by providing personal motivations for selecting this research area and by transparently exposing my perspective about the subject. The next chapter positions the present study in the context of seminal decision making research, with the aim of using gaps in the literature as insights to reflexively refine the research question and shape the subsequent methodological decisions.
Chapter 2
METHODOLOGICAL AND EMPIRICAL BACKGROUND

2.1 INTRODUCTION

The previous chapter identified referral as an important decision made by nurses in general and critical care settings with a potential impact on improving patient outcomes. The overall purpose of this study was to provide an in-depth exploration of the factors associated with this decision. The present chapter, therefore, situates the study in the context of the decision making literature, thereby enhancing my sensitivity to the issues that need to be considered in addressing this purpose and orienting the reader to the current body of knowledge about decision making and referral. The chapter summarises the different approaches used in decision making research and discusses their applicability to the purpose of the present study. An overview of what is presently known in relation to the process of referring and the current research gaps about this topic is also provided, on the basis of which the preliminary research question is refined and supplemented by additional issues which the present study sought to address. Insights from this review also helped to shape the methodological and research design decisions discussed in the subsequent two chapters. The use of the literature throughout the various stages of the present study is summarised in Appendix I.

2.2 APPROACHES TO DECISION MAKING RESEARCH

Several approaches have been utilised in research about clinical reasoning and decision making. The principal ones are summarised in Table 2.1, following which their applicability to the purpose of the present study is discussed.

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10 Clinical reasoning has been defined as “a complex cognitive process that uses formal and informal thinking strategies to gather and analyse patient information, evaluate the significance of this information and weigh alternative actions” (Simmons, 2010, p. 1553).
# RESEARCH APPROACH

## BEHAVIOURAL OR PSYCHOMETRIC

- Focuses on the observable steps (behaviours) adopted by clinicians when solving a clinical problem.
- Developing and testing instruments for assessing clinicians’ functioning by comparing and contrasting the observed performance with statistically predicted models, rather than describing their clinical reasoning (Patel & Arocha, 2000; Elstein & Schwartz, 2000; Unsworth, 2008).
- Underscored clinicians’ (including expert ones’) susceptibility to error, and subsequently their need for some form of decision support (Elstein & Schwartz, 2000).
- Applicable to the Advanced Life Support (ALS), Advanced Trauma Life Support (ATLS) and similar courses aimed at enhancing clinicians’ identification and prompt management of patient deterioration in a prioritised and systematic manner (Ahern & Philpot, 2002).

## COGNITIVE

- Understanding the nature of, and the development of expertise in, clinical reasoning (Higgs & Jones, 2000)
- Describing the thinking processes and knowledge involved in such reasoning (Unsworth, 2008).
- Often makes use of cognitive psychological theories as a framework, e.g. the Subjective Expected Utility Theory (SEUT) and the Information Processing Theory (Simmons, 2010).
- Employs “contrastive methods” to compare the reasoning performance of experts and novices within a particular field (Patel & Arocha, 2000; Unsworth, 2008).
- Increased researchers’ understanding of the processes used by clinicians when making clinical decisions
- Description of the thought processes underpinning nurses’ assessment and planning activities (Cioffi, 2002).

## MENTAL REPRESENTATION

- Expertise in medical practice is not particularly dependent on better reasoning skills or deeper pathophysiological knowledge, but rather on the development of “illness scripts” (Thompson, McCaughan, Cullum, Sheldon, & Thompson, 2000).
- Such scripts consist of mental representations that describe the features of typical or actual patients, and are therefore particularly rich in clinically relevant information related
- By developing and storing several of these “scripts”, expert physicians are more efficient in solving clinical problems than beginners, who have to rely on pathophysiological causal models of the disease (Norman, 2005).
- Similarly, research by Cioffi (1997; Cioffi & Markham, 1997; Cioffi, 2002) suggests that expert nurses frequently make use of heuristics¹¹ and propositional

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¹¹ *Heuristics* are “mental rules of thumb that assist in reasoning and are acquired over time” (Fonteyn & Ritter, 2000, p. 110).
to illnesses, their context and their consequences (Schmidt et al., 1990; Norman, 2005).

rules\(^{12}\) as a way of simplifying complex problems into representations or chunks of information, thereby compensating for human limitations in memory and recall (Bucknall, 2007; Simmons, 2010).

\(^{12}\) Propositional rules involve predicting the occurrence of some event upon observing another event (Cioffi, 2002).

### Table 2.1 – Principal approaches utilised in decision making research and their respective characteristics and contributions to knowledge

A purely behavioural or psychometric approach was not considered suitable for the purposes of the present study, mainly because my aim is not that of evaluating critical care nurses’ decision making skills but describing and explaining the factors associated with their decisions to seek help in the clinical and social context of a local intensive care unit. Furthermore, psychometric research typically occurs in simulated settings, deliberately devoid of actual interaction between the clinician taking part in the study and fellow clinicians or patients; conversely, nurses’ decisions to seek help from, and their interaction with, other health professionals was an important focus of the present study.

A cognitive approach to decision making research was similarly considered inappropriate to address the aims of the present study, mainly because of two limitations. First, the cognitive approach has been criticised for focusing on (decontextualized) decisions, which might not necessarily reflect the those that occur in clinical practice (Tanner, Padrick, Westfall, & Putzier, 1987; Cioffi, 2002). Furthermore, as pointed out by Thomson (2013), due to their almost exclusive attention to diagnostic reasoning cognitive-based studies give

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\(^{12}\) Propositional rules involve predicting the occurrence of some event upon observing another event (Cioffi, 2002).
utmost credit to biomedical (propositional) knowledge with barely any acknowledgement of other forms of (non-propositional) knowledge. Conversely, I contend that several, more tacit, forms of knowledge, including aesthetic and personal knowledge (Carper, 1978; 2013), constitute a quintessential aspect of critical care nurses’ decisions, including those related to seeking help.

A main focus in the present study is that of eliciting the social processes surrounding referring in a critical care setting. Indeed, the critical care environment does not only consist of machinery, but is characterised by nurses’ interaction with patients, their relatives, other nurses in similar or different ranks, and members of other health professions, as depicted through various ethnographic studies (e.g. Chase, 1995; Manias & Street, 2000). Therefore, an interpretivist approach is particularly applicable to my research area because I agree with Burn & Higgs’ (2000) assertion that it would be incomplete and unnatural to attempt to explore critical care nurses’ decisions to seek help from doctors and from other nurses without “taking into account the complex social, psychological and ethical interactions which this [critical care] work demands” (p. 301). Specifically, as discussed in the next chapter, the present study is underpinned by a symbolic interactionist perspective, with close attention being paid to the significance of social interaction in deriving the meaning of social actors’ actions. From a symbolic interactionist perspective, therefore, the nurse’s interpersonal relationship with patients and other health providers is placed in the centre stage (Stevenson, Grieves, & Stein-Parbury, 2004), which makes symbolic interactionism particularly useful in understanding nurses’ decisions to seek help from doctors. Furthermore, while acknowledging the value of other interpretative approaches to decision making research – such as phenomenology’s potential to address research questions focused on participants’ experience of the phenomenon of clinical

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13 Higgs and Titchen (2000, p. 27), among others, distinguish between propositional knowledge (or “knowing that), which is based on formal instruction and attempts to generalise findings from research, and non-propositional knowledge (or “knowing how”), which is essentially gained through practice and confined to the practitioner’s own experience. According to the same authors, non-propositional knowledge incorporates both professional craft knowledge (i.e. procedural and practical knowledge) and personal knowledge.

14 Aesthetic knowledge (also known as the “here and now”) refers to an awareness of the immediate situation, resulting in immediate practical action. This includes awareness of patients and their circumstances as uniquely individual, and of the combined wholeness of the situation (Carper, 1978).

15 While generally referring to knowing the patient, both as a person and in terms of his/her response to illness (Carper, 1978; Moule & Goodman, 2009), Higgs and Titchen (2000) extend the meaning of personal knowledge to also incorporate knowing oneself.

16 According to Crotty (1998), there are three main strands of Interpretivism, namely symbolic interactionism, phenomenology and hermeneutics.
reasoning (e.g. Benner, 1984), and ethnography’s relevance in describing the cultural context of clinical reasoning (e.g. Chase, 1995; Hancock & Easen, 2006) – the present study focused on nurses’ experiences of referring as a social process, and aimed to generate a theoretical explanation of nurses’ decisions surrounding referring. For this and other reasons discussed in the next chapter, grounded theory was chosen as a methodological approach.

Several methods have been utilised to collect data about the decision making processes and activities of nurses, physicians and other health professions. These methods can be broadly classified as being quantitative or qualitative in nature; or as being used for descriptive, or prescriptive purposes. Table 2.2 summarises the aims and characteristics of quantitative and qualitative decision making research, and distinguishes between descriptive and prescriptive quantitative studies.

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<th>QUANTITATIVE DECISION MAKING RESEARCH</th>
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<td>• Aims to mathematically map decisions made by clinicians for subsequent examination from an objective point of view (Unsworth, 2008).</td>
<td>• Enables researchers to study single decision episodes in detail, as opposed to predicting average measures for general situations, thus placing it closer to real-life decisions (Patel &amp; Arocha, 2000).</td>
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<td>• Researchers control the research environment and the kinds of information that are presented.</td>
<td>• Offers a “rich and vivid description” about decision making within particular clinical contexts (Thompson, 1999, p. 819).</td>
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<td>• Typically use a formal decision making theory or model to which data are compared through mathematical and statistical methods (Patel &amp; Arocha, 2000).</td>
<td>• Enables the exploration of complex and tacit aspects of a health profession within the context of actual clinical practice (Thomson, Petty, &amp; Moore, 2011).</td>
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<td>• Adds depth and meaning to findings from quantitative studies (Thompson, 1999).</td>
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Table 2.2 – Aims and characteristics of quantitative and qualitative decision making research
In summary, quantitative decision making research is useful for testing and comparing aspects of clinical reasoning and has been credited with the development of influential models of clinical reasoning (Thomson et al., 2011), such as pattern recognition and hypothetico-deduction (Elstein, Shulman, & Sprafka, 1978; Post, 1979). It was not, however, considered suitable for the present research project, mainly because it considers the decision making process as linear and quantifiable, without taking the “mediating process between the attributes and the decision” into account (Patel & Arocha, 2000, p. 82). Furthermore, quantitative studies often attempt to generalise average scores across individuals rather than focusing on the factors underlying the individual’s and the group’s decisions (Unsworth, 2008). In other words, quantitative decision making research aims to determine how general a phenomenon is, rather than investigating whether it is present (Patel & Arocha, 2000), making it inappropriate for exploring the clinical and non-clinical factors related to nurses’ help seeking decisions and processes. Consequently, the present study gathered and analysed qualitative data in an effort to seek a better understanding of the factors surrounding nurses’ decisions around referring, as shall be explained in Chapter 4 and illustrated in Chapter 5.

Thus far, this chapter has attempted to situate the present study within the context of the methodological approaches to studying clinical decisions. The chapter proceeds by presenting a preliminary overview of research related to the subject matter of the present study, in an effort to enhance the researcher’s and the readers’ sensitivity to issues which should be considered when studying referral in a critical care setting and to situate the study in the current context of the decision making literature.

2.3 BACKGROUND TO THE PRESENT STUDY

It is often contended that a grounded theory research project should not be preceded by an in-depth review of the literature relating to the area of inquiry in order to prevent prejudicing the study’s processes and outcomes towards the existing theoretical concepts (Birks & Mills, 2011). Nonetheless, a preliminary review of the literature can be useful in orienting the researcher to the area of study without artificially imposing existing theories and knowledge (Urquhart, 2007). Thus, the aim of this section is not to provide a comprehensive review of the findings from decision making research; rather, it attempts to
situate the present study in the context of related work, thereby sensitising the researcher and the reader to what is already known and what needs to be explored about nurses’ decisions to seek help, while maintaining a generally “sceptical” (Chenitz, 1986a, p. 44) and “non-committal” (Urquhart, 2013, p. 136) stance towards the insights from previous studies.

This review is based on a literature search of online electronic databases (particularly PubMed®, Academic Search Complete® and the Cumulative Index of Nursing and Allied Health Literature (CINAHL)®) using combinations of various search terms such as “decision making”, “seeking help”, “asking for help”, “referral”, “referring”, “critical care”, “doctor-nurse relationships”, “collaboration”, “collaborative practice”, “patient outcomes” “nurse”, “nursing” and their variants. An attempt to retrieve grey literature was made by conducting similar searches on Google Scholar®. The search was restricted to articles in the English language, but no limits were imposed in terms of years of publication; indeed, this review includes studies published both before and after the present study’s various stages of data collection. Most of the retrieved studies were carried out in the United Kingdom, the United States, Australia, Canada and the Scandinavian countries, but studies conducted in other countries, such as Ireland, Iran and Italy, were also retrieved. Very few studies have, as yet, specifically explored the actual process of referring in the critical care setting. Therefore, the review presented in this section is mostly based on findings emerging indirectly from studies focusing on decision making in general or on referral in non-critical care areas. Moreover, practically no published studies have explored any aspect of decision making among local critical care nurses, making it even timelier to explore this area from a local perspective.

2.3.1 Strategies used in clinical reasoning

Several research studies have examined how nurses and other health providers process information when making clinical decisions. This research genre suggests that clinicians make use of different strategies to facilitate information processing, including hypothetico-deductive reasoning, pattern recognition and intuition, which are summarised in Table 2.3.

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17 Ways in which the literature enhanced theoretical sensitivity before, during and after the iterative process of data collection and analysis are discussed in more detail in Chapters 3 and 4, particularly in Sections 3.4 and 4.6 respectively. Subsequently, Chapter 5 incorporates some contextual comparisons between the findings of the present study and those of other ones, while Chapter 6 engages the emergent substantive theory with empirical and theoretical literature in related fields.
<table>
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<th>STRATEGY</th>
<th>CHARACTERISTICS</th>
<th>CRITICISM / LIMITATIONS</th>
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| **Hypothetico-deductive reasoning**       | Rapid generation and testing of multiple diagnostic hypotheses in a series of overlapping inductive and deductive stages:  
1. Acquiring “cues” through patient assessment and history taking;  
2. Organising this information into hypotheses;  
3. Assessing information according to its relative contribution to the hypotheses;  
4. Evaluating the generated hypotheses on the basis of whether they are supported by the available information  
(Elstein et al., 1978; Neufeld, Norman, Barrows, & Feightner, 1981; Elstein & Schwartz, 2000; Higgs & Jones, 2000; Banning, 2008; Simmons, 2010) | ➤ Generation of incorrect hypotheses may lead to incorrect or unsafe clinical decisions (Buckingham & Adams, 2000), especially if clinicians do not challenge their preliminary diagnosis with subsequently generated hypotheses (Scholes et al., 2012).  
➤ Depends on the availability of accurate relevant knowledge while making decisions; nonetheless, clinical decisions often need to be made within a limited timeframe, in a context of uncertainty (Banning, 2008).  
➤ Human limitations, especially their bounded rationality: only a limited amount of information can be stored and quickly retrieved from short term memory; the rest needs to be stored in long term memory, retrieval from which is slower (Newell & Simon, 1972; Tversky & Kahneman, 1974; Bucknall, 2007).  
➤ Minimal evidence of hypothetico-deductive reasoning in everyday life (Lowenstein, 2001). |
| **Pattern recognition**                    | Involves *forward reasoning*, i.e. incorporating new information to further refine the held view or plan (Fonteyn & Ritter, 2000; Cioffi, 2002).  
Mainly occurs in non-problematic situations (Higgs & Jones, 2000).  
Exclusively inductive process because it makes use of the clinician’s knowledge base to support the generation of hypotheses from the retrieved data (Higgs & Jones, 2000).  
Two main forms of pattern recognition:  
1. *Categorisation* - A new case is placed in the same category with similar signs and symptoms or therapeutic options encountered during the clinician’s experience;  
2. *Prototypes* - clinicians use the signs, symptoms and therapeutic options they encounter to develop abstract associations (prototypes), and subsequently match new clinical patterns against these prototypes (Higgs & Jones, 2000, p. 6). | ➤ Its lack of (deductive) testing of the generated hypotheses makes pattern recognition error prone.  
➤ It is susceptible to a clinician’s faulty knowledge and bias in favour or against a specific diagnosis or decision (Jones, Jensen, & Edwards, 2008).  
➤ Subsequently, in non-familiar or uncertain situations, clinicians have to retract to hypothetico-deductive reasoning (Schmidt et al., 1990). |
Intuition

Defined as:

- “Understanding without a rationale” (Benner & Tanner, 1987, p. 23);
- “gut feelings” about patient trajectories (Pyles & Stern, 1983);
- Clinicians’ strong feelings about themselves, their patients and their anticipated outcomes, which are elicited without going through an analytical reasoning process (Rew, 1990);
- “The deliberate application of knowledge or understanding that is gained immediately as a whole and that is independently distinct from the usual, linear and analytical reasoning process” (Rew, 2000, p. 95);
- Quick response to developing situations based on the applications of “tacit rules” (Eraut, 2000, p. 127).

More commonly used among experienced clinicians (Benner, 1984; Benner & Tanner, 1987; Benner, Tanner, & Chesla, 1992; Dowding, 2009; Bjork & Hamilton, 2011; O’Leary & Mhaolrunaigh, 2012).

- Intrinsically “difficult to articulate” (Rew, 2000, p. 95) and incompletely described (Fonteyn & Ritter, 2000).
- Excessive reliance on intuition may lead to a failure to identify and act upon early physiological signs of deterioration, particularly among inexperienced clinicians (Odell, Victor, & Oliver, 2009).
- The tenability of intuition as a basis of expertise in nursing has also been challenged in view of the demand for objective, quantifiable means of assessing clinical performance and demonstrating the value of nursing work (English, 1993; Cash, 1995), particularly in the context of increasing financial constraints on public health care (Burn & Higgs, 2000).

<table>
<thead>
<tr>
<th>Table 2.3 – Summary of the characteristics, limitations and criticism of different strategies used in clinical reasoning</th>
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<td>The body of research summarised above has provided a comprehensive understanding of the strategies generally used in clinical reasoning. However, much less is known about the strategies used by nurses specifically when making referrals to doctors, a gap in the literature which the present study sought to address. Indeed, in these and similar studies the main focus is on nurses’ decisions in relation to patient management with any data about referring emerging only indirectly; conversely, the present study considers help seeking itself as an important clinical decision and sought to describe and explain the factors associated with that decision.</td>
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2.3.2 Types of decisions

Researchers have also attempted to seek information about the types, complexity and frequency of decisions made by nurses in the critical care and other settings. Four often cited studies of this type are summarised in Table 2.4.
A frequent decision reported in these and several other studies is “communication”, which includes what McCaughan (2002, p.102) defines as “referral to colleagues / senior nurses / doctors / clinical nurse specialists / therapists / pharmacists” and what later studies have explicitly called “referral” (Thompson et al., 2004; McCaughan, Thompson, Cullum, Sheldon, & Raynor, 2005) and “seeking help” (Aitken, Marshall, Elliott, & McKinley, 2010). Research also suggests that clinical decision making is a social activity, usually involving more than one clinician (Thompson et al., 2000; Cioffi, 2000). In fact, several UK studies have suggested that nurses rarely make decisions on their own on any aspect of care, and constantly seek information and advice from their nursing colleagues and other health providers on how to act when faced with uncertainty (Thompson et al., 2000; Jinks & Hope, 2000; McCaughan, 2002). It is, therefore, evident that referring, which the present study focuses on, is a very common nursing decision. Yet, little is known about the actual process of referring in a critical care setting and about the personal, professional and social factors associated with critical care nurses’ decisions to seek help. The present study sought to address these gaps in the literature in the context of a local intensive care unit.
2.3.3 Reasons for seeking or for not seeking help

Previous research has suggested that critical care nurses frequently decide to involve members of the medical professions in their decisions because the physician was often the only health provider with the legal authority to approve certain changes in patients’ treatment modalities (Chase, 1995; Hancock & Easen, 2006; Villa et al., 2012). Additionally, nurses make several referrals in an attempt to influence doctors’ decisions about treatment modalities’ (Baumann & Bourbonnais, 1982; Jenks, 1993; Chase, 1995; Ramezani-Badr, Nasrabad, Yekta, & Taleghani, 2009) and to correct medical error (Rothschild et al., 2005; Henneman et al., 2006; Henneman et al., 2010). Nurses also seek help from other nurses and from physicians when they are not confident in their own decisions (Fulton, 1997), especially in situations which they consider complex and non-routine (Burman, Stepans, Jansa, & Steiner, 2002; McGrail, Morse, Glessner, & Gardner, 2009; Ramezani-Badr et al., 2009; Lavelle & Dowling, 2011). Recent Irish (O’Leary and Mhaolrunaigh, 2012) and Australian (Marshall et al., 2011; Marshall et al., 2013) studies lend support to earlier research conducted in the UK, the US and Canada (Thompson et al., 2004; Pravikoff et al., 2005; Estabrooks et al., 2005a; Kosteniuik et al., 2006) suggesting that nurses invariably prefer to seek information to guide their clinical practice from other health professionals rather than from formal text-based or electronic sources. This is congruent with Eraut’s (2005) analysis about knowledge transfer in the workplace which implies that, in most work settings, learning from immediate work colleagues and other members of the organisation is the more significant than published material or online sources of knowledge.

Earlier research has also revealed that nurses prefer to refer certain decisions to doctors because they were not prepared, or indeed willing, to assume the responsibility accompanying such decisions (Ramezani-Badr et al., 2009; Villa et al., 2012; Endacott et al., 2012). In Villa et al.’s (2012) study, for instance, Italian critical care nurses reported that they considered the final decision to extubate patients too risky to take on their own, and therefore referred it to doctors, even though they felt sufficiently knowledgeable about the timing of this decision, leading the authors to coin the term “nurses’ near-decision making” (p. 41). Similarly, in Endacott et al.’s (2012) research among Australian acute ward nurses, the participants demonstrated a dependence on doctors’ support in their management of rapidly deteriorating patients, and were frustrated that the doctor in the simulated scenario was insufficiently experienced to provide such assistance. These findings corroborate with those from an earlier community nursing study in which the
inability to discuss case management with a colleague emerged as a source of risk and uncertainty (Luker & Chalmers, 1989). Thus, referral in critical care and other settings is apparently compelled by a combination of organisational requirements and nurses’ need to alleviate their own insecurity. However, the type of insecurity they seek to defend is not well understood; therefore, in the climate of patient safety and increasing professional accountability, this is an area that requires further investigation.

Conversely, nurses may be unwilling to seek help from doctors or may prefer to seek help from other colleagues with an equal status rather than from physicians because seeking help may appear to acknowledge one’s inability to solve problems autonomously, as well as an inferiority to, and dependence on, other health providers (Janss et al., 2012). This suggests that help seeking decisions are not exclusively based on patient-related considerations (Hancock & Easen, 2006) but also involve a “social cost” (Lee, 2002) and occasionally a risk (Chase, 1995). In fact, O’Leary & Mhaolrunaigh’s (2012) study demonstrated a clear preference for seeking help from fellow nurses, and from nurses in a managerial, clinical specialist or practice development role, rather than from members of other professions. Likewise, the most frequent sources of information in several other studies were nursing colleagues (Thompson et al., 2000; Thompson et al., 2004; Pravikoff et al., 2005). Knowledge about the various motivations that underlie local critical care nurses’ decisions to seek or not to seek help from colleagues or other health professionals is absent, as is information about who they prefer to seek help from and under what circumstances that help seeking behaviour is framed within the physical and social context of their workplace.

2.3.4 Critical care nurses’ involvement in decisions about treatment modalities

In the critical care area, nurses’ involvement in decision making was investigated in research about the transfer of patients to less intensive settings (Higgins, 1999; Brand, 2006); nurse-doctor interactions during ward rounds (Porter, 1991; Manias & Street, 2001a; Coombs, 2003; Carroll et al., 2008); nurses’ involvement in decisions about common critical care procedures (Bucknall & Thomas, 1996); and nurses’ decisions about changes in mechanical ventilator settings (Rose, Nelson, Johnston, & Presneill, 2007) amongst others. Recent studies have reported a significant and highly influential role of nurses in decisions about sedation assessment and management (Aitken, Marshall, Elliott, & McKinley, 2008; Randen & Bjork, 2010; Bjork & Hamilton, 2011) and weaning from
mechanical ventilation (Kydonaki, 2010; Rose et al., 2011b; Lavelle & Dowling, 2011; Haugdahl & Storil, 2011), with experience, confidence, education and knowledge being particularly valuable in facilitating participation in treatment modality decisions. In this context, a lately updated meta-analysis by Blackwood and colleagues (2011) showed that nurse-implemented weaning protocols reduce weaning time; however, it cannot be ascertained whether this reduction is due to the implementation of protocols per se or their facilitation of nurses’ input in decisions about weaning (Kydonaki, 2010).

Research has also highlighted critical care nurses’ minimal or absent input in decisions about patient discharge from high dependence areas (Brand, 2006); weaning from mechanical ventilation (Hancock & Easen, 2006); pain management (Subramanian, Alcock, James, & Lathlean, 2011); end of life care (Carnevale et al., 2011; Piers, Azoulay, Ricou, & DeKeyer Ganz, 2011; Festic, Wilson, Gajic, Divertie, & Rabatin, 2012); and treatment modality changes in general (Miller, 2001; Coombs, 2003; Coombs & Ersser, 2004). Authors have also lamented critical care nurses’ inadequate participation in or absence from ward rounds (Parissopoulos et al., 2013), as well as their failure to advocate their patient’s preferences in such decisions, even though nurses, patients and their families alike perceive this to be detrimental to patient care (Kennard et al., 1996). These and other studies identified several factors which impede nurses’ participation in such decisions about treatment modality changes, such as lack of peer and managerial support (Hagbaghery, Salsali, & Ahmadi, 2004; Hancock & Easen, 2006; Villa et al., 2012); educational limitations (Chaboyer & Patterson, 2001; Hagbaghery et al., 2004); low confidence levels (Fulton, 1997; Randen & Bjork, 2010); and low nurse to patient ratios (Rose et al., 2011b). Critical care nurses’ involvement in decisions about ventilator weaning and extubation appears to be enhanced through the use of protocols (Rose, Blackwood, Burns, Frazier, & Egerod, 2011), by being perceived as competent by physicians and colleagues (Hancock & Easen, 2006; Villa et al., 2012) and especially through “knowing the patient” (Crocker & Scholes, 2009; Lavelle & Dowling, 2011). However, their involvement in decisions is frequently affected by the attitude of physicians and nurse managers (Hancock & Easen, 2006; Rose et al., 2008) and several hierarchical factors, particularly the perceived or actual power differences between nurses and doctors (Fulton, 1997; Chaboyer & Patterson, 2001; Hagbaghery et al., 2004; Leonard, Graham, & Bonacum, 2004; Villa et al., 2012).
In view of their well-documented role in improving patient outcomes and enhancing patient safety (Chapter 1), it was considered timely to investigate the nature and extent of local critical care nurses’ involvement in decisions about changes in critically ill patients’ treatment modalities; factors which facilitate and hinder such participation; and strategies used by nurses in an effort to enhance their involvement in decision making. Also, while most of the reviewed studies investigated nurses’ help seeking decisions in relation to specific treatment modalities, in the present study referral is explored in more general terms, rather than in relation to one particular mode.

2.3.5 Type of knowledge and strategies used in referral

Chaboyer and Creamer’s (1999) study indicated that the referring process involves intellectual work because nurses have to think and work out the physiological processes that are going on before actually approaching a doctor to propose treatment modality changes. Luker and Chalmers (1989) use the phrase “working up a referral” (p.176) to sum up the complex process health visitors engage in to refer clients to other health professionals. Andrews and Waterman (2005) conducted grounded theory research into the way nurses in general medical and surgical wards report physiological deterioration to doctors and concluded that effective referral involved nurses using vital signs and Early Warning System scores to “package” information about patient deterioration, thereby convincing doctors about the urgency of the situation. Similarly, the critical care nurses in an ethnographic study by Chase (1995) felt it was their duty to “assemble the data” before discussing treatment modality changes with doctors. More recently, in a study about nurse-physician communication in long term care settings, it emerged that nurses’ referrals were more successful in producing what they considered to be an appropriate response from physicians when they were brief but prepared with relevant clinical information (Tjia et al., 2009), while Liu et al.’s (2012) study about ward rounds on medical wards reported nurses’ use of “the discourse of preparation” (p. 126) whenever they felt the need to affirm their point about a particular medication task. It was considered timely to explore whether and which particular strategies are used by nurses in a critical care setting when reporting changing patient trajectories to, and when discussing treatment modality decisions with, medical practitioners.

Stein-Parbury & Liaschenko’s (2007) research suggests that nurses and doctors use a different type of language because they are experts in different types of knowledge, a
situation which often leads to a breakdown in collaborative decision making, particularly when doctors perceive ‘their’ type of knowledge to be superior, which may be related to doctors’ traditional hegemony within the healthcare system. In this context, it has been argued that the status of knowledge does not only depend on the actual subject matter, “but also on the manner of its representation…and the social relations between the participants”, thereby emphasising the “social” element of knowledge (Eraut, 2005, p. 56). This reiterates the views of Leonard, Graham and Bonacum (2004) who claim that nurses and doctors use a different form of communication with the former being “taught to be narrative in their descriptions of clinical situations” whereas the latter are trained “to be very concise and get to the ‘headlines’ quickly” (p. i86). This difference in communication style and knowledge sources is frequently reflected in differing priorities in clinical practice. For instance, studies about weaning from mechanical ventilation suggest that nurses look at the overall psychological and emotional picture surrounding a critically ill patient’s condition while doctors focused almost exclusively on physiological parameters (Crocker & Scholes, 2009). In another study, doctors tended to be more aggressive in their approach to weaning while nurses were inclined to act more conservatively (Kydonaki, 2010). Similarly, a study in Danish intensive care units suggested that doctors and nurses with different levels of experience had different priorities in sedation management: less experienced nurses tended to focus on the short term goal of using sedation to achieve patient comfort while doctors and experienced nurses were more concerned with the longer term effects of sedation in prolonging mechanical ventilation (Egerod, 2002). These and similar findings sensitised me to keep in mind that critical care nurses might perceive their priorities to be different from those of medical practitioners in the management of critically ill patients.

2.3.6 The value of experience

Several studies have investigated the value of experience in decision making in nursing in general and in critical care nursing in particular. An early study about the decision making abilities of critical care and coronary care nurses by Baumann and Bourbonnais (1982) suggested that the capacity for rapid decision making was mostly associated with nurses’ knowledge and experience. There is also some evidence that experience is influential in the strategies adopted by nurses to collect and cluster clinical cues, which enables experienced nurses to make faster and more accurate decisions (Cioffi, 2002; Hoffman, Aitken, & Duffield, 2009). In Corcoran’s (1986) study, for instance, inexperienced nurses gave equal
importance to all aspects of a clinical situation, irrespective of its complexity, while experienced ones were able to determine the salience of different aspects and used different strategies according to the complexity of the task. Similarly, in Hoffman et al.’s (2009) study, experienced nurses were more effective in making proactive decisions to anticipate and prevent problems rather than reacting to them after they occurred.

The work of Benner, Tanner and colleagues underscored the increasing ability of nurses to anticipate patient related trajectories, to concentrate simultaneously on multiple aspects of patient assessment and management, and to recognise priorities in patient care as experience is gained (Benner, 1984; Benner & Tanner, 1987; Benner et al., 1992; Benner, Tanner, & Chesla, 1996). Conversely, beginners tend to rely on decontextualized propositional knowledge based on formal instruction; to overvalue information which confirms their judgement and undervalue contradictory information (Benner, 1984; Cioffi, 2002); and to base their actions on a single cue instead of collecting several (Scholes et al., 2012). Experienced nurses also tend to reflect on past experience and incorporate it into the assessment and management of current clinical situations (Cioffi, 2002), which confirms the value of reflection on practice as a means of learning and improving clinical decision making (Tanner, 2006).

Studies have also suggested that experience in nursing is useful in facilitating involvement in decisions (Rose et al., 2008; Randen & Bjork, 2010; Kydonaki, 2010) and reduces the need to seek confirmation from colleagues and physicians (O'Leary & Mhaolrunaigh, 2012; Villa et al., 2012). Indeed, minimally experienced practitioners tend to rely on more experienced practitioners’ help when making decisions and often attempt to avoid situations which compel them to make decisions on their own, which aspects are gradually reversed as a nurse gains experience, and subsequently confidence, in his / her clinical area (Benner, Tanner, & Chesla, 1996). Thus, as they gain experience, nurses “move from the position of detached observer standing outside the situation to a position of full involvement in the patient situation” (Burn & Higgs, 2000, p. 299). Thompson (1999), on the other hand, is more sceptical about experience per se being the most important aspect for the development of expert practice. While acknowledging the role of experience in decision making, he underscores research evidence suggesting that experience can lead to biased decision making when clinicians give more attention to incidents they have encountered recently and downplaying the importance of less recent, but potentially equally important, incidents. According to the same author, when evaluating the role of
experience, it should be kept in mind that seasoned practitioners “are more likely to have accrued a higher proportion of dramatic events in their careers, which is unfortunate given that individuals have a tendency to oversample these dramatic exemplars” (Thompson, 1999, p. 822).

In this context, it was considered significant to study whether nurses’ individual characteristics, including experience, affect the frequency and nature of referring among critical care nurses, as well as the extent of their involvement in decisions about their patients’ treatment modalities.

2.4 REFINED RESEARCH QUESTION AND PURPOSE

The overall purpose of the present research study is to explain the process of referring in the context of an intensive care unit by means of a substantive theory derived from the data. As indicated in the previous chapter, the initial research question focused on the factors related to critical care nurses’ decisions to refer to doctors when they want treatment modality changes for their patients. Early in the study, however, it became evident that securing changes in patients’ treatment modalities was only one of several motivations underpinning nurses’ decisions to seek help. Subsequently, the principal research question was expanded to: What are the factors associated with critical care nurses’ decisions to refer to medical practitioners?

Reviewing and/or expanding the research question on the basis of emerging data is congruent with the grounded theory principle of ensuring that the (refined) research question reflects what is significant to the persons experiencing the phenomenon or social process (Glaser & Strauss, 1967; Birks & Mills, 2011). Early data also indicated that nurses’ decisions to seek help from other nurses and not to seek help from doctors were considered as equally important aspects of the process of referring. Furthermore, insights from research findings and from gaps in the literature (see Section 2.3) indicated the need to take a number of issues into consideration when conducting research on referring. These include:

- The extent of nurses’ involvement in decisions about treatment modality changes;
- Nurses’ motivations for their decisions to seek or not to seek help from medical doctors;
The circumstances under which nurses make referrals;
The nature of nurses’ communication with medical practitioners to achieve timely responses when they elicit the need of a change in a critically ill patient’s treatment modalities;
The strategies employed by nurses to increase their involvement in decisions about changes in treatment modalities;
The effect, if any, of experience on the frequency and nature of nurses’ referral;
The factors that help and hinder collaborative decision making in the local critical care setting;
The basis on which critical care nurses decide from which of their medical and/or nursing colleagues to seek help.

Reflexivity was, therefore, crucial in both identifying and refining the aims of the present project. As explained in Chapter 1, the research area and preliminary research question were partly identified by reflecting on my own professional values and clinical experience. Subsequently, adopting a reflexive stance during the preliminary literature review and early data collection and analysis was useful in updating and expanding the research question (Birks & Mills, 2011).

2.5 CONCLUSION

This chapter has situated the research question guiding this project in the context of other research about clinical decision making. Although considerable knowledge about nurses’ decisions has been gained through a range of research designs and approaches, little is known about the explicit and tacit factors associated with critical care nurses’ decisions to seek help from doctors, and about the complex social interactive process that constitutes referral. In view of this social and interpersonal aspect of referral, and in the light of insights obtained from this review, the next chapter proposes symbolic interactionism and the grounded theory method as a theoretical and methodological approach for gaining a deeper understanding of this frequent and multifaceted decision within a particular context, namely a local intensive care unit.
Chapter 3

METHODOLOGICAL FRAMEWORK

3.1 INTRODUCTION

This chapter presents the methodological approach adopted to address the research question presented in the previous one. It starts with an overview of the ontological, epistemological and theoretical assumptions influencing the present study, followed by a discussion of grounded theory, dimensional analysis, and their applicability to this project. Strategies which were utilised for enhancing and maintaining theoretical sensitivity are then described followed by an overview of the methodological decisions underpinning data collection and their rationale in the context of grounded theory principles. The chapter ends with a detailed discussion of the strategies employed to ensure methodological rigour throughout the study.

3.2 ONTOLOGY, EPISTEMOLOGY AND THEORETICAL PERSPECTIVE

Since this study sought to explore the process of referral through critical care nurses’ perspectives of the factors affecting their decisions to seek help, it was necessary to give these participants a voice to express their thoughts, experiences, feelings and actions. Indeed, while my views on referring were presented in Chapter 1, it was especially the participants’ perspectives and meanings that I wanted to elicit. Thus, this research project is underpinned by relativist ontology and a social constructionist epistemology. Relativism implies that the same phenomenon is interpreted differently by different people in different places and at different times (Erlandson, Harris, Skipper, & Allen, 1993; Crotty, 1998). In other words, people’s understandings of reality are “historically and culturally effected interpretations rather than eternal truths of some kind” (Crotty, 1998, p. 64). Social constructionism holds that truth and meaning come into existence through our engagement with the realities in our world and that, as such, different people may construct a different meaning about the same phenomenon (Crotty, 1998). According to the social constructionist view, the concept of the social world is constructed by individuals through their social practices, rather than being a fixed objective entity external to them (Cohen,
Duberley, & Mallon, 2004). Indeed, the social and cultural realities of critical care, as well as nurses’ personal experiences and characteristics, shape nurses’ views of and decisions about referring. Social constructionism, therefore, challenges taken-for-granted knowledge and affirms that knowledge is generated and sustained by social interaction, particularly through language, and that descriptions or social constructions of the world lead to particular forms of action (Burr, 2003; Young & Collin, 2004).

In contrast with objectivists, social constructionists reject the notion that there is an objective truth waiting to be discovered; rather, they believe that meaning is constructed by both the subject and the object (Guba & Lincoln, 1994; Crotty, 1998). An endeavour was, therefore, made to include the participants’ voice in the process of data analysis by taking the findings and the emerging theory back to the participants to make sure that these reflected their perceptions. Furthermore, social constructionism assumes that our understandings of the world are culturally and historically specific (Burr, 2003; Cohen et al., 2004). Bearing this in mind, I constantly reflected on the role of my own discipline and professional background (Chapter 1) in data construction, and how these influence my own role as the author of an account of a shared experience (Mills, Bonner, & Francis, 2006).

In accordance with the social constructionist approach, attempts were also made to modify the power imbalances between the researcher and the participants as both are considered to have a role in constructing the findings of a study (Mills et al., 2006). As such, several efforts were made to inform the research participants about all the details of the study and to include them in several decisions about it. For instance, as explained in Chapter 4, data collection sessions took place at their preferred time and venues (Duffy, Ferguson, & Watson, 2004). Similarly, as recommended by Davis (1986), the nature and extent of my participation in patient care during participant observation was negotiated with the participants themselves.

The study is also guided by a symbolic interactionist perspective, which focuses on the meaning of events to people in natural everyday settings, and on social interactions through which an individual achieves a sense of self (Chenitz & Swanson, 1986). Symbolic interactionism attempts to understand how human behaviour is affected by circumstances, rules and conditions which regulate the shared meanings of objects (Aldiabat & Le Navenec, 2011). Eliciting such meanings from the social actors within a particular social

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18 Other reasons for exposing the findings to the participants are discussed later in this and in the next chapter.
context is, therefore, crucial in understanding their behaviour and the interactions and social processes they engage in (Jeon, 2004). From this perspective, the best way to understand nurses’ decisions about seeking help from their colleagues involved actually observing them during the process of referral, as well as listening to their accounts and personal reflections about these processes and their previous related experiences. Thus, through participant observation and interviews, I actively engaged in the participants’ setting and elicited the social actors’ (critical care nurses’) points of view about referral through purposeful conversations. Accordingly, an attempt was made to determine what meaning actions and words have for nurses when interacting with doctors and other colleagues to seek their help in patient management. Indeed, it is “only through dialogue that one can become aware of the perceptions, feelings and attitudes of others and interpret their meanings and intent” (Crotty, 1998, p.75).

Blumer (1969, p. 2) elicited the principal assumptions of symbolic interactionism as follows:

1. *Human beings act toward things on the basis of the meanings that the things have for them*;
2. *The meaning of such things is derived from, or arises out of, the social interaction that one has with one’s fellows*;
3. *These meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he encounters*.

The first assumption implies that people’s actions are based on the meanings they give to social situations (Blumer, 1969). Likewise, in the complex world of critical care, a nurse’s interactions with a doctor or another nurse take place within a symbolic system involving implicit but powerful rules and a specific language. From a symbolic interactionist perspective, therefore, to describe and explain critical care nurses’ decisions to seek help it is necessary to understand not just the actions related to the process of referring but also the meaning that nurses attribute to the act of seeking help from a member of their or another profession. Consequently, it was necessary to capture nurses’ actions (through participant observation) and their perceptions about those same actions (through interviews).
The second assumption is that the meaning of social phenomena is derived from and arises through an individual’s interaction with other persons (Blumer, 1969). In the case of the present study, nurses who opted to take part came with a concept of themselves as ‘nurses’ in general and ‘critical care nurses’ in particular, which concept had been built and modified through several previous episodes of interacting with patients, colleagues and other health professionals throughout their professional experience. Even the interpretation of language and the discourse that is employed creates a shared symbolic meaning, specific to that particular context (Stevenson et al., 2004). For instance, the term ‘weaning’ normally refers to the gradual introduction of solid food in a baby’s diet with the concurrent reduction in the baby’s dependence on milk as a source of nutrients. In critical care parlance, however, the term is almost invariably used to imply the gradual reduction in the ventilatory support delivered to a mechanically ventilated patient or the gradual discontinuation in the infusion of a particular drug. It was, therefore, crucial to choose a research paradigm and design which gives due consideration to the contextual aspects in which nurses’ interactions when seeking help from colleagues are embedded. Subsequently, a naturalistic, rather than a simulated, approach was adopted, particularly by observing nurses during actual clinical practice, and subsequently talking to them about those practices.

The third assumption of symbolic interactionism is that meanings are assigned and modified through a process of interpretation (Blumer, 1969). Thus, meanings are not static but modified by the persons dealing with the particular situation (Crotty, 1998). In this study, therefore, it was important to consider nurses’ perceptions of their relationship with doctors in the social, cultural and historical realities of the local critical care context, and the effects of this relationship on the process of referring. This relationship is based on an interpretative process that takes place between these social actors and is not fixed but changes as both parties are exposed to different experiences in the course of their clinical practice.

3.3 GROUNDED THEORY AND DIMENSIONAL ANALYSIS

In order to address the research question, the dimensional analysis approach to generating grounded theory was adopted (Schatzman, 1991; Kools et al., 1996; Bowers & Schatzman, 2009), because this enables the conceptualisation of behaviour while stressing the
importance of the context in which this behaviour takes place, and is compatible with the symbolic interactionist perspective (Chenitz & Swanson, 1986; Jeon, 2004; Aldiabat & Le Navenec, 2001). This section opens with an overview of grounded theory in general and dimensional analysis in particular. Subsequently, the motivations for selecting a qualitative approach to research using the principles of grounded theory and dimensional analysis are explained in more detail.

3.3.1 Overview of grounded theory and dimensional analysis

**Grounded theory** is a mode of inductive, deductive and abductive analysis which aims to generate a theory that is systematically derived from and “grounded” in data obtained from a real life setting (Benton, 1996; Byrne, 2001). It is, thus, a means of describing and explaining social processes through the development of a substantive or a formal theory (Jeon, 2004). Substantive theories are so called because they address specific areas of study or specific social processes, while formal theories are a further development of substantive theories and are concerned with more general and conceptual areas of enquiry (Backman & Kyngas, 1999; McCann & Clark, 2003a; Glaser, 2011). Both substantive and formal theories are considered to be “middle-range” theories because they fall between “minor working hypotheses” of everyday life and all-inclusive “grand” theories which are spread across societies but have no foundation in systematically analysed data (Glaser & Strauss, 1967, p.32-33; Glaser, 1982; Charmaz, 2006). Grounded theory is especially applicable to nursing research because it enables the generation of theories about dominant psychosocial processes characterising human interactions, and is therefore strongly applicable to everyday clinical practice (Chenitz & Swanson, 1986; Elliott & Lazenbatt, 2005).

Grounded theory makes use of various sources of data including interpersonal contact between the researcher and the participants (through participant observation and interviews) and documentary evidence (Benton, 1996). Analysis of early data influences subsequent sampling of participants and data on the basis of the emerging theory.

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19 The way in which the principles presented in this section were applied to the present study is discussed more specifically in the next chapter.

20 *Inductive* reasoning extrapolates trends or patterns from a range of individual examples, while *deduction* applies generalised or abstract concepts to specific cases. *Abductive* reasoning “entertains all possible explanations from the observed data, and then forms hypotheses to confirm or disconfirm them until the researcher arrives at the most plausible interpretation of the observed data” (Charmaz, 2006).
(theoretical sampling). Sampling is therefore guided by data analysis and aims at theory construction rather than population representativeness (Charmaz, 2006). Concurrent collection and analysis of data proceed until theoretical saturation. The latter occurs when the examination of newly collected data yields no new information and theoretical concepts and their relationships are completely developed (Benton, 1996; Kools et al., 1996; Polit & Hungler, 1998).

In grounded theory, the researcher enters the field with a flexible and open-minded approach to data collection (McCann & Clark, 2003a), which enables theoretical concepts to be developed from data, rather than from preconceived, logically deduced hypotheses (Charmaz, 2006). Glaser and Strauss (1967, p. 47) warn against the dangers of committing oneself exclusively to one specific preconceived theory as this prevents the researcher from “seeing around his pet theory...as he becomes insensitive or even defensive as he is preoccupied with testing, modifying and seeing everything from this one angle”. Yet, it is also important to enter the field theoretically sensitised21 with an awareness of the subtleties of the data (Glaser & Strauss, 1967; Glaser, 1978). Thus, grounded theorists need to sensitise themselves to their own and others’ experience, as well as to other theories, without foreclosing on them (Kelle, 2007). Analysis is guided by the constant comparative method, through which different data elements are compared with each other element (Benton, 1996). Memo writing is used as a reflective tool throughout the process to enable the researcher to document abstract thinking about the data; to identify gaps in the emerging theory; and to remember, analyse and capture the significance of the time spent with the participants (Mills et al., 2006). Although no in-depth critique of the literature is normally conducted before developing an independent analysis of the phenomenon (Charmaz, 2006), the literature itself may be used as a basis for comparing, supporting and critiquing the emerging theory (Benton, 1996).

A broad distinction can be made between an objectivist and a constructivist approach to grounded theory (Charmaz, 2000). According to Charmaz (2006), in constructivist grounded theory data and theories are not discovered but, rather, constructed through the researcher’s constant involvement and interaction with the research participants and with the data. It, therefore, adopts a reflexive approach which recognises and promotes the researcher’s position in the research process. Likewise, instead of attempting to present an “exact picture” of the process of referral in a critical care unit, the present study

21 Theoretical sensitivity involves recognising and extracting data elements which are relevant for the developing theory. This is discussed in Section 3.4.
endeavours to provide an “interpretative portrayal of this studied world”, which incorporates the research participants’ and the researcher’s constructions of reality (Charmaz, 2006, p. 10). In this context, a more subtle distinction can be noted between a constructionist and a constructivist approach to knowledge and research; the former puts the social dimension of meaning at centre stage while the latter emphasises a more individualistic focus of the cognitive processes that accompany knowledge (Crotty, 1998; Young & Collin, 2004). However, these terms are sometimes used interchangeably and the ‘constructivist’ approach to grounded theory proposed by Charmaz (2006; 2009) appears to be underpinned by the ‘social constructionist’ epistemology discussed in the previous section.

Since its original formulation in the sixties (Glaser & Strauss, 1967), grounded theory has undergone several transformations (Stern, 2009). Indeed, one can now speak of at least five different approaches to the methodology, namely the Glaserian version, the Straussian version, dimensional analysis, constructivist grounded theory and situational analysis (Morse, 2009). Although this classification, proposed in Developing Grounded Theory: The Second Generation (Morse et al., 2009), appears to restrict the term constructivist grounded theory to the strand proposed by Kathy Charmaz (2006; 2009), according to Charmaz’s (2000) own broader distinction the term actually applies to the view that theory can be co-constructed with the participants, with the researcher’s task being that of defining what is happening in the data, as opposed to an objectivist approach to grounded theory in which the researcher assumes full control over the construction of theory, which in turn assumes that there is an external reality which can be discovered. On the basis of this general distinction between objectivist and constructivist grounded theory (Charmaz, 2000), the present study is broadly constructivist in its approach, while the collection and analysis of the data and the generation of a substantive theory from those data are driven by dimensional analysis.

**Dimensional analysis** is concerned with how researchers and research participants define situations, while explicitly outlining the analytic processes involved in the interpretation, discovery or construction of social processes (Schatzman, 1991; Bowers & Schatzman, 2009). Although dimensional analysis is characterised by some unique analytic procedures, there is significant overlap between grounded theory and dimensional analysis, so much so that the latter is often considered as a form of second generation grounded theory (Bowers & Schatzman, 2009; Morse, 2009). Like ‘traditional’ grounded theory, dimensional
analysis aims to generate theory directly from data; however, rather than focusing exclusively on a basic social process (Glaser, 1978), dimensional analysis aims to uncover “what ‘all’ is involved” (Schatzman, 1991, p. 310) in a particular social phenomenon. Furthermore, dimensional analysis emphasises the similarity between natural analysis (everyday processes used by people to interpret and understand problematic experiences of phenomena) and research analysis which it considers to be an exaggerated, sustained and intentional degree of analysis but which essentially uses the same logic (Schatzman, 1991; Kools et al., 1996; Bowers & Schatzman, 2009). Moreover, dimensional analysis considers past experience and knowledge as an essential part of the individual’s thinking process (Schatzman, 1991; Bowers & Schatzman, 2009). The relevance and application of the qualitative research paradigm, grounded theory and dimensional analysis to the present research project will now be discussed.

3.3.2 Relevance of the qualitative paradigm, grounded theory and dimensional analysis

The main aim of the present study was to achieve a deeper understanding of a complex social interactive process, namely referring, within a particular context, specifically a critical care unit in a local general state hospital. It focused on the dynamic, holistic and individual aspects of this process and, in line with the naturalistic research paradigm, attempted to capture these aspects in their entirety within the context of those who were experiencing them (Polit & Hungler, 1998). This project, therefore, adopted a qualitative research approach by seeking to elicit rich in-depth information from the very persons, i.e. critical care nurses, involved in this process. As such, it is grounded in a philosophical position that is broadly interpretivist as it is concerned with how the social world is interpreted, understood and explained (Mason, 1996). A qualitative approach to research is appropriate for this study because it seeks to elicit variables (in this case, factors related to a decision making process) which are not easy to identify (Cresswell, 1998); because relatively little is known about the process of referral, especially in the critical care context (Morse & Field, 1996); and because this research seeks reasons for, rather than causes of, nurses’ behaviours (Porter, 1996).

Grounded theory methodology was considered especially suitable for this research project because:
• The study sought a deeper understanding of the complex, and often tacit\(^{22}\), factors surrounding critical care nurses’ decisions to seek help from members of the medical profession, several of which are not easily articulated;

• Referring is a process that involves an interpersonal activity between nurses and other health professionals, and therefore needed to be explored in the real world context and explicat ed by the people who are involved in this social interaction. Grounded theory is very useful in such research situations with an inherently embedded social process (Glaser, 1978; May, 1986);

• Prior research around this type of decision is scanty (see Section 2.3) and grounded theory is particularly adapted for conducting research in which little or no theory exists (McCann & Clark, 2003a; 2003c);

• An ultimate aim of this project is to generate a substantive theory which explains referring and which is “grounded” in data about clinical nurses’ actual concerns, perceptions and actions related to this process (Benton, 1996; Jeon, 2004; Aldiabat & Le Navenec, 2011).

More specifically, dimensional analysis is applicable to research about decision making in a real life clinical context because, as explained earlier, it is based on normal everyday interpretation of life events and phenomena (Schatzman, 1991). When people assess such real life situations and make decisions about them, they analyse options, attribute values and select among possibilities (Kools et al., 1996; Bowers & Schatzman, 2009). Likewise, I attempted to “identify all factors” (Corley, 1998, p. 325) associated with critical care nurses’ decisions to seek help from other health professionals, describe their properties and organise them according to their salience\(^{23}\). Thus, the present study involved making research decisions in order to understand and explain real-life clinical decision making, using an approach which underscores the similarity between natural and research analysis. Indeed, I was particularly drawn to the dimensional analysis approach to generating

\(^{22}\) The term tacit factors hereby refers to aspects of non-propositional knowledge (see Chapter 2), which underpin clinical practice but which often render themselves invisible unless clinicians reflect upon or document them (Higgs & Titchen, 2000) or are encouraged to articulate them, as this study attempted to do. Indeed, several studies using grounded theory attempt to identify aspects of a social process that are often not articulated (McCann & Clark, 2003a).

\(^{23}\) The actual process will be illustrated in Section 4.6.
grounded theory because of this emphasis on the similarity between research and natural analysis, and the importance it ascribes to the perspective of both the researcher and the participants. In fact, in dimensional analysis, the researcher’s “perspective (commitment, discipline, or personal biography) is embedded in the analysis, guiding the identification and designation of dimensions, the direction of comparative analysis…and the organisation of dimensions (theory development)” (Bowers & Schatzman, 2009, p. 95). Therefore, my experience as a clinician and educator in the area of critical care nursing, discussed in Chapter 1, naturally influenced several aspects of the research process, including the selection of the research area, establishing a rapport with the research participants and gathering and analysing data. This is compatible with the social constructionist epistemology (Section 3.2) and the broadly constructivist approach to grounded theory (Charmaz, 2000; Mills et al., 2006) adopted in the present study. Furthermore, dimensional analysis’ aim of interpreting natural events and social interactions between human beings, which stems from Leonard Schatzman’s roots within the symbolic interactionist tradition (Stern, 2009; Gilgun, 2010), is congruent with the present study’s symbolic interactionist underpinnings (Section 3.2).

3.4 DEVELOPING AND MAINTAINING THEORETICAL SENSITIVITY

An essential element of grounded theory research is the development and maintenance of theoretical sensitivity, which involves “the ability to recognise and extract from the data the elements that have relevance for the emerging theory” (Birks & Mills, 2011, p. 176). According to the same authors, theoretical sensitivity is characterised by the researcher’s personal, professional and experiential history; can be enhanced through several strategies; and increases as the research progresses. Glaser and Strauss (1967) identify four potential sources of theoretical sensitivity. First, personal experiences prior to or outside the research can be crucial in providing insight to the researcher. Second, such insight may also come from other people’s experiences. Third, existing theory may act as a source of insight about the researcher’s own data. Fourth, the cultivation of new insights should continue until the end of study (Glaser & Strauss, 1967, p. 252 – 253).

Throughout the different stages of the present study, a variety of methods were used to enhance and sustain theoretical sensitivity:
• **Immersion in and interaction with the data** involved becoming as familiar as possible with the participants’ perspectives about the research area through transcribing and frequent listening of interviews. Memos about my reactions to the data elicited through observations and interviews were written at various stages: while still in the research field; just after leaving the field; during transcription and field note expansion; during later analysis; and while writing various drafts of this thesis. Interpretation of observation and interview data was followed by returning to the field to confirm or refute emerging concepts, to clarify queries and to fill in gaps in the interpretation. A record of my research decisions, my reactions to the data and how these changed throughout the study was kept through memo writing and by maintaining a reflexive research journal.

• **Preliminary observation sessions**, prior to actual data collection, were invaluable in making me look at a familiar place from a sociological stranger’s viewpoint (Hammersley, 1985; Glesne, 2011). In the process, these preliminary observations sensitised me to the subtleties of the referral process which I was then able to follow up during actual data collection. For example, through these preliminary observations I became aware that referral to certain doctors, particularly consultants, often did not take place directly; rather, some nurses made their referrals through senior colleagues and through more junior doctors. I also noted that most episodes of referral took place during doctors’ ward rounds; subsequently, I made it a point to observe such events during actual data collection through participant observation\textsuperscript{24}.

• **Insights from professional experience**. Glaser and Strauss (1967, p.3) recognised that researchers do not approach research as a *tabula rasa*; rather, they should use their perspective and experience “to help them see relevant data and abstract significant categories from their scrutiny of the data”. Similarly, Strauss and Corbin (1998) and Bowers and Schatzman (2009) acknowledge the value of the researcher’s knowledge and professional experience in enhancing theoretical sensitivity, while Schatzman and Strauss (1973) warn that “to entirely repress past experiences and their associated observational consequences is neither possible nor useful to the researcher” (p. 53). When I embarked on this study, I had already been

\textsuperscript{24} These preliminary observation sessions and their value in making the familiar strange are discussed in more detail in the next chapter (Section 4.5).
working as a critical care nurse for nine years, during which I had first-hand experience of the process of referral on a daily basis in my clinical work. While the focus of my research is on the participants' perceptions about referring, having several experiences of the process myself made the engagement in purposeful conversations with the participants and the understanding of their experiences somewhat easier than it would have been for a complete outsider to the process, even though, as explained in the next chapter, I tried to remain reflexively vigilant against foreclosing on these perspectives. This is in keeping with Schatzman and Strauss’ (1973, p. 53) advice to “capitalise on whatever sensitivities may be yielded by the [researcher’s] past experiences…[as] they can be a rich source of sensitivities whose validity can later be checked upon” and concurs with Mruck and Mey’s (2007, p. 519) claim that “personal experiences may lead to precious insights and perspectives, hardly available for researchers unfamiliar with such topics”.

- **Enhancing theoretical sensitivity through insights from the literature.** The literature was used as a catalyst for theoretical sensitivity throughout the entire research process. Although an in-depth review and appraisal of the literature was not performed before data collection, I was aware that “fruitful insights can be gotten from existing theory” (Glaser & Strauss, 1967, p.253). The use of the literature in the earlier stages of a grounded theory project is a particularly contentious issue, with Glaser (1992) warning that this could “contaminate, stifle or otherwise impede the researcher’s effort to generate categories” (p. 31). Nonetheless, I agree with Urquhart’s (2007) argument that “there is no reason why a researcher cannot be self-aware and able to appreciate other theories without imposing them on the data” (p. 351). As elegantly stated by Dey (2007), it is important to approach the data with an “open mind” and not with an “empty head” (p. 176). Thus, early “non-committal” (Urquhart, 2013, p. 29) reading of articles about critical care nurses’ decision making in general, and non-critical care nurses’ decisions to seek the help of colleagues improved my awareness of and sensitivity to relevant and significant elements in the data. This preliminary reading was also useful as an “orienting process” (Urquhart, 2007, p. 351), by helping me identify the scope and range of research which had been carried out25 (Chenitz, 1986a); the “gaps or systematic bias in existing knowledge” (May, 1986, p. 149); and,

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25 This was presented in Section 2.3.
subsequently, the formulation and refining of the research questions and their rationale (May, 1986; Urquhart, 2013).

The literature was also helpful during the process of inductive and deductive data analysis (Section 4.6 refers). Thus, whenever data analysis led me to re-interpret data using different conceptual terms, I attempted to broaden my understanding of the terms I was using by reading around the topic. For example, when the concept of “advocacy” was re-interpreted as “patient agency”, I read around the concept of “agency” as used in financial sector in an effort to “line up what one takes as theoretically possible or probable with what one is finding in the field” (Glaser & Strauss, 1967, p. 253). Such use of the literature as a means of enhancing theoretical sensitivity during analysis is also advocated by grounded theory authors such as Stern (2007) and Lempert (2007). The latter author, in particular, proposes comparisons with the literature as a means of alerting the researchers to gaps in their theorising by encouraging them to ask increasingly analytical and complex questions of the data. Similarly, Schatzman & Strauss (1973) recommend using the literature as a “conceptual lever” (see Section 4.6.3), while Chenitz (1986a) contends that an ongoing literature review helps the discovery process by ensuring that no salient elements of the data are overlooked. Throughout this process, however, I used a reflexive stance to prevent forcing insights from the literature onto my data by keeping the data themselves at the forefront (explained earlier in this section) and by using reflexive memos to document any insights obtained from the literature and any changes in the analytical direction as a result of such insights (Charmaz, 2006).

Finally, drafting the findings was accompanied by a fresh and more detailed search for theoretical/conceptual literature and empirical research about agency, dual agency and moral agency as a means of comparing my theoretical insights with those of earlier researchers, thereby “delimiting the boundaries of the existing theory while generating a more general one” (Glaser & Strauss, 1967, p.255). While reviewing the literature in the earlier stages of grounded theory research is contested, there seems to be an agreement that comparing and contrasting the emerging theory to the existing substantive and formal theories in the subject area is valuable as a means of enhancing the level of conceptualisation (Glaser, 1978),

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26 The preliminary research question was presented in Chapter 1, and refined and updated in Chapter 2.
and the “power and depth” (May, 1986, p. 152) of the generated substantive theory. Indeed, Urquhart (2013, p. 29) considers the grounded theorist as having an “obligation…to engage the emergent theory with the existing literature”, while Stern (2007) underscores the value of reviewing related literature in demonstrating the original contribution of the present work.\(^{27}\)

### 3.5 OVERVIEW OF METHODOLOGICAL DECISIONS

From a symbolic interactionist perspective, when interacting, people do not merely react to each other’s actions; rather, they attribute a meaning to other people’s actions and respond on the basis of this interpretation (Whittemore, Chase, & Mandle, 2001; see Section 3.2). Researching a complex social interactive process such as referral, therefore, required me to elicit and untangle nurses’ interactions with other health professionals and their interpretations of such interactions. Persistent observation of, and in-depth conversations with, the social actors were, therefore, essential to interpret the meanings that referral has for the participants. Thus, in this study, data were mainly generated\(^{28}\) by means of participant observation and informal interviews in the field, followed by formal individual interviews. Focus groups were used at a later stage for additional theoretical sufficiency\(^{29}\) and for verification purposes. These different forms of data generation were essential to provide different forms of knowledge about the same social process. Data collection and data analysis started concurrently and iteratively; therefore, detailed analysis of each observation session and individual and focus group interview influenced, developed and focused subsequent data collection sessions. This section elaborates on the rationale for adopting this combination of data generation methods to address the research question, whereas the actual processes of data generation and analysis adopted in the present study are discussed in the next chapter.

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\(^{27}\) In this thesis, a comparison of the emerging theory with the extant literature is presented in Chapter 6, whereas the use of the literature as a conceptual lever during the different stages of data analysis is explained in Section 4.6.3. Uses of different sources of literature during the various stages of the study is summarised in Appendix I.

\(^{28}\) The term data generation is being used to underscore that this involved “the researcher directly engaged with…the participant” as opposed to data collection in which “the researcher has limited influence on the data source”. This is based on the distinction made by Birks and Mills (2011, p. 73).

\(^{29}\) Theoretical saturation and sufficiency, and measures of enhancing it will be discussed in the next chapter (Section 4.3).
Participant observation is a method of data collection based on intensive interaction between the researcher and the study participants in the participants’ own environment (Burgess, 1982a; Barker, 1996b; Casey, 2004). This form of field research enables the researcher to observe people in real-life situations and participate, to different extents, in their day to day activities (Burgess, 1982b). Observation as a means of data collection is particularly useful in grounded theory research because it facilitates the understanding of concepts which are difficult to understand from outside (McCann & Clark, 2003a). In the context of exploring the process of referral within a critical care setting, participant observation enables the researcher to focus on patterns of interaction, their consequences and their symbolic meaning in specific situations (Chenitz & Swanson, 1986). Also, according to Ambrosino (2005), participant observation explicitly acknowledges research participants as collaborators (rather than “subjects”) in the research process, which is coherent with the social constructionist approach underpinning this study (see Section 3.2).

The main advantage of using observation in research about practice based professions is that it allows researchers to watch what people actually do in a particular context (Oliffe, 2005; Caldwell & Atwal, 2005). Kennedy (1999, p.58) emphasises the value of participant observation in health care research settings as it helps to “unpack” knowledge, undocumented practice and factors associated with decision making. Similarly, Savage (2003) argues that when studying clinical decision making it is important to find ways to articulate experiential forms of knowledge acquired by nurses. Making clinical judgements may indeed depend in part on the use of “taken for granted bodily skills and non-verbalised knowledge” that nurses often employ without deliberate thought or reflection (Savage, 2003, p. 63). The outcomes of such research is, therefore, more direct and specific and may give unique insight to specific problems, such as decision making in clinical practice (Barton, 2008). Indeed, previous work related to decision making in the critical care nursing setting has indicated that contextual observations in the research field are more revealing than the restrictive nature of simulations in a de-contextualised “laboratory” setting (Watson, 1994; Bucknall, 2000; Bucknall, 2003). Hence, participant observation places the researcher in a unique position to gain access to the research setting and establish a rapport with the research participants, thereby gaining insight into the social world of nursing (Gerrish, 2003).
Besides watching people in the situations they encounter, participant observers also enter into conversations with their participants, thereby capturing the participants’ interpretations of the observed events (Burgess, 1982d). Simultaneously watching and listening to participants offers researchers the “distinct advantage” of capturing both the “is’s” and the “because’s” of the participants (Schatzman & Strauss, 1973, p. 68). Thus, in the present study, during the observation sessions I engaged in informal conversations with the participant being observed, not only to allow the participants to feel at ease while being observed, but especially to seek their immediate perceptions and reactions about observed events and their motivations for the actions taken. Such informal interviews have been described as “the backbone of participant observation” (Chenitz, 1986b, p.82) and “the most important single tactic in field research” (Schatzman & Strauss, 1973, p. 68) because certain observed events raise questions that cannot be answered unless the researcher actively pursues the topic immediately after the situation has occurred.

Participant observation combined with informal interviewing was particularly relevant to the present study in view of my considerable familiarity with the research setting. Although as a former critical care nurse I had participated in the process under investigation (referral within a critical care setting), I did not know about other nurses’ experiences related to that same process. The choice of these methods of data collection enabled me to spend time with other nurses, observing and hearing them while participating in this process and listening to their experiences and perspectives about it. In other words, participant observation and interviewing helped me learn more about this process by making “the strange familiar and the familiar strange” (Glesne, 2011, p. 67)\(^{30}\).

### 3.5.2 Relevance of formal individual interviews

Since “brief questioning and casual conversation will only begin to answer important questions” (Schatzman & Strauss, 1973, p. 71), each participant observation/informal interview session was followed up by a formal individual interview with the same participant. Although the content of interviews was partly determined by aspects which had been observed in the preceding observation session, they were generally minimally structured in nature. Such unstructured interviews\(^{31}\) enable the researcher to follow the

\(^{30}\) My efforts to make the familiar strange will be discussed in more detail in Section 4.4.

\(^{31}\) In view of the emerging theoretical insights, later interviews became more semi-structured in nature. This shift is discussed in Section 4.5.2.
direction taken by conversation; obtain detailed information in the participant’s own words; open up new dimensions of a problem; and secure a vivid account of the participant’s perspective on the research topic in a flexible and natural manner (Schatzman & Strauss, 1973; Burgess, 1982c; Swanson, 1986; Mack, Woodsong, MacQueen, Guest, & Narasimhan, 2005; Birks & Mills, 2011).

Although they take considerably longer to perform and analyse when compared to self-administered questionnaires (Barker, 1996c), unstructured interviews were considered particularly useful to this research study because of several advantages. First, they are much more useful to obtain in-depth information about factors associated with a social interactive process (in this case, referral in a critical care setting) because they enable the researcher to clarify any areas of ambiguity or uncertainty with the participants (Barker, 1996a). Second, they enable the researcher to explore in depth an area in which the participant is highly experienced and about which he/she has substantial insight (Charmaz, 2003). Third, through interviews the notion of “participant as expert” is made more explicit and this is congruent with a constructivist approach to grounded theory in which the researcher and the participants construct knowledge and meaning together (Mills et al., 2006). Thus, interviews were considered as the best way to obtain an explanation about participants’ decisions from the voice of the participants themselves, rather than from the imposed views of the researcher.

3.5.3 Relevance of focus groups

Focus group interviews are a method for collecting qualitative data in which one or two researchers meet up with a group of participants to discuss a research topic (Mack et al., 2005). A moderator (usually the researcher him/herself) enhances participation by all participants and ensures that the resulting interaction remains “focused” on the research topic (Frey & Fontana, 1993; Doodey, Slevin, & Taggart, 2013a). The interactions constituting focus group interviews are useful in exploring a research issue in more depth; revealing additional aspects associated with the topic; and allowing the participants to collectively make sense of the topic (Doodey et al., 2013a). Additionally, focus groups are helpful in identifying social, cultural or group norms, and the participants’ views about these norms (Mack et al., 2005).
Focus groups are also useful in assisting researchers in their interpretation of previously collected qualitative data (Stewart, Shamdasani, & Rook, 2007). Similarly, in the present study, focus groups were conducted after a process of iterative collection and analysis of observation and interview data, and an additional period of intense analysis during which a preliminary substantive theory, grounded on the findings, was generated. Thus, a primary aim for conducting focus groups was that of exposing my emerging theory to the participants, thereby gauging their reactions to it in terms of its coherence and relevance to their everyday critical care nursing practice. This concurs with Glaser & Strauss’ (1967) advice that “a grounded substantive theory that corresponds closely to the realities of an area will make sense and be understandable to the people working in the substantive area” (p. 240). Similarly, Dick (2007) points out that “involving participants in analysing the information they provide [which in the present study was attempted through focus groups]…offers researchers further protection against their own preconceptions” (p. 406).

Furthermore, I felt that I “owed it” to the participants to explain how I had organised and interpreted the data that they had provided me with individually, which reflects the constructivist approach of enhancing “a sense of reciprocity between the participant and the researcher” (Mills et al., 2006, p.9). Judging by the participants’ comments towards the end of each focus group and my own experience in moderating them, it was evident that there was a process of “mutual education” between the researcher and the participants, and also between the participants themselves (Dick, 2007, p.406). In fact, it has been reported that focus group participants typically enjoy interactions, sharing and learning from each other’s experience (Morgan & Kreuger, 1993; Hernandez, 2011).

Although the use of focus groups within grounded theory studies is a relatively recent development, it has been advocated by several grounded theory authors. It has been pointed out, for instance, that focus groups are “valuable in category development in grounded theory” (Birks & Mills, 2011, p. 77). Similarly, in the present study, focus groups indirectly served as a means of additional data collection by saturating pre-existing dimensions with additional examples or properties, thereby enhancing theoretical sufficiency (see Section 4.3). Birks & Mills (2011, p. 77) also cite examples of grounded theory studies in which focus groups followed individual interviews and in which the same

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32 The pros and cons of this form of group validation of the emerging theory as a means of enhancing rigour are discussed in section 3.6.
group of participants were involved in individual and focus group interviews (Melendez, 2008 and Hill et al., 2009 respectively, both cited in Birks and Mills, 2011), as was the case in the present study. Hernandez (2011) also strongly advocates the compatibility of focus groups with grounded theory in view of the type of data that they collect; the possibility of exposing those data to constant comparative analysis; and the opportunity of creating a substantive theory grounded on focus group data. Urquhart (2013, p. 69) concurs, arguing that grounded theory’s analytical methods “can be applied to documents, focus groups – pretty much everything that is a text can be coded”, which, in turn, is consistent with Glaser’s (1998, p. 8) contention that “all is data”, even though the latter does not advocate verifying the emerging theory with the participants.

3.6 METHODS OF ENHANCING RIGOUR

3.6.1 ‘Classic’ criteria for evaluating grounded theory research

In The Discovery of Grounded Theory, Glaser and Strauss (1967) identified four quality criteria related to the applicability of a substantive theory generated by the grounded theory method. First, the generated theory should fit the substantive field in which it is intended to be used. Second, the theory should be understandable and make sense to the people working in that area. Third, the theory should be general and flexible to make it applicable to ever-changing everyday situations, and yet not too abstract as to lose its sensitising aspect. Finally, the substantive theory should make it possible for its users to control it, thereby making it worthwhile for them to apply it in everyday situations. Eventually, Glaser (1978) updated these quality criteria by emphasising that, to be credible, the emerging theory should fit the generated data, be workable (i.e. able to explain and predict), be relevant and demonstrate modifiability (to ensure continued relevance). In summary, therefore, the classic criteria for evaluating grounded theory research involve generating a theory that is both structurally relevant and pertinent to one’s data.

As explained earlier in this chapter (Section 3.5) and in the next one (Section 4.6), in the present study I attempted to generate theory from diverse data by constantly comparing newly emerging concepts with previously analysed data collected from theoretically sampled participants. In this way, it was assured that the generated theory fits the data and is, therefore, “closely related to the daily realities (what is actually going on in the substantive area [of critical care nursing]) and highly applicable to dealing with them”
Also, concurrent data collection and analysis ensured that the dimensions illustrated in Chapter 5 adequately represent the patterns in the data (Fei, 2007). Eventually, the interpretation of the data was also taken back to the participants themselves for feedback, thereby ensuring that “the major propositions were tested or checked against the experiences and understanding of the hosts” (Schatzman & Strauss, 1973, p. 134). Indeed, according to May (1986, p. 153), “the best test of a grounded theory’s ‘fit’ is the reaction of individuals in the setting under study”. In addition, the iterative cycles of induction and deduction characterising the concurrent data collection and analysis (illustrated in Section 4.6) enhanced modifiability, through the comparison of emerging concepts and the developing theory with new data and their subsequent modification in a more conceptual and abstract direction.

By taking my findings and their interpretation back to my participants through focus groups, I also aimed to ensure the understandability of my theory to the nurses working in the critical care setting. Indeed, Glaser and Strauss (1967) contend that the people working in the substantive area’s “understanding of the theory tends to engender a readiness to use it, for it sharpens their sensitivity to the problems that they face and gives them an image of how they can potentially make matters better” (p. 240). Similarly, this study is guided by a research problem which, judging from my former experience as a clinician and my interactions with the participants, is particularly relevant to critical care nurses.

In this study, I attempted to generate a substantial amount of data surrounding the process of referral in a critical care setting. Thus, it is envisaged that the theoretical framework produced from these data includes “a sufficient number of general concepts relevant to most situations and plausible relations among these categories to account for much everyday behaviour in these situations” (Glaser & Strauss, 1967, p.242), thereby ensuring the principle of generality. As explained and exemplified throughout this and especially the next chapter, the use of analytical memos were indispensable in interpreting and comparing data segments in an increasingly abstract manner, thus enhancing my “analytic grasp” on the data (Charmaz, 2006, p. 3). Finally, the theory demonstrates workability because the central organising dimension and the other dimensions and theoretical concepts forming part of the generated substantive theory reflect the participants’ main concerns about their decisions to seek help from their medical colleagues. It also reveals

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This form of “host verification” (Schatzman & Strauss, 1973, p. 134) is discussed in more detail in the section about measures used to enhance credibility in the present study (Section 3.6.2 below).
their attempts to resolve these concerns, thereby helping to explain critical care nurses’ decisions around referral.

The next subsection looks at more generic measures of ensuring rigour in qualitative research studies, their relevance to grounded theory, and how their achievement was attempted throughout the present study.

### 3.6.2 Credibility and reflexivity

**Credibility** refers to the authenticity of the data or the degree to which the data are a genuine reflection of the participants’ experience of the phenomenon under study (Beck, 1993; Cresswell, 1998). Chiovitti and Piran (2003) identified several ways in which credibility can be enhanced in a grounded theory study, each of which was attempted in the present study.

First, *the participants should be involved in guiding the inquiry process*. In the present study, this was attempted in several ways. Issues raised by the participants in relation to the process of referral were explained in more formal, increasingly conceptual terms. Importantly, in keeping with the constant comparative method, issues raised by one participant were explored with subsequent participants, who were selected by theoretical sampling (Sections 4.2.3 and 4.6.2 include examples of this process). Moreover, as discussed in Section 4.5.2, the nature of interview questions changed as the study progressed, on the basis of the emerging theoretical concepts (Beck, 1993; Cooney, 2011). Furthermore, the interpretation of the research question was slightly extended on the basis of data generated by the participants themselves (refer to Section 2.4). In fact, while the research question originally intended to explore nurses’ decisions to seek help from doctors exclusively when they wanted treatment modality changes for their patients (see Section 1.1), issues raised by the participants in early data collection sessions and my interaction with these data made it clear that actually the process of referral involves seeking help in other contexts which were equally important for the participants. For example, help from medical colleagues is frequently sought for confirmation, and therefore to reduce nurses’ own anxiety. Also, nurses frequently sought the help of other colleagues instead of seeking a doctor’s help. Since these issues were evidently relevant for the participants, they are an essential component of referral, and therefore considered relevant.
Second, the generated theoretical construction should be checked against the participants’ meanings of the phenomenon (Chiovitti & Piran, 2003). Some authors have questioned the value of this type of verification in grounded theory research, arguing that checking the emerging theory is an integral part of constant comparative method (Elliot & Lazenbatt, 2005), with Glaser & Strauss (1967) insisting that the grounded theorist should focus on generating, rather than verifying, theory. However, verifying my theory with the participants themselves was considered particularly important in view of the constructivist approach to grounded theory adopted in this study (Mills et al., 2006). Thus, since I wanted to ensure that participants are involved in the different stages of the present research project, I considered it crucial to seek consensual validity by taking the findings of the study and their interpretation back to the participants to enable them to confirm and refute the emerging theory, as recommended by Benton (1996). Two main strategies were used to enable such **member checking**. Firstly, during all data collection sessions, I attempted to enhance my understanding of each participant’s perspective by supplementing observation sessions with informal interviews and by frequently summarising and seeking additional feedback during formal interviews (Section 4.5 refers). Secondly, as explained in Section 3.5.2, focus groups were mainly convened to expose the emerging theory to the participants and enable them to give their feedback about it. This is in keeping with the principle of group validation, whereby participants are assembled to inform an emerging model. In these focus groups, participants were asked whether my analysis makes sense to them, and requested to “look for a match between their experience and the emerging theoretical model” (Morse, 2007, p.241). Dick (2007) partly contests the involvement of participants in the interpretation of data due to their views being mostly local (emic) rather than generalised (etic); however, since this study aimed at generating a substantive (rather than a formal) theory, I felt that such (admittedly “local”) views were important to gauge. The adopted approach also concurs with the notion of “phenomenon recognition” as a means of enhancing the credibility of the emerging theory (Schatzman & Strauss, 1973, p.135).

As shall be explained in Section 4.5.3, the aim of conducting focus groups was not that of achieving consensus, a point which is also emphasised by Schatzman and Strauss (1973) in their discussion of host verification. Indeed, as indicated in the focus group excerpts below, two specific participants expressed some reservations about specific points, which were then taken into consideration while refining the substantive theory:
I am not sure I entirely agree with what you implied about the consultant’s role. Things are the way you described them specifically because consultants have the authority to prescribe treatment. And I also think that with the nursing role you need to consider the nursing plan...because we have our own plan. We carry out an assessment from the nursing point of view. It is on the basis of this plan that the nurse proceeds to propose changes in treatment modalities; without a proper assessment, the nurse wouldn’t be able to [propose such changes].

- Jacqueline, Focus Group 1

I don’t think it’s just about the patient and the doctor, but about me as well. It’s also about me... I am a factor as well. I am not just playing between the factors; I am a factor myself.

- Judith, Focus Group 2

Conversely, focus groups were aimed at ensuring that “the propositions offered to the hosts did not empirically contradict their own understandings of the situation” and that they “recognise the validity of the grounds upon which the propositions rest” (Schatzman & Strauss, 1973, p. 134). The excerpts below, eliciting the participants’ reactions to a written and visual presentation about the findings indicate that, to a considerable extent, this was successfully achieved:

MODERATOR: Having read the story, do you have any general reactions before we go through it bit by bit?
SALLY: For me, it looked very real...I kept saying “wow!” I could see several things which we actually do.
JEREMY: Practically, I agree with all of it as well. While reading it, I said to myself: “it’s true; that’s what I do” or “yes, this happens to me as well!”

SIMON: It’s good...very realistic!
JOHN: It includes everything, doesn’t it?
SALLY: You couldn’t have explained it better...once I was able to understand it, everybody should! [laughs]
JUDITH: I understood all of it because it flows smoothly from one section to the next, so you can easily follow it.

- Excerpts from beginning and end of Focus Group 1

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34 Before the actual focus group session, participants were invited to read a storyline of the emerging theory (see Section 4.5.3).
JACQUELINE: Your interpretation is sensible...And I liked the terms you put in...I don’t know if you knew the terms before or whether they came out after the interview...very nice terminology...and the graphics were very nice. Wow!

JACQUELINE: I really like it, especially the weights35 [laughs] ...yes.
SEPHORA: I am so impressed with the terms that you used. Very good, I think. The terms were really helpful to understand what is going on and to summarise...
JACQUELINE: ...They help unspoken things to become spoken.
SEPHORA: Yes, and to think about many things which we take for granted.

- Excerpts from Focus Group 2

The latter points raised in this conversation were particularly important because they entirely reflect the argument that “the theory should explain clearly what the (social) actors take for granted as true in their social world” (May, 1986, p. 153). In addition, a considerable degree of relevance, fit and understandability was demonstrated by the fact that several participants, including those who expressed some disagreement about specific points, made use of the very terms proposed in the substantive theory during the focus group interviews.

Finally, credibility can be enhanced by articulating the researcher’s personal views and insights regarding the phenomenon explored (Chiovitti & Piran, 2003), and therefore by engaging in reflexivity. Reflexivity involves actively and systematically developing insight into one’s work as a researcher and guides subsequent decisions (Birks & Mills, 2011). To enhance such researcher credibility, this dissertation provides background information about my own professional experience and limitations and how these may have influenced the selection of the research area and setting and the collection, interpretation and analysis of the data, as recommended in the qualitative research literature (e.g. Polit & Hungler, 1998; Maijala, Paavilainen, & Astedt-Kurki, 2003). Furthermore, my immediate and subsequent reflexive reactions to the data were documented distinctly from the observation and interview data themselves (see Section 4.5). Concurrently, I engaged in critical self-scrutiny about my research decisions, and the process and outcome of the various stages of data generation and analysis, as exemplified through the following excerpt (Box 3.1) written during the transcription and early analysis of a focus group session:

35 The participant is referring to a diagram representing different dualities surrounding the referral process in the form of several weighing scales (see Figure 5.10).
1. Overall, I am extremely positive about the way the participants “recognised” (to use Schatzman’s words) what I came up with. All stated that the issues included were very relevant to them as critical care nurses and that the way the story was presented was clear and easy to follow.

2. Although some participants (one in particular) expressed some reservations about certain details, I reminded myself not to be too concerned about this because: (a) my aim was not that of reaching consensus; conversely, some level of disagreement actually confirms the “Individual Characteristics” aspect of my model; (b) in some of these areas, the reasons for “disagreement” which were listed actually confirm the way I am interpreting these concepts.

3. Notwithstanding the fact that this was the first focus group I moderated, overall I feel that it went well. However, I recognise that I could have handled the most talkative member better, something which would have concurrently “protected” the most timid member. I intend to be more vigilant about this during the next session.

BOX 3.1

Example of a reflexive memo about methodological processes, outcomes and decisions.

Reflexive memo writing was particularly important to document my subjectivity; to record my abstract thinking about the data; to keep track of my insights and analytic ideas (Chiovitti & Piran, 2003; Jeon, 2004); and to gain an insight on how my underlying assumptions might have influenced the way in which data were gathered, analysed and presented. In particular, it was crucial to document my views on and experience of the referral process, both in this thesis (see Chapter 1) and during data collection and analysis. The following memo (Box 3.2) illustrates how I attempted to document the differences between my first participant’s views on the critical care nurse’s role in referral and my own perspectives on this subject prior to the commencement of data collection. It is hoped that this sort of reflexivity enables the readers to judge the authenticity and persuasiveness of the findings.

36 Examples of this are provided in the next chapter.
MEMO: My perspective on referral (especially during ward rounds)

I immediately note that my views of the role of the ward round are quite different from this participant’s. For me, the ward round is a unique opportunity to give my input about the patient’s treatment modality and presenting the “best interests” of the patient. If this opportunity is not given, then I will strive for it myself, even if this involves physically making my way to the inner circle around the patient during a ward round. Preparation for a ward round for me involves not only getting to know the patient and his condition really well (which was also mentioned by the participant) but at times also preparing my case. I did not mention this after the participant answered this question, but only mentioned it towards the end of the interview when the participant specifically asked me whether and in what way my views were different from hers.

BOX 3.2
Memo documenting my views about referral when compared to those of a participant.

Furthermore, keeping a research diary was helpful in capturing my lived experience as an inexperienced qualitative researcher and a novice grounded theorist. Birks and Mills (2011) emphasise the importance of documenting one’s feelings during particular moments of the research process as this allows the researcher to “reflexively analyse much more than just an audit trail of decisions made in relation to operational or analytical processes” (p. 54). Box 3.3 is an excerpt from my research diary documenting “how I felt” on the eve of my first data collection session.

BOX 3.3
Excerpt from research diary prior to embarking on data collection

Additionally, credibility was enhanced through the following measures, based on Lincoln and Guba’s (1985) criteria for trustworthiness in qualitative research.

i. *Prolonged engagement* and *persistent observation* involved me, as the researcher, spending sufficient time in data collection activities to ensure an in-depth understanding of the process of referral in the context of the critical care unit under study. Several hours were spent in the research field, both in preliminary
observation sessions (Section 4.4) and in subsequent sessions of participant observation to collect data. Moreover, both during interviews (Section 4.5.2) and during observation sessions (Section 4.5.1) an effort was made to focus on the various characteristics and aspects which are relevant to the social interactive phenomenon under study.

ii. The use of different methods of collecting data, namely participant observation accompanied by informal interviews, followed by formal individual interviews was another measure for enhancing credibility. This enabled me to obtain a broader, deeper and “more complete picture” (Fenech Adami & Kiger, 2005, p. 19) of the social interactive process being explored. Atkinson and Coffey (2003) contend that “participant observation and interviewing are themselves distinctive forms of social action, generating distinctive kinds of accounts and giving rise to particular versions of social analysis” (p. 425), while Schatzman and Strauss (1973) and Erlandson, et al. (1993) maintain that these are both necessary to aid the researcher’s understanding of a social context in an interactive way.

Furthermore, while some people feel more comfortable sharing their experiences about seeking help from doctors in an individual interview rather than in front of a group (Polit & Hungler, 1998; Birks & Mills, 2011), I was aware that others are less inhibited to share their views when “having the security of being among others who share many of their feelings and experiences” (Morgan & Kreuger, 1993, p. 15). Thus, the use of both individual and focus group interviews with the same group of participants enhanced both “completeness” and “confirmation” (Fenech Adami & Kiger, 2005) and enabled the generation of complementary views about the same subject (Lambert & Loiselle, 2008).

Conducting focus group interviews with the same participants after collecting and analysing observation and interview data and generating a preliminary substantive theory grounded on those data was also useful to ensure that the way I had interpreted those data reflected the participants’ experiences. In other words, through focus groups, I gave the participants from whom I had collected those data the opportunity to accept or reject the emerging theory (Benton, 1996). In this context, Frey and Fontana (1993) encourage the use of focus groups in conjunction
with interviewing and observation, contending that “group interviews can be a source of validation for events observed and for individual interview data” (p.32).

This combination of data collection methods was particularly applicable to the present study because of its overarching aim of gaining a deeper understanding of the factors associated with critical care nurses’ decisions to seek help from colleagues. Crombie (2006, p.411), for instance, argues that “participant observation and in-depth interviewing allow access to the powerful social and cultural assumptions which have an impact on the way decisions are taken in clinical practice”. Furthermore, from a grounded theory perspective, this diversity in data collection methods increases the rigour of the study by eliciting richer data (Benton, 1996; McCann & Clark, 2003c), thereby increasing the confidence that the emerging theory is actually “grounded” in the data (Duffy et al., 2004; Birks & Mills, 2011). Similarly, Chenitz (1986b) affirms that “these methods [participant observation, and different types of interviews] are used conjointly in the conduct of a grounded theory research project to assure validity in the data” (p. 82).

iii. Besides member checks [described earlier in this section], another form of external check involved peer debriefing (Lincoln and Guba, 1985). This is a process that exposes the researcher’s progress in data collection and analysis to the searching questions of others who are experienced in methods of naturalistic inquiry, the phenomenon being studied, or both (Polit & Hungler, 1998), thereby enhancing concept clarity (Benton, 1996). In the present study, such peer debriefing took place, throughout the entire research process, in the form of supervision meetings with my academic supervisors.

Another form of peer debriefing was attempted by exposing the emerging theory to audience feedback at academic and professional conferences, which Schatzman and Strauss (1973) consider valuable in providing “thoughtful criticism and questions which suggest further reflection, and possibly some revisions, in thinking about the data” (p. 132). An early version of the findings was presented in the form of a poster at an international doctoral student conference (Trapani, 2011) and at a national critical care conference (Trapani, Scholes, & Cassar, 2011). Eventually, a more integrated version of the substantive theory was presented to practitioners and academics in the critical care nursing field as an oral concurrent presentation at an
international conference (Trapani, Scholes, & Cassar, 2012). On reflection, however, the value of this exercise in enhancing the emerging theory’s credibility is somewhat smaller than anticipated. Although the emerging theory was not challenged and the members of the audience appeared to react positively to what I proposed, the audience to each of these presentations was, unfortunately, much smaller than desired. Also, while the nurses and lecturers attending the latter conference were formally invited to send their reactions to the emerging theory, none of them actually got in touch with any sort of feedback.

3.6.3 Auditability and transferability

**Auditability** refers to the possibility of other researchers and readers to follow the decisions taken by the researcher at every stage of the research process (Beck, 1993). In this study, this can be demonstrated through an audit trail of the research decisions made and the actions taken. This includes not only the account provided throughout this thesis, especially in Chapter 4, but also field notes written in and out of the field; methodological, analytical and theoretical memos to keep track of the decisions taken about data collection and analysis and theory development (examples of which are provided in the next chapter); as well as regular reflections about the entire research process entered in the research journal. It is envisaged that this material would enable “an external check to be conducted on the processes by which the study was conducted” (Erlandson et al., 1993, p. 34).

In terms of grounded theory research, auditability involves *specifying the criteria built into the researcher’s thinking* and *indicating how and why study participants were selected* (Chiovitti & Piran, 2003). In the present study, the former was addressed by keeping a record of the questions and working hypotheses used to address and interact with the data; these will be exemplified in the next chapter (Section 4.6). The latter was demonstrated through memos documenting sampling decisions from initial purposive sampling, through theoretical sampling until theoretical saturation; this process will be explained and exemplified with memos in Section 4.2.

**Transferability** is concerned with the extent to which the data are relevant to other settings or groups (Beck, 1993; Polit & Hungler, 1998). This was addressed by attempting to provide a rich and thorough description of the research context (Chapter 1) and of the transactions and interrelations observed during the inquiry (Chapter 5), thus enabling the
readers to determine the applicability of the data to other contexts (Lincoln & Guba, 1985). This is important because, in the present study, the theory emerged “from the study of a phenomenon [referral] situated in a particular situational context [a local critical care unit]”, therefore constituting a substantive (rather than a formal) theory (Strauss & Corbin, 1998, p. 174). This is in keeping with Chiovitti and Piran’s (2003) criterion of delineating the parameters of the research in terms of the sample, setting and level of theory generated as an indicator of quality in grounded theory research studies.

Box 3.4 summarises this section by listing the principal measures utilised to enhance and maintain rigour throughout the present study.

- Diverse data collection methods
- Iterative and concurrent data collection and analysis
- Constant comparative analysis
- Checking phenomenon recognition with participants (member checks)
- Audit trail through
  - Detailed field notes
  - Methodological, analytic and theoretical memos
  - Reflexive journal
- Involving participants in research decisions, e.g.
  - Refining research question on the basis of the participants’ data
  - Discussing nature and timing of data collection methods
- Reflexivity, e.g.
  - Transparency about my views on research topic, my experiences and my limitations
  - Recording my reactions to the data separately from the data themselves
  - Critical self-scrutiny about research decisions and the process and outcome of data collection
  - Documenting my thoughts about data, insights from the literature and changes in analytic direction
- Peer debriefing
  - Academic supervision
  - Audience feedback at academic/professional conferences

**BOX 3.4**

*Summary of the strategies used to enhance rigour throughout this study*
3.7 CONCLUSION

This chapter included reflections on my ontological and epistemological assumptions, on the basis of which the present study is underpinned by a relativist and social constructionist position. It also proposed the symbolic interactionist perspective and the dimensional analysis approach to generating grounded theory as particularly appropriate in acquiring deeper knowledge about a complex social interactive phenomenon, namely referral in a critical care setting. The next chapter discusses the process in which these methodological decisions were put into practice during the various stages of recruitment and sampling of participants, and the generation and analysis of data. It also illustrates the principles of methodological rigour which were discussed in the present chapter by providing a detailed audit trail of the research procedures adopted throughout the study.
Chapter 4
RESEARCH DESIGN AND METHODS

4.1 INTRODUCTION
This chapter illustrates how the epistemological and methodological principles discussed in the previous chapter were applied to the present study. The sampling strategy is presented with an account of how this proceeded from purposive to theoretical sampling until theoretical sufficiency. The iterative process of data generation and analysis is discussed in detail and supplemented with several examples of methodological, reflexive and analytical memos. The chapter concludes with a discussion of the ethical principles that were adhered to throughout the study. A timeline of the key stages of this research project and their approximate starting data is presented in Figure 4.1. The research decisions described throughout the chapter are backed up with references to authors providing similar advice and to earlier studies utilising comparable research actions.

4.2 THE SAMPLE

4.2.1 Access and recruitment
This research project took place in the intensive therapy unit of a local general state hospital, and participants were nurses working in this unit. Access to the clinical area was gained following a series of information letters to, and meetings with, key persons in the administration of the hospital and the unit, in which details about the aims and procedures of this project were provided. Formal institutional permissions were obtained from the hospital’s Chief Executive Officer, Medical Administrator, Director of Nursing Services, chairperson of the anaesthesia department, and data protection officer, as well as from the ward managers and departmental nursing manager in charge of the critical care unit (Appendices II – V).
### Institutional permissions & ethical approval

- Information meetings
- Information letters
- Participants opting in

### Recruitment

- Non-participant ‘Grand Tour’ observation
- Making the familiar strange
- Enhancing theoretical sensitivity
- Preparation for participant observation sessions

### Preliminary Observations

- Purposive sampling of participants
- Early dimensionalising
- Theoretical sampling
- Iterative data collection and analysis
- Starting of constant comparative analysis

### Participant Observation/Informal Interviewing + Formal Interviews

- Inductive-deductive cycles
- Perspective shifting
- Increasingly conceptual dimensionalising
- Differentiation
- Using the literature as a conceptual lever

### Intensive Analysis

- Longer and increasingly abstract theoretical memos
- Drafting story-line
- Writing transfer document

### Writing and Integration

- Member checking / Group validation
- Enhancing theoretical sufficiency
- Assessing coherence, relevance, & phenomenon recognition

### MPhil - PhD Upgrade

- Refining the story-line & further integration of the emerging theory
- Engaging substantive theory with the literature
- Writing PhD thesis

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**Figure 4.1** – Timeline incorporating several key stages in the research project. The left hand side indicates the approximate starting date for each stage, while the right hand side indicates the section of this thesis in which that stage is predominantly discussed. Although, for diagrammatic purposes, several processes are presented as discrete stages, in reality there was considerable overlap between several stages. For instance, data analysis started during data collection and continued until final drafting, while some form of writing practically took place throughout the project.
To ensure that participation in this study was entirely voluntary (refer to Section 4.7.1), nurses were not individually approached and asked to participate; rather, following a series of information meetings in February 2010, potential participants individually decided whether they were willing to participate or not. Nurses working in this unit, therefore, could opt in the study on the basis of their consent after they fully understood all the implications of what participation involved. As such, a meeting was held with each of the four teams (shifts) of nurses to introduce the study and to give details about what participation in the study actually involved. During these meetings, questions from the potential participants were answered and contact details of the researcher and the research supervisors were provided. The meeting was supplemented by written information about the study in a letter of invitation given to each nurse working in this unit through their respective head of shift (Appendix VI). Participants were also informed that expressing interest in the study might not necessarily lead to being selected, because of the inclusion and exclusion criteria and the sampling strategy (discussed later on). Following this series of meetings, 38 nurses of the 80 potential participants expressed an interest to take part. These nurses formed the pool from which actual participants were selected by means of purposive and theoretical sampling, following the application of the following criteria:

**Inclusion Criteria:**

- Being registered as a first level nurse with the local Council for Nurses and Midwives;
- Having worked as a staff nurse at the intensive therapy unit constituting the research setting for at least six months.

**Exclusion Criteria:**

- Nurses enrolled in academic modules delivered and assessed by the researcher;
- Nurses who had worked in this unit for less than six months.

Although this latter exclusion criterion automatically excluded nurses in the ‘novice’ stage of their professional development (Benner, 1984), this choice was considered necessary in view of the multiple issues and potential stressors characterising a nurse’s inductive period in a critical care setting. Nurses working in this unit who were undertaking an academic module which I delivered were also excluded to ensure there is no perceived coercion or favouritism in the recruitment of participants (see Section 4.7.2).
4.2.2 Initial sampling

In accordance with the grounded theory method, selection of participants for this study proceeded from purposive sampling (to get a general understanding of the phenomenon under study) to theoretical sampling (guided by the emerging theory) (Benton, 1996; Coyne, 1997; Sutcliffe, 2000; McCann & Clark, 2003a; McCann & Clark, 2003c; Birks & Mills, 2011). Purposive sampling maximises the discovery of a variety of patterns and problems that occur in a particular research context by selecting participants who will be most helpful in answering the research question. Hence, in the initial phase of sampling in grounded theory research, people are selected on the basis of being experienced in the process which the researcher is focusing on (Birks & Mills, 2011).

From my experience as a nurse in the same unit, I was aware that the nurses working in this critical care unit (described in Section 1.3.1) were experienced in and willing to talk about the issues associated with seeking help from doctors and other colleagues. This is consistent with the suggestion that purposive sampling should include participants who are significantly knowledgeable about the subject being explored (Morse, 2007). Initially, therefore, I selected nurses from different age groups, with different levels of work experience in this critical care unit, to maximise the possibilities of obtaining extensive data about the process of decision making around referral. This variation was helpful in making sense of referring in this particular research setting by including people with diverse backgrounds and, therefore, with different viewpoints about the subject under study (Polit and Hungler, 1998). Each of these nurses was observed and interviewed in an effort to follow their decision making processes (refer to Section 4.5).

4.2.3 Theoretical sampling

My engagement with the data generated from this initial sample made me aware of issues that required expansion, clarification or confirmation; thus, the direction for subsequent data collection was determined by theoretical sampling (Birks & Mills, 2011). Glaser and Strauss (1967, p. 45) define theoretical sampling as the “process of data collection for generating theory whereby the analyst jointly collects, codes, and analyses data and decides what data to collect next and where to find them, in order to develop [the] theory as it emerges”. Eventually, therefore, more nurses were selected on the basis of my analysis and conceptual interpretation of the generated data. Charmaz (2006) points out that, while the criteria for purposive sampling may be defined before the researcher enters
In congruence with the principles of theoretical sampling, I deliberately sought nurses “in whom particular concepts appear significant” and listened to their experiences to add to the existing data about these emerging concepts (Morse, 2007, p.240). For instance, in the early observation sessions and interviews, “experience” and “assertiveness” emerged as important factors mitigating a nurse’s decision to refer. To explore these concepts in more depth, nurses with different levels of experience, and who were perceived to have different levels of assertiveness were selected in an effort to further explore the effects of these characteristics on the decision and process of referral. At a later stage, “group membership” (including “nationality”) and “shift differences” started to emerge as significant. Subsequently, I theoretically sampled nurses from different shift groupings and also recruited non-national nurses. Theoretical sampling thus enabled the clarification, testing and consolidation of conceptual linkages in theory (Kools et al., 1996), thereby filling the gaps in the emerging theory (Charmaz, 2003).

Holton (2007) stresses the crucial role of memoing in facilitating theoretical sampling as this permits the researcher to intuitively follow and develop conceptual ideas as they emerge through constant comparison. An audit trail, through memos and a reflective journal, was therefore kept of sampling decisions, thereby enhancing the auditability of the study (Chiovitti & Piran, 2003; Cooney, 2011). Box 4.1 includes an example of such a methodological memo which documents the decisions for theoretically sampling one of the participants. Some emerging preliminary concepts which I intended exploring with this particular participant are written in capital letters.
METHODOLOGICAL MEMO: Reasons for selecting Judith

At this stage I would like to further explore the emerging concepts of EXPERIENCE and ASSERTIVENESS in the decision to refer. The main reasons for originally wanting to select Judith were:

1. Her relative inexperience and
2. My (and my early participants’) perceptions of her being a very assertive person. When I first contacted her (last June and then in late September) she was not available, so, in the meantime I have selected another participant (John) with these characteristics. However, I thought it was still worthwhile approaching her to participate now that she was available, especially because I wanted to compare her views to those of similarly inexperienced participants in her shift (Jeremy, Jessica) and, in view of the emerging concept of GROUP MEMBERSHIP, to compare her views with those of a member of another shift (John).

In later stages, theoretical sampling also was also used to select participants and ask them more targeted questions, thereby verifying aspects of the emerging theory (Morse, 2007). This is exemplified through the memo in Box 4.2 which shows that one of the reasons for theoretically sampling this particular non-national nurse involved the verification of theoretical concepts emerging from my interaction with the data generated earlier on from another non-national participant (Morse, 2007).

METHODOLOGICAL MEMO: Reasons for selecting Jennifer

In view of the emerging concept of IN-GROUP BIAS and NATIONALITY (which emerged strongly in my observation session and interview with Jacqueline), I think it is very important to gather the perspective of another non-national nurse so as to compare and contrast her views/experiences with those of Jacqueline. In particular, I wanted to explore some of the main nationality-related issues mentioned by Jacqueline, such as:

- Differences between national and non-national nurses’ NEED FOR CONFIRMATION
- Difference between national and non-national doctors’ NEED OF BEING KEPT INFORMED
- Being looked down upon by doctors/nurses on the basis of BEING A NON-NATIONAL / CULTURAL OUTSIDER
- Being impeded from participating in decisions due to NOT KNOWING THE SYSTEM.

Participants’ names have been deliberately replaced to conceal their real identity; refer to the introduction of the next chapter (Section 5.1) for more information about this.
In summary, both the initial purposive sampling and the subsequent theoretical sampling were crucial in enhancing a more complete understanding of referring. Purposive sampling (see Section 4.2.2) attempted to seek out people known to have different views about, and understanding of, the topic, in an effort to gather the divergent constructions of reality about referral in a critical care setting. Subsequently, theoretical sampling enabled the exploration of concepts emerging from previously analysed data (see Section 4.2.3). This chapter proceeds by discussing the measures for enhancing theoretical saturation and sufficiency.

4.3 THEORETICAL SATURATION AND SUFFICIENCY

In grounded theory studies, sample size “is a function of theoretical completeness” (Sutcliffe, 2000, p. 1447) and cannot be determined in advance but can only be identified retrospectively (Benton, 1996). Indeed, Polit and Hungler (1998) argue that this can be achieved with a relatively small number of participants if the data are sufficiently deep. Therefore, sampling continues until nothing new emerges from the observations and interviews about the concepts being explored (Byrne, 2001; Chiovitti & Piran, 2003) and reoccurrence of previously explained concepts is noted (Benton, 1996). This constitutes theoretical saturation, which, according to Glaser and Strauss (1967, p. 61) occurs when “no further data can be found whereby the sociologist can develop properties of the categories”. Similarly, Kools et al. (1996) state that, in dimensional analysis, theoretical saturation occurs when “a consistent level of repetition in the concepts and their relationship becomes evident” (p. 319), whereas Bryant and Charmaz (2007b) contend that theoretical saturation is the point at which gathering more data does not “yield any further insight about the emerging grounded theory” (p.611).

While there appears to be an overall agreement that this is an essential part of grounded theory research, defining and, indeed, demonstrating theoretical saturation is more problematic. Urquhart’s (2013) definition, however, has the virtue of simplicity. She claims that theoretical saturation is reached when “the researcher finds no new concepts are emerging from the data – all that is happening is that there are more instances of existing categories” (p. 9). In the present study this occurred quite emphatically during the
ninth and especially the tenth data collection set. While this sounds considerably subjective, it is in line with several authors’ statements that it is when the emerging “theory makes sense to the researcher” that theoretical saturation occurs (Birks & Mills, 2011, p. 115). For instance, Morse (2007, p. 243) argues that theoretical saturation takes places once researchers are “convinced that they understand what they see”; Wiener (2007, p. 306) equates theoretical saturation with the researcher’s “judgement that there is no need to collect further data”; whereas Charmaz (2003, p. 325) admits that “saturation tends to be an elastic category that contracts and expands to suit the researcher’s definitions, rather than any consensual standard” [emphasis added in each case].

Nonetheless, since I was conscious about the importance of avoiding premature closure (Charmaz, 2006), this did not bring data collection to a complete end. Indeed, focus groups conducted with the participants during the integration stage of dimensional analysis (see Section 4.6.5) served to generate more data which, while not resulting in any new dimensions, were helpful in further condensing existing ones, thereby enhancing theoretical sufficiency. Importantly, focus groups also aimed at giving the participants the opportunity to confirm whether the emerging theory “makes sense to them” (Morse, 2007, p. 241). The use of such member checking has been contested by some authors; Sandewloski (2002), for instance, contends that participants’ often fluid beliefs and understanding make them unreliable in enhancing validity, while Charmaz (2006) asserts that other features of grounded theory (such as theoretical sampling and the inductive-deductive approach to data collection and analysis) render member checking redundant as a form of verification. However, ensuring phenomenon recognition by the participants is compatible with the dimensional analysis approach to generating theory from the data, and is strongly encouraged by Schatzman and Strauss (1973) as a means of ensuring completeness. Similarly, Bowen (2008) argues that such member checking is a useful means of demonstrating theoretical saturation. In the present study’s focus groups, for example, participants remarked that the emerging substantive theory was “realistic” and “includes everything” (refer to section 3.6.2). This enhanced my confidence that I had collected “enough data to build a comprehensive theory” which, according to Morse (1995,

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38 A data collection “set” hereby refers to a participant observation session lasting between four and five hours, an accompanying informal interview and a subsequent formal interview lasting an average of one and a half hours. The way in which each of these was conducted is explained in Section 4.5.

39 Examples of this will be provided later in this chapter. For a more detailed account of how and why focus groups were conducted, refer to Sections 3.5.3, and 4.5.3. Their outcome and its value in data analysis and enhancing rigour are discussed in Sections 4.6.5 and 3.6.2 respectively.
p. 148) is the principal determinant of theoretical saturation. During the focus groups, participants also underscored that the emergent substantive theory had “very nice terminology…and graphics” and “flowed from one section to another” (see Section 3.6.2). This suggests that the dimensions and their properties “were clearly articulated and integrated”, which Strauss & Corbin (1990, p. 99) identify as one of the determinants of theoretical saturation.

This notwithstanding, I am aware that theoretical saturation can only be reached to “a matter of degree” (Strauss & Corbin, 1998, p. 136); that “there is always the potential for something ‘new’ to emerge” (Strauss & Corbin, 1998, p. 136); and that “new interpretations can arise till the very end” (Glaser & Strauss, 1967, p. 40). Therefore, while this thesis provides evidence of a considerable degree of theoretical saturation, in no way do I claim to have reached theoretical saturation. On the other hand, on the basis of my participants’, my peers’ (see Section 3.6.2) and my own evaluation, I feel confident that the substantive theory emerging from this study possesses theoretical sufficiency. I consider this latter term, proposed by Dey (1999, p. 257) and endorsed by Charmaz (2006, p. 114), less problematic and more compatible with the social constructionist epistemology and interpretivist perspective underpinning the present study. Thus, while this section made use of the term “saturation” in view of this being much more commonly spread in the grounded theory literature, other sections mostly refer to theoretical sufficiency. In particular, Section 4.6.5 will discuss how theoretical sufficiency was eventually further enhanced by engaging the emergent theory with the literature.

4.4 PRELIMINARY OBSERVATIONS: MAKING THE FAMILIAR STRANGE

In order to improve my theoretical sensitivity (see Section 3.4) and practice my data gathering skills, prior to the commencement of actual data collection general overarching non-participant observation sessions were carried out in the intensive therapy unit constituting the research setting of this project. This preliminary data collection stage started in March of 2010 and five such non-participant observation sessions, each lasting approximately four hours, were held. These sessions were not geared at collecting data per se; rather, they were performed to enable me to seek general information about the research setting and the social process under investigation. As such, these sessions were guided by what Spradley (1980) calls “Grand Tour observations” and focused on the space, actors, activities, objects, acts, events, time, goals and feelings in the research setting.
Particular attention was given to verbal behaviours and interactions (who speaks to whom and for how long), human traffic (people who enter, leave and spend time at the observation site) and people who stand out (Mack et al., 2005). Thus, these preliminary observation sessions were invaluable in becoming more conscious of the subtleties of the process and timing of referral, thereby enhancing my theoretical sensitivity about this social process.

These preliminary observation sessions also served to familiarise the members of the unit, particularly those taking part in the study, about my new role as a researcher rather than clinician or educator with which they were more familiar. This was important because researchers, such as Allen (2004), had noted that when interviewing colleagues the respondents tended to shorten their answers to the researcher’s questions, specifically because they presumed that the researcher, being an insider to the field, already “knew the facts” (p. 48).

From a practical point of view, these sessions were also helpful in guiding my actions in the subsequent, more specific, observation sessions, such as which places to locate myself in during these observations (Davis, 1986). It was also during these preliminary sessions that I conducted field observations for the first time ever. Hence, I made use of these sessions as a way of practising my observation skills, and particularly by documenting what I was seeing, my reactions to it, as well as learning and action points in field notes and memos, a process which required patience and tolerance for ambiguity and inexperience (Schatzman & Strauss, 1973). Furthermore, preliminary observations were valuable in terms of event sampling (Schatzman & Strauss, 1973; Burgess, 1982c), by giving me ideas about which events were particularly important to observe in order to capture aspects related to the process of referral. Thus, while not formally collecting data, during these sessions I indirectly started learning about the phenomenon guiding my inquiry, identifying points which I needed to observe and developing questions about the subject which I eventually explored with my participants during actual data collection.

These sessions were also motivated by the fact that, being a former staff nurse within the same unit and a novice researcher, I wanted to look at a site and process with which I was familiar as a clinician from the perspective of a sociological stranger (Hammersley, 1985, p. 152). The potential drawbacks of insider research are well documented (Reid, 1991; Rudge, 1996; Gerrish, 2003; Rudge, 2003). While the researcher’s familiarity with the
respondents and the setting facilitates access and enhances trust, it may also lead to an “epistemological liability of taking too much for granted” (Pink Dandelion, 1997, p. 187). Similarly, Burnard (2004, p.48) writes about a “cultural paradox”: while outsider researchers are likely not to appreciate certain elements of the group they are observing, insiders researching their own group are likely to be too familiar with the territory and take for granted many of the “culturally coloured” activities of the group. In fact, it was during these preliminary observation sessions that I started shedding my clinician / educator roles and replacing them with what for me was a new role – that of a researcher. Standing in this unfamiliar situation simulated me to ask questions – to myself and eventually to my participants – about processes and activities with which I had previously considered myself acquainted in the way a stranger would (Cowie, 2010; Brown Buchanan, 2012). I began to look at nurses’ interactions with colleagues, their decisions to seek help from doctors and the factors associated with these aspects, not from the point of view of another nurse but from that of an outsider. Eventually, I started to realise that several nurses’ experiences and perceptions about referral were significantly different from mine, which realisation enhanced my understanding of nurses’ referring within a critical care context and because of which I agree with Bernard’s (2006, p. 367) claim that “if you look carefully you’ll be surprised at how heterogeneous your culture is and at how many parts of it you really know nothing about”. Subsequently, the lessons learnt during this preliminary stage of data collection impelled me to adopt a more “naïve” stance towards the subject I was interested in learning more about (Bernard, 2006).

4.5 DATA GENERATION

Following preliminary observations, data generation proceeded as follows. Starting in April of 2010, each selected participant was observed while on staff nurse duty at the ICU throughout a participant observation session lasting between four and five hours, during which an informal interview also took place. A few hours later during the same day, permission was sought from the ward manager to carry out a formal interview with the same participant with his/her agreement and after ensuring that he/she was not fatigued. The observation data were preliminarily analysed during and just after the observation session itself. This enabled me to identify salient issues which I wished to pursue in further depth in the subsequent interview, which was also aimed at eliciting the participants’ motivations and interpretations of their own actions and interactions observed during the
preceding participant observation session. Thus, each combined session of participant observation and informal interviewing influenced the subsequent formal interview with the same participant. Eventually, collection and analysis of each set of data influenced the selection of the subsequent participant and the focus of the subsequent data collection session. Following a period of intense data analysis, during which the findings were organised into a storyline and a preliminary substantive theory was developed, in the summer of 2012 focus group interviews with the same participants were held. In an effort to counterbalance any perceived power differentials with the participants, and thereby establish “reciprocity” (Birks & Mills, 2011, p.56), the date for the observation sessions and the venue for the interviews were decided in agreement with the participants.

The data collection process is summarised in Figure 4.2, which also shows how the findings presented in the next chapter are based on approximately twenty hours of preliminary non-participant observation, fifty hours of a combination of participant observation and informal interviewing, fifteen hours of individual formal interviewing, and four hours of focus group interviews. Table 4.1 summarises the duration of each data collection session with each participant.
PRELIMINARY OBSERVATIONS
(20 hours)
- to enhance theoretical sensitivity
- to practise “observer” role
- to prepare for actual data collection

PARTICIPANT OBSERVATION
+ INFORMAL INTERVIEWS
10 participants
A total of 15 hours
Total: c. 50 hours

Preliminary Analysis of
Field Notes

UNSTRUCTURED FORMAL
INTERVIEWS
10 participants
A total of 15 hours
of interviewing

FOCUS GROUPS
2 sessions x 2 hours
(5 participants in each session)

Refined
Substantive Theory

- Field note expansion
- Interview transcription
- Comparative data analysis
- Theoretical sampling + guide for next data collection session

Emerging Theory

Figure 4.2 – Summary of the data generation process
**Table 4.1** – Summary of the participants’ years of work experience in the present critical care unit at the time of recruitment, their nationality and the duration of each data collection session.

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Nationality</th>
<th>Experience in Critical Care Nursing</th>
<th>Duration of Observation Session + Informal Interview</th>
<th>Duration of Interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sephora</td>
<td>National</td>
<td>9 years</td>
<td>4 ¼ hours</td>
<td>1 ½ hours</td>
</tr>
<tr>
<td>Sally</td>
<td>National</td>
<td>4 ½ years</td>
<td>4 hours</td>
<td>1 ¼ hours</td>
</tr>
<tr>
<td>Jeremy</td>
<td>National</td>
<td>6 months</td>
<td>4 ½ hours</td>
<td>2 hours</td>
</tr>
<tr>
<td>Susan</td>
<td>National</td>
<td>12 years</td>
<td>4 hours</td>
<td>1 hour</td>
</tr>
<tr>
<td>Jacqueline</td>
<td>Non-national</td>
<td>2 years</td>
<td>4 ¾ hours</td>
<td>1 ¾ hours</td>
</tr>
<tr>
<td>Jessica</td>
<td>National</td>
<td>1 ½ years</td>
<td>4 ½ hours</td>
<td>1 ½ hours</td>
</tr>
<tr>
<td>John</td>
<td>National</td>
<td>2 years</td>
<td>4 ¾ hours</td>
<td>1 ½ hours</td>
</tr>
<tr>
<td>Simon</td>
<td>National</td>
<td>10 years</td>
<td>4 ¼ hours</td>
<td>1 ¼ hours</td>
</tr>
<tr>
<td>Judith</td>
<td>National</td>
<td>1 ½ years</td>
<td>4 ¾ hours</td>
<td>1 ½ hours</td>
</tr>
<tr>
<td>Jennifer</td>
<td>Non-national</td>
<td>1 year locally</td>
<td>4 ¾ hours</td>
<td>1 ¼ hours</td>
</tr>
</tbody>
</table>

This section proceeds by discussing the various aspects of participant observations and informal, formal and focus group interviewing adopted in this study. Each of these methods involved me, as the researcher, interacting with the sources of data (the participants); thus data were “generated” rather than merely “collected” (Birks & Mills, 2011, p.73). Also, although discussed in a separate section (Section 4.6), my interaction with and analysis of the data commenced concurrently with data generation.

### 4.5.1 Participant observation and informal interviews

In congruence with the symbolic interactionist assumption that human beings act towards things on the basis of the meaning these have for them (Section 3.2), it is crucial for a researcher to observe health professionals during the actions and interactions in which they are involved in their clinical practice, if s/he is to understand their decisions to seek help from their colleagues. In fact, I concur with Aitken and Mardegan’s (2000) statement that “it is unlikely that the simulated setting can truly replicate the complexity and unpredictability of the real-life setting”. Observation sessions were, therefore, carried out during each of which I observed a critical care nurse working with the patient/s allocated to him/her in an effort to gain an understanding of the process of referral. My observations, however, were not restricted to this focus; rather, all the actions and interactions which the nurse I was observing undertook or took part in, as well as his/her interpretations of these
events, were considered as data. According to Schatzman and Strauss (1973, p. 83) such “tracing” of a single participant during his/her “normal tour of activities throughout a given period of time” enhances the researcher’s understanding of social and organisational processes. Not restricting my observations to actual instances of referral was particularly important because of two reasons. First, I wanted to look at nurses’ decisions to seek help without preconceived ideas about any events or factors being more important others (McCann & Clark, 2003a; Jeon, 2004); rather, it was important to look at “all” that is involved in such decisions (Schatzman, 1991; Bowers & Schatzman, 2009). Secondly, in order to gain a more complete picture of nurses’ decisions to refer, decisions not to seek help are just as important to explore as decisions to seek help.

Nevertheless, it is was also considered important to enter the research field theoretically sensitised to the subtleties of the data (Glaser, 1978). Thus, particular attention was given to instances in which the nurse communicated with other health professionals to seek help in the management of the particular patient allocated to his/her care and to the manner in which nurses discussed with and sought the approval of doctors in terms of effecting treatment modality changes for their patients. In this context, previous research in the critical care (Manias & Street, 2001a; Coombs, 2003; Carroll et al., 2008; Parissopoulos et al., 2013) and general (Royal College of Physicians & Royal College of Nursing, 2012; Duffin, 2012; Moroney & Knowles, 2013) settings, my own experience as a clinician, as well as the preliminary observations carried out prior to formal data collection (Section 4.4) suggested that ward rounds constitute a particularly important event in terms of such collaborative decision making, with Weber et al. (2007) describing ward rounds as “the central market place of information” (p. 343). Thus, an effort was made to observe ward rounds particularly attentively.

Informal interviews. These participant observation sessions were accompanied by informal interviews. Informal interviewing occurs whenever a researcher asks a question to a research participant during the course of participant observation (Spradley, 1980; Chenitz, 1986b). This was particularly congruent with my constructivist and symbolic interactionist approach to grounded theory because it enabled me to ask the participants to explain their meaning of the unfolding events and accompanying decisions. Thus, while observing each participant at work at the ICU I constantly engaged in conversations with the participant, mostly to seek clarification about, and ask for the motivations for, any actions he or she had taken or any interactions he or she had been involved in. Occasionally, I also asked my
participants what, if anything, was on their mind at that particular moment in time. I did this in an effort to unpack the process of their clinical decision making in a natural manner; indeed, seeing something and then asking questions about it is a normal activity for most people (Davis, 1986). Yet, there were instances in which I felt it prudent to ask questions after, rather than during, certain events such as ward rounds and critical situations. In these instances I stepped back and waited for a good time to seek clarification, thereby moving back and forth between my role as observer and interviewer (Chenitz, 1986b). Also, given the participants’ awareness of my critical nursing background, before and during the observation sessions I reminded the participants that I was there as a research student. I explained that, as such, I was not asking them questions to which I knew the answers; on the contrary, I wanted to capture their interpretation of the events I was observing (Burgess, 1982d).

The value of supplementing observations with informal interviews during clinical decision making is strongly supported by Aitken, Marshall, Elliot and McKinley (2010), whose analysis of their own data collection methods revealed that different methods were better equipped at eliciting different types of decisions. In fact, assessment decisions were mostly identified through the participants’ verbalisations of their thinking while the researchers’ observations were more effective in eliciting management decisions.

Attire. The issue of what to wear during participant observation sessions within a hospital setting has been tackled by Davina Allen amongst others. In her ethnographic study within a hospital setting, Allen (2004) elected for wearing a white coat over plain clothes. While, this occasionally led her to being mistaken for a medical student, in the main it achieved her ultimate aim of not being associated with any particular professional group (by wearing a uniform) or being mistaken for relatives (had she worn plain clothes). In view of this, I initially decided to similarly wear a white coat over plain clothes. However, during my second preliminary observation session, one of the nurses who had already opted in the study stated that she did not find my attire appropriate as it appeared “too formal”, thereby creating an unnecessary barrier. In accordance with my attempt to involve my participants in decisions about the study (Mills et al., 2006), I thus opted to wear a labcoat over scrubs instead of over plain clothes during subsequent observation sessions. Moreover, within an hour of each observation session, in agreement with each respective participant, I removed my labcoat as this facilitated the process of actually assisting the participant in his/her nursing duties, thereby engaging more easily in participant observation. For identification
purposes, I wore my University of Brighton student card; this was deemed important not only to inform any person I encountered that I was there as a research student and not as a member of the organisation but also to remind myself that I was there in a researcher (and thus an outsider) role, not as a clinician. All decisions regarding the attire during participant observation sessions were taken in agreement with the managers of the unit.

**Nature and Extent of Participation.** During participant observation, the researcher’s role may vary from complete observer to total participant (Schatzman & Strauss, 1973; Spradley, 1980; Gans, 1982; Ambrosino, 2005). With the participants’ consent, and, at times, on their request, I participated in some aspects of nursing practice during these observation sessions by helping the nurse whom I was observing. This mainly consisted of observing and recording a patient’s vital signs; preparing and administering medications; assisting the nurse in bed-bathing, turning, feeding and ambulating patients; and, to use the words of another novice field observer, generally “trying to be helpful” (Kite, 1999, p. 49). Such participation occurred naturally and proved to be very helpful in enhancing the researcher-participant rapport, and in giving me the opportunity to be “right there where the things happen, and where the members talk about what has happened” (Schatzman & Strauss, 1973, p. 62). In other words, participation was crucial in helping me immerse myself into the realities of clinical practice (Gans, 1982; Mack et al., 2005).

Yet, I was aware that participation could only occur to an extent which would not be detrimental to my aim of observing and documenting the participants’ actions, interactions and thoughts. Indeed, Schatzman and Strauss (1973, p. 62) warn about the potential dangers of “going native” whereby the researcher becomes so immersed in the participation aspect of participant observation that s/he “unwittingly absorbs certain viewpoints that his participatory activities tend to reinforce” without adequately challenging them. Furthermore, it has been pointed out that helping with the work “to the extent of not getting the research done” is even more likely in typically over worked and/or understaffed critical care environments (Kite, 1999, p. 49). Thus, an effort was required to balance my insider participant and outsider observer roles (Burgess, 1982d; Jones, Torres, & Arminio, 2013), and attempting to use the former role to aid the latter. This balance was partly achieved by constantly evaluating the quantity and density of the field notes I was taking, both during and after fieldwork sessions. Thus, while in the field I tried to reflexively ask myself whether I was “getting the data I want and need...[and] able to maintain my identity and conceptual distance” (Schatzman & Strauss, 1973, p. 63). In
addition, notes about what my participation actually involved and how this could have affected the participant’s behaviour were taken immediately after each such episode (Davis, 1986).

Field notes and memos. During the participant observation sessions, handwritten field notes were taken in a spiral bound field book about the following elements (Chenitz, 1986b):

1. Observation data
2. My conversations with the participant
3. A record of my participation in nursing activities
4. My initial reactions to what was being observed.

Field notes about what I observed and my conversations with participants, as well as methodological memos documenting my participation in nursing activities were written on one side of the field book. My initial reactions and points for exploration in the subsequent interviews were documented as reflective memos in a different colour on the opposite page (Figure 4.3). No attempts were made to conceal note taking while in the field because it was felt that visibly taking notes reassures the participants that, with their help, the researcher was gaining useful data (Schatzman & Strauss, 1973; Chenitz, 1986b). Moreover, jotting down notes is something which most practitioners in this area do very frequently throughout their duty, and, as such, seeing a person writing notes did not appear out of the ordinary. Field notes were generally kept brief, consisting of phrases (and, at times, mere words), occasionally supplemented by sketches (Schatzman & Strauss, 1973; Davis, 1986). However, for some interactions (for instance, when participants were explicitly seeking help from a doctor or colleague) and for some answers to my questions, a verbatim record of the interaction was made (Spradley, 1980).

While the grounded theory literature considers memo writing as a quintessential element of the method, most authors focus their attention on the value of memos in enhancing data analysis. Schatzman, on the other hand, distinguished between three types of memos, all of which were used in the present study. These include observation notes [ON], which consist of pure descriptions of what the researcher notices in the field, hereby referred to as field notes; methodological notes [MN], in which the researcher documents what he/she is doing or needs to do; and theoretical notes [TN] in which theoretical ideas emerging from the social setting are documented and eventually compared to the social science literature (Schatzman & Strauss, 1973; Covan, 2007). This chapter includes several examples of different types of memos used throughout the present study.
Birks & Mills (2011, p. 71) point out that “preliminary analysis of fieldwork notes is more likely to be effective when undertaken within a short timeframe”. Hence, as soon as possible after leaving the field, field notes were reread and expanded, and additional reflective memos were added in a different colour (Chenitz, 1986b; Mack et al., 2005) so as to clearly distinguish between raw data and analytical abstractions (Glaser, 1978). This was particularly useful in identifying areas which needed to be discussed with the participant during the subsequent formal interview held later that day. All the field notes were expanded and processed into a more detailed account as soon as possible after each data collection session, usually during the following day (Schatzman & Strauss, 1973). During field note expansion, personal impressions were added in a different colour and preliminary analysis took place (Figure 4.4). As such, time was specifically reserved in advance for expanding and starting to analyse the field notes after each data collection session (Spradley, 1980; Mack et al., 2005). Also, following each data collection session, reflections about the research experience, including learning and action points from each observation session, were entered in the research diary (Davis, 1986).
Figure 4.4 – Typed and expanded field notes about observation data [left hand column], and data from informal interviews and memos about my participation [middle column]. The right hand column shows early reflective and analytical memos originally written while in the field [in red], between the observation and interview session [in green] and during field note expansion [in blue].

4.5.2 Formal individual interviews

Since the multiple events and interactions taking place during these observation sessions made it impossible to assimilate all the data into one set of field notes, it was considered necessary to also engage in a fuller conversation with the participants outside the field. A formal interview was therefore carried out with each participant a few hours after the end of the observation session with the same participant. With the ward managers’ permission and in agreement with each participant, the interviews took place in a quiet room at the periphery of the intensive therapy unit itself. This was useful to provide a comfortable, private, relaxed environment (Holloway & Fulbrook, 2001; Dearnley, 2005) which was free from interruptions and distractions (Swanson, 1986). In this context, Charmaz (2003) affirms that the interviewee’s “comfort should be of higher priority for the interviewer than obtaining juicy data” (p. 315). Additionally, conducting interviews in a private room but within the same unit would have made it possible for the participant to immediately return to the clinical area of the unit had his/her presence been required in the event of an emergency. The latter point was imperative given that interviews were conducted while each participant was still on duty.
Consistent with my constructivist and symbolic interactionist approach to grounded theory, the aim of these interviews was mainly twofold. First, I wanted to gather a deeper insight of each participant’s perceptions of referring. Secondly, participants were given the opportunity to reflect upon, and explain their motivations for, their actions and decisions and their interpretations of events and interactions observed during the previous observation session. This approach to interviewing underscored my attempts at listening to the participants’ thoughts and, eventually, inductively building a theory on the basis of their experiences and perceptions, rather than exclusively imposing my interpretation of the observed actions. Consequently, some questions had to be considerably general to cover a wide range of experiences, while others had to be sufficiently narrow to explore specific experiences of the participant (Charmaz, 2003). A “funnel approach” to interviewing (Swanson, 1986, p.74) was thus adopted, with the interview starting with broad general questions (related to the participants’ general perceptions about referral in the critical care setting) and proceeding with more specific questions (about incidents observed during the observation session).

Early interviews were essentially unstructured, taking the form of guided conversations with the participants about their perceptions on referral, because listening to respondents recounting their stories is very important during early stages of grounded theory (Glaser & Strauss, 1967; Duffy et al., 2004). In later stages of data collection, interviews became slightly more structured, with theoretically sampled participants (Section 4.2.3) being asked more targeted questions in order to confirm, alter, add to, clarify and substantiate what had emerged from the analysis of earlier interviews (Swanson, 1986; Chiovitti & Piran, 2003), thereby verifying the emerging theoretical propositions (Schatzman & Strauss, 1973; Morse, 2007). Accordingly, since data collection, analysis and sampling took place simultaneously (McCann & Clark, 2003a), ongoing data analysis influenced the questions that were asked in subsequent interviews, with the direction of the interviews being driven by the emerging theory (Duffy et al., 2004).

Leading questions and questions requiring a yes or no answer were avoided in order to allow participants’ perspectives to be expressed more fully. Glaser (1992, p. 25) strongly argues against asking direct questions “as this would preconceive the emergence of data”. Probes were used whenever a response was brief or unclear and whenever it seemed that the participant had more to say about the subject (Mack et al., 2005). An effort was, however, made to achieve a balance between probing and listening to the participants’
stories (Charmaz, 2003). Increasing interpersonal comfort and familiarity with the participants during the course of the interview enabled me to occasionally ask challenging “devil’s advocate” questions presenting the informant with an opposing point of view (Schatzman & Strauss, 1973; Burgess, 1982e); however, no judgemental remarks were passed on any actions observed in the field or on any answers provided in the interview (Mack et al., 2005). Sometimes, hypothetical questions were asked in an effort to broaden my understanding of referral in different circumstances (Schatzman & Strauss, 1973). To ensure my understanding of the participants’ perspectives, I summarised and rephrased their responses at regular points of the interview and invited the participants to confirm whether I was correctly perceiving what they were trying to express. Two examples of this latter strategy are provided below:

Q. Let me see if I am understanding this. So in your mind you would be saying: ‘listen, this patient is too acidotic...he needs continuous haemodialysis’, but you would still not say: ‘listen, shall we start haemodialysis?’

A. No, I wouldn’t; I would simply keep repeating: ‘the pH is acidotic’, ‘the patient is acidotic’... so that you bug them ... ‘the patient is acidotic’. If I see there is a renal problem, I go and tell them ‘listen, there is a renal problem, the patient has a renal problem.’ And I continue to repeat it until one of them says: ‘all right, let’s start this, then’.

- Judith, Formal Interview

Q: But, from what I am gathering, this seems to be part of something much larger in a way...

A: Yes, exactly!

Q: There seems to be something blocking you from...directly speaking to the consultant...

A: ...from directly conveying to her, yes.

Q: And you seem resorting to, for example, use other doctors as an intermediary.

A: It is true. In fact it looks like that.

- Jacqueline, Formal Interview
Each interview started with a “warm-up” period in which informal questions were asked in an effort to build a relaxed atmosphere (Erlandson et al., 1993). Considering the ongoing consent approach adopted in this study\textsuperscript{41}, participants were also reminded about the aims and the confidential nature of the research data, and that they were free to stop the interview at any point if they so desired (Swanson, 1986). This initial phase was also useful as a debriefing session about the observation session held earlier on. Similarly, towards the end of each interview, participants were given the opportunity to ask questions about any aspect of the research project and encouraged to give their feedback about their experience as participants (Swanson, 1986). This was valuable to avoid ending the interview abruptly after very searching questions, thereby allowing the participant and the interviewer to resume a more normal conversational level (Charmaz, 2003). Also, efforts were made to keep communication channels open, even after the interview was over (Schatzman & Strauss, 1973; Erlandson et al., 1993). Participants were, therefore, reminded that a need to seek further clarification might arise later during the research project (Schatzman & Strauss, 1973). Likewise, participants were encouraged to contact me again if they remembered other issues related to what was discussed in the interview or if new thoughts arose. Thus, the researcher’s contact details were provided in the thank you note (Appendix VII) handed to each participant at the end of each interview.

Although virtually all local nurses are fluent in English, I was aware that some of the participants feel much more comfortable speaking in their native language. Thus, in keeping with my constructivist approach of involving the participants in decisions related to the research project (Mills et al., 2006), participants were given the option to conduct the interview in the native language if they so preferred. Indeed, two participants chose this option. In these cases, interview transcripts were translated to English for analysis purposes (Lopez, Figueroa, Connor, & Maliski, 2008). My own experience as a translator was helpful in this respect. In conjunction with the previously described attempts at reflexively considering and counteracting any perceived power imbalances between the researcher and the participants (such as carrying interviews at their preferred time and venue), allowing the participants to choose the language in which the interview was conducted helped to establish a position of reciprocity between the participants and the researcher (Birks & Mills, 2011).

\textsuperscript{41}The distinction between an ongoing and a perpetual consent is discussed in Section 4.7.1.
With the participants’ permission, each interview was audio-recorded. Audio-recording ensures an exact record of everything the participant has said during the interview, not just what the researcher perceives to be important at that moment in time (Whyte, 1982). Being a novice researcher and these being the very first interviews I conducted as part of a research project, listening to interview audio-recordings was also useful in reflecting on ways in which my interview strategies could improve (Birks, 2007). For example, I reflected on whether I had sufficiently probed to allow concepts to emerge and whether I had avoided leading questions (Dearnley, 2005). Although it has been suggested that audio-recording might make the participant overly self-conscious (Erlandson et al., 1993), this did not appear to be the case, except for the very first few minutes of some of the interviews, which were dedicated to ice-breaking anyway. The small size of the audio-recorder without the use of any microphones probably helped in this respect.

Again with the participants’ permission, audio recordings were supplemented by additional handwritten field notes during the interview itself. These were used to remind me to return to earlier points which had not been completely discussed (Charmaz, 2003), and also to document the participant’s non-verbal cues, the contextual aspects of the interview, and my immediate impressions about what the participant was saying (Dearnley, 2005; Birks & Mills, 2011). These notes were expanded and supplemented with additional impressions immediately after the interview and subsequently during transcription, which again resonates with Birks & Mills’ (2011) argument that preliminary analysis of interview recordings and field notes is more effective when undertaken as soon as possible after data collection. I transcribed the interviews myself because this is considered helpful in fostering the researcher’s familiarity with the participants’ perspectives and thus facilitating data analysis (Chenitz, 1986b). Indeed, Charmaz (2006) argues that studying data in an audio recorded and transcribed form captures the “nuances…of language and meanings”. Verbatim transcription started as soon as possible after each interview, normally on the following day (Mack et al., 2005). However, in order to allow time for transcription and early analysis of each interview, and thus enable each observation session/interview to inform, develop and focus subsequent interviews, data generation sessions had to be scheduled at least between one and two weeks apart (Duffy et al., 2004). This interval permitted me to consider the meaning of the newly generated data and whether it was confirming, contradicting, clarifying or expanding my evolving theory (Birks & Mills, 2011). It also allowed me to reflect on any new directions suggested by the data, and
therefore helped to determine the selection of subsequent participants by means of theoretical sampling, as discussed in Section 4.2.3.

**4.5.3 Focus group interviews**

After several inductive-deductive cycles of data analysis (see Sections 4.6.2 and 4.6.3) had enabled me to produce a preliminary substantive theory and organise the data in the form of a detailed storyline\(^{42}\), I took my interpretation of the findings back to the participants (refer to Sections 3.5.3 and 3.6.2 for the motivations of this decision) through focus group sessions. Each participant was individually contacted and asked, verbally and in writing, whether s/he was willing to participate in a discussion, lasting about two hours, about how I had interpreted and organised the data I had collected throughout this study. Once they confirmed their participation, I sent each of the participants a detailed summary (approximately 5,000 words long) of the storyline and invited them to read through it before the actual focus group session. A copy of this was also made available during the meeting.

While the recommended number of participants in a focus group varies from author to author from four to fifteen (Polit & Hungler, 1998; Doody et al., 2013a), Hernandez (2011) provides a helpful guide by advising no more than 7 to 10 participants for a three-hour session and no more than 4 to 6 participants for a 2 hour focus-group. Focus group productivity tends to drop considerably after two hours (Mack et al., 2005; Doodey et al., 2013b); additionally, I did not wish to take up more than two additional hours of the participants’ time, particularly since these focus groups took place outside the participants’ hours of work. Thus, two focus group interviews, each lasting between one hour and 45 minutes and two hours, were held with five participants in each group. This relatively small number is also easier to manage for minimally experienced researchers like myself (Krueger, 2006). Although all participants were critical care nurses, consideration was given to fact that homogeneity within focus groups is considered helpful in enhancing free expression (Morgan & Krueger, 1993; Polit & Hungler, 1998); as such, the non-national participants and those who felt most comfortable speaking in English constituted one focus

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\(^{42}\) In grounded theory, the term *story* refers to “a descriptive narrative about the central phenomenon of the study”, while a *storyline* is a “conceptualisation of [that] story” (Strauss & Corbin, 1990, p. 116). As pointed out by Birks and Mills (2011), and as was the case in the present study, storylines are useful both as a tool for theoretical integration in the later stages of data analysis [as explained in Section 4.6.5]; and as a means of presenting the findings to the participants [as explained in this section] and to the readers [see Chapter 5].
group, while those who preferred to speak in the native language constituted the other group.

As requested by the participants, focus group interviews took place late in the afternoon, which enabled participants who were on night duty to go to work just after the session. Besides preparing a slide presentation, stationery and refreshments (Doodey et al., 2013b), logistic preparation focused on setting up the room in a manner which creates a comfortable and conducive atmosphere (Janesick, 2004; Doodey et al., 2013a). The seating was arranged in a way which enabled participants to face every other group member (Doodey et al. 2013b), and also to comfortably look at the screen when requested. Two audio recorders were placed close to the ends of the table in order to ensure voice capture of all participants (Hernandez, 2011).

At the beginning of each session, the participants were reminded that the focus group was being held to gauge their reactions to the story I had written on the basis of the data they had contributed to; that the aim was to get their honest views about whether my interpretation was coherent and relevant to their clinical practice, and not to reach a consensus (Morgan & Krueger, 1993; Doodey et al., 2013b); and that they were free to leave at any point they wished (Mack et al., 2005). Additionally, ground rules were established (Mack et al., 2005; Doodey et al., 2013b) and written on a flipchart visible to all participants. These are reproduced in Box 4.3 below.

<table>
<thead>
<tr>
<th>Ground rules established at the beginning of each focus group session</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Only one person talks at one time</td>
</tr>
<tr>
<td>2. Listen to others</td>
</tr>
<tr>
<td>3. Anything said in the room stays in the room</td>
</tr>
<tr>
<td>4. There are no right or wrong answers: only ideas, experiences and opinions, all of which are valuable.</td>
</tr>
</tbody>
</table>

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Each focus group started by asking the participants to give their general reactions to the storyline of the findings which they had read beforehand, particularly about whether it adequately reflected the factors associated with referring in the critical care setting and whether any aspects were unclear. The focus group then proceeded by displaying the slide presentation in three parts, corresponding to the three sections of the storyline (Sections 5.2, 5.3 and 5.4 in the next chapter), thereby ensuring that all the important aspects of the story were discussed. Following each set of slides, a discussion ensued about the coherence and relevance of the presented points. In my role as moderator, I made an effort to encourage participation by each member of the group, particularly less talkative members. I also attempted to establish a balance between keeping the discussion “focused” on the subject at hand (namely to assess the clarity and coherence of the presented story) and encouraging the generation of additional data. While acknowledging my significant inexperience in focus group moderation, I had the advantage of having developed considerable theoretical sensitivity (see Section 3.4) to the research area. As Morgan and Krueger (1993) point out, “someone with the appropriate sensitivity may be a more effective moderator than someone who merely has professional credentials” (p. 5).

Prompts were occasionally used (Mack et al., 2005), for example, to encourage reactions to a statement by a fellow participant, thus ensuring that focus group data were mainly derived from interactions between the participants (Webb & Kevern, 2001), rather than by a series of sequential individual interventions. For instance:

MODERATOR: What do the others think? Did you ever experience something similar to what Jacqueline has just said?

- Excerpt from Focus Group 2.

MODERATOR: [addressing all members] Do you concur with Simon’s thoughts about this?

- Excerpt from Focus Group 1

As recommended by Doodey et al. (2013b), towards the end of each focus group, participants were asked for additional comments about any previously discussed aspects or about any pertinent aspect which might have been left out of the discussion. During each focus group session, I jotted down some immediate reactions to what the participants were
saying, transcribed phrases which I thought were particularly revealing, and also wrote observation notes about the nature of the interaction. Ideally, this latter role should have been taken by an additional “note-taker” so as to keep focused on my role as moderator (Mack et al., 2005). However, this was not considered feasible, mainly because having an additional “outsider” in such a small group (two researchers with five participants) might have been considered too intruding, and subsequently hindered the openness of the discussion. These field notes, together with “immediate reflections” about the process and outcome taken down just after each session (Doodey, Slevin, & Taggart, 2013b), were expanded during the transcription and early analysis of the focus group data. This took place in the few days following each session, in a manner similar to that adopted for the transcription and field note expansion of observation sessions and individual interviews (see Sections 4.5.1 and 4.5.2 respectively). The contribution of the focus groups to the findings and their analysis will be presented towards the end of the next section, while their role in enhancing rigour was discussed in Section 3.6.

4.6 DATA ANALYSIS

4.6.1 Overview of the dimensional analysis process

Dimensional analysis is a method of generating grounded theory which aims to derive meaning through the interpretation or analysis of the component parts of a phenomenon or situation (Schatzman, 1991; Bowers & Schatzman, 2009). In dimensional analysis, a number of overlapping steps are involved, namely dimensionalising, differentiation and integration (Kools et al., 1996):

- First, the phenomenon being explored is broken down into a variety of components (known as “dimensions”) and properties of each dimension are identified (dimensionalising). These dimensions typically consist of larger chunks of data than the initial coding used in ‘mainstream’ grounded theory (Endacott et al., 2010).

- Secondly, the relationship between these different dimensions is explored and the dimensions are organised into an explanatory matrix which meaningfully describes the phenomenon (differentiation). According to Schatzman, this involves identifying a dimension which acts as a central perspective aligning “all the other
dimensions – rendering some of them irrelevant, some of them sufficient, and some of them critical” (Gilgun, 2010, p.24). The explanatory matrix, therefore, is a scheme identifying which dimensions are context (explaining the situation or environment in which the social process occurs), conditions (salient dimensions which facilitate, impede or modify actions and interactions), processes (actions or interactions that are prompted by specified conditions) and consequences (outcomes of specific actions or interactions) (Kools et al., 1996, p.329). The central organising phenomenon (central dimension) is determined after checking which of several dimensions offers the most fruitful explanation, on the basis of evidence from the data. The explanatory matrix is refined through more focused data collection and/or reassessing previously analysed data on the basis of new theoretical insights (Schatzman & Strauss, 1973).

- Eventually, in the integration stage, the position of the dimensions and properties within the explanatory matrix is refined and a substantive theoretical account is created (Kools et al., 1996).

The process is characterised by the researcher’s interaction with the data and the constant comparison of different data elements through a series of inductive-deductive cycles. Abstract concepts (labels) are used to explain and interpret segments of data (inductive thinking), while deductive reasoning is used to focus from abstract concepts to specific instances in the data. Working hypotheses are used to interrogate the data by looking for both positive and negative evidence for the inductively derived labels (Schatzman & Strauss, 1973). In the process, concepts are relabelled with an increasing level of abstraction, which is facilitated by the researcher’s continuing development of theoretical sensitivity. The analytical process starts concurrently, and occurs iteratively, with data collection. This allows researchers to adjust data collection in a way which shifts “some emphasis towards those experiences which bear upon the development of their understanding and generally to exercise control over their emerging ideas by virtual simultaneous ‘checking’ or ‘testing’ of these ideas” (Schatzman & Strauss, 1973, p.110). The nature and source of subsequent data collection is determined by theoretical sampling (Section 4.2.3) and continues until theoretical sufficiency (Section 4.3). Diagrams and memos are used throughout the entire process to document analytical thoughts, theoretical insights, methodological decisions (including those related to theoretical sampling and relabeling of concepts), and reflexive learning.
The next subsections describe how I used these principles of dimensional analysis to guide the generation and analysis of the data and my interaction with them. Examples of memos, data segments, working hypotheses and reflective notes are interspersed in an effort to illustrate some key stages of the data analysis process, thereby enhancing the study’s auditability. In keeping with the dimensional analysis approach, some findings and their theoretical interpretation have been included to illustrate the analytical process, and to demonstrate how early data analysis drove subsequent data collection, sampling and analysis (Scholes et al., 2012). The actual substantive theory, accompanied by evidence from the data, is presented in the next two chapters.

### 4.6.2 Dimensionalising

My interaction with and analysis of the generated data started during data collection sessions themselves. During participant observation sessions and interviews, my initial interpretation of what I was observing and listening to were documented in memos in the field book, but using a different colour from that used for actual observation data. In this process, I also documented my questions about the emerging data and highlighted areas which needed further clarification. This process continued immediately after leaving the field, between an observation session and its associated interview with the same participant. During this interval I focused on identifying areas which I wanted to clarify with, and learn more about from, that same participant. Figures 4.3 and 4.4 showed examples of such field memos in the original handwritten format and in the subsequently typed out version.

During the first few days following each data collection session, I wrote notes and reactions about the newly emerging data, followed by a reflective summary about the data elicited from each participant, areas that needed further exploration, and aspects which I could improve in my observation/interviewing technique. In this process, initial coding took place as chunks of data were labelled; some of the labels were considerably literal and others were more conceptual. This marked the start of the dimensionalising stage of dimensional analysis, by identifying the “principal components” (Corley, 1998) of the social process of referring. An example of early identification of dimensions from an interview transcript is provided in Appendix VIII.

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43 Auditability as a means of enhancing rigour in qualitative research was discussed in Section 3.6.3
Analytic memos were written about the principal emerging themes, and these were supplemented with data excerpts. Consistent with the constant comparative method of analysis (Glaser & Strauss, 1967), I compared and contrasted sets of data with each other, looking for similarities and differences in participants’ actions, interactions, feelings and experiences within the data generated from the same participant and between data generated from different participants (Charmaz, 2006). In particular, I compared the presence of labels (Corley, 1998) elicited from the data of the most recent participant with those in the data elicited from previous ones. This is exemplified in Box 4.4, which depicts the comparison of data from the third participant with those elicited from the first two, and also in the right hand column of the table in Appendix VIII.

![Preference for referral even among nurses](image)

*Preference for referral even among nurses*: “...even with other colleagues, I search who I ask, I don’t just ask anyone...initially I try to ask those two, three, four people I feel most close to”. This is very similar to what Sally had said and which I had termed as an unofficial buddy system. However, Jeremy takes this a step further: Certain doctors are preferred from certain nurses; this is based on his initial experiences in the ICU: “...in my orientation I used to see it [being almost degraded for not knowing certain things]...when someone says ‘oooh’ in a way that makes me feel uncomfortable, and I feel put off. Then my confidence, sort of the little I have, not the much [laughs], I feel it declining more when they speak to me like that. So I like to ask people who, apart from giving good advice, I feel confident to speak to; people with whom I feel that I won’t be judged. People who wouldn’t say: ‘look what he asked me!’” *This is an interesting new concept because even the decision to or not to refer to nurse colleagues may also be based on maintenance of integrity.* Indeed, “feeling comfortable with someone plays an important role...it’s not a matter of a nurse or a doctor; it is a matter of the individual”.

*Jeremy insisted that deciding when and to whom to refer is a difficult decision...confirms Sephora’s position but contrasts with Sally’s.*

**BOX 4.4**

*Memos and data excerpts illustrating comparisons of the data elicited from the third data collection session with data elicited during the two previous sessions. See also Appendix VIII.*

Thus, comparative analysis within and between sets of data started early in the process of iterative data collection and analysis. This constitutes a deviation from the analytical process proposed by Schatzman who advocates delaying comparative analysis “until a larger bank of dimensions has been identified” (Bowers & Schatzman, 2009, p. 95). While understanding that Schatzman’s advice is based on the importance of preventing premature closure, early commencement of comparative analysis was considered more natural as it
enabled subsequent coding of chunks of data (dimensionalising) to be theoretically sensitised by what had already been identified as relevant in earlier data. Without such early comparison across cases, it would have been difficult to identify what was salient and what was not in the new data set.

Following the first sets of data collection sessions, two dimensions appeared quite frequently, namely “maintenance of integrity” and “filtering”. The memos below (Box 4.5) illustrate how these initial dimensions were defined.

- **(MAINTAINING) INTEGRITY** – refers to decisions about whether to seek help or not, being influenced by the consequences of that act of seeking help on one’s own peace of mind.

- **FILTERING** – considering several factors (including time of day, the urgency of the situation, and the person from whom to seek help) before the actual act of referral.

**BOX 4.5**

*Coding memos defining two early dimensions: “Maintenance of Integrity” and “Filtering”*
This inductive process was followed by a deductive one in which the amassed data were interrogated on the basis of working hypotheses related to the main recurrent dimensions. This was important in ensuring that development of dimensions was not forced[^44], but actually supported with evidence from the data (Schatzman & Strauss, 1973). Grids were set up to enable the comparison of the different participants in terms of whether data segments were present to either support (positive evidence) or reject (negative evidence) each working hypothesis (see Table 4.2 and Figure 4.5 for examples of this process). Inconclusive or unavailable evidence, and therefore the need to seek further clarification about certain aspects of a dimension, influenced my decisions about which participants to subsequently select and what data to collect (theoretical sampling)[^45]. Thus, concurrent data collection and analysis enabled me to “move back and forth between gathering and analysing the data” (Schatzman and Strauss, 1973, p.117).

![Table 4.2](image)

**Table 4.2** – Example of grid testing some working hypotheses related to the dimension of “self-preservation” in the data from the first five participants (P1 – P5). Ticks show the presence of data supporting the hypotheses; crosses show the presence of negative data; while circles and question marks indicate unavailable or inconclusive evidence. Much larger grids, supplemented with evidence consisting of actual data chunks and properties, were subsequently constructed, as depicted in Figure 4.5.

[^44]: In grounded theory parlance, the term “forcing” refers to imposing a particular view upon the data which might deviate from the aim of generating theory from the data themselves (Glaser, 1992; Urquhart, 2013).

[^45]: The theoretical sampling strategy adopted in this study was discussed in more detail and illustrated with examples in Section 4.2.3 above.
Figure 4.5 – Part of a larger grid with data segments supporting or rejecting several working hypotheses elicited from several participants. These grids (matrices) enabled comparison between participants in terms of the emerging dimensions and properties, thereby enhancing the identification of new analytical insights from the data themselves [as illustrated in the study by Endacott et al. (2012)].

Eventually, on the basis of some reading around it, “maintaining integrity” was renamed to “self-preservation” as the data indicated that it reflected even more clearly one of the principal reasons for seeking help from doctors. The memo below (Box 4.6) documents the rationale for this relabeling.

**INTEGRITY** - Chosen as a dimension because it came out very clearly from the first sets of data, initial grids, and particularly after supervision sessions in May and June 2010. Following an Internet search, I am strongly considering renaming it to SELF PRESERVATION which is a “behaviour that ensures the survival of an organism” and, when used figuratively, refers to “the coping mechanisms one needs to prevent emotional trauma from distorting the mind” as it reflects the participants’ experiences more closely.

**BOX 4.6**
*Coding memo documenting the relabeling of a dimension*
4.6.3 Differentiation

Subsequently, in the beginning of the differentiation component of dimensional analysis (see Section 4.6.1), self-preservation was being considered as particularly central to the emerging theoretical model. I noted, however, that self-preservation was closely related to other aspects influencing the decision of whether to refer or not, particularly “advocacy/altruism” and “desire for autonomy”. In view of this, I decided to revisit the data to look out not only for self-preservation per se but also for other “Motivations for the decision to seek help or not”. As my working frame I used the working hypotheses I had formulated earlier on about self-preservation, which had been refined by combining questions which were closely related. This helped me conflate this dimension and, therefore, see “what ‘all’ is involved” (Schatzman, 1991, p. 310) in relation to self-preservation. After sketching some diagrams (e.g. Figure 4.6) and writing an extended theoretical memo, I concluded that, while very important, self-preservation was part of something larger, rather than the central dimension.

![Figure 4.6](image)

**Figure 4.6** – Early “see-saw diagram” depicting the balancing of several, occasionally conflicting, motivators for nurses’ decisions to seek help from doctors, including patient advocacy, protecting oneself from anxiety (self-preservation), and seeking autonomy.

Following a discussion during one of my supervision meetings, I was prompted to do some basic reading around social identity and negotiated order theory (e.g. Strauss, 1978), following which I attempted to re-interpret my data using insights from the “staged

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46 Although, they are presented in separate subsections, in effect there was considerable overlap in the stages of dimensional analysis, as demonstrated later in this subsection.
performance” metaphor. A theoretical memo was written and another “see-saw” diagram was sketched, similar to the one about self-preservation but this time based on following and deviating from the script. However, this route was eventually discarded as I felt that this interpretation of my data was rather “forced”. The memo in Box 4.7, excerpted from my reflective diary, refers.

Following this, I wrote a 2-page theoretical memo summarising my interpretations on the basis of the staged performance metaphor (scripted behaviour). My feelings were mixed between this making sense and a feeling of having “forced” the theories I had read about onto my data.

BOX 4.7
Excerpt from reflexive journal documenting a change in the analytical direction

This led to another inductive-deductive cycle, initiated by the sampling of some literature about several ideas that had emerged from a supervision meeting (particularly about risk management and negotiation). In this context, Schatzman and Strauss (1973, p. 119) point out when the researcher tells his story to an interested and sympathetic colleague or supervisor, “the listener’s questions may catalyse him to a new relationship with his data”. The use of the literature as a source of conceptual ideas is also encouraged by the same authors who argue that “concepts, models and even data drawn from the examination of secondary sources can be utilised directly and openly by the researcher in any way which facilitates his understanding” (p.127). Thus, at this point both supervision and the literature served as conceptual levers (Schatzman & Strauss, 1973, p.117). Of note, while the literature was helpful in asking increasingly complex questions of the data (Lempert, 2007) thereby increasing my theoretical sensitivity (see Section 3.4), it was viewed in a “non-committal manner” in order to prevent premature closure and forcing (Urquhart, 2013). This was followed by relabeling several of the concepts previously used to interpret the data into more conceptual ones in what Schatzman and Strauss (1973, p. 113) call “shifting the grounds”47 (exemplified in Table 4.3), and then revisiting the data once more to check whether evidence was present for this reinterpretation.

47 In the grounded theory literature, the term “shifting the grounds” is probably more frequently associated with Charmaz (2009), who uses it in a completely different context, namely the changes in the ontological and epistemological underpinnings from “classic” to “constructivist” grounded theory.
Sephora decides to ask the consultant to speak to the relative about the possibility of a flight home. She phones him up [at the doctors’ room in the same unit] and explains the situation.

I am a foreign nurse, so naturally I am getting along better with foreign doctors. We are on the same boat…we have the same mentality…we feel very similar and we speak similar language.

Of course, it’s past experiences! I wouldn’t come to this conclusion just from a single incident. Yes, because by time [I noticed that] whatever I think the consultant disagrees with me: if I say the opposite she does the opposite. So, in order not to make her object, I have learned to shut my mouth.

These young doctors sometimes ask you about CPAP or sedation, and certain things; they come to you. It feels good, yes; you feel respected.

I think there is a legal requirement [to seek doctors’ approval]… because everything should be prescribed in a way. For example…you can’t start a medication on your own; it has to be prescribed. So you need the advice…You need to ask the doctor and take his advice.

When I come in I try to read the history of the patient. For how many days has the patient been in ICU? What does he have? What type of operation was carried out? In the ward round the consultant normally asks the juniors to see if they have read about, but still it is better for me so that I can understand what they are doing.

She says that she would definitely prefer speaking to the (more junior) resident than the consultant…because she feels more comfortable speaking to a “more junior” doctor, especially one who works on call duties with them.

<table>
<thead>
<tr>
<th>DATA EXCERPT (Observation or Interview Data)</th>
<th>ORIGINAL DIMENSION (Initial Labelling)</th>
<th>RELABELLED DIMENSION (Advanced Labelling)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sephora decides to ask the consultant to speak to the relative about the possibility of a flight home. She phones him up [at the doctors’ room in the same unit] and explains the situation.</td>
<td>Advocacy</td>
<td>Acting as the patient’s agent</td>
</tr>
<tr>
<td>I am a foreign nurse, so naturally I am getting along better with foreign doctors. We are on the same boat…we have the same mentality…we feel very similar and we speak similar language.</td>
<td>Nationality and Shift grouping</td>
<td>In-group bias</td>
</tr>
<tr>
<td>Of course, it’s past experiences! I wouldn’t come to this conclusion just from a single incident. Yes, because by time [I noticed that] whatever I think the consultant disagrees with me: if I say the opposite she does the opposite. So, in order not to make her object, I have learned to shut my mouth.</td>
<td>Learning from past experiences</td>
<td>Reflection / Reflexive feedback</td>
</tr>
<tr>
<td>These young doctors sometimes ask you about CPAP or sedation, and certain things; they come to you. It feels good, yes; you feel respected.</td>
<td>“Joint” decisions</td>
<td>Collective esteem</td>
</tr>
<tr>
<td>I think there is a legal requirement [to seek doctors’ approval]… because everything should be prescribed in a way. For example…you can’t start a medication on your own; it has to be prescribed. So you need the advice…You need to ask the doctor and take his advice.</td>
<td>Legal reasons to refer</td>
<td>Acting as the medical practitioner’s agent</td>
</tr>
<tr>
<td>When I come in I try to read the history of the patient. For how many days has the patient been in ICU? What does he have? What type of operation was carried out? In the ward round the consultant normally asks the juniors to see if they have read about, but still it is better for me so that I can understand what they are doing.</td>
<td>Learning the patient</td>
<td>Acquiring positive information asymmetry</td>
</tr>
<tr>
<td>She says that she would definitely prefer speaking to the (more junior) resident than the consultant…because she feels more comfortable speaking to a “more junior” doctor, especially one who works on call duties with them.</td>
<td>Attitude of person from whom help is sought</td>
<td>Preventing personal risk</td>
</tr>
</tbody>
</table>

**Table 4.3** – “Shifting the grounds” (Schatzman & Strauss, 1973, p.113): Examples of how some data segments were relabelled using more conceptual nomenclature.

Data segments were thus recoded on the basis of the new (more conceptual) dimensions, accompanied by diagramming and writing of an extended theoretical memo with the renamed dimensions. An excerpt from the latter is presented in Box 4.8 below, which also shows (through colour coding) the way certain dimensions were reworded. Revisiting the data in this manner is in keeping with Schatzman and Strauss’ (1973, p. 117) description of the analytic process as being “grounded” in the data, “where ‘grounded’ means both interpretation of the data and checking upon that interpretation by the gathering of more data”. In other words, data collection was driven by data analysis both in terms of collecting new data from subsequent theoretically sampled participants [as demonstrated earlier in this chapter, especially in Section 4.2.3] and by re-evaluating previously
analysed data “once incidents of analytical importance had been recognised and understood” (Scholes et al., 2012, p. 4) [as exemplified here]. This also shows that dimensionalising and differentiation were cyclical iterative processes rather than discrete stages.

Nurses’ decisions about whether to refer to doctors are motivated by the following consequences:

1. **Risk aversion** – There is a generalised need to keep risk levels as low as possible, either by transferring problems in patient management to or by sharing them with another party. This is partly dependent on a nurse’s *risk appetite*, or threshold of risk, and is balanced against one’s need to act as an autonomous practitioner.

2. **Contract clarity** – As a general rule, an agent is only entitled to indemnity from the principal if s/he has acted within the scope of his/her actual authority. In the assumption that, formally or informally, nurses are considered as the consultant’s agents, they are required to clarify and/or verify with a consultant or doctor whether they can take certain actions. Such referral for contract clarity is particularly important because such “consultant-nurse contract” varies substantially between one consultant and another and also because consultants do not always clearly communicate their “plan” with nurses. Directly or indirectly, several participants referred to this as “legal reasons to refer”. How much one is ready to act outside this “principal-agent contract” partly depends on one’s *risk appetite*. Contract clarity as a reason for referral is, therefore, replacing what earlier on I had labelled as “Referral for Verification / Confirmation”, “legal reasons for referral” and “seeking cover”. Just as nurses’ actions are limited by their obligation to act as doctors’ agents, junior doctors are similarly hindered from taking certain decisions before they consult their principal (the consultant).

3. **Patient agency** – Nurses also feel duty bound to act as agents for their patients. In view of this, they frequently refer to doctors to either seek authorisations for actions they deem most beneficial to their patients or to influence doctors’ decisions in the light of what they feel their patients would benefit most from. Previous labels: “altruistic referral”; “advocacy”.

4. ** Participative decision making** – Some referrals are driven by nurses’ needs to be involved in their organisation, specifically by taking part in decisions about patients’ treatment modalities. Participative decision making is at times hindered by **negative information asymmetry** and aided by **positive information asymmetry**. Participative decision making is desirable by all nurses but its occurrence varies substantially according to the preferences / characteristics of other social actors, particularly consultants. Previous label: “professional integrity”.

5. **Addressing negative information asymmetry** – Some referrals are specifically made because of perceived or actual deficiencies in nurses’ knowledge about how to manage specific situations. **Structural factors**, especially the need to follow routines, may both cause and prevent negative information asymmetry. Non-local **nationality** (“not knowing the system”) and communication breakdown also contribute to negative information asymmetry.

6. **Autonomy and collective self-esteem** – Nurses’ decisions not to seek help from doctors are partly influenced by their attempts to act as autonomous practitioners. Similarly, nurses’ preference to seek the help of a member of their profession, rather than (immediately) seeking help from a doctor, is partly motivated by collective self esteem. Attempts at acting autonomously, however, are hindered by structural factors and balanced against the need for risk aversion and the need to follow the “principal-agent contact” with the consultant. Indeed, acting autonomously is considered to be accompanied by additional risks, which, in the case of some nurses, overwhelm the generally expressed need for autonomy [balance between need for risk aversion and need for autonomy]. Previous labels: “seeking autonomy”.

**BOX 4.8**

Excerpt from a theoretical memo eliciting some principal motivations for nurses’ decisions to seek help from doctors (in red) and how these replaced earlier dimensions (in green).
4.6.4 Identifying the central organising phenomenon

An important abductive\textsuperscript{48} moment occurred when, after approximately four months of intensive analysis, I started to consider some concepts from the economic theory of agency\textsuperscript{49} (Ross, 1973; Eisenhardt, 1989; Abdalla, 2008) as potentially helpful to explain what was going on in my data. It was evident early on that nurses’ referrals to doctors were at least partly determined by an informal yet powerful contract. Insights from agency theory, however, underscored significant similarities between critical care nurses’ relationship with medical practitioners and the relationship between an agent and a principal. Eventually, while revisiting the data with this new perspective, I began to notice that nurses did not only feel legally obliged to act as agents to medical consultants, but also morally obliged to act as agents to their patients. The latter analytical direction conceptually elevated what I was earlier simply labelling as “patient advocacy” to “the nurse as the patient’s agent”. This consideration of nurses acting as agents to two different principals was invariably characterised by a potential conflict of interest, leading me to coin the term “dual agency”, a term which I had never read about or even heard before. The appropriateness of this conceptual label was ensured after discovering, through a brief internet search, that in the real estate sector it refers to situations in which a person concurrently acts as an agent to both the buyer and the seller, leading to an inevitable conflict of interest (Eisenhardt, 1989; Teichner, 2005; Kadiyali, Prince, & Simon, 2008).

The progression of my ideas in this regard is illustrated through the following series of memos and working hypotheses (Box 4.9 and 4.10). Box 4.9 also illustrates how I made use of insights from the literature to look at the data in a more conceptual manner, which is strongly advocated by Schatzman and Strauss (1973) and Lempert (2007) among others. Importantly, the literature used at this stage was not from the critical care or from the referral field; rather, as advised by Glaser (1978, p. 139), I “read in other fields so as not to pre-empt [my] thoughts regarding the significant variables in the substantive area under research”. Schatzman offers similar advice in his biographical interview with Gilgun (2010).

\textsuperscript{48} In grounded theory research, abduction occurs “when something unintelligible is discovered in the data, [making it] clear what the case is” (Riechertz, 2007, p. 219), leading to new working hypotheses and a shift in the researcher’s perspective.

\textsuperscript{49} An overview of Agency Theory (also known as Principal-Agent Theory) is provided in Section 6.3.1.
Points from Reading:

The law of agency is an area of commercial law dealing with a contractual or quasi-contractual, or non-contractual set of relationships in which a person, called the agent, is authorised to act on behalf of another (called the principal) to create a legal relationship between the parties. Succinctly, it may be referred to as the relationship between a principal and an agent whereby the principal, expressly or impliedly, authorises the agent to work under his control and on his behalf. An agent, as a general rule, is only entitled to indemnity from the principal if s/he has acted within the scope of her actual authority, and may be in breach of contract, and liable to a third party for breach of the implied warranty of authority.

Analytical Memos:

- “Agency” may very well be the theoretical explanation for “legal reasons for referral”
- Clarifying the principal-agent contract (frequently termed as “PLAN” by the participants) necessitates “referral for clarification”, particularly because the contract (what is expected) varies substantially with different social actors [e.g. some consultants expect to be kept informed for minor changes to a much greater extent than others].
- Also, just as nurses’ actions are limited by their obligations to act as doctor’s agents, junior doctors are similarly bound from taking certain decisions before they consult their principal (i.e. consultant).

Data Segment

This patient declares that she would like to eat and the nurse promises that ‘we will ask the doctors’ about that’ (Sephora, Observation Session)

Analytical memo:
Interestingly, I now note that advocacy itself may be described as the nurse being the patient’s (rather than exclusively the doctor’s) agent.

Data segment:

“We are the mediators, kind of, between the doctor and the patient”.

- Sephora, Interview

Analytical memos:

Her own words confirm that there is a principal-agent relationship going on, with the nurse acting, not only as the doctor’s agent, but especially as the patient’s agent.

On further reflection, this incident [Int. 1 JT 8] might be interpreted as:
1. Confirming the nurse acting as a patient’s agent, so much so that when referral is done without consulting the patient (if this is possible) the outcomes might not be successful
2. It also confirms that decisions to refer have an external cost to the patient.

BOX 4.9
Inductive-deductive cycle identifying a principal-agent relationship between doctors and nurses and also between patients and nurses.
Data segment:

And I do speak up, yes...even when doctors tell me: “extubate the patient”, and then after half an hour they come and say, “didn’t you extubate?” I say: “Wait a minute: extubate? How? He was on BIPAP, on the ventilator, full ventilation; do you want me to extubate in half an hour? He is not ready for extubation. What are you thinking?” There were instances in which I told consultants: “Wait a minute: You can’t go that fast!”

- Judith, Formal Interview

New working hypothesis:

Is there a conflict (of interest) due to simultaneously acting as the doctor’s and the patient’s agent?

Theoretical Memo:

Nurses are contracted by the organisation to act as agents to physicians. However, they are also the patient’s agent [a concept which may incorporate what I was referring to as advocacy/altruistic referral]. Having to act as an agent to two different principals may lead to goal conflict, particularly when instructions from physicians are contrary to patients’ requests. [E.g. doctors insisting on ambulating patients at a time when patients would not feel like – Interview 2 – JT9; Interview 9 – JT16]. This constitutes a dual agency.

To ensure that my new analytical insights were actually grounded in evidence from the data, I again used several working hypotheses to interrogate the data. Table 4.4 below shows how some of some earlier working hypotheses were reworded on the basis of later theoretical development.
Advocacy (and speaking out) may also have negative effects on one’s self-preservation, particularly due to lack of peer support. This confirms that advocacy is also balanced against the possibility of conflict.

Goal conflict may arise due to the nurse acting as an agent both to the consultant and the patient.

Conflict prevention seems to keep other nurses from participating in decisions, while others attempt to reword (rather than stop) their attempts at influencing changes (pg. 5, 7, 11, 15) without causing conflict.

One negotiation strategy to influence decisions about patients involves rewording the language used.

Advocacy is motivated by the nurse’s role in acting as the patient’s agent.

Table 4.4 – Rewording of working hypotheses used to interrogate the data into increasingly conceptual ones and on the basis of a change in the analytical direction

In the process, “dual agency”\(^{50}\) appeared as increasingly central in the emerging theoretical explanation. Subsequently, a more specific extended theoretical memo, with “dual agency” as the central organising dimension, was written, an excerpt of which is reproduced in Box 4.11 below. Other important dimensions were determined as being context (e.g. power asymmetry; institutional constraints), conditions (e.g. trust and reputation risk; moral

\(^{50}\) This section includes several theoretical labels / dimensions (between inverted commas or in italics) derived from the data as a means of illustrating the analytical process. These will be defined, illustrated with data evidence and situated in the context of the substantive theory in Chapter 5.
agency; nurse’s characteristics; agent scrutiny; information asymmetry), process (negotiating; reflecting; socialisation) and consequences (e.g. risk aversion; contract clarity; individual/collective autonomy; self-preservation; moral distress). Figure 4.7 depicts an explanatory matrix incorporating several of these dimensions. The latter theoretical memo and explanatory matrix were subsequently populated with data and this formed the basis of the early drafts of the storyline of the findings presented in Chapter 5. Thus, writing proceeded from drafting increasingly theoretical memos (as exemplified in this section) to supplementing those memos with evidence from the data (as presented in the next chapter) and eventually writing about the resultant theory in the context of relevant literature (Chapter 6), which progression is encouraged by Charmaz (2006) and Stern (2007) among other grounded theory authors.

Nurses can, therefore, be seen as fulfilling a dual agency role because they act as agents to two different principals, namely the ICU consultant and their patient. The term dual agency is normally used in the real estate sector to refer to persons who act as an agent to both the buyer and the seller, resulting in an inevitable (and insoluble) conflict of interest between obtaining the lowest price for the buyer and the highest price for the seller (Kadiyali et al., 2008; Albert, 2011). Although nurses’ position of acting as an agent to both the consultant and the patient poses a less drastic dichotomy, parallels can be drawn to the dual agency scenario, mainly due to the following potential conflicts directly arising from their role as agents to two different principals:

1. Nurses’ requirement to only carry out actions that have been authorised by the consultant is dynamically opposite to their desire to act autonomously;

2. Nurses and doctors tend to draw upon different types of knowledge to guide patient management;

3. There are occasions in which nurses feel that their consultants’ preferences are incongruent with (and, at times, opposite to) their patient’s expressed or implied preferences. Therefore, although agents are supposed to avoid conflicts between their and their principal’s interest (Abdalla, 2008), acting as agents to two different principals (dual agency) places nurses in a delicate position of having to juggle between the preferences of the former with the interests of the latter...

 BOX 4.11

Excerpts from a theoretical memo with ‘dual agency’ as the central dimension, and with references to the literature as a means of enhancing the conceptual level (Lempert, 2007).

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51 The terms context, process, conditions and consequences, in terms of dimensional analysis, were defined in Section 4.6.1.
4.6.5 Integration and scaling up the theory

This led to the integration phase of data analysis, in which the theory is further refined and consolidated and a substantive theoretical account is produced. Writing was clearly part of, and actually enhanced, the analytical process (Glaser, 1978; Charmaz, 2006; Stern, 2007) because, to borrow Schatzman’s words, “in preparing for any telling or writing, the researcher is apt to see his data in new ways: finding new analytic possibilities or implications he has never before sensed” (Schatzman & Strauss, 1973, p. 132). This was particularly evident during my preparation for conference presentations (refer to Section 3.6.2); while compiling a transfer document in part-fulfilment of the upgrade of my registration from MPhil to PhD; in drafting a storyline of the findings in preparation for focus group interviews; and eventually while writing the present thesis.

Apart from writing itself, theoretical integration was facilitated by two important events in the iterative process of collecting and analysing data, both of which helped to enhance theoretical sufficiency. First, the emerging theoretical framework was exposed to the

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52 Theoretical saturation and sufficiency are discussed in more specifically in Section 4.3.
critical feedback of peers (in the form of conference presentations and academic supervision\textsuperscript{53}) and of the participants themselves (through focus groups aiming at ensuring phenomenon recognition\textsuperscript{54}). Although no new dimensions were identified in this process, these helped to explain existing dimensions more clearly. For instance, while earlier data collection through individual interviews had revealed several \textit{negotiation strategies} used by nurses when referring to doctors (discussed in Section 5.2.9 in the next chapter), it was during the interaction between the participants in the focus groups that the negotiation strategy of \textit{using reverse psychology} was elicited as a sub-dimension of this existing dimension. Similarly, \textit{self-preservation} and \textit{preventing personal risk} featured in the emerging theory \textit{before} I conducted focus group interviews; nonetheless, data emerging from focus groups helped me situate these dimensions more confidently within the \textit{balancing personal and professional risk} duality, and subsequently within the central dimension of \textit{acting as dual agents}.

Second, during this late phase of data analysis I started to “engage the emergent theory with the existing literature” (Urquhart, 2013, p. 29). According to the same author, which literature is sampled is determined by the researcher’s enhanced theoretical sensitivity and by the emerging theory itself. At this stage, therefore, I conducted a fresh literature search sensitised by the emerging central dimension, namely theoretical and empirical studies about principal-agent theory and dual agency, and their previous applications to healthcare and non-health care settings. As illustrated in Section 6.3, this was very useful “to render the new theory in the context of existing knowledge, and, thus, make the theory more valuable” (Urquhart, 2013, p. 30), particularly by making the contribution of the generated theory to knowledge about the substantive area more explicit (Stern, 2007).

At this stage, the literature also helped to broaden my understanding of agency from a philosophical and sociological perspective by reading about the notion of moral agency in nursing and structure-agency integration in the social sciences respectively. Subsequently, a final working hypothesis was formulated to look at the data and the literature in an even more abstracted manner, by exploring the relationship, if any, between nurses’ moral agency and their role as dual agents. The resultant theoretical link is proposed in Section 6.4 of the discussion chapter.

\textsuperscript{53} These forms of \textit{peer debriefing} are discussed in point (iii) of Section 3.6.2.

\textsuperscript{54} This form of \textit{member checking} is discussed in the first part of Section 3.6.2.
The value of “scaling up” (Urquhart, 2013, p. 130) the developing theory by comparing and contrasting it to extant formal theories, as attempted in the present study, has, indeed, been pointed out by the founders of grounded theory, both individually (Glaser, 1978; Strauss, 1987) and together (Glaser & Strauss, 1967). Thus, as suggested by Urquhart (2007; 2013), while the use of the literature in the early stages of the study was non-committal, the aim of this latter search was integrative as it helped to “line up what [is] theoretically possible…with what [I was] finding in the field” (Glaser & Strauss, 1967, p.253).

4.7 ETHICAL CONSIDERATIONS

Ethical approval for this study was sought and obtained from the University of Brighton’s Faculty of Health and Social Science Research Ethics and Governance Committee in December, 2009 (Appendix IX). Since the actual research project took place in another country, ethical clearance was also sought and obtained from the local University’s Research Ethics Committee (Appendix X), which also has the role of vetting applications for research taking place in the teaching hospital in which this study took place, in February, 2010. During this process, institutional permission to access the research area was obtained from the hospital and unit management (Section 4.2.1 refers). The present section discusses the ethical principles adhered to during this study.

4.7.1 Respect for autonomy and informed consent issues

To ensure that the participants’ rights to self-determination are respected, prior to the commencement of the study meetings were held with potential participants to give them all the information relevant to the purposes and procedures related to this study and to answer any queries they might have (McHaffie, 1996; Latvala, Janhonen, & Moring, 1998). Moreover, participants were given a letter which summarises what their role in the study would consist of (Appendix XI). The participants are all qualified health professionals; they were, therefore, considered to be able to understand the information given and intellectually competent to make decisions about whether they want to participate or not (Moore & Savage, 2002). However, every effort was made to ensure that, prior to giving their consent to participate, the participants were exactly aware of what their participation would actually involve. The fact that I am a former colleague of many of the nurses
working in this unit and that I now have a lecturing role made it even more important to explain to the prospective participants that they should not in any way feel pressured to take part in the study. Furthermore, the four nurses working in this unit who, during the data collection phase, were undertaking a module which I deliver and assess were excluded to ensure there is no perceived coercion or favouritism in the recruitment of participants. No form of inducement was offered to the participants and I was never secretive or misleading in my role (Mack et al., 2005); conversely, my researcher role was clarified with the participants during all stages of data collection (Chenitz, 1986b).

Nurses who accepted to participate were asked to sign a consent form summarising the pertinent information about their role in the study (Appendix XII). Participants were also reminded that they have the right to withdraw from the study at any point and without giving any reason, even though concurrent data collection and analysis might make it impossible to disaggregate and remove the data which they had already contributed (Orb, Eisenhauer, & Wynaden, 2001; Mack et al., 2005; American Association of Critical Care Nurses, 2008). Participants were reminded of each observation session at least 24 hours in advance, giving them enough time to decide whether they were still willing to take part in the study. At regular instances during data collection, they were again reminded of their right to withdraw from the study. Thus, like various authors using a similar design (e.g. Lawton, 2001; Goodwin, Pope, Mort, & Smith, 2003; Bailey, 2007), I elected for an ongoing “process” consent which, according to Polit and Hungler (1998), is a transactional process whereby the researcher continually renegotiates consent, thereby allowing participants to play a collaborative role and ensuring that every stage of their participation in a research study is voluntary. In view of this, even though they had consented to participate in an observation session and interview earlier in the study, participants were again given an information letter (Appendix XIII) and asked for their verbal and written informed consent (Appendix XIV) prior to taking part in the subsequent focus groups.

The research question guiding this study is related to nurses’ decision making, and not patients; as such, prior to the observation sessions, written informed consent was only obtained from nurses (Bunch, 2000; Haugen Bunch, 2001; Currey, 2003; Rose et al., 2007; Scott, Estabrooks, Allen, & Pollock, 2008). The study did not seek to collect any patient related data, but, in the occasional instances during which reference was made to a

55 In contrast, “perpetual” consent refers to the assumption that it is sufficient to obtain consent from participants only at the beginning of a study (Carnevale, Macdonald, Bluebond-Langner, & McKeever, 2008).
patient’s physiological parameters in the context of critical care nurses’ referral to doctors, these data were disaggregated from the identity of the individual patients (Happ & Kagan, 2001). During the observation sessions, I introduced myself as a research student to the conscious patient/s being cared for by the respective nurse participants and made them basically aware that my observations will be essentially focusing on the nurse and not them. Similarly, retrospective verbal assent was obtained from patients, relatives and any other health professionals who were indirectly observed while interacting with the nurse whom I was observing (Lundgren & Segesten, 2001; Birkler, Damkier, & Hansen, 2008). This is considered sufficient if the risks are judged to be minimal (American Association of Critical Care Nurses, 2008; Carnevale et al., 2008; Griffiths, 2008). Moreover, posters were placed on notice boards in key locations as another means of informing people that a research study was taking place (Appendix XV). These included information about the identity of the researcher and how more information about the research could be obtained (Kennedy, 1999; Currey, 2003).

4.7.2 Measures to ensure confidentiality, privacy and data security

Participants were informed that the formal individual interviews and the focus group sessions were being audio recorded, and that data collected from observations and interviews would be transcribed and electronically stored; data collection proceeded only once they agreed to this. To safeguard the privacy and confidentiality of the participants, I expanded notes from the observation sessions, and transcribed the individual and focus group interviews myself. In accordance with the Data Protection Act (Chapter 440 of the local laws) and the Code of Practice for MPhil, PhD and Professional Doctorates (University of Brighton Doctoral College, 2011), all data were kept in a safe place, accessible only to me and the supervisory team. No data were stored on the University’s computer mainframe. Measures were taken to ensure that individual participants are not identifiable in the thesis, and in conference proceedings arising from this study. Pseudonyms were used instead of the participants’ real names and non-relevant case material was distorted so as to make it impossible for the readers to recognise them, as recommended by other qualitative researchers (Archibald, 1986; Currey, 2003). At the beginning of each focus group interview, participants were reminded of the importance of not divulging anything said during the session to outsiders; nonetheless, participants were made aware that there was no way of guaranteeing this, and that they were free to
withdraw their participation in the study if they felt that this issue was a concern (Morgan & Kreuger, 1993; Mack et al., 2005).

4.7.3 Ethical implications of a ‘dual’ role

An additional challenge I had to face is related to my being both a researcher and a health professional which, while helpful in increasing the familiarity with the environment and the rapport with the participants, might also lead to a ‘dual-role’ conflict (Kite, 1999; Orb et al., 2001; Gerrish, 2003; Allen, 2004; Simmons, 2007; Bailey, 2007). In view of this, prior to the commencement of data collection I negotiated with the nurse managers and with the research participants themselves under which exact circumstances I would intervene in patient care as a qualified nurse. An informal research contract was thus developed with decisions about my participation being taken by both the research participants and the researcher (Casey, 2004). Furthermore, participant observation could have led me to observe unsafe or unethical behaviours in the clinical setting. In such a situation, since as a nurse I am governed by the Code of Professional Conduct (Council for Nurses and Midwives, 1997), I would have been bound to stop my data collection, and, according to established practice, seek the help of the nurse in charge, even though this might have meant eroding the established rapport with the research participants (Currey, 2003; Johnson, 2004). No such instances were encountered; however, there were some rare instances in which I suspended my data collection in order to help other nurses (not the participant I was observing) in need of assistance; such incidents were documented in field memos (Archibold, 1986).

In addition to the established principles of beneficence, non-maleficence, justice and respect for persons’ autonomy (Gillon, 1994; Orb et al., 2001; American Association of Critical Care Nurses, 2008), I made an effort to adhere to the concept of respect for the community, which, according to the Mack et al. (2005) “confers on the researcher an obligation to respect the values and interests of the community in research” (p. 9). Hence, throughout the study, I consulted the nurses in charge of the unit constituting the research setting to make sure that it was appropriate for me to collect data, and that I would stop if and when they felt that the needs of the unit demanded so.
4.8 CONCLUSION

This chapter has explained the methods used to generate and analyse data on the basis of the methodological decisions presented in the previous chapter. Exposing the data to successive inductive-deductive analytic cycles led to the elicitation of several dimensions of the process of referral, aided by conceptual leverage from the literature. Dual agency emerged as a central dimension organising the several factors associated with nurses’ decisions to seek help from doctors. The emergent theory was refined after exposing it to the participants’ and peers’ feedback while additional integration was achieved through increasingly conceptual writing. The next chapter uses the explanatory matrix introduced in the present chapter to propose a substantive theory grounded on evidence from observation, interview and focus group data.
Chapter 5
FINDINGS

5.1 INTRODUCTION

This chapter will present the principal factors related to critical care nurses’ decisions to seek help from doctors, and concurrently proposes a substantive theoretical explanation derived from the analysis of these findings. To ensure that the latter is “grounded” in the data (see Chapter 3), excerpts from observation field notes, interview transcripts and focus group conversations are interspersed throughout the presentation of the findings. Such excerpts are presented in italics (to distinguish them from my analytical commentary), while underlined words or phrases within these excerpts indicate emphasis made by the participant on those words or phrases. Some data excerpts are also presented in tabular form to highlight, summarise and exemplify specific points in the discussion. Most data segments included in this chapter were selected on the basis of their representativeness; nonetheless, “atypical” data were occasionally included in order to provide a more complete picture of the variation in the factors associated with the process of referring. While the individual interviews and focus groups were transcribed verbatim, some of the excerpts provided in this chapter have undergone minor editing without changing the meaning in order to facilitate reading. An example of an original and an edited quote is provided in Appendix XVI.

The headings summarising the data in each subsection are deliberately literal, rather than conceptual. This decision was taken in an effort to demonstrate how the concepts constituting the emergent substantive theory were actually derived from data segments (as explained in Sections 4.6.2 and 4.6.3). Subsequently, in congruence with the dimensional analysis approach described in the previous chapter, the conceptual components of the emerging theory derived from the data presented in each subsection (dimensions) are presented in bold, whereas a number of sub-dimensions are identified in italics. The position of several of these dimensions within the emergent substantive theory is illustrated by means of diagrams; whereas their status as context, conditions, processes and consequences (Schatzman, 1991; Kools et al., 1996) was indicated in the written account (Section 4.6.4) of the analytical processes which preceded the writing of this finalised storyline, particularly though the explanatory matrix in Figure 4.7.
Participants’ names have been deliberately replaced with pseudonyms to conceal their real identity. However, each pseudonym and its first letter shed some light on the corresponding participant’s gender and level of work experience within the intensive care unit (ICU) in which the study was carried out. Thus, pseudonyms starting with a J [junior] are used for participants with less than three years of nursing experience and those starting with an S [senior] represent participants who have been working in the unit for more than three years. For example, the pseudonym “Sally” represents a female senior nurse, while “John” is a male nurse with fewer years of experience. Table 4.1 in the previous chapter provided a summary of each participant’s characteristics. Unless otherwise indicated, the personal pronouns “we” and “they” within the data excerpts represent nurses and doctors respectively.

The chapter is divided into three main sections. First, a discussion is provided about nurses’ motivations for seeking help from doctors and the strategies used during the process of such referring (Section 5.2). Second, to gauge a better understanding of the process of referring, it was also considered important to explore critical care nurses’ reasons for not seeking help from doctors; these are discussed in Section 5.3. Finally, to depict a more complete picture of referral as a social phenomenon, participants’ decisions about who to seek help from are explored in Section 5.4. The central organising phenomenon – namely, nurses’ dual agency relationship with medical practitioners and patients – is introduced and discussed in detail in Section 5.2, whereas Sections 5.3 and 5.4 respectively portray the relationship of this central dimension to nurses’ motivation for not referring to doctors and to their preferences when referring. Introducing this central duality relatively early in the findings was considered essential to enable the explanation of other dimensions’ relationships with, and in the context of, this central one; consequently, evidence sustaining the centrality of dual agency is provided throughout the chapter.

These findings will be discussed in the context of related empirical and theoretical work in the next chapter. However, the present chapter also contains occasional references to pertinent points in the literature; these are mostly presented through footnotes as a device for separating the data from the related points in the literature, thereby ensuring that “they do not take precedence over the generated theory” (Glaser, 1978, p. 138). Footnotes are also utilised throughout the chapter to define certain technical terms and to give additional contextual information in relation to aspects of critical care mentioned in data excerpts.

56 The process through which this central organising phenomenon was generated was explained in Section 4.6.4.
5.2 MOTIVATIONS AND STRATEGIES FOR SEEKING HELP FROM DOCTORS

This section discusses some principal reasons for nurses’ decisions to seek help from doctors. The participants frequently stated they did so in order to confirm they understood decisions taken about a patient’s treatment modalities and to seek the doctors’ approval for some of the actions they intended to take. The section also highlights aspects of the nurses’ relationships with medical practitioners and with patients, and how these affect the motivations for referral. The information and strategies used by nurses during referral are also discussed, as are the means through which such strategies are mastered.

5.2.1 Checking with and seeking permission from doctors

Nurses frequently communicate with medical practitioners to make sure they have understood their decisions, and that their actions comply with the patient’s treatment modalities. For example:

The consultant round puts my mind at rest, in a way, because it enables me to verify my actions with the consultant or another doctor.

- Simon, Formal Interview

During the last duty I was asking the consultant and other doctors several questions, both during and after the ward round...mostly to verify what actions needed to be taken because different doctors were saying different things.

Jessica, Informal Interview

These and similar comments suggest that a recurrent motivator for referring is nurses’ need to clarify with and seek verification from doctors regarding decisions about a patient’s treatment modalities. As indicated by the second excerpt above, this is particularly important when contradictory instructions are given by different doctors.

57 As explained in Section 5.1, the principal constituent concepts of the emerging substantive theory are presented in bold and follow a selection of data segments from which they were derived, in order to emphasise the “grounding” of the emerging theory in the data (see Section 4.6). In conjunction with Appendix VIII, this should help to illustrate the connection between the raw data and the emerging substantive theory, through the analytical procedures described in the previous chapter.
On other occasions, nurses refer to doctors specifically to obtain the latter’s approval for their actions. Examples include seeking permission for reducing the rate of inotropic infusions on the basis of haemodynamic improvement and changing ventilator settings on the basis of arterial blood gas results:

Let’s say…the blood pressure is high, and we’re still giving inotropes. I would ask the doctors: ‘Shall we start weaning the inotropes?’

- Susan, Formal Interview

If I feel that the patient needs more oxygen, for example, I would increase it and then go straight to the doctor and tell him ‘the result is this, and I did this. Do you agree?’ If he tells me ‘yes’, then it’s fine; if he tells me ‘no’, I would just change back [to the original settings].

- John, Formal Interview

Sally explained to the doctor that the patient had asked whether some of her intravenous lines, particularly her central line, could be removed. Although she felt that there were enough reasons for removal (particularly the fact that the patient was not getting any fluids through it, thus making it an unnecessary risk for infection) she says she preferred to seek a doctor’s “go ahead” first.

- Field Notes + Informal Interview, Observation Session 2

Just after Judith reviews her second patient’s ABG results, she decides to reduce the patient’s pressure support [the patient had already been weaned to CPAP]

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58 This refers to intravenous infusions of drugs with a positive inotropic effect, i.e. drugs which enhance the contraction of heart muscle, particularly useful for patients in shock, acute cardiac conditions and other critically ill patients (Branfield, 2012). The administration of such drugs necessitates strict haemodynamic monitoring, and normally occurs in a critical care setting.

59 An arterial blood gas (ABG) is a set of investigations on blood withdrawn from a patient’s artery giving an indication of a patient’s respiratory and metabolic status through the measurement of several indicators, such as the partial pressure of oxygen (pO$_2$), partial pressure of carbon dioxide (pCO$_2$), pH levels and base excess/base deficit (Woodrow, 2004). Normally, nurses decide on the frequency and timing of this set of investigations, but, as indicated by the data, they frequently consider it appropriate to discuss the results with doctors.

60 A central venous catheter (usually referred to as a central line in everyday clinical practice) is a catheter inserted into a large central vein (most commonly the subclavian or the internal jugular). Among other reasons, it is used for the administration of certain drugs and fluids.

61 Pressure support is a setting on the mechanical ventilator which provides a ‘push’ to aid any breath initiated by the patient. This is reduced gradually during ‘weaning’ of mechanical ventilation.
mode during the ward round\(^6\). Judith approaches the ventilator and is about to start changing the settings, but immediately stops and decides to inform a doctor about it first. She crosses the 8-bedded section towards the area where the doctors’ round has arrived and shows the ABG results to one of the doctors.

- Field Notes, Observation Session 9

In the subsequent interview, the latter participant confirmed that she felt the need to obtain a doctor’s “blessing” (to use her words) prior to implementing this change, even though she was confident that she was making the right decision:

A [answer]: I normally analyse ABGs myself first, to see how the patient’s condition has changed from the previous investigations. I check, for example, whether the pCO\(_2\) remained the same, whether the pO\(_2\) is better; I look at the base excess and the pH. For example, if there was a change in the pH and the pCO\(_2\) increased from the previous ABGs, the patient might be unfit for further weaning. So first I make my own decisions and then, after I arrive to my own conclusion, I go and ask the doctor...

Q [question]: So you still need to ask the doctor, even though you have arrived at this conclusion...

A. I still feel the need to confirm, because everything I do needs to get the blessing of a doctor [laughs].

- Judith, Formal Interview

Nurses’ practice of obtaining permission from medical practitioners after making some adjustments in patients’ treatment modalities was confirmed by an experienced participant during one of the focus groups:

But still, after you make the decision you would tell the doctor what you’ve done, because you still need that. For example, during the night you can change the oxygen percentage [delivered to the patient by the ventilator]; you might

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\(^6\) Weaning a patient from mechanical ventilation involves gradually reducing the ventilatory support provided by a mechanical ventilator and its replacement with spontaneous ventilation (Intensive Care Society, 1995).
supplement potassium; you give magnesium. And then in the morning you tell him what you’ve done and ask him to sign them... we do it often.

- Susan, Focus Group 2

In such instances, referral is motivated by nurses’ efforts at **seeking authorisation** from a medical practitioner about actions which they would have just taken or are about to take. Indeed, it appears that there are several areas in which nurses consult doctors, not because they are not aware about what actions should be taken, but, rather, because they are conscious of the uneven decision making power between doctors and nurses, and subsequently feel that doctors should be involved in several of the clinical decisions they make:

Some consultants don’t like the fact that we take initiative. Sometimes it’s better to have the go-ahead of the consultant or the doctor to decrease or increase the rate of inotrophic infusions [...because] as a nurse I cannot just start or authorise something; I need the permission of the doctor. You cannot just take the responsibility and mess around with delicate situations like that.

- John, Formal Interview

There’s a social aspect as well... [because] as a culture, we consider that the consultant always has the biggest decision. So how can I, an ICU nurse, break all this culture in one day? You simply can’t...we have to abide by this culture. So if the culture dictates that we have to abide by what the consultants say, we have to [seek their authorisation]...because the medical profession is up there and the nursing profession, culturally, was down there...there’s a divide in our ICU. Some doctors show it and some don’t. The junior doctors are more approachable, but with some consultants [it’s different]...I think it’s from their education: they were educated in a way that makes them think they are the one and only.

- Judith, Formal Interview

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63 Similarly, in Allen’s (1997) ethnographic study of a UK district general hospital, nurses routinely requested specific drug prescriptions for patients and these were rarely questioned by medical staff, leading the author to classify this activity of doctors as ‘writing up’ rather than ‘prescribing’ drugs.

64 This comment also suggests that, irrespective of the need for medical authorisation, some nurses feel that they are not prepared to make independent decisions in some aspects of patient management. This is discussed in Section 5.3.6.
It is, therefore, evident that nurses’ relationship with medical practitioners is characterised by a state of power asymmetry, about which nurses are constantly mindful, and which makes it necessary for them to seek doctors’ authorisation prior to making certain decisions. In this context, power asymmetry\(^{65}\) essentially refers to the difference in the extent to which different individuals or groupings (in this case doctors and nurses) are empowered to make decisions autonomously. As indicated in Section 1.3.1 and by the latter participant’s reference to the “social aspect” and the need to “abide by the culture”, in this particular ICU the occurrence of such power asymmetry is somewhat associated with the historically rooted difference in prestige between medicine and nursing in this country. Both within and outside the healthcare system, several people adopt a reverential and deferential approach towards doctors, and their decisions are rarely contested. As indicated in the quote above and those below, this power asymmetry is most significant with regards to doctors the grade of consultant:

> It’s not just us; even other doctors depend on his go ahead. The consultant controls their actions as well; they phone him all the time, because he [or she] has the final say on several decisions. So even if a doctor is very knowledgeable, he or she would still need to refer to the consultant. For example, if a patient has deteriorated, the doctor won’t just intubate him there and then, but would ask for the consultant’s authorisation, unless it’s an absolute emergency.

- Judith, Focus Group 1

**JEREMY:** It doesn’t only happen to us [nurses]. Yesterday, the pharmacist was suggesting some treatment changes, but his advice was still ignored by the consultant…

**SIMON:** …I think that consultants are still at the very top.

- Excerpt from Focus Group 1

**SUSAN:** Yes…consultants are the king of the castle…

**SEPHORA:** The king of the castle… it’s true!

**SUSAN:** Ultimately, it’s what they say that goes, right?

- Excerpt from Focus Group 2

\(^{65}\) In the critical care literature, the term power asymmetry has been used by Silver and Windland-Brown (2000) and Blanchard & Alavi (2008), among others. These authors, however, used the term to discuss the power differentials between healthcare providers and relatives of critically ill patients, rather than that between the different professions. A discussion about both types of power asymmetry will be presented in the next chapter (Section 6.3.2).
These and similar examples throughout the chapter underscore the **positional authority** held by ICU consultants, with both nurses and other health professionals acknowledging that several decisions must be referred to, and authorised by, them. In fact, several nurses stated that medical authorisation was necessary in procedures guided by a protocol as well, insisting that they feel obliged to inform doctors (and seek their authorisation) even for actions which are supposedly ‘authorised’ by a protocol:

*If you believe something should be changed or something crops up, you should consult a doctor...because even though we have a protocol for nasogastric feeding, for example, different consultants want different things.*

- Jessica, Formal Interview

*I seek medical approval...not because I don’t have the knowledge to make this decision, not because protocols don’t suggest this, but because with this particular consultant I prefer to seek his [verbal] authorisation.*

- Jacqueline, Formal Interview

*We do have a protocol to reduce sedation. We can actually adjust the sedation level ourselves, but it’s always nice to ask the doctor first.*

- Susan, Formal Interview

Thus, although protocols are frequently introduced to empower nurses to implement certain actions without the need to consult a doctor, it is evident that, in this specific setting, they often do not replace the need for nurses’ verbal referral to doctors, partly because medical practitioners insist on nurses consulting *them* rather than a protocol.

This suggests that there is an implicit agreement requiring nurses to constantly work under the consultant’s control, and that while protocols have a role in setting out this inter-

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66 The term **positional authority** refers to the ability of persons in a leadership position to get things done by virtue of their job title (Designing Leaders, 2011).

67 **Clinical protocols** are sets of rules followed by health practitioners within a particular setting. In the intensive care unit in which this study was carried out, protocols have been introduced relatively recently in a fairly limited number of areas of care, notably enteral feeding, management of central venous catheters, blood glucose management and discontinuation of sedation.

68 Although gauging doctors’ views was beyond the purview of the present study, research from the UK does suggest that medical practitioners are much more dismissive of the value of protocols than nurses (Parker & Lawton, 2000; McDonald, Waring, Harrison, Walshe, & Boaden, 2005).
professional agreement as a set of standardised rules (McDonald et al., 2005), it is mostly through the unwritten “culture” of the unit that these rules are reinforced. This “agreement” is discussed in the next subsection, while the ways in which its rules are learnt are discussed later on (Section 5.2.10).

5.2.2 Unspoken agreement with consultant

The positional authority of the ICU consultant and the critical care nurse’s constant mindfulness of it are exemplified by the fact that nurses prefer, and occasionally insist, that admitting consultants visiting a patient in ICU discuss any changes in treatment with the ICU consultant. During one of the observation sessions, for instance, an experienced male nurse was engaged in a conversation with the admitting consultant of his head injured patient. The following field notes refer:

The patient’s admitting consultant, a neurosurgeon, visits the patient accompanied by a more junior doctor. The following conversation ensues:

ADMITTING CONSULTANT: Has he been stable?
SIMON: Yes, quite stable...
ADMITTING CONSULTANT: Is he being sedated?
SIMON: Yes, throughout the night
ADMITTING CONSULTANT: Are pupils reactive?
SIMON: They are reactive, but there is no response to DPS [deep painful stimuli]. He is still heavily sedated, though.
ADMITTING CONSULTANT: We may have to repeat the CT scan...
SIMON: Yes, that is the plan.

Immediately after updating this admitting consultant and answering his questions, Simon declared that it was best to involve the ICU consultant. Indeed, he instantly went to look for the ICU consultant and asked him to come to speak to the external consultant.

- Field Notes, Observation Session 8

69 On admission to this general state hospital, a patient is formally assigned to the care of an “admitting” consultant working within a particular specialty (e.g. general surgery; orthopaedics; gastroenterology; neurosurgery; cardiology) who is responsible for the patient’s entire hospital stay. If the patient needs to be transferred to the intensive care unit, it is the ICU consultant (also known as an intensivist) who assumes overall responsibility for the patient’s treatment modalities during his/her stay in ICU. However, the admitting consultant normally visits the patient as part of his/her ward rounds and is involved in several of the decisions related to the patient, including discharge from the ICU.

70 Using painful stimuli to assess the motor response of a head injured patient who is not moving his limbs spontaneously or to requests forms part of the Glasgow Coma Scale, a widely used neurological assessment tool (Waterhouse, 2009; Canton-Richards, 2010).
Asked to elaborate for his motivations during the subsequent formal interview, this participant confirmed that:

_Ultimately, my superior is our [i.e. the ICU] consultant, and it’s to him that I’m accountable_”

- Simon, Formal Interview

A similar incident was noted in another observation session with a junior female nurse:

_The admitting firm (consultant and another doctor) of the second patient also visit. Judith and the other doctor from that firm flank the admitting consultant. The consultant advises transferring the patient to a unit in which she can be cardiac monitored. Judith immediately refers the admitting consultant to the ICU consultant:_

JUDITH: _If you want, Dr A [ICU consultant] is here and I can call him_

[No answer from the admitting consultant. A few seconds later…]

JUDITH: _Shall I call Dr A, or will you talk to him yourself?_

- Field Notes, Observation Session 9

These examples suggest that nurses feel they owe some loyalty to the ICU consultants, and that, to use the words of one of the participants above, their actions are “accountable” to them. In this context, the data also suggest that there is an informal understanding between doctors and nurses that the former authorise which actions nurse are to take in relation to a patient’s treatment modalities. Indeed, several participants spoke about needing to clarify what they refer to as the “plan” as being a frequent motivator for referral to doctors:

_You do need a plan from the consultant, especially if the patient is unstable._

- Sally, Informal interview
For example, the day before they had to stop dialysis\textsuperscript{71} because of the [low] blood pressure and I told the consultant: ‘Shall I keep on increasing inotropes accordingly? Yesterday they had to stop dialysis, so what is your plan for today?’ She told me: ‘We’ll see, but for now increase noradrenaline\textsuperscript{72} to 20ml/h’

- Jessica, Formal Interview

Mostly it’s about the management plan that I ask doctors, in order to make sure what they have in mind. I would approach the consultant and ask: ‘what is the plan?’ And he answers: ‘weaning the patient from the ventilator’, for instance. Once I know about that, I’m not going to stay asking ‘shall I reduce pressure support further?’ I know how to proceed. I know when to stop weaning. The important thing is that I know what the consultant’s plan for the day is, or what the aims are.

- Simon, Formal Interview

Subsequently, unequal decision making power between consultants and nurses explains the motivation for several instances in which nurses refer to doctors. Essentially, by seeking authorisation from doctors (Section 5.2.1) and by agreeing with doctors about what treatment modalities they expect them to implement (referred to as “the plan” in the data segments above), nurses are actually seeking to establish a “contract” with the medical practitioner about what actions can and need to be taken. This motivation for referral is henceforth termed referring for contract clarity. The next subsection presents some factors which affect the need for this type of referring.

5.2.3 Factors affecting the need for contract clarity

Establishing such contract clarity is particularly important because there are different extents to which consultants (and other doctors) expect to be kept informed about changes in the patient’s treatment modalities. This is illustrated by the data below:

\textsuperscript{71} Dialysis is a procedure which caters for several of the functions normally carried out by the kidneys in a patient with acute or chronic renal failure, mostly by excreting excess fluid and waste products.

\textsuperscript{72} Noradrenaline is an inotropic drug.
One particular consultant would not like us to reduce the ventilator settings unless she’s informed. If you change any setting she would tell you: ‘Who told you to do so?’ And I you would say: ‘Doctor X’. And she doesn’t like it. So sometimes even when a doctor tells me: ‘Go down with oxygen’, I would tell him: ‘She [the consultant] told me not to go down’ or ‘she told us to wait’. With some other consultants, it’s different.

Jeremy, Formal Interview

Which particular consultant is on duty makes a difference too, in my opinion, because we have certain consultants...who just want to know about anything that is happening...any minor change. And they wouldn’t even want other doctors to change things...So, especially with that type of consultants, you have to consult someone [from the medical team] before making any changes.

- John, Formal Interview

Q: So, if I am understanding you well, there isn’t a clear cut decision about what you would need to refer or not...

A: No, absolutely not; because it depends a lot on who the consultant or doctor is...There are some doctors who make you feel like: ‘make sure tell me everything before you do it’. Then there are others who leave several things up to you.

- Jessica, Formal Interview

This indicates that treatment modalities frequently change on the basis of the characteristics of the doctor on duty or the consultant in charge, suggesting that a different “contract” is set up between the nurse and the different consultants. In other words, there are different extents to which different medical practitioners scrutinise nurses, which further underscores the need to refer to doctors for contract clarity. Box 5.1 provides further examples of this variation in the extent to which different consultants scrutinise nurses’ actions, and subsequently the different extents to which authorisation for nurses’ actions must be sought.
Sometimes, for example, if the $pO_2$ is really good we just reduce the $FiO_2$ ourselves. But it also depends on who is on duty; because some consultants make you feel you have to ask everything before you touch anything so, you know, you have to ask just to make sure.

- Jessica, Formal Interview

With some consultants you can take several decisions on your own. However, there are two consultants that are extremely over-protective; they don’t want *anything* to happen to the patient without their knowledge. I don’t know if it’s because they don’t trust anybody or if they feel so much accountable for everything that happens to the patient. I can’t judge that, but they’re extremely overprotective. With them you can’t feel free to take decisions.

- Jacqueline, Formal Interview

There are some [doctors] who make you feel as though they almost leave everything in your hands...at night it happens a lot...I had a patient who was not breathing properly, so I called whoever was on call at about 2 o’clock in the morning and I said: ‘Listen, should I start a morphine infusion?’ And he said: ‘Look, I leave it up to you; do whatever you think is best’. And that was it. So there are some people who make you feel like: ‘Make sure tell me everything before you do it or ask’; then there are others who leave things up to you.

- Jessica, Formal Interview

Some consultants, particularly those who are present in the unit almost all the time, do not allow you to take any decisions autonomously; they don’t even allow doctors to take decisions, let alone us [nurses] taking initiative. So, if one of these consultants tells you: ‘we’re going to try weaning the patient’ she would expect you to inform her of every minor change you make in the pressure support. So you have to stay telling them: ‘Listen, I am reducing this and that’.

- Simon, Formal Interview

**BOX 5.1**

*Examples illustrating variations in the extent to which nurses’ actions are scrutinised by consultants with a corresponding variation in the need for referral.*

The ward round\(^{73}\) appears to be a particularly good opportunity to achieve such contract clarity, particularly because it enables nurses to clarify the contract (management plan) directly with the consultant. The views of a highly experienced nurse and a minimally experienced one about this aspect follow:

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\(^{73}\) In the context of this ICU, the ward round (occasionally referred to as the consultant round) refers to the practice in which the consultant, usually accompanied by other doctors, the nursing officer in charge of the unit, one or more physiotherapists and occasionally a pharmacist, successively approaches each patient in the unit to assess patient progress and discuss and direct changes in treatment modalities.
Actually, I like the ward round because it enables you to clarify your real concerns about the patient. Sort of, I feel more comfortable getting the answer directly from the consultant, rather than from another doctor, because you are getting an answer directly from the person making the decisions.

- Simon, Formal Interview

The ward round is important to clarify things, and you have to identify certain things you need to clarify beforehand.

- Judith, Formal Interview

Another reason why nurses need to clarify their “contract” with consultants and other doctors is driven by the fact that some consultants do not directly communicate the management plan with all members of the team, particularly nurses:

Sometimes, I have to overhear what the doctors are saying...because at times these things are only shared from doctor to doctor...They don’t include you [the nurse]. Only a few consultants tell you: ‘listen, today this is what we need to do’ For example, that’s what Dr B. does; he tells you: ‘today’s plan is this’. He even tells you without you having to ask. But with the others you often have to ask for the plan.

- Simon, Formal Interview

There are certain consultants who come to see the patient and talk to each other in [the native language]. I appreciate that it is their mother tongue and that everybody speaks it, but if you see that the nurse doesn’t understand you should be more considerate...and sometimes when you tell them: ‘could you please speak in English’, they get a bit upset but then they do switch to English. Or else the consultant would tell me: ‘I will explain to you later’.

- Jennifer, Formal Interview

Very often they [doctors] only discuss things between themselves and they don’t tell you straight forwardly ‘this is our plan’...so you need to make things clear. So most of the time I seek doctors’ help specifically to ask them for clarification about what they have decided.

- Jessica, Formal Interview
JACQUELINE: There is something which I really hate: when the consultants and the doctors are discussing something which the nurse is not aware of. And then they expect you to do things which you are not aware of, and you don’t know the reason behind it. You are not aware about what you are doing, and I really hate this.

SEPHORA: They do it...

SUSAN: Sometimes they come behind your back and write something on the chart – they do not tell anybody. And then they come and ask you: ‘did you do this?’

SEPHORA: They take things for granted.

- Excerpt from Focus Group 2

Thus, it appears that some doctors only share the management plan with members of their profession. Subsequently, as illustrated by the comments above, communication breakdown between doctors and nurses affects the extent of contract clarity, and the subsequent need of referral for contract clarity.

This subsection proceeds by discussing other factors (apart from the consultant’s characteristics and inter-professional communication breakdown) which affect nurses’ need for referral for contract clarity, this time related to the traits of the nurse.

I think it is very important to refer most things to the doctor...because everything should be prescribed by them...For example, you can’t start a medication on your own; it has to be prescribed. So you constantly need to seek the doctor’s advice. For example, if I think that the patient needs more sedation I can’t just go and increase it...You need to ask the doctor and take his advice about it, and he has to prescribe it ultimately. I can’t intubate the patient without his

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This type of communication breakdown between medical and nursing staff was partly addressed with the introduction of specific forms on which doctors can document their “plans” for the patient for a specific day. This information emerged during the first focus group. Nonetheless, the fact that the issue was brought up again during the second focus group suggests that the problem had not been completely resolved.

In the context of critical care, “intubation” is generally used to imply tracheal intubation which involves the insertion (normally by an anaesthetist) of an endotracheal tube (a flexible plastic or rubber tube) into the trachea to prevent airway obstruction and enable the delivery of mechanical ventilation. Mechanical ventilation involves the artificial control of a patient’s breathing by means of a machine (known as a ventilator or respirator).
prescription...So everything really requires medical advice. We should have a
good say in the final decision, but the final decision should be taken by the
medical staff, not us, because otherwise my decision won’t be backed up. I am
not backed up for changing the ventilator setting without letting him know. They
can come and tell me: ‘you are not authorised to do this!’

- Judith, Formal Interview

There was a very complicated case...and I really did not have any time to go to
look for and confirm with a doctor. So I took my risk and I said I am going to stop
the infusion myself. So when the consultant came, none of the doctors had been
informed that I had stopped noradrenaline, even though I had been told in
advance: ‘ask if the doctors if we are to stop it or not’. But since I saw that the
blood pressure had risen to 160/80 [mmHg] I decided to take the risk and stop the
infusion without asking one of the doctors.

- Jacqueline, Formal Interview

The two segments above suggest the amount of risk that a nurse is willing to take
(hereafter referred to as risk appetite76) can be reinterpreted in terms of contract clarity.
Nurses who have a low risk appetite are extremely reluctant to act without a doctor’s
authorisation (as exemplified by the need to refer “everything” in Judith’s quote, above).
Conversely, in the quote by Jacqueline, the nurse has decided to “take the risk” [her words]
of performing an action which normally requires medical authorisation without actually
seeking approval from a doctor. Thus, nurses with a high risk appetite generally have a
lower need for contract clarity, and therefore make referrals for contract clarity less
frequently. Jacqueline’s quote also suggests that risk appetite enhances nurses’ readiness to
take actions which they perceive their patient would benefit from, even before they get
medical approval for those actions77.

76 Risk appetite refers to the amount of risk a person is prepared to take to achieve a specific goal (KPMG, 2008).

77 This point also emerged in a review of expert nursing practice by Morrison & Symes (2011) who state that
“with patient advocacy comes the responsibility for accepting the consequences for such actions” (p. 166).
Patient advocacy in the context of referring will be discussed in more detail shortly.
However, this approach only becomes possible by time as one starts to gain a better understanding of the principles of patient management, and to become more familiar with doctors’ preferences for action. For instance:

*That wouldn’t have been possible before; but now, since I’m gaining competence and experience, there are cases where I don’t need to ask other nurses or doctors*

- Jacqueline, Formal Interview

*If I only had two years’ nursing experience, I would definitely have asked for help, no doubt about that...because you wouldn’t know what doctors’ responses would be; not even the steps. You wouldn’t know about fluids, you wouldn’t have started to grasp the concepts; you wouldn’t have any idea at all.*

- Simon, Formal Interview

*Seeking help, both from doctors and from nurses, becomes somewhat less frequent because then you start learning through experience. As you gain experience, you start saying to yourself: ‘the last time this happened I spoke to somebody about it and we decided so and so’, or ‘the last time I approached a doctor, we did this’. Then there are some doctors who really explain to you, so the next time you remember about that time and you say: ‘OK, it is the same sort of thing, so there is no need to ask’. And then you learn what things you need to speak about there and then, and what you should keep your eye on without referring immediately.*

- Jessica, Formal Interview

Therefore, another factor which determines the need for referral is **experience**. Indeed, as evident from the quotes above, experience seems to reduce both the frequency and the immediacy of seeking help from doctors.

Furthermore, nurses who qualified in another country frequently have particular reasons for referring. For example, during her informal interview one non-national participant spoke about her surprise on discovering that local nurses frequently change certain

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78 Although an analysis of nurses’ patterns of clinical reasoning is beyond the scope of the present study, this quote clearly lends support to pattern recognition as a mode of clinical reasoning which is developed as a clinician gains experience. Refer to Table 2.3 in Chapter 2.
ventilator settings, give certain drugs (potassium) and manage glucose (according to a protocol) without necessarily consulting a doctor. Conversely, in her home country nurses frequently inserted peripheral intravenous catheters without needing to consult a doctor, while locally this task is normally referred to doctors. This was elaborated upon in the formal interview with the same participant:

*The role of the nurse in my country, as I told you, is quite different. We don’t call the doctor to insert a cannula*, to take blood or to take arterial blood: we do these things ourselves. On the other hand, in my country it is always the doctor who changes the settings of the ventilator; they decide if the patient is suitable to be weaned off...or if we have to decrease sedation or all these things. We understand how they do that...but we never do it on our own. In this country, the nurse sometimes decides if, for example, the patient is breathing himself, and has to be changed from SIMV to another mode, CPAP or BiPAP.

- Jennifer, Formal Interview

In other words, nurses who had undergone training in another country frequently need to make referrals because they are initially unclear about what actions they can and cannot carry out without a doctor’s authorisation; due to language barriers with other members of the team; and because they are aware that local practices may vary substantially from those in their country of origin. Subsequently, **professional biography** constitutes another factor which affects the need for referral for contract clarity.

Although, at first glance, the quote by Jennifer (above) may appear to contradict what has been explained earlier on in terms of power asymmetry between doctors and nurses in the local critical care setting, this specific nurse is actually making reference to three specific exceptional issues to the general rule. First, in this unit, nurses had, for several years, been unofficially authorised to administer paracetamol and to supplement potassium without a doctor’s prescription, and although there were no formal written policies about this, both

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79 The term *cannula* is often used interchangeably with intravenous catheter, i.e. a small tube inserted in a patient’s vein to administer fluids and certain types of drugs.

80 SIMV (synchronised intermittent mandatory ventilation), CPAP (continuous positive airway pressure) and BiPAP (bi-level positive airway pressure) are three modes of invasive mechanical ventilation, used very frequently in this unit.

81 **Professional biography** hereby refers to whether a specific nurse received his/her training locally or in another country. In this thesis it is used interchangeably with *country of origin*. 
doctors and nurses acknowledged this extended role\textsuperscript{32}. Second, protocols have recently been introduced to guide nurses’ independent management of blood glucose levels; nonetheless, as explained earlier, several nurses still prefer to seek a doctor’s authorisation for areas of care guided by a protocol. Third, as evident from earlier in this subsection, while several nurses make changes in certain ventilator settings and in the infusion rates of certain drugs without consulting a doctor, the ability to do so depends tremendously on which consultant is on duty and on the amount of risk an individual nurse is prepared to take.

These data about nurses’ risk appetite, experience and professional biography, and their association with the extent of referral therefore suggest that the need for contract clarity also depends on nurses’ individual characteristics.

In summary, asymmetry between doctors’ and nurses’ decision making power, particularly consultants’ positional authority, necessitates frequent referrals by nurses to discuss with doctors what actions they are authorised to take in relation to a patient’s treatment modalities, thereby clarifying the contract governing this relationship. The extent to which such referral for contract clarity is required varies according to the characteristics of each party (including the degree to which different consultants scrutinise nurses’ actions, and the experience, risk appetite and professional biography of the nurse); and on the quality of communication between the two parties. These factors determining the need for contract clarity are summarised in Figure 5.1.

\textsuperscript{32} These and similar roles are learnt during the induction programmes for new recruits, continuing professional education courses and, mostly, by referral to other more experienced nurses. Subsequently, clinical guidelines for potassium supplementation, clearly specifying liaison with medical officers, have recently been introduced.
5.2.4 Different and unequal information

In this intensive care unit, nurses spend much more time next to, learning about, and caring for individual patients than doctors, mostly because nurses are allocated to one or two patients while consultants and other doctors are responsible for all twenty odd patients in the unit. To use the words of two of the participants:

*Ultimately, you [the nurse] are with the patient practically all the time and they [doctors] wouldn’t know the details. Even when you ask them for help, they have to come near you to check because they don’t know the specific details.*

- Simon, Formal Interview
Doctors can't know everything. They have twenty patients; they have 24 hour duties and their attention is spread between different patients. They cannot possibly keep up with all the changes that are taking place.

- Jacqueline, Formal Interview

This has important implications on the possession and transfer of information between medical and nursing practitioners. For instance:

If a patient is on dialysis, on Prisma\textsuperscript{83}, the doctors invariably ask you about certain details, because really they are not much in the picture about all the details.

- Jeremy, Formal Interview

That is why we are there 24 hours with the patient after all, because we need to know what changes are happening, and the consultants, I think, expect us to tell them about these changes so they can act on them.

- John, Formal Interview

Thus, according to the participants, their close and prolonged work with the same individual patients places each nurse in a potential position of knowing much more about a specific patient than medical practitioners who need to divide their time and attention among a much larger number of patients. Nurses’ claims above also suggest that the ability of medical practitioners to make several decisions about patients’ treatment modalities actually depends on nurses’ information about patients. Subsequently, the need to share this additional information with doctors is, itself, another important motivator for referral:

If you don’t tell them, sometimes they tell you: ‘why didn’t you inform us?’ So I like to keep them informed [in this case, about arterial blood gas results]; there is nothing to lose.

- Sally, Formal Interview

Updating doctors about ABG results in this manner had, indeed, been noted during the observation session with the same participant:

\textsuperscript{83} Prisma\textsuperscript{®} is a machine used for performing various types of continuous haemodialysis in the ICU itself, rather than in a separate renal unit.
On her way back to her patients, Sally encounters a doctor and shows her the ABG results. I ask why she had done so. She says that she knew that the doctor would not advise any changes but was aware that some doctors would question the fact that they would not have been informed of significant results prior to a ward round.

Field Notes, Observation Session 2

Several other participants stated that they felt duty bound to update medical practitioners in different circumstances, as shown in Box 5.2 below.

**Box 5.2**

Examples of updating the doctor as a reason for referral

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I like to keep doctors informed about several things...for example, today we had a consultation with the tissue viability nurse and things like this; if you don’t tell the doctors about them they wouldn’t be aware unless they ask. So you definitely have to prompt the doctor about several of the patients’ needs.

- John, Formal Interview

I can’t expect him [the doctor] to be fully aware about the patient’s condition, and I know his condition very well because when I come for duty I read the old notes, I read a few nursing reports to update my knowledge about the patient and to know him better. And I don’t think that the doctors know that much about the patient. That’s why, according to my information and suggestions, decisions can be made more consciously.

- Jennifer, Formal Interview

We have our own plan; we do our own assessment, from the nursing point of view, which includes all aspects of the patient’s treatment. It is only after you get to know the patient through this assessment that can you can propose changes [in a patient’s treatment modalities].

- Judith, Focus Group 1

I constantly update the doctor about the patient so that he or she is aware about what is going on with the patient...about the progress of the patient. For example, if the patient is being weaned off the ventilator and he is doing very well, the doctor needs to be informed about the ventilator settings, the [arterial blood] gases...everything...the potassium. Like that he knows more about the condition of the patient...Of course it’s our role...it’s the job of the nurse because, the consultant is not here 24 hours. It’s true that he checks, but if I don’t bring it to his attention certain things could just go unnoticed.

- Susan, Formal Interview
On the basis of the participants’ claims presented in this subsection, therefore, although nurses have less decision making power (negative power asymmetry), they are frequently in a position of **positive information asymmetry**\(^{84}\) in relation to doctors. Subsequently, nurses have a crucial role in updating doctors about patient-related changes, because of which nurses’ positive information asymmetry constitutes another important reason for referral. In this case, however, rather than a way of ‘seeking help’ from doctors in the literal sense, referring takes the form of: (1) **updating doctors about relevant changes in a patient’s conditions**, and (2) **attempting to influence decisions about treatment modality changes**. These frequently occur simultaneously, as exemplified by the interview segments above. Information asymmetry shall be discussed again in the context of the factors affecting nurses’ ability to take part in decisions about patients’ treatment modalities (Section 5.2.8). The next subsection integrates the effect of the points introduced so far on the type of relationship between critical care nurses and medical practitioners.

**5.2.5 The relationship between critical care nurses and medical practitioners**

The data presented thus far portray critical care nurses in a recurring need for verification and medical authorisation about what actions they can take with regards to a patient’s treatment modality. Combined with the asymmetrical power between the two parties, this implies that the relationship between doctors (especially consultants) and nurses is guided by an implicit, but nonetheless significant, agreement about what constitutes the responsibilities of each professional group within the critical care setting. According to these data, it is generally understood that the **consultant** has the overall responsibility to **decide, mandate and plan** treatment modalities for critically ill patients. However, the data also indicate that it is usually **nurses** who:

1. Act on and **implement** this plan;
2. Hold more contextual information (positive **information asymmetry**) about individual patients;
3. **Inform and update** the consultant (or another doctor) about the patient’s condition;
4. **Propose changes** in the patient’s treatment modalities\(^{85}\).

\(^{84}\) **Information asymmetry** refers to situations in which one party has more or better information than the other. The party with more or better information is thus considered to be in a state of **positive information asymmetry** compared to the other party (Wilson, 2008).

\(^{85}\) The actual strategies used by nurses in their attempts to influence decisions about treatment modality changes are discussed in Section 5.2.9.
These aspects of the consultant-nurse relationship are summarised and illustrated by excerpts from the data in Table 5.1 below.

<table>
<thead>
<tr>
<th>ROLES / BEHAVIOURS OF…</th>
<th>DATA EXAMPLE</th>
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<tbody>
<tr>
<td><strong>Consultants…</strong></td>
<td></td>
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<tr>
<td>• Exhibit significant positional authority</td>
<td>The consultants are still on top... - Simon, Formal Interview</td>
</tr>
<tr>
<td>• Scrutinise nurses’ actions</td>
<td>One particular consultant would not like us to reduce the ventilator settings unless she’s informed. If you change any setting she would tell you: ‘Who told you to do so?’ - Jeremy, Formal Interview</td>
</tr>
<tr>
<td>• Authorise nurses’ actions</td>
<td>It’s better to have the go-ahead of the consultant or the doctor to decrease or increase the rate [of inotropic infusions]…because as a nurse I cannot just start or authorise something; I need the permission of the doctor. - Judith, Formal Interview</td>
</tr>
<tr>
<td>• Assume overall responsibility for deciding and directing treatment modalities</td>
<td>It’s not just us; even other doctors depend on his go ahead. The consultant controls their actions as well; they phone him all the time, because he [or she] has the final say on several decisions. - Judith, Focus Group 1</td>
</tr>
<tr>
<td><strong>Nurses…</strong></td>
<td></td>
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<tr>
<td>• Act on and implement a consultant’s plan</td>
<td>When consultants tell us to do something, we do it, and never ignore what the consultant is saying. I do it...if the consultant tells me: ‘You have to do this’, I just do it. And I suppose he says: ‘Look, she is working well...she is doing what I’m telling her’. - Judith, Formal Interview</td>
</tr>
<tr>
<td>• Hold additional and updated contextual information about the patient</td>
<td>Doctors can’t know everything. They have twenty patients; they have 24 hour duties and their attention is spread between different patients. They cannot possibly keep up with all the changes that are taking place. - Jacqueline, Formal Interview</td>
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<tr>
<td>• Inform and update medical practitioners</td>
<td>Doctors rely on us [nurses] on information about the patient. They ask us lots of things, for example...‘Has the chest X-ray been done?’ ‘Has this particular blood test been taken today?’ Or, for example, if the patient was complaining of pain, they would ask: ‘did he take something for pain today?’ - Sephora, Formal Interview</td>
</tr>
</tbody>
</table>
There are certain things which we are more aware about. Take the ward round, for example. If consultants need to decide something for the next 12 hours, I am sure that I can have a lot of influence on what they [doctors] are going to decide because I can tell them: ‘Listen, this happened’. So that they can base their plan on my contribution; not base it entirely on what I’ve said, but I may have a significant influence on what they’re trying to plan.

- Jessica, Formal Interview

Table 5.1 – Summary, with examples, of the roles of consultants (and other medical practitioners) and nurses, on the basis of data reported in the previous subsections.

Thus, the relationship between medical practitioners (most notably, consultants) and nurses bears a considerable resemblance to that between a principal and an agent. A principal-agent relationship normally refers to a set of interactions between two parties whereby the principal expressly or implicitly authorises the agent to work under his/her control and on his/her behalf. The agent has a duty to undertake the task/s specified by the principal and must not do things that s/he has not been authorised by the principal to do (University of Cologne, 2008). In addition, the agent is usually in a position of knowing more about the task at hand than the principal (Smith, Stepan, Valdmanis, & Verheyen, 1997); subsequently, the agent informs, updates and, at times, proposes ideas to the principal, whereas the principal attempts to scrutinise the agent’s actions and ultimately decides, mandates or directs a plan of action (State Services Commission [SSC], 2003). This relationship is summarised in Figure 5.2 below.
In the context of this critical care unit, therefore, the role of the medical practitioners (most notably, those at consultant grade) is comparable to that of a principal, while nurses are considered to act as their agents. This relationship is hereafter referred to as consultant agency. The principal-agent relationship described here also explains nurses’ relationship with other medical practitioners in more junior grades. The term “consultant agency” was specifically selected because of the positional authority [see especially Section 5.2.1] of the ICU consultant as the person who assumes ultimate responsibility for treatment modality decisions in the unit, and because, as evidenced by the data excerpted throughout the chapter, nurses mentioned their relationships with consultants most frequently during their discussions about referring. Subsequently, in the rest of this and the next chapters, consultant agency refers to the nurse acting as the medical practitioner’s agent. The factors establishing a principal-agent relationship between medical practitioners and critical care nurses, on the basis of data reported above, are summarised in Figure 5.3.
5.2.6 Safeguarding the patient

The previous subsections explained how nurses’ referrals to doctors are frequently motivated by the need to seek medical authorisation for their actions, particularly in view of their principal-agent relationship with doctors. Nonetheless, referrals to doctors are frequently and, at times, concurrently, motivated by a need to ensure that the patient gets the most beneficial treatment options. For example:

*If I don’t seek doctors’ advice, I might be making a mistake affecting the patient and keep doing it.*

- Judith, Formal Interview

*The ward round is important because it enables me to clarify my true concerns about the patient...with the person taking the decisions.*

- Simon, Formal Interview
This suggests that by seeking verification about their actions, and by clarifying what doctors consider as being the best options for their patients, nurses often feel that they would ultimately be helping their patient and safeguarding his/her interests. This assumes greater importance due to nurses’ awareness of the patients’ and relatives’ difficulties in expressing their own queries and concerns in front of medical consultants:

*Patients and their relatives, in general, are afraid of speaking or asking certain things to the consultant. When they’re in front of the consultant they blank and feel incompetent. Then, when they’re in front of a nurse they speak up.*

- Sephora, Focus Group 2

This quote lends further support to the positional authority of medical consultants (Section 5.2.1), this time in terms of patients’ and their significant others’ deferential power, which inhibits them from speaking up. Subsequently, nurses take actions in an attempt to diminish the effects of these difficulties. To use the words of one of the participants:

*We, nurses, are mediators, kind of, between the doctor and the patient.*

- Sephora, Formal Interview

This takes several forms. For instance, nurses feel duty bound to explain doctors’ decisions in a language which patients can understand:

*They [doctors] don’t really explain anything to the patient. For example, today the patient asked me: ‘What did he [the consultant] say?’ He didn’t really explain whether she can leave, because she actually wanted to leave and go to the ward. I told her: ‘We have to wait; you cannot leave ICU as yet’. I explained what had been said. If it were not for us…no one would really explain.*

- Sally, Formal Interview

Alternatively, this may indeed involve forwarding a patient’s questions or concerns to a consultant on behalf of the patient. In one of the observation sessions, for instance, prior to the ward round the nurse informed the patient that the consultant was approaching, and

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86 Incidentally, Happ (2000) uses the term “interpreting” with reference to activities of critical care nurses similar to those described in the present subsection.
explicitly asked him whether there was anything he wanted her to tell the consultant on his behalf, as captured by the following field note:

At 8.25am the nurse asks her patient whether he is ‘all right’. She then informs the patient that the consultant is approaching and asks him: ‘Is there anything which you want me to tell the consultant? Would you like me to ask him anything?’

- Field Notes, Observation Session 1

In addition, this desire to safeguard the patient leads nurses to prompt doctors to make decisions which the patient would benefit from:

I asked one of the junior doctors: ‘What do you think? Do you think she should have anti-embolic stockings?’ And he told me: ‘Yes, she should have anti-embolic stockings’.

- Susan, Formal Interview

A short while later, two doctors approach the second patient, whom Sally has just finished bathing, and she asks them whether they need anything. As soon as they say ‘no’, she immediately tells them: ‘Listen, I’m going to take her out of bed, OK?’ The doctors agree.

- Field Notes, Observation Session 2 (Sally)

In these instances, nurses elicit the need for treatment modality changes which their patient would benefit from, but which require medical authorisation, and therefore referral. Accordingly, seeking authorisation for actions which nurses deem most beneficial to their patients is another important motivator for referring, notably because power asymmetry and consultant agency (discussed in the previous subsection) frequently hinder nurses’ ability of taking such actions independently. The following excerpts further illustrate the motivations behind this type of referral:

Of course it’s our role to speak up for the patient! It’s the job of the nurse…it’s my role to bring certain things concerning the patient to the consultant’s attention.

- Susan, Formal Interview
I do not feel intimidated at all to speak up for the patient because that’s my work. If we don’t speak up for the patient, why are we here?

- Judith, Formal Interview

[Today] I am satisfied because at least I achieved what I wanted; what I thought is better for the patient was implemented.

- Jennifer, Formal Interview

These and similar remarks suggest that, for several nurses, acting and speaking up on behalf of the patient is considered to be a moral duty, a central role of their profession and a source of professional satisfaction. Concurrent with their obligation of acting as the consultant’s agent, therefore, nurses strongly perceive a crucial part of their role to involve acting on behalf of the critically ill patients they are assigned to care for.

In addition, according to several participants, a nurse’s role also includes that of making doctors realise the negative consequences of certain decisions on patients and their relatives. For example, nurses may alert doctors to the negative consequences of not sedating extremely restless patients (first quote below), or draw their attention to potential errors in drug prescriptions (second quote):

You explain to them that, without adequate sedation, the patient may not tolerate lines; that the patient may self-extubate; that the relatives may be disturbed to see the patient like this, and you try to make her [the consultant] see what she is not seeing…and then tell them: ‘Listen, but she will self-extubate and that would be worse…but she will remove the arterial line’;

- Judith, Formal Interview

87 Extubation is the process of removing an endotracheal tube from a patient’s trachea. This is normally done by a nurse or another health professional in planned manner, but occasionally patients accidentally or deliberately remove their endotracheal tube themselves, with potentially harmful consequences. The latter is frequently referred to as “self-extubation”.

88 An arterial line or arterial catheter is a narrow tube inserted into a patient’s artery to enable continuous blood pressure monitoring, and frequent withdrawal of arterial blood (mostly for the purposes of arterial blood gas monitoring) without the need to repeatedly puncture the patient.
I would call the doctor if I am in doubt about [the correctness of] something they would have told me... For example, if I have a renal patient and they tell me to start Ringer’s Lactate at 100 ml/h...usually with renal patients we would start with normal saline... I would call the doctors...to bring it to their attention.

- Sephora, Formal Interview

As illustrated by these examples, referral on behalf of the patient frequently takes the form of giving an input in and trying to influence decisions which are taken by doctors. The latter example, in particular, also involves the nurse correcting doctors’ decisions. In all these examples, however, referring is clearly motivated by a desire to improve patients’ outcomes, and subsequently acting on their behalf.

In summary, since, as suggested by several of these quotes and by the literature (Blanchard & Alavi, 2008; O’Keefe-McCarthy, 2009), critically ill patients and their relatives are frequently unable to speak up about their interests, nurses feel morally obliged to act as their patients’ and their relatives’ intermediaries with medical practitioners, thereby moderating the considerable inferiority that critically ill patients and their families often feel with respect to health professionals. Subsequently, nurses are involved in another principal-agent relationship, this time with the patient as the principal and the nurse, acting on his/her behalf, as the agent. This relationship is hereafter referred to as patient agency. As evident from the data excerpted in this subsection, which are summarised diagrammatically in Figure 5.4, this is another important motivator for several instances of nurses’ referrals to doctors.

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89 Compound Sodium (Ringer’s) Lactate is a fluid administered intravenously for hydration purposes. Unlike normal saline, it contains potassium, which makes its use for renal failure patients problematic.

90 Factors enhancing and inhibiting nurses’ potential to correct medical error were studied by Henneman et al. (2010); see Section 6.4.2.

91 In this context, critically ill patients’ difficulty to communicate, which Happ (2000, p. 1250) conceptualises as the “voicelessness of critically ill patients”, refers to both their physical inability to speak (due to several of them being sedated and intubated), and to their and their families’ perceived or actual limited power relative to health care providers.

92 In the nursing context, moral agency involves “working on another’s behalf and representing the concerns of the patient, the family and the community” (Hayes, 2000, p.90). A discussion of nurses’ moral agency in the context of their principal-agent relationship with patients and medical practitioners will be presented in the next chapter.

93 This advocacy role is ingrained through nurse education, and especially through the Code of Professional Conduct which explicitly states that “nurses and midwives should at all times treat each patient/client as an individual person, respect his/her rights and act as his/her advocate in all situations” (Council for Nurses and Midwives, 1997).
Referral to doctors for patient agency is often prompted by concerns *directly expressed by a patient or his/her relatives*, and which could range from starting nutrition and ensuring proper pain relief to the removal of unnecessary invasive lines and discharge from ICU. In other instances, referral for patient agency is not triggered by patients’ explicit requests; rather, it is *prompted by nurses’ observations* about what they think would benefit the patient most. Table 5.2 below illustrates referring for patient agency with several examples of referrals stimulated by requests from patients or their relatives, and others triggered by cues observed by nurses themselves.

**Figure 5.4 – Aspects of nurses’ role of acting as the patient’s agent**
**REFERRALS PROMPTED BY PATIENTS AND/OR RELATIVES**

| This patient declared that she would like to eat | In the ward round we have a duty to bring up things which are not going well with the patient…problems we have discovered. |
| and the nurse promises that: ‘we will ask the doctors about that’. | - Simon, Formal Interview |

- Field Notes, Observation Session 2

| During visiting hours, while speaking to the patient and his friend about their wish to have him flown to his home country, Sephora decides to ask the consultant to speak to the relative about the possibility of a flight home. She phones him up [at the doctors’ room in the same unit] and explains the situation. | Q. ‘Do you normally point anything else during ward rounds?’ I ask. |
| | A. ‘Yes’, she replies, and as an example she mentions pointing out patients who are not receiving any form of nutrition after having been intubated. |

- Field Notes, Observation Session 1

| I would give the paracetamol if it is written down and if the patient remains in a lot pain, I would call and tell him: ‘I have given paracetamol but the pain persists…why don’t you come and see the patient?’ | Sally notices that the second patient has not been given anything to eat since she was extubated. She informs me that she is going to tell the doctors about feeding the second patient. |
| - Sephora, Formal Interview | - Field Notes, Observation Session 2 |

| From outside the drawn curtains I hear Sally say: ‘We cannot just remove those…they [the doctors] need to tell us to’... |
| At 9 am, two doctors who are going round the ward approach her first patient. Sally immediately asks these doctors whether they are on duty and discovers that they will be in the unit only till midday. She also asks whether she could remove the patient’s central line because the patient was ‘not getting anything through it’. | For example a patient is on a certain antibiotic and I just tell him, why don’t we start him on this…This antibiotic was there for ten days; since there is no improvement, should we try something else? Or, for example, a patient came in and no anticoagulants were prescribed...so I would say: ‘listen we should start this. What do you think?’ |
| - Field Notes, Observation Session 2 | - John, Formal Interview |

| Q. What prompted you to ask the doctors about central line removal? | I actually think that that’s why we [nurses] are here: to bug them [doctors] about the patient’s problems. The patient can’t speak; if I see there is a renal problem, I go and tell them: ‘Listen, there is a renal problem, the patient has a renal problem.’ |
| A. First of all, the patient started complaining about it...then I checked whether she actually needed it, which she didn’t...so, it was bothering the patient, and there is an infection risk... | - Judith, Formal Interview |

- Sally, Formal Interview

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**Table 5.2 –** Referral for Patient Agency: Exemplars of patient/relative-prompted referrals and of referrals prompted by nurses’ own observations.
This subsection has presented nurses as critically ill patients’ and their relatives’ agents by seeking authorisation for treatment modality changes they would benefit from, speaking up on behalf of patients and their relatives, explaining treatment modality decisions to patients in a language they can understand, safeguarding patients from their or doctors’ inappropriate decisions, and generally moderating their differential power with respect to medical practitioners. Therefore, while several referrals are motivated by the requirement of nurses to follow their principal-agent relationship with doctors (referral for consultant agency), referring is also very frequently prompted by nurses’ attempts to act on behalf of their other principal, namely the patient (referral for patient agency). The implications of nurses having two different principals are discussed next.

5.2.7 Two principals, one agent

The last two subsections discussed the role of nurses as agents to doctors and as agents to the patients they are assigned to care for. Nurses, therefore, concurrently act as an agent to two different principals: the medical practitioner on one hand and the patient on the other. However, according to several participants, doctors’ priorities are frequently different from, and at times conflicting with, what they [nurses] consider to be a priority for patients and their relatives:

*Our priorities are very different.*

- Sally, Formal Interview

*They [doctors] have different priorities, when it comes to sedation and things like that.*

- Susan, Formal Interview

As shown in Table 5.3, for example, nurses feel that some doctors frequently ignore patients’ expressed preferences about the timing of certain events, such as ambulation, and often disagreed with doctors in terms of their patients’ sedation requirements. In particular, nurses frequently urge doctors to prescribe sedation for their patients, because they feel that this would promote their patient’s comfort and improve the effectiveness of

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94 In this unit, the term “ambulation” is frequently used for the process of assisting patients out of bed onto an armchair, and not necessarily walking about.
mechanical ventilation, especially in the case of very restless patients; however, doctors frequently disagreed, partly because of their concern that this might extend patients’ length of stay in the ICU. Nurses’ position of dealing with patients’ suffering and relatives’ distress, on the other hand, prompts them to suggest improving patient comfort through sedation, confirming the presence of potentially diverging priorities between the two groups. Similarly, nurses feel that, in certain circumstances, patients and especially their relatives would benefit from less aggressive treatment modalities than those prescribed by ICU consultants, particularly in end of life situations.

Another area in which nurses may feel that the interests of their two agents (the consultant and the patient) are different is related to the speed with which patients are weaned from ventilatory support. In some instances, doctors instruct nurses to rapidly wean and extubate patients while nurses may feel that the patient is not physiologically and/or psychologically ready to breathe without any mechanical support. This frequently leads nurses to try to delay the extubation process so as to safeguard what they consider to be their patient’s interests [the nurse as the patient’s agent], keeping in mind their obligation to respect the medical practitioner as their other legitimate principal [the nurse as the medical practitioner’s agent]. Other areas of disagreement that were reported included the nature and timeliness of treatment, the necessity or otherwise of certain investigations and procedures, and the types of patients that are admitted to the intensive care unit (refer to Table 5.3 below).

<table>
<thead>
<tr>
<th>AREA OF DISAGREEMENT</th>
<th>EXAMPLE</th>
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| Timing of events (e.g. ambulation) | Doctors don’t give that much importance to patient comfort…If they decide that the patient should get out of bed now, they ignore the fact that the patient might prefer getting out of bed in two hours’ time and not immediately. It’s because they are not there with the patient all the time. We are the ones who are continuously there, so they are not always aware. They have their own ideas, but perhaps they don’t see the whole picture at the time.  
- Sally, Formal Interview |
| Sedation management | Sometimes they explain to you why they don’t want give sedation. We do have patients that are very restless and are quite old, and if you ask the doctors: ‘Shall we give something to calm the patient down?’ they totally refuse. They say they don’t want to give any [sedation]. The consultant would say: ‘she’s too old, so it’s better if she stays awake...’ And this patient is restless, trying to get out of bed, but they still don’t give anything sometimes.  
- Susan, Formal Interview |
| **Timing of extubation** | I told the doctor: ‘He’s full of secretions; we are suctioning all the time. Think about it: how are we going to suction if we take out the tube?’ He was weak as well, so I felt he was not ready to expectorate; he was not ready for extubation. But then I said: ‘If you want to extubate, just be prepared to re-intubate’.  
- Jeremy, Formal Interview |
|---|---|
| **Care of relatives** | And very often I go and find the consultant and tell him: ‘Listen, the relatives of this [patient] want to speak with you’. There are some consultants who are not so keen to speak with the relatives; it could be because they are not prepared to handle the relatives, and this is something which I don’t like because all the relatives need to know the truth. They need to be informed; even if it’s the worst case, they have to know the truth. I really felt sorry for this woman today; you saw her, she started crying. Her husband, spent two months on this bed, and he was hopeless from the beginning, and these people have hopes about this particular man that he is going to survive and that he is going home maybe, and obviously nobody mentioned that he is not going to [make it].  
- Jennifer, Formal Interview |
| **End of life situations** | At that point I felt that we should not start further treatment and that the relatives should come in, and they were foreigners. I said that what was important at that point was that the relatives should come and spend the last hour with him, because that was the most valuable thing. If it were me and I someone in my family...if it were my father, I would rather spend one hour [next to him], rather than all those machines...  
- Jeremy, Formal Interview |
| **Speed of weaning** | Sometimes a decision is taken to extubate the patient, and after half an hour they come and say: ‘Haven’t you extubated the patient yet?’ And I would say: ‘Wait a minute. Extubate? How? He is not ready!’ Once I told the consultant: ‘Listen, the patient was on these settings, he was on BIPAP I changed it, I did this, I changed him to CPAP, now this is the final step, but this has to take me an hour and a half, at least’.  
- Judith, Formal Interview |
| **Timeliness of treatment** | Some consultants allow the patients to deteriorate to the last moment before taking action. For example, it would be evident that the patient would benefit from starting Prisma [continuous haemodialysis] but you have to wait 24 hours before somebody starts Prisma.  
- Jacqueline, Focus Group 2 |
### Types of Admissions

SIMON: Sometimes we disagree on the type of admissions they accept. Some patients are in such a poor state that they are not going to benefit from an ICU admission.

JUDITH: It’s true. Sometimes we admit terminally ill patients and you can’t help asking yourself: ‘wouldn’t he be better off in the ward, surrounded by his family, rather than in ICU, with a central line and everybody pricking him? It’s like you’re inflicting pain unnecessarily...and in ICU we ask the relatives to wait outside, because we have a restricted visiting policy. I don’t think it’s fair for the patient to die like that.

SIMON: Yes, that’s another area of disagreement with doctors

- Excerpt from Focus Group 1

### Patient suffering due to ‘unnecessary’ investigations and procedures

JOHN: Sometimes we disagree with doctors about certain investigations and procedures. I have encountered cases of literally unnecessary investigations. Once, a consultant wanted to take a patient for a CT scan simply because of a swollen arm.

SALLY: Sometimes – and this really bothers me – when we have a patient who is somewhat important, we take investigations over and above what’s necessary. We had a patient recently...I pitied him.

JUDITH: These things make the patient suffer...

SALLY: ...Suffer unnecessarily! They started Prisma...I don’t know what they didn’t start...all this because he was an important person!

- Excerpt from Focus Group 1

### The nature of treatment

JACQUELINE: Sometimes there is disagreement about fluid management. Sometimes the patient is dehydrated and they don’t give him anything.

SEPHORA: Or sometimes [they hesitate to give] Lasix...they say “Give 200[mls of fluid]...give 200...give 200” and the patient doesn’t pass 1ml of urine.

- Excerpt from Focus Group 2

<table>
<thead>
<tr>
<th>Table 5.3 – Implications of acting as an agent to two different principals: Exemplars of different priorities of doctors and nurses, leading to a potential conflict between nurses’ role as agents for both the consultant and the patient.</th>
</tr>
</thead>
</table>

95 Furosemide (Lasix®) is a loop diuretic, which increases urine output and helps to treat heart failure and systemic or pulmonary oedema.

149
The data excerpts listed in Table 5.3 provide several examples of disagreement between critical care doctors and nurses stemming from nurses’ having to safeguard the patient’s interest while keeping in mind their obligation to act within the requirements of their principal-agent relationship with medical practitioners. In other words, concurrently acting as agents to two different principals places nurses in a position of dual agency\textsuperscript{96}, due to the potentially conflicting priorities of the two principals to whom they act as agents, namely the patient and the medical practitioner (Figure 5.5).

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{dual_agency.png}
\caption{Critical care nurses’ dual agency relationship with medical practitioners and patients}
\end{figure}

Subsequently, nurses are frequently limited in the extent to which they can act as their patient’s agent, as indicated in the following excerpts related to the weaning of ventilatory support:

\begin{quote}
I was ready to go down with oxygen by myself, but since the consultant was nearby I decided that I definitely need to involve her in this...especially her [laughs]. I asked her and she advised me to keep the patient on the same settings.

- Jacqueline, Formal Interview
\end{quote}

\begin{quote}
Sometimes if I try to suggest something to the consultant [in relation to a patient’s treatment modalities], I’m afraid he’s going to say: ‘a new nurse is trying to tell me what to do?!’ [sarcastically]

- Jessica, Formal Interview
\end{quote}

\textsuperscript{96} The next chapter will include an in-depth discussion of dual agency in the context of the healthcare and non-healthcare literature.
I didn’t feel the patient was ready for extubation, but he [the consultant] said it in an aggressive way, like: ‘Do it!’ So I said: ‘It’s his responsibility’. So I did it.

- Judith, Formal Interview

These data suggest that situations exist in which nurses are unable to implement what they consider best for their patients because they are considerably conditioned by their inferior decision making power with respect to doctors and consultants. Hence, dual agency also implies that nurses’ desire to act on behalf of their patient (Section 5.2.6) is restricted by their duty to follow their principal-agent relationship with the ICU consultant (Section 5.2.5). In other words, in examples such as those above, nurses are constantly mindful of their obligations to act within the scope of practice authorised by the consultant, even when this is incongruent with what they perceive to be their patient’s best interest. This notion was confirmed in the focus group sessions, as exemplified by the excerpts in Box 5.3.

A consultant said ‘Stop the sedation. Do you think I will pity you?’ I said: ‘Me, no; but what about the patient?’ But he insisted: ‘Stop the sedation.’ So what can I do? I had to stop it!

- Jacqueline, Focus Group 2

I was taking care of a 95 year old patient. We were on night duty and he was on an amiodarone\(^\text{97}\) infusion and he was very bradycardic and hypotensive. And with this amiodarone on top of his bradycardia and hypotension, I told the doctor: ‘please, let’s reduce this infusion or stop it completely because he is going to arrest’. But he couldn’t do anything because the consultant had instructed otherwise. And I didn’t dare to stop it myself.

- Jennifer, Excerpt from Focus Group 2

I would suggest things; for example: ‘don’t you think we should start Zantac?’ If they say ‘no’, my reaction would be: ‘All right; isn’t it what you say?’ I did my job, you know? I can’t prescribe it, can I?

- Sephora, Excerpt from Focus Group 2

BOX 5.3
Excerpts confirming a potential conflict between acting as an agent to the patient and the consultant

\(^{97}\) Amiodarone is an antiarrhythmic drug used to correct several types of irregular heart rhythms, side effects of which include hypotension (low blood pressure) and bradycardia (low heart rate).
Together with the examples cited in Table 5.3, these data segments show that there are several occasions in which nurses feel that consultants’ preferences are incongruent with (and, at times, opposite to) their patient’s expressed or implied interests. In these instances, nurses’ moral agency (acting on behalf of the patient) is evidently hindered by the institutional obligations to abide by medical practitioners’ preferences (consultant agency). In other words, acting as an agent to both the consultant and the patient places nurses in a delicate and often *morally distressing* position of having to juggle between the preferences of the former and the interests of the latter.

Nonetheless, the need to follow medical instructions does not completely hinder nurses from giving their input in decisions about patients’ treatment modalities. Conversely, nurses make use of the unique information which they possess about patients and resort to various strategies in an attempt to strike a balance in their dual role as agents to both the consultant and the patient. These aspects are discussed in the next two subsections respectively.

### 5.2.8 Factors enhancing and hindering participation in decisions

The data in Section 5.2.4 suggested that nurses’ position of positive information asymmetry enables nurses to take a more influential role in patient management and in decisions about a patient’s treatment modality changes. This is particularly the case when doctors themselves acknowledge nurses’ expertise in certain aspects of care, such as infection prevention and control, medication administration and the management of sedated and mechanically ventilated patients, as illustrated in the excerpts in Box 5.4 below.

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*Moral distress occurs “when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action”* (Jameton, 1984, p.6).
There are doctors who show you that: ‘listen, we know that you know more in this area’. So if there is something that I don’t agree with and I’m quite sure that I’m basing my objection on something sound, then yes, I tell them. For example, when they’re going to insert a central line some of them tell you: ‘Pour Betadine’. And last time I said: ‘I think you should be using chlorhexine’. They said: ‘no, we always use Betadine’. But I said: ‘No, you should be using chlorhexine, because studies are showing blah, blah, blah’…evidence-based things, basically. Then they say ‘OK, pour chlorhexine then’.

- Jessica, Formal Interview

Even these young doctors, sometimes they actually learn from you. For example, on ventilators…these young ones sometimes come to ask you about the different modes and settings, or else about sedation, and certain other things…they come to you. It does feel good, yes. At least for once you are, kind of, valued, you know?

- Sephora, Formal Interview

Sometimes the junior doctors don’t even know what to do with the patient without your help…for example they even ask you about the correct dosage of certain medication.

- Judith, Formal Interview

But then there are others who respect you; for example, one of our doctors recently went to see a patient in casualty and he called here and specifically wanted to speak to a nurse to ask: ‘If I have noradrenaline, going peripherally because we haven’t yet done a central line, can I connect something else to the three-way tap or should I leave the noradrenaline alone?’ So he called and specifically asked for a nurse. So he’s showing you like: ‘In this area your knowledge and expertise are superior to mine’. And that makes you feel ‘Wow!’

- Jessica, Formal Interview

**BOX 5.4**

Positive information asymmetry: Doctors’ recognition of nurses’ expertise in several aspects of critically ill patient management enhances their participation in decisions and their professional satisfaction

In such instances, nurses’ acknowledged information asymmetry is being used to directly help doctors and to indirectly help patients because by sharing their knowledge with doctors nurses are effectively helping them to improve patients’ outcomes. In other words, positive information asymmetry consolidates nurses’ role as agents to patients (by helping doctors to make decisions which can improve their outcomes) and to medical practitioners (by informing them and influencing their decisions). Subsequently, as indicated by the quotes above, the resulting increased participation in decisions is a source of professional satisfaction.

99 “Referencing standards or experts”, which this nurse appears to be doing here, was also identified by Henneman et al. (2010) as a strategy used by nurses to correct medical errors.
Conversely, there are several aspects of critical care in which nurses acknowledge their limited knowledge, expertise or skill with respect to doctors. These include the insertion of invasive lines and tubes, and the management of rapidly deteriorating patients. For example:

*I would definitely refer situations of uncertainty. When I’m not really certain what to do with the patient, and if I know this will affect his recovery or lead to deterioration, I’m definitely going to call a doctor.*

- Jacqueline, Formal Interview

*I would seek a doctor’s help if I see that the patient has self extubated, let’s say; if I see the patient is going to arrest\(^\text{100}\) in front of my eyes. I would ask for a doctor’s help in an emergency situation...such as respiratory arrest, cardiac arrest...if I see that the arterial line is dislodged or infected, or, let’s say, the central line needs to be changed. In these cases I would search for a doctor’s help.*

- Jennifer, Formal Interview

Such instances place nurses in position of **negative information asymmetry\(^\text{101}\)** with respect to doctors, and therefore require referral. Their moral duty of safeguarding patients and acting as their agents prompts nurses to immediately seek help from doctors, thereby facilitating the improvement of patient outcomes. Additionally, such circumstances consolidate nurses’ position as medical practitioners’ agents by working under their overall leadership in patient management. Negative information asymmetry, therefore, constitutes another reason for referring which is concurrently embedded in both aspects of nurses’ dual agency role.

The data in the present subsection (and those in Section 5.2.4) indirectly lend support to the notion that doctors and nurses are experts in different aspects of patient management. Indeed, patient outcomes depend on decisions informed by two *interdependent* sets of knowledge: nurses need to refer several patient-related problems to doctors whom they perceive as more knowledgeable in certain areas of patient management, while doctors

\(^{100}\) A patient “goes into (cardiac) arrest” when his/her heart stops contracting effectively, leading to the cessation of normal blood circulation.

\(^{101}\) In this context, *negative* information asymmetry implies that a person/group possesses less knowledge/information/skill than another person/party.
depend on nurses’ unique knowledge about specific patients and aspects of their management to arrive at clinical decisions\textsuperscript{102}.

Consequently, the different type and amount of information which nurses hold about the patient reinforce the concept of nurses having a dual agency role. Indeed, nurses’ positive information asymmetry about patients stimulates them to share that information with doctors, thereby concurrently fulfilling both aspects of their dual agency role: keeping doctors updated about patients [the nurse as the doctor’s agent] and helping doctors take the best decisions for their patients [the nurse as the patient’s agent]. Concurrently, by seeking doctors’ help in areas in which they acknowledge a negative information asymmetry with respect to doctors, nurses are again concurrently fulfilling both aspects of their dual agency role: implementing decisions which are formulated by doctors [the nurse as the doctor’s agent] and improving patient outcomes by seeking advice from the persons who are more competent in that particular area [the nurse as the patient’s agent]. Hence, both positive and negative information asymmetry constitute reasons for referral to doctors which are motivated by nurses’ dual agency role.

Although positive information asymmetry facilitates nurses’ attempts at participating in decisions, and despite such participation being desired by virtually all participants, the extent of nurses’ input in decisions about patients’ treatment modalities varies according to other factors and is often dependent on the approach adopted by medical practitioners, as illustrated by the interview excerpts in Box 5.5 below.

\textsuperscript{102} Inter-professional differences in acquiring and utilising knowledge and co-dependence in knowledge between different health providers in a critical care setting have been discussed by Chase (1995), Leonard, Graham & Bonacum (2004) and Pathanassoglou & Karanikola (2013) amongst others. Later in this chapter, the different knowledge held by doctors and nurses is raised again in the context of nurses’ decisions about who to seek help from (Sections 5.3.5 and 5.4.1). Subsequently, the notion of co-dependence of knowledge is discussed in more detail in the context of nurses’ dual agency role in the next chapter, particularly in Sections 6.3.5 and 6.4.4.
Sometimes I really feel that I am not involved, but I would really like to be involved, because after all I would be with the patient continuously; much more than the doctor would be. So I would be seeing the whole picture of the patient. I really wish to raise my opinion because I feel it’s valuable, but I don’t always manage to because I am not always given the opportunity.

- Jeremy, Formal Interview

Today’s ward round was fine. The consultant was all right. All that I had in mind for my patient was implemented; I had no problems. At least I felt involved and that makes me feel good, unlike other situations in which I am totally ignored, making me feel like I don’t know what...

- Sally, Formal Interview

There are doctors who really listen to the nurses’ opinion. For example, some consultants specifically ask nurses for their help. Let’s say, they say: ‘Good morning. How is the patient?’ And, if you have anything to worry about, you are ready to share with them. However, in other cases, they just enter the room and the other doctor is already reporting about the condition of the patient. If you try to open your mouth you are not given all the attention.

- Jacqueline, Formal Interview

Very often, in the ward round, any input comes from them [doctors] not you. Ideally, during the ward round they address you; their plan should be discussed with you as a nurse, and you feel free to ask whatever you have to ask, you’re free to suggest and give your opinion on things. Two of the consultants actually do address you or ask you what you’ve seen. Sometimes they ask you: ‘What do you think about...?’ And they really make you feel you are really part of the team. With others, during the ward round, you sometimes feel that you’re at the side to answer whatever questions they may ask and that’s as far as it goes. So sometimes I intervene because I say the patient is my patient; if I don’t ask and leave it up to them, they’re never going to come and tell me anything. So in a way you feel more involved and you are having an influence in what’s being done for your patient.

- Jessica, Formal Interview

**BOX 5.5**

Examples of structural constraints to nurses’ moral agency: The extent to which nurses manage to give their input in decisions affecting their patients is considerably related to doctors’ approach towards nurses.

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103 Nurses’ irregular involvement in ward rounds is not limited to this unit, as evident from recent research similarly suggesting that most of the input comes from medical practitioners (Weber, Stöckli, Nübling, & Langewitz, 2007; Liu, Manias, & Gerdtz, 2012).

104 This and other nurses’ frequent use of possessive pronouns (“my”, “your”, “our”) with reference to patients in several interview excerpts supports the notion of acting as their (moral) agent.
In addition to earlier data about power asymmetry, these excerpts highlight the existence of structural constraints\(^{105}\) to nurses’ moral agency. According to the participants, moral support from peers and superiors\(^{106}\) is helpful in mitigating the effect of these constraints; however, the availability of such support is often lacking:

> Sometimes there are other issues that are bigger than us...for example, the layout of the unit, the problem of the cubicles, being short staffed...and you don’t find support. Some doctors tell you: ‘listen, nursing staff shortages are not my problem; for me that issue is irrelevant, I’m sorry’. Sometimes consultants put more pressure on us, and I think the pressure should be decreased by the [nursing] management; the management should act as a buffer, sort of. Sometimes, unfortunately, you don’t find this help. Sometimes the managers just say ‘yes’ to the consultant, instead of supporting us.

- John, Formal Interview

> As a nurse, I feel that even the people above you [nurse managers], who are also nurses, don’t support us [in cases of disagreement with consultants]. They’re just saying ‘yes, yes, yes’ to them. Sometimes nurses don’t help each other either. It makes you feel: ‘so why should I open my mouth about anything? Why should I contradict a doctor if I don’t even find support from my colleagues’...It is not a nice feeling. Because sometimes in a way you expect it from consultants [not to support you], but from your own colleagues you think we are on the same wavelength, but it’s often not the case...Being nurses you would think that your ideas are somewhat similar...

- Jessica, Formal Interview

In summary, the data presented in this subsection indicate that nurses’ contribution to decisions about treatment modalities is facilitated by being more informed about individual patients than doctors (see also Section 5.2.4) and by their expertise in certain aspects of patient management (positive information asymmetry). Nonetheless, such participation in decisions is frequently impeded by several structural constraints as well as their acknowledged limitations in terms of knowledge and technical expertise in other aspects of

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\(^{105}\) From a sociological perspective, agency refers to the capacity of individuals to act freely and independently, while structure refers to factors which limit or constrain such independent action and decision making (Baker, 2005). The next chapter will include a discussion about nurses’ moral agency and its constraints in the context of the structure-agency debate.

\(^{106}\) A discussion of these and other factors enhancing and hindering nurses’ moral agency, in the context of the present findings, is provided in Section 6.4.2 of the next chapter.
critical care (negative information asymmetry). In other words, as depicted in Figure 5.6, nurses’ involvement in decisions is prompted by their moral agency and enhanced by their positive information asymmetry but impeded by their inferior decision making power and negative information asymmetry relative to doctors. Subsequently, to enhance their participation in patient related decisions, nurses need to make use of strategies which help them balance their dual agency role. These are discussed in the next subsection.

**Figure 5.6** – Factors facilitating (+) and hindering (−) nurses’ involvement in decisions about patients’ treatment modality changes. Nurses’ moral agency prompts them to influence treatment modality decisions, but is partly hindered by power asymmetry and other structural constraints. Positive information asymmetry enhances nurses’ ability to influence decisions, whereas negative information asymmetry hinders such involvement.
5.2.9 Strategies for enhancing participation in decisions

Nurses generally feel that consultants (and, at times, even other doctors) prefer to make decisions themselves, without other people’s involvement. For example:

*If a suggestion comes from a doctor it is usually accepted [more] than if it comes from me, a nurse, and a foreigner as well. Actually consultants don’t seem to like suggestions from any person other than their own selves, but that’s because...I don’t know...maybe the psychology of people changes as they grow in the hierarchy.*

- Jennifer, Formal Interview

*We have to convince the consultant, but we should convince him in a way which makes him feel that all the decisions are his. So we need to be tactful to convince someone who is always thinking that the decisions are his. Even other doctors sometimes find it difficult to convince consultants, let alone a nurse...I think it is a social approach...Being polite [and] respecting them as they are people of a certain position. I think we should respect them.*

- Judith, Formal Interview

Thus, nurses’ acknowledgement of their deferential position with respect to doctors, particularly consultants, stimulates them to adopt particular strategies through which to coax and manoeuvre them to mandate the treatment modalities which they consider best for their patient. Two examples of this are provided in Box 5.6 below:
EXAMPLE 1:

A. If I think the patient is having an internal bleed post-operatively, I would tell the doctor: ‘the haemoglobin has changed from this to this’, you know, but I won’t directly tell him: ‘I’m thinking of an internal bleed’. Or if I feel the patient needs to be started on continuous dialysis because of metabolic acidosis, I would point out the pH so they will take notice [laughs]. For example, I would tell them: ‘the pH is still 7.1, the pH is still like this, the pH is still like this...’

Q. Let me see if I am understanding this. So in your mind you would be saying: ‘listen, this patient is too acidotic...he needs continuous haemodialysis’ but you would still not say: ‘listen, shall we start haemodialysis?’

A. No, I would simply keep repeating: ‘the pH is acidotic’, ‘the patient is acidotic’... so that you bug them ... ‘the patient is acidotic’. If I see there is a renal problem, I go and tell them ‘listen, there is a renal problem, the patient has a renal problem.’ And I continue to repeat it until one of them says: ‘all right, let’s start this, then’.

Q. But why? What would stop you from making the suggestion...the actual suggestion about management? Why would you tend to stop only at the indicator, sort of? Is there a particular reason for it?

A. I think it’s from the culture; as nurses, we never prescribe management. I am not saying that we never decide it, because we decide it jointly with doctors, but we never prescribe; we never do...I think that’s why we are here, actually: to bug them about patient’s problems; the patient can’t speak.

- Judith, Formal Interview

EXAMPLE 2:

JOHN: Before starting to work in ICU, I used to work in the wards with several surgeons, and they can be incredibly childish. If you treat them like young children, and praise their qualities and the like, you can literally have it your way with them. And I have seen this with some ICU consultants as well; sometimes you literally praise them just to make them feel good...

SIMON: ...they would listen to you more, sort of.

JUDITH: Exactly.

JOHN: Their ego is so huge that if you try to contradict them, you’re bound to fail to convince them. So you have to turn around the problem...

SALLY: ...and you still arrive where you want to.

JUDITH: You have to be cunning!

JOHN: They would feel that if you suggest it, you are limiting their importance...

SIMON: I have done what John is describing, as well: you make the consultants feel important and then they feel fine and say: ‘OK, go ahead’.

- Excerpt from Focus Group 1

BOX 5.6

Examples of strategies used by nurses to enhance their influence on doctors’ decisions: Making doctors feel that they are making the decision.
Power asymmetry, therefore, occasionally leads nurses to behave according to the rules of what Stein (1967) had described as the *doctor-nurse game*\(^{107}\), which involves nurses influencing decisions about patients in a way which still makes doctors feel that *they* are the ones making the decisions.

This suggests that nurses feel that they are more likely to influence doctors’ decisions if they acknowledge the power asymmetry that exists between themselves and doctors, and use behaviours which show that they respect the doctors’ status of power. Thus, nurses consider it essential to make use of **persuasion and negotiation strategies** as a means of making their voice heard in decisions about a patient’s treatment modalities. The latter part of the first example in Box 5.6 [“that’s why we are here…the patient can’t speak”], in particular, further underscores that it is patient agency which essentially drives nurses to give their input in decisions, while remaining mindful of their principal-agent relationship with doctors.

In practice, **persuading** doctors involves the adoption of various approaches, the use of which was observed during the observation sessions and/or described by the participants themselves in the interviews and focus group sessions. Examples of such strategies follow.

> While bedbathing the patient, the consultant round approaches the bedside. The consultant opens the curtain and says: ‘hello’. [On my suggestion] we cover the patient again and Jacqueline props him up. Jacqueline immediately removes her gloves, applies handrub, cleans the ear pieces of the stethoscope with alcohol swabs and hands it to the consultant. She later explains that she did this so as to ‘anticipate’ the consultant as she perceived that she was going to listen to the patient’s chest.

- Field Notes, Observation Session 6

\(^{107}\) Essentially, the doctor-nurse game involved nurses guiding doctors’ clinical decisions in a covert manner, in conformity with the subservient role which was generally expected of them at that point in time (Stein, 1967). On revisiting this inter-professional relationships several years later, Stein and colleagues noted that the situation had changed, with nurses adopting a much more proactive role in clinical decisions, and explicitly offering advice to doctors (Stein, Watts, & Howell, 1990; Reeves, Nelson, & Zwarenstein, 2008). This generally appears to be the case in the present study as well; however, some instances, such as those referred to in these data excerpts, suggest that some elements of the original doctor-nurse game are still present. Indeed, on the basis of the quotes in Box 5.6, Sandelowski’s (2000) remarks that, historically, “nurses were in the bizarre position of having to be mindful of symptoms without speaking their minds about them” and that they “were to say (report and record) only what they saw, unlike physicians, who maintained the right to say what they knew” (p. 88) might bear some contemporary relevance in this particular context.
The participants’ motivations for her actions in this instance were explained in the subsequent formal interview:

Seeing the consultant washing her hands I anticipated that she was going to listen to the chest, so I prepared the stethoscope in order to show her that I am concerned. I realised what her actions are going to be and I anticipated her so that at least she would be a little more pleased. So in a way I was setting the right environment and the right tone to prevent conflict.

- Jacqueline, Formal Interview

In this incident, the nurse is using *accommodating strategies* in order to start her interaction with the consultant on a right note making subsequent participation in decisions easier. It also appears that junior doctors make use of such strategies as well:

If today I approach the doctors angrily and the next day I need something from them, then they are not going to help me. They would say: ‘It’s the same; it’s always the same complaining’. Even the junior doctors here in ICU, they might ask for your help about, let’s say, the dose of a medication. So that’s why they treat you nicely sometimes: because they know that they lack in certain areas and they are aware that the nurses can help them.

- Judith, Formal Interview

Several (but not all) participants claimed that some consultants contradict nurses’ suggestions for the sake of doing so:

There are some consultants with whom you would know that if you ask them something they would tell you the opposite thing. It’s true; some of them are like that. So I don’t suggest changes to certain people, because it would be useless.

- Sephora, Formal Interview

Some consultants tend to contradict whatever is suggested by other doctors and by nurses.

- Sally, Informal Interview

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108 Some of these labels were selected after being sensitised to the issues surrounding negotiation through Shell’s (2006) analysis.

109 Similar examples of doctors seeking nurses’ help about correct dosages was reported by Allen (1997).
This dominating approach appears to disregard the importance of relationships, thereby constituting competitive negotiation. Some nurses respond to this approach by similarly adopting competing as a negotiation strategy. For example:

Even the way you approach a doctor and how he approaches you makes a difference... If he approaches you aggressively, you automatically try to defend yourself. Sometimes, you [the nurse] might have approached him [the doctor] in a negative way, or you might have appeared arrogant, or he might think that you are trying to tell him what should be done and he doesn’t like it. These things do happen.

- Sally, Formal Interview

Although I tried to advise him not to, the consultant insisted that we extubate the patient, and he said it in an aggressive way, so I extubated him. But then the patient deteriorated, as I had expected he would...So when the consultant visited again in the evening, I confronted him! I made it a point that I tell him, and in fact he told me: ‘it’s true; we were a bit fast’. Because sometimes, unfortunately, when the negative consequence you had warned them about occurs they will be feeling that they didn’t succeed, so they will be more timid...so at that point in time you can tell him... before, like, leave him and then when he is a bit timid tell him: ‘I don’t think it was the right time...I told you so!’.

- Judith, Formal Interview

JEREMY: It depends on the character as well. Some doctors enjoy being sarcastic...

JOHN:...In that case you end up being sarcastic with them, you know?

- Excerpt from Focus Group 1

In this context, in view of this dual agency role, nurses require a certain deal of assertiveness to make sure that what they feel is best for their patient is listened to. This may take the form of attempting to make their voice heard and is also reflected in the spatial position they occupy during ward rounds, as exemplified by these data excerpts:

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110 Disagreement about the speed of weaning and the timing of extubation has been reported by other researchers, e.g. Chase (1995).
That is why I think it is very important for the nurse to interfere in the discussions during the ward round and to express her point and her views about the patient’s condition.

- Jennifer, Formal Interview

Jessica distinguishes between disagreements with doctors which have consequences on her and disagreements with consequences on her patient. She claims that she would not contest things which are related to her personally, but would definitely contest things which affect her patient.

- Jessica, Informal Interview

Sometimes you have to defend the patient from the doctor, unfortunately. Yesterday I had another such case. The cuff [which keeps an endotracheal tube in place to provide proper ventilation] wasn’t working properly, and I kept saying ‘come and change the tube; come and change the tube’. Eventually they came after one and a half or two hours and I kept inflating the balloon all the time to ensure good ventilation, but this was an emergency situation and should not have been postponed.

- Jennifer, Focus Group 2

But I think it comes from our behaviour: if we go near the patient ourselves, it’s like you’re saying: ‘I’m near the patient, so you have to face me...’ [laughs] I might be in the outer circle\textsuperscript{111} as you said, but I try to make it a point to go near the patient. If the doctors are in a circle, they never go near the head of the patient, so if I go there, I’m here [laughs]: this is my patient, I am the nurse; you have to address me [laughs].

- Judith, Formal Interview

\textsuperscript{111} By “outer circle”, this participant is making reference to the spatial distribution of different health professionals during ward rounds, which normally takes the form of one or more concentric semicircles around the patient’s bed, as captured in the following field note from one of the preliminary observation sessions:

Ward round Bed 7 - ‘crowd’ around patient’s bed. The way I am seeing it from here reminds me of two concentric, incomplete circles, with the inner circle consisting of the consultant in the middle, just facing the patient, with doctors and the nursing officer on each of his sides. Two physiotherapists stand at the left edge of this inner circle. Two nurses stand on the other end but slightly backwards, forming a smaller peripheral incomplete circle.

- Field Notes, Preliminary Observation Session 1

This spatial positioning resonates with that observed in an ethnographic study about medication communication during medical ward rounds in a Melbourne hospital (Liu et al., 2012). While this positioning reaffirmed the power relationship between doctors and members of the other professions, in both studies nurses struggled for space and did attempt to give their input in decisions when such was deemed necessary in the patient’s interest.
Indeed, this spatial position had been noted in the preceding observation session with the latter participant:

When the ward round approaches her second patient, Judith is not next to, but actually facing the consultant from the other side of the table, next to the patient’s bed (similar to Simon in the previous observation session).

- Field Notes, Observation Session 9

Alternatively, nurses may respond to medical practitioners’ anticipated negative reaction to their request by suggesting treatment modality changes which are diametrically opposite to those that they would actually like to implement:

SALLY: If, for instance, you feel that your patient needs to get out of bed, you tell X [a specific consultant]: ‘isn’t it better to keep the patient in bed today?’ She will invariably tell you: ‘no, get her out of bed’.

JUDITH: It’s true; that’s what she would say.

- Excerpt from Focus Group 1

Or else, if you would like to reduce pressure support, you would tell her: ‘isn’t it better to keep the pressure support as it is for the time being?’ And she would say: ‘no, reduce it’. She would always instruct the opposite of what you suggest.

- Sally, Focus Group 1

It sounds weird, but I have witnessed such situations, and sometimes I ask myself ‘why didn’t I suggest the opposite?’ For example, the patient was fitting, and I said the patient is fitting, and the patient is under sedation; shall we increase the sedation? And the answer was: ‘OK, stop the sedation’. I said: ‘shall we increase the anti-epileptic drug?’ ‘Reduce the anti-epileptic drug’. At this point I said: ‘I should have suggested the opposite of what I want!’

- Jacqueline, Focus Group 2

When adopting this approach, nurses are clearly considering or actually using reverse psychology. Conversely, several nurses appear to prevent conflict by avoiding contact with consultants whose attitude they perceive as aggressive or competing, a strategy which

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112 Reverse psychology is defined as: “a technique involving the advocacy of a belief or behaviour that is opposite to the one desired, with the expectation that this approach will encourage the subject of the persuasion to do what actually is desired: the opposite of what is suggested” (Wikipedia, 2013a)
is also allegedly used by some junior doctors in their interactions with consultants, as exemplified by the second quote below:

Yes, there are consultants whom I try to avoid. For instance, one of them does irritate me a bit, even though I would still ask him something if it’s vital. But if it’s not something crucial, I won’t ask him; because his attitude bothers me...he makes a fuss over small issues. It’s only with this particular person...in general, I find most of the other doctors quite approachable.

- Simon, Formal Interview

There is one doctor that is extremely competent and if there is a problem I always try to ask him for help. And he often tells me: ‘This consultant is going to create a panic. I don’t think it’s necessary. But in order to make her happy, I am going to shut my eyes and shut my mouth’. So everybody is coping [with this consultant] in different ways.

- Jacqueline, Formal Interview

Nonetheless, nurses’ desire to prevent conflict does not always impede them from giving their input in decisions about treatment modalities, leading nurses to resolve to other negotiation strategies. For example, rather than making referrals directly to consultants whom they perceive as unapproachable, nurses prefer to make the same referral through another doctor, as exemplified in Box 5.7 below.

Yes, I would keep my mouth shut in front of the consultant. But then I will go and mention this to one of the other doctors and my input still gets through.

- Jennifer, Formal Interview

Something seems to block me from directly speaking to her [the consultant]...so I prefer to bring up certain problems with one of the other doctors.

- Jacqueline, Formal Interview

There are certain consultants who – if they’re in a hurry, or in a bad mood – will make you feel this small in the ward round. If it is that type of case I let it pass, and then I speak to one of the doctors and whatever I have to say I say it to another doctor not the consultant. It depends a lot on their approach with you...and their mood. Sometimes they come in the morning and you know they’re going to pick on every single thing, so I keep my words with them to a bare minimum and then I deal with somebody else; another doctor, but not the consultant. And it’s not a very nice feeling.

- Jessica, Formal Interview

**BOX 5.7**

*Examples of “bypassing the consultant”*
In these instances, the nurses are bypassing consultants whom they perceive as unapproachable but still manage to give their input by communicating with a more junior doctor whom they perceive as more approachable and who would then speak to the consultant.

Another negotiating strategy used by nurses involves deliberately adopting a particular type of language. For example, with consultants whom they perceive to contradict anything suggested by nurses, some nurses prefer asking neutral questions. Conversely, other nurses mentioned using leading questions in an effort to make it less likely for doctors to give a negative answer to their suggestions. Examples of each are provided in Table 5.4 below, in which nurses also elaborate on their rationale for the use of these strategies.

<table>
<thead>
<tr>
<th>ASKING NEUTRAL QUESTIONS</th>
<th>ASKING LEADING QUESTIONS</th>
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| **Just before the ward round leaves, Jacqueline says something to the consultant (for the first time in the round) but I am not sure what. She later tells me that she had asked about whether to administer enalapril**, which was prescribed but which was marked ‘ask medical officer’ on the prescription chart, and about which the night nurse had told her to liaise with a doctor about before administering. Jacqueline tells me that she asked it in a neutral way because, had she suggested one course of action, the consultant would invariably have instructed the opposite. | **Sometimes you keep aspirating from the nasogastric tube, but they still tell you to continue the feed.** They don’t tell you to start Maxalon. You aspirate another 220 [mls], you ask a second time and they tell you not to give. And then last week, the third time, instead of saying: ‘Shall I start Maxalon?’ I said: ‘Listen, this is the third time I have aspirated 200; I’m going to give Maxalon’. And then you add: ‘OK?’...something to show that you’re still waiting for their go ahead... but not say ‘Shall I give?’ because that in a way prompts them to say ‘no’. So you show them: ‘Listen, I know what I am talking about’.

- Field Notes + Informal Interview, Observation Session 5 | - Jessica, Formal Interview

|  | **The question I used was: ‘Shall I remove the central line of the patient in bed 1?’...something like that, and he told me: ‘yes, yes of course’. That was his answer ...rather than doing it myself without him knowing.** |
|  | - Judith, Formal Interview |

113 Enalapril is an angiotensin converting enzyme (ACE) inhibitor, commonly used to treat chronic heart failure and high blood pressure.

114 This refers to the administration of food through a nasogastric tube (a tube inserted into the stomach through the nose). When a patient is receiving a nasogatric feed, the amount of gastric content needs to be checked regularly (which is what this participant means by “aspirating”) in order to ensure that the feed is being absorbed.

115 Metoclopramide (Maxalon®) is an anti-emetic drug, used to prevent vomiting and assist gastric emptying and, therefore, the absorption of a nasogastacric feed.
When you have consultants who are over-protective, and many times they tend to object to everything you are saying, I would avoid saying: ‘Should I omit enanapril?’ or ‘Shall I not give enanapril?’ I just ask: ‘What shall I do about enanapril? What’s your opinion?’ – A very neutral question with this consultant. To be honest with you, I figure out the question before the consultant comes for the ward round.

- Jacqueline, Formal Interview

For example, there is a particular consultant who will never want to wean anything. You could have a patient with a systolic blood pressure of 200 mmHg, and noradrenaline is at 20 ml/h and in the handover the night nurse would have said: ‘Don’t wean; they don’t want us to wean’. And then, instead of saying: ‘Shall I wean?’ I would usually tell her: ‘Listen, the systolic has been 200 all night. I’m going to start weaning slowly. What do you think?’ So I’m not telling her: ‘Listen, this is my decision, and that’s what I’m doing’ because at the end of the day she is the consultant. But I try to put the question in a kind of way which would make it more difficult for her to say ‘no’.

- Jessica, Formal Interview

**Table 5.4 – Wording of a referral: Examples of neutral and leading questions and nurses’ explanation of the rationale behind their use.**

This confirms that the way in which a nurse words a referral to a doctor is an important determinant on whether it achieves its intended outcome. Two of the quotes in particular illustrate how, in that specific context, asking a leading question was more successful than a neutral one in convincing a doctor to authorise the weaning of an inotropic infusion and to prescribe an antiemetic drug.

Furthermore, referrals to doctors, particularly those intended to influence changes in a patient’s treatment modalities, tend to be more successful when the nurse uses the type of language with which doctors identify, namely, by making reference to physiological parameters. For instance:

*I talk to the doctor in a certain way...I would give him the physiological reason. I think that if we use a good rationale we will come to a decision between what I think as a nurse and what the doctor thinks as a doctor, because the doctor may have a different thought; maybe he’s seen something that is not true, and by talking to me maybe he will change that impression.*

- Judith, Formal Interview

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116 In this context, *weaning* refers to the gradual reduction in the rate of an inotropic infusion.

117 Jessica’s first quote in Table 5.4 also suggests that the doctor and the nurse in this scenario are basing their decisions on somewhat different sets of knowledge: the nurse is prioritising the patient’s current problem of not absorbing a nasogastric feed and its associated consequences, while the doctor is probably focusing on the possible effect of administrating an anti-emetic drug. Different ways of gathering and utilising information about a critically ill patient were also brought up in Section 5.2.8 and will be discussed in the context of the literature in the next chapter.
In summary, nurses’ behaviours, as observed during clinical practice and as described by the participants themselves, indicate their use of several persuasion and negotiation strategies, including:

- Accommodating
- Competing
- Assertiveness (including spatial position in ward rounds)
- Using reverse psychology
- Avoiding
- Bypassing
- Formulating neutral questions
- Asking leading questions
- Using ‘medical’ language (making reference to physiological parameters)

The use of these strategies appears to be motivated by nurses’ attempt to find a compromise between their desire to prevent conflict with doctors (most notably, consultants) and their attempts to participate in patient-related decisions, thereby achieving a balance between acting on behalf of the patient and respecting medical practitioners’ preferences. Therefore, although nurses’ constant awareness of their limited decision making power conditions the way they interact with doctors, this power asymmetry does not stop them from influencing and participating in decisions about a patient’s treatment modalities. Indeed, acting as a patient’s agent empowers the nurse to use such strategies in order to prompt doctors to take the decisions which they feel are best for their patients but which only doctors can prescribe. This further supports the concept of dual agency because it involves nurses attempting to safeguard the patient’s interest while remaining mindful of their obligation to respect doctors’ authority, as illustrated in the following excerpts:

*With some consultants that’s what you have to do [use reverse psychology]. It’s not just to have your way with them, but because of the patient him/herself. It’s a bit silly if you just do it for your own sake. But there are things which are bound to be more successful for the patient if you suggest the opposite of what you really want.*

- John, Focus Group 1
You [the nurse] are between the doctor and the patient, and the most important thing is that you have to keep a balance to please the doctors and to safeguard the patient...

- Jennifer, Focus Group 2

In other words, their moral obligation of safeguarding the patient empowers nurses’ moral agency, in this case through the adoption of negotiation strategies, and partly moderates the stifling effects imposed by consultant agency. Thus, the two components of nurses’ dual agency relationship with patients and medical practitioners respectively enhance and constrain nurses’ moral agency. The next subsection expands the discussion about negotiation within this critical care unit by highlighting several factors which contribute to nurses’ learning and mastering of such negotiation strategies.

5.2.10 Learning the rules

Nurses’ confidence in their attempts to influence decisions about patients’ treatment modalities improves by time. For example:

Sometimes when the oxygen saturation\(^{118}\) is dropping, the doctor would tell me: ‘Listen, let’s put him back on the ventilator’ or ‘instead of CPAP, put him on SIMV’;\(^{119}\) Now that I am more experienced, I would tell him: ‘Listen, let’s do this first, maybe he will get better and we’ll avoid going backwards in our care plan’. But I wouldn’t have been able to do that earlier on.

- John, Formal Interview

Therefore, the negotiation strategies discussed in the previous subsection are learned and improved as experience is gained. Furthermore, the nature of the referral changes with experience, as illustrated by this excerpt from an interview with an experienced participant:

I think that by experience you start having more influence on the decisions about patient management. I am sure about it actually, because the decisions you are taking, or those which you think are most beneficial, are backed up by what needs

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\(^{118}\) Oxygen is mostly transported around the human body by binding to haemoglobin, a chemical found in red blood cells. Oxygen saturation refers to the percentage of haemoglobin-binding sites that are saturated with oxygen, and therefore one of the indicators of a patient’s respiratory status.

\(^{119}\) This involves increasing the patient’s ventilatory support provided by the mechanical ventilator.
to be done, or backed up by knowledge. For example, if I ask a doctor: ‘Listen, we have a low CVP\textsuperscript{120} here…shall we give some fluids?’ So, I’m giving a reason for my choice and not just firing ideas…I am suggesting something because I know the reason behind it. And like that they would know that you took all the necessary steps…you are talking sensibly. So you might tell them: ‘shall we give some fluids since the CVP is so low’ and they might see something which you haven’t seen and tell you: ‘you’re right about the CVP, but remember that this is a head injury patient; it’s better not to’. So even their response is different; it’s like a discussion…because you would be right in suggesting that but he would be thinking one step ahead and tells you: ‘that’s true, but…’ They’re not just telling you ‘No’ and that’s it.

- Simon, Formal Interview

This suggests that experience is one factor which helps to change the nature of referral, moving it closer to a discussion between colleagues, rather than simply a question and answer session.

Apart from the benefits of experience itself, by time nurses learn other valuable aspects related to process of referral. For example:

> When doctors ask you about something, through experience you would know what they expect and what they need, and you would be able to point it out to them beforehand.

- John, Formal Interview

…everything matters in decision making: everything matters. I see it happening with my colleagues; they would ask: ‘Who is the consultant today?’ They already have a picture of what would take place, and also the preferences of some doctors. One doctor will tell you ‘please set up morphine’. Then another one will come and say: ‘Why are you giving morphine? Why didn’t you set up Rapifen\textsuperscript{121}?’ So we also know the preference of the doctors, and we hope to react according to the preference of the doctors. So everything really matters; it is very complicated.

- Jacqueline, Formal Interview

\textsuperscript{120} Central venous pressure (CVP) reflects the pressure in the right atrium of the heart and is often used as an indicator of the effectiveness of intravenous fluid administration.

\textsuperscript{121} Morphine and alfentanil (Rapifen\textsuperscript{*}) are often administered to critically ill patients for their analgesic and/or sedative properties (Woodrow, 2012).
Indeed, successful referral also entails learning more about different consultants’ preferences and attitudes because this influences nurses’ subsequent behaviour. For example:

*First of all you have to learn the consultant’s traits and personality, and then you would be able to talk to the consultant. If this consultant is very conservative and he or she only wants her or his thoughts to be put in practice, then you have to be more cautious when you speak to them.*

- Judith, Formal Interview

*Some of them [consultants] do not even listen to other doctors, let alone to nurses; so with those consultants you have to shut up and use another strategy.*

- Judith, Informal Interview

*There are certain nurses that behave like me; we are very neutral when it comes to decisions. When she’s the consultant on duty, we don’t take any decision on our own. Usually, as a person, I like to take decisions for my patient. But when she is around, a fight starts in me: should I do that [without asking her], or should I ask her? And sometimes I make compromises with myself...and today I just decided to bypass her.*

- Jacqueline, Formal Interview

In these quotes, nurses appear to decide whether and in what way they attempt to influence consultants’ clinical decisions on the basis of their perceptions of the consultants’ attitude, which they learn as they become familiar to the “rules” of the critical care unit. Thus, nurses’ behaviour, including their referrals to medical practitioners, changes substantially according to the characteristics of the other party\(^\text{122}\). This is especially because nurses choose to use different negotiation strategies (such as avoiding, bypassing and accommodating behaviour\(^\text{123}\)) according to which one/s they perceive to be most successful with different consultants.

\(^{122}\) In this context, “knowing the individual physician” has already been described as an important source of knowledge for critical care nurses because it informs them about doctors’ preferred treatment modalities and the extent to which they can implement treatment modality changes autonomously (Rodney, Brown, & Liaschenko, 2004, p.159).

\(^{123}\) These and other negotiation strategies were described in Section 5.2.9
This also suggests that the negotiation strategies described in the previous subsection are partly learnt through socialisation. Socialisation involves learning about the norms, customs and ideologies characterising a society or organisation, and provides individuals with the skills and habits necessary for participating within their own society (Bilton et al., 2002). Thus, socialisation involves nurses learning about the “institutional” (Jameton, 1984, p.6) or “situational” (Rodney & Starzomski, 1993, p.24) constraints (particularly power asymmetry) that limit their ability to implement what they feel is most beneficial to the patient, but against which they struggle by using negotiation strategies. As indicated by the data cited in this subsection, both experience and socialisation appear useful in enabling nurses to become more aware of consultants’ preferences and expectations, and this, in turn, improves their ability to use the most appropriate negotiation strategy in a particular situation.

Finally, nurses’ evaluation of earlier attempts at influencing decisions further refines their negotiation strategies with doctors. Indeed, according to one of the participants, negotiation skills are learnt...

‘...by trial and error. At the beginning I used to avoid the consultant or immediately abide with what he or she is saying. Then an incident occurred with one consultant in which I phrased my objection in a different way and it worked. I didn’t even realise what had happened at that moment. And I am the sort of person who reflects...when I go home I think about all that had happened! And I said maybe that’s why I got such a different and better response. So now, automatically, I stop and to think: ‘let me rephrase it like this...’

- Jessica, Formal Interview

So from now on I would know that, if I see a patient who has difficulty in swallowing, I’m going to check out if the speech therapist had come, and if he hasn’t come I am going to insist that he comes...I learnt how I have to persevere to get the information I need for the patient. This is what I took as a conclusion. I reflect a lot; I’m sorry if you think I reflect too much.

- Jacqueline, Formal Interview

She tells me about an accidental extubation a few days before, which prompted her to check for the presence of all emergency equipment and drugs even more meticulously.

- Jennifer, Informal Interview
You learn a lot by observing others, and even seeing their shortcoming in certain aspects. For example, when I take over in the morning I search. You might tell me: ‘do you actually search for others’ mistakes?’ But that’s not the point; I search for what happened so I won’t do the same mistakes.

- Judith, Formal Interview

Similarly, a minimally experienced participant spoke about how she observed various aspects of senior nurses’ behaviour, particularly the way they negotiated with doctors, so as to ‘imitate’ successful negotiation strategies and prevent unsuccessful ones:

I think the key to it is observing...ICU is very hectic; a lot of things are going on; so many decisions; several different patients. So sometimes I do it: I stay back and observe what’s happening so that I can watch and learn...For example, the nurse taking care of the patient next to mine wanted something to be done and her approach was a bit aggressive or she didn’t understand well...and she had an argument with the consultant. I try observe what’s happening, so next time I won’t do the same. Thus, I learn by seeing...I move back and observe. Even when we are admitting patients, at the beginning I used to observe what one nurse is doing, what the other person is doing, and I made it a point to learn the traits of people that were doing their job well in my opinion; those who convince me that they did a good job. And I observed the way they approach doctors, the way they approach the ward managers, other colleagues, the way they work with others, how they manage to do their own work and still manage to help others as well...how all that is done.

- Judith, Formal Interview

This suggests that negotiation skills are also improved by reflection, which involves nurses pondering on the response to, or outcome of, their own or their colleagues’ earlier attempts to use different negotiation strategies. As indicated through some of the quotes, reflection also involves learning from one’s own and one’s colleagues’ mistakes.¹²⁴

Even nurses’ decisions about whether to refer to doctors or not are partly influenced by reflecting on past experiences of doctors’ reactions to these actions, because “…these small things [doctors’ reactions] really determine your behaviour further” (Jacqueline,

¹²⁴ These examples lend support to the body of literature highlighting the importance of reflective practice in nurses’ professional development. Indeed, according to Morrison and Symes (2011) nurses learn through several experiences which include “reflecting on experiences of untoward results or mistakes” (p.166).
Formal Interview). Similarly, such reflection may determine from whom nurses choose to seek help. One participant, for instance, spoke about how previous reactions to her requests for help determined her subsequent choices regarding to whom to refer:

**Q:** If there was anything which you thought needed to be discussed in relation to the patient, would you discuss it with the consultant?

**A:** Not with the consultant who is currently on duty.

**Q:** Why?

**A:** Because he can be very sarcastic and because of a past incident in which he had made me look stupid by telling me that ‘a good nurse should always check for that’ [in relation to an arterial line not working properly].

- Jessica, Informal Interview

Once I asked a consultant to sign an X-ray form and she told me: ‘Don’t you know this is a junior doctor’s job? You don’t ask a consultant to sign a form’. So that remained stuck in my head.

- Jessica, Formal Interview

To summarise, nurses’ use of negotiation strategies is learnt and refined through various factors, such as being socialised into the critical care environment and reflecting on the outcome of previous attempts at seeking help or influencing decisions about patients’ treatment modalities. Experience is crucial in determining which negotiation strategies to use with different consultants, and in modifying the nature of referral accordingly.

### 5.2.1 Summary of motivations and strategies for referring

On the basis of the data elicited in the study, this section presented several factors which lead nurses to seek help from doctors, and portrayed dual agency as a central factor associated with this decision. As depicted in Figure 5.7, nurses’ motivations for referring can essentially be classified into two broad categories, both of which are strongly related to their dual agency role:

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125 Nurses’ decisions about who to seek help from are discussed in detail in Section 5.4.
(1) When nurses seek doctors’ authorisation for their actions or clarification about medical decisions they are concurrently acting as *agents to medical practitioners* (by implementing the latter’s decisions or seeking doctors’ approval for their own decisions) and as *agents to patients* (by implementing doctors’ decisions or seeking authorisation for their own decisions, both of which are motivated by an improvement in patient outcomes). This strand of referring is also activated whenever nurses’ acknowledgement of their negative information asymmetry prompts them to seek advice from medical practitioners.

(2) When attempting to influence decisions, nurses again implement both aspects of their dual agency role. By informing, updating and proposing treatment modality changes to medical practitioners on the basis of their additional contextual information about the patient (positive information asymmetry), nurses are acting as medical practitioners’ agents. In so doing, they are concurrently safeguarding patients by proposing decisions which they feel their patients would benefit from.

Although both components of dual agency lead to referral, each is prompted by a different factor. Acting as medical practitioners’ agent is mostly underpinned by nursing’s socio-culturally entrenched deferential power with respect to medicine; conversely, acting as the patient’s agent is prompted by nurses’ moral agency, which is itself enhanced when they successfully act as their patient’s agent.

This section also showed that the need for referring varies substantially according to the characteristics of the individual agents (nurses) and principals (doctors) involved, and the adequacy of communication between the two professional groups. Several negotiation strategies (learnt by experience, socialisation and reflection) are used to strike a balance between safeguarding the patient’s interest and adhering to consultants’ preferences, including the terminology they use, the manner in which they ask questions, using accommodating strategies and making doctors feel that they are making the final decision.

The next section addresses the factors associated with nurses’ decisions to act independently, without referring to doctors.
Figure 5.7 – Dual agency as a central motivator for nurses’ decision to refer to doctors

- Negative Information Asymmetry
  - ... to obtain authorisation and seek advice (1)
    - Implementing doctors’ decisions
    - Improving patient outcomes
    - Informing/advising doctors
    - Safe-guarding patients
  - Power Asymmetry
    - Referring...
  - Moral Agency
    - NURSE AS MEDICAL PRACTITIONER’S AGENT
      - Informing/advising doctors
    - NURSE AS PATIENT’S AGENT
      - Safe-guarding patients
  - Dual Agency

- Positive Information Asymmetry
  - ... to influence decisions (2)
5.3 MOTIVATIONS FOR ACTING INDEPENDENTLY

The previous section identified nurses’ role in acting as an agent to both their patient and the ICU consultant as a major motivator for seeking help from doctors. Nonetheless, while nurses are particularly mindful of their duty to act within the parameters of their principal-agent relationship with medical practitioners, there are several factors which stimulate them to act without seeking doctors’ authorisation for their actions. Hence, the present section will discuss the factors associated with nurses’ decisions not to refer to doctors, which are also essential in gaining a full understanding of the process of referral within a critical care setting. Throughout this section, “acting independently” and similar terms denote nurses’ decisions made, or actions taken, without referring to a medical practitioner.

5.3.1 Protecting the patient from aggressive treatment

Several examples in the previous section indicate that patient agency often acts a motivator for nurses’ decisions to seek help from doctors. However, patient agency may also constitute a reason for not referring to doctors. In some rare instances, certain nurses prefer not to inform doctors about certain minor changes in the patient’s condition because they would feel that, if they do, they would prompt doctors to adopt more aggressive treatment modalities from which patients would not actually benefit. The following segment from an interview refers:

*Sometimes you would try to adjust some things on your own before calling the doctor, because when you do call the doctor everything tends to grow. So sometimes even preventing escalation in treatment would be beneficial for the patient, because unfortunately, doctors, especially the young ones, just think about doing this, this and this by the book. Sometimes by experience you get to know that even if you deviate a bit, the road might be less aggressive and smoother, with the same outcome. So by experience you learn to try and adjust some things yourself.*

John, Formal Interview

In this situation, therefore, patient agency encourages the nurse to mediate and filter information from doctors, thereby preventing escalation in treatment (e.g. endotracheal intubation), when the nurse feels that an improvement in a patient’s condition

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126 This strategy, together with several of the negotiation strategies discussed in the previous section, are bear some resemblance to what Hutchinson (1990, p. 7) had described as “bending the rules” and what Rodney et al. (2004, p. 116) label as “responsible subversion”.

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can be achieved through less invasive measures (e.g. chest physiotherapy). Therefore, while the two aspects of dual agency underpin the majority of nurses’ decisions to seek help from doctors (see Section 5.2), patient agency occasionally motivates their decisions not to seek such help (as illustrated by this example)\textsuperscript{127}.

### 5.3.2 Helping doctors by not overburdening them

Nurses’ decisions to act without seeking doctors’ help occasionally stem from a desire not to overburden doctors with additional decisions:

> If we see that the patient needs potassium, or he is febrile and needs paracetamol,\textsuperscript{128} we don’t need to ask the doctor about these things. We can do them without bothering the doctor.

- Jennifer, Formal Interview

> I’m not confident at all, but if I can I try not to bother doctors, basically. It’s not because I am anything good or anything better, you know, but I try and do things on my own.

- Sephora, Formal Interview

> They [doctors] complained that several nurses are bothering them for things that we can take decisions about, and I completely agree with them because being a nurse in ICU for five years you should know when to give potassium or when not to give potassium; you know when to put the oxygen down or up; you know when to increase or decrease the inotropes. These are simple things…if we don’t know this, what do we know then? And they really bother the doctor during the night: ‘The potassium is 2.3; should I give potassium?’ Of course you should give potassium!

- Jacqueline, Formal Interview

\textsuperscript{127} It must be pointed out that only one participant came up with the notion of filtering information from doctors to safeguard the patient in the original individual interviews. Yet, even if idiosyncratic to this participant, this negative case is still important as it widens the understanding of acting as a patient’s agent. Furthermore, when exposed to other participants during the focus group sessions, there was some recognition of the notion of protecting the patient by preventing escalation in treatment.

\textsuperscript{128} In the unit constituting the research setting for this study, nurses had, for several years, been unofficially authorised to administer paracetamol without a doctor’s prescription; see also Section 5.2.3.
JOHN: [Discussing reasons for not seeking doctors’ help...:] Then there’s an element of altruism as well.

JUDITH: Yes; he [the doctor] would have been in the unit until midnight, so you wouldn’t bother him unnecessarily at the middle of the night...you show some respect. Of course, if it’s an emergency it’s a totally different story...but if you can manage without calling him it’s better.

MODERATOR: So there’s this element of appreciating that these people have very difficult duties as well...

SALLY: Yes, you have to keep that in mind as well.

- Excerpt from Focus Group 1

These quotes equate seeking a doctor’s help about certain issues at certain times of the day with ‘bothering’ them, which implies that the decision not to refer certain decisions to doctors is also partly motivated by altruism, which term was used by one of the participants himself in the latter segment. Specifically, appreciating that doctors have to take decisions about several critical patients, throughout their long shifts\(^{129}\) prompts some nurses to avoid seeking their help unnecessarily for issues they feel competent about\(^ {130} \), particularly in view of the fact that they have more contextual information about the patient, as indicated by the data about their positive information asymmetry (Section 5.2.4).

Therefore, this collaborative approach of not seeking help unnecessarily not only helps nurses to maintain a good relationship with doctors (see ‘accommodating negotiation strategies’ in Section 5.2.9), but is ultimately beneficial to patients as well because it allows decisions to be taken by the person who is in a better position to take them at that point in time.

5.3.3 Unavailability as a reason for not seeking medical help

On certain occasions, nurses do not refer to doctors simply because no medical help is available at that particular instant. For example:

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\(^{129}\) Doctors on night duty would be working as part of a 24-hour shift.

\(^{130}\) Similar efforts at easing the burden of doctors’ work emerged from an ethnographic study by Allen (1997).
Then there are instances in which everyone is so busy: the anaesthetists would be inserting a central line; a new admission would have just arrived. This is what happened today, for example, when they admitted that boy...Had I needed to ask something related to urine output, for instance, I wouldn’t have asked about it at that very instance. At that time, all doctors would be focused on the other patient, so I would feel awkward asking about something which is much less urgent.

- Simon, Formal Interview

If the doctor is busy with a patient who is deteriorating rapidly or with an admission or with something else, you shouldn’t ask about things which you can do yourself.

- Jennifer, Focus Group 2

I think that sometimes the nurse takes decisions there and then when there isn’t enough time to inform the doctor, even if she updates him about it later on. Also, the doctor has several patients to take care of, as we said before, so you can’t possibly wait until he comes next to you. Sometimes, if your patient is suddenly deteriorating you have to act immediately.

- John, Focus Group 1

5.3.4 Factors promoting independent practice

Virtually all participants expressed a desire for being able to manage at least some aspects of patient care without the need to refer to other members of the team, not least because this constitutes a source of professional satisfaction. For example:

There is an element of pride, or perhaps self-worth; I’m not sure what to call it. You do feel better whenever you are able to manage the patient on your own.

- Simon, Formal Interview

If there is a patient whose lines have to be changed, I would prefer to change them myself because this is what I have done for twenty years, and not having to call the doctor, because if I do I would have to wait till he comes and depend on him...but few doctors know that I can do it myself and give me green light; the others prefer to come and do it themselves, maybe because here it is their responsibility.\textsuperscript{131}

- Jennifer, Formal Interview

\textsuperscript{131} In this ICU, intravascular lines, such as arterial lines and intravenous catheters are usually inserted by doctors. This participant, however, was trained and had worked for several years in another country in which this is frequently carried out by nurses.
As nurses, we should take some more decisions in relation to patient care, and not always ask the doctors to make the decisions, because then you end up with no choice but to ask: ‘shall I do this on my own? Shall I do this?’

- Jeremy, Formal Interview

In fact, some participants actually “complained” of the fact that it was often not possible to take certain decisions independently of doctors. For example:

It makes me feel annoyed [that I can’t make certain decisions on my own] because there are certain things for which as a nurse you should be able to have a certain amount of responsibility; otherwise what’s the point of working here and having a 1 to 1 nurse-patient ratio? I understand my limitations hundred per cent, and I know there are certain things I can’t take into my own hands. But then, with things like adjusting ventilator settings and other stuff like that, why shouldn’t I be able to take that decision myself?

- Jessica, Formal Interview

The quotes above indicate that nurses’ decisions not to seek help from doctors are partly influenced by their desire for autonomy in some aspects of patient management. In fact, several nurses spoke about various instances in which they attempted to solve a problem independently prior to seeking a doctor’s help:

For example, if the patient is not passing urine. I would allow an hour to pass, observe what happens and take certain measures myself first. Only then would I ask the doctor for help, but not immediately.

- Sally, Formal Interview

This strategy was, indeed, carried out in practice by the same participant, in a different scenario (related to relative drop in oxygen saturation), during the preceding observation session:

While writing a note next to the second patient’s bed, I hear Sally instructing her first patient to take deep breaths. I go next to her and ask why she is doing this. She explained that the oxygen saturation had dropped to about 85% but that this

132 As shall be discussed in the next chapter, “autonomy” is a problematic concept and, in its absolute sense, unachievable. However, reference is hereby being made to a desire for some degree of autonomous practice.
was probably because the patient was eating. Indeed, after the patient took a few deep breaths, during which Sally remained extremely calm, the oxygen saturation returned to its previous low normal levels (above 96%). I ask Sally whether she had considered asking for a doctor’s help. ‘No’, she says, ‘because first I try to deal with the problem myself and not seek a doctor’s help at the first minor problem’. On further probing, she says that earlier in her career, in such a circumstance she might have asked another nurse for help, but even back then she still wouldn’t have ‘panicked’ [her words].

- Field Notes + Informal Interview, Observation Session 2

This latter comment seems to denigrate seeking help from doctors as a form of ‘panicky’ behaviour, suggesting that unnecessarily requesting a doctor’s help is interpreted as a failure in nurses’ attempts at working with a certain degree of independence\(^{133}\). Indeed, data from the subsequent formal interview with the same participant confirms this and further elaborates about her motivations not to seek a doctor’s help in this and similar situations:

\[\ldots\text{because I feel that we [nurses] should have at least some autonomy, you know? You don’t need to go and tell every single thing to the doctor. We have skills of our own, and if we know how to solve certain problems on our own that is what we should do. You have to wait a bit and not immediately report every trivial issue to the doctor...at least you try to solve it on your own first.}\]

- Sally, Formal Interview\(^{134}\)

Furthermore, according to another experienced participant, it is useless asking for a doctor’s help in instances in which one knows what the doctor’s response is going to be:

\[\text{Actually, I would know exactly what’s going to happen. For example, I would know that if a patient is not passing any urine and I ask for the doctor’s help within the first hour, I am sure that his answer is going to be that is not a clear indicator of [a drop in] urine output. In any case I know what he would suggest before taking any further action. So, I try to try to take all the steps which I think he would be recommending. I know that the first thing he’s going to ask is: ‘have}\]

\(^{133}\) This is somewhat reminiscent of Lee’s (2002) notion of requesting help being associated with a social cost. Social costs associated with seeing help shall be referred to in more detail in the context of nurses’ decisions about who to seek help from (Section 5.4) and critically discussed in the next chapter (Section 6.4.4).

\(^{134}\) While a similar desire to make certain decisions autonomously was expressed by practically all the participants, the extent to which this desire is put into practice appears to vary substantially from one nurse to another, on the basis of their individual characteristics, most notably their readiness to accept risk. This was discussed in Section 5.2.3.
you flushed the catheter?’ Since I would have taken such steps on my own, I would
be able to answer him: ‘yes, the catheter is patent but there is still no
improvement’.

- Simon, Formal Interview

Perceived competence or self-efficacy\textsuperscript{135}, therefore, constitutes another reason why nurses
may decide not to seek a doctor’s help, and subsequently take decisions autonomously.
According to the same participant,

\begin{quote}
Certain nurses really bug the doctors with their phone calls. Then there are others
who, like me, are competent enough\textsuperscript{136} to only ask the doctor for help in specific
circumstances in which it is really necessary to ask.
\end{quote}

- Simon, Formal Interview

This subsection has introduced nurses’ desire to act independently as one of the
determinants of their decisions about whether to seek help from doctors or not. The next
subsection extends this concept in terms of its effect on nurses as a professional group,
rather than exclusively as individual practitioners.

\textbf{5.3.5 Deciding as a group}

The desire for independent practice introduced in the previous subsection is particularly
strong in areas in which nurses feel they are more competent than doctors, such as wound
management and mouth care, as emphasised by the following participant:

\begin{quote}
I hate it when the doctors try to tell you what to do in an area totally related to
nursing; for example, I don’t expect a doctor to tell me to do a mouthwash or how
to dress a wound because I feel that it is not a matter in which they are more
competent. In our programme of studies, we cover more of these aspects than if we
would have studied medicine. In medicine they have got their curriculum; it is
what it is. Ours is different – that’s what makes us nurses after all – and I think I
that I have better judgment, for example, on how to manage wound care,
\end{quote}

\textsuperscript{135} Bandura (2012) defines \textit{self-efficacy} as a person’s perception of his/her ability to complete a task, or
perform in a manner which produces a positive outcome.

\textsuperscript{136} In a somewhat comparable finding, video data from Endacott et al.’s (2012) simulated scenario study
about the identification of deterioration by Australian rural hospital nurses revealed that the participants
who were most likely to do all that they possibly could before seeking help from doctors were the ones who
had obtained the highest scores in the objective structured clinical examination (OSCE) which preceded the
observations.
compared to what a doctor could tell me about it. I know when to do a mouthwash; there is no need for a doctor to tell me. And sometimes I find it written on the treatment chart!! I do not like to overstep the doctor and the consultant on whatever decisions that are their areas, and likewise I think that in things that are within my area, the doctor should not come and say: ‘Do the dressing, like this, like that, like this’.

- Jeremy, Formal Interview

In this excerpt, the participant is making specific reference to what he considers to be “nursing areas”. Indeed, several participants stressed the fact that, in issues which they consider to be “theirs”, they prefer to seek the help of another nurse rather than a doctor. This is further exemplified through the quotes below:

...because there are certain things that, not exactly we know more about, but which are part of nursing care not doctor oriented. For example: care of a central line and things like that. OK, doctors insert a central line, but in my opinion that’s as far as it goes, because even sometimes I’ve uncovered it and it’s red, it looks really inflamed, I see how long it’s been in, I tell them about it and they say ‘no, it’s ok’ full stop. These things, such as infection prevention and care of invasive lines, are more nursing oriented than doctor related, so nurses would probably have a better answer then a doctor would...a nurse would look at it from a different perspective.

- Jessica, Formal Interview

There are nursing procedures which the experienced nurses would know; we don’t need to ask the consultant how [certain] things are done...

- Judith, Formal Interview

First, we try to solve things between us. And that is why we are here, not to immediately ask the doctor; we should try to at least use our brains and try to solve problems ourselves.

- Sally, Formal Interview

I still prefer asking a nurse because, if it is within the competence of nursing, why should we ask for the doctor’s help? That’s the way I see it. And also, experienced nurses can tell me more, if it is within our domain of decision making.

- Jacqueline, Formal Interview
This suggests that several referrals are made directly to other nurses rather than to doctors specifically because nurses feel that in certain issues, such as those specified in Box 5.8 below, they are more knowledgeable and have a greater level of expertise than doctors. This also confirms that the type of knowledge of these two professional groupings is reasonably distinct, a point which was introduced in Section 5.2.4.

- Mouth care
- Infection prevention and control
- Pressure sore prevention
- Management of ventilator weaning (but usually after receiving the go-ahead to start the process by the consultant)
- Non-invasive measures of improving ventilation (e.g. positioning)
- Care of invasive lines (except insertion)
- Wound management

**BOX 5.8**

*Examples of procedures which critical care nurses consider as being within their domain, and therefore about which they prefer to seek help from another nurse, rather than from a doctor.*

This emphasis on certain areas being within the nursing domain and not wanting any ‘interference’ from doctors in them suggests that the desire for some degree of autonomy can be extended from the self to the professional group. A similar collective sense of esteem also motivates nurses to participate in decisions taken about patient management:

*We show them that we are able to understand the physiology behind certain things. We are not ignorant: we are nurses. We are educated; we have university degrees...some of us are reading for a master’s degree. So we are not empty minded and can make decisions.*

- Judith, Formal Interview

*So I think that when it comes to emergencies, the nursing say is always there. We, nurses, are usually the ones who identify an emergency. I think that if you know your patient well, you will be able to say how the patient is doing...you will anticipate from beforehand.*

- Judith, Formal Interview
While the data in the previous subsection indicated that some degree of autonomy at an individual level is associated with a sense of professional satisfaction, this subsection suggests that seeking help from other nurses, rather than from doctors, is similarly associated with a sense of collective esteem\textsuperscript{137}. In particular, when seeking help from a member of his/her own professional group, the individual nurse would not be taking a decision independently, but nurses, collectively, would be. Hence, seeking help from a nurse colleague, rather than from a doctor, is indirectly related to the desire for collective autonomy\textsuperscript{138}.

In summary, the need for a certain extent of both individual and collective autonomy in certain aspects of patient management is an important motivator for nurses’ decisions to act without referring to doctors, and a source of professional satisfaction\textsuperscript{139}. However, such efforts at enhancing independent practice at an individual and collective level are hindered by several other factors. These are discussed in the next subsection.

### 5.3.6 Factors limiting autonomous practice

Despite their frequently expressed desire for individual and collective autonomy, there are several factors which impede nurses from making decisions without consulting doctors. These limits to autonomy are discussed in this subsection.

First, as explained in Section 5.2.8, there are several aspects of critical care in which nurses acknowledge that doctors possess more technical expertise and/or knowledge, such as the insertion of invasive lines and tubes and the management of rapidly deteriorating patients. In such instances of negative information asymmetry, independent practice is not possible and a decision to seek medical help would be taken because acting in the patient’s best

\textsuperscript{137} Collective esteem refers to the feelings of self-worth that one derives from one’s group membership (Garcia & Sanchez, 2009).

\textsuperscript{138} From a sociological standpoint, collective autonomy can be considered as an example of macro-level agency (Ritzer & Goodman, 2004). This is discussed in the context of the factors enhancing and constraining nurses’ moral agency in the next chapter (Section 6.4.5).

\textsuperscript{139} These points are congruent with the findings from recent surveys among critical care nurses from various European countries indicating that work satisfaction is associated with the extent of perceived autonomy (Papathanassoglou et al., 2012) and with the extent of nurse-physician collaboration (Karanikola et al., 2013). These studies also indicated that low levels of perceived autonomy and poor nurse-physician collaboration were related to a higher incidence and severity of moral distress.
interest (patient agency) is considered to be a much stronger motivator than the need for autonomy.

Second, there are several areas in which nurses feel that they are capable of acting autonomously, but about which they do not feel empowered to take action prior to seeking authorisation from a doctor. In these instances, the desire to acting autonomously is limited by the need to follow the *principal-agent* contract with medical practitioners, about which nurses are constantly mindful. This was discussed in detail throughout Section 5.2.

Third, the extent of nurses’ autonomy varies significantly according to the characteristics of the respective consultants. Indeed, while some consultants (and other doctors) allow, and actually expect, nurses to take certain decisions on their own, others insist on having the final say on virtually all decisions about a patient’s treatment modalities. In other words, there are different extents to which different principals (consultants) *scrutinise* their agents (nurses). This was explained, with examples, in Section 5.2.3.

Finally, but particularly significantly, nurses’ desire to act autonomously must be discussed in view of the fact that, in several instances, help is sought in view of the responsibility, risk or consequences accompanying one’s decisions. For example:

*Jeremy shares his concern with a neighbouring nurse and asks her whether, like him, she thinks his patient has deteriorated over the last few days since they have last seen her.*

- Field Notes, Observation Session 3

*Susan approaches the patient from the left hand side and...checks the patient’s neurological status: flexion of arms to pain; pupil reactivity. Immediately, she asks me to double the check pupil reaction with her to make sure her assessment was correct.*

- Field Notes, Observation Session 4

*If you stay thinking about their [doctors’] reactions [to your referrals] you go crazy; I don’t think about it and just tell them what I feel I need to tell them. Then it’s off your mind and you can get on with your work; that’s it! Then it’s up to them and, if anything happens, you know that you have told the doctors about it, full stop. Your mind would be at rest that you are covered.*

- Sally, Formal Interview

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In the first two incidents above, nurses’ verification of their observations with another nurse may be interpreted as a means of *sharing the responsibility* of their assessment with another person. Furthermore, the quote from the third data segment explicitly states that nurses may seek a doctor’s help to get things “off their mind”, suggesting that some referrals are made to actually *transfer risks* to another person\textsuperscript{140}. Conversely, when nurses act independently, the possibility of such responsibility sharing or risk transfer is lost, with some nurses actually arguing that work is less stressful when they have to make fewer decisions autonomously:

*In a way, with those consultants who expect to take every decision themselves you have to verify and this allows you to be more relaxed while working. You have to do the work as usual, but when it comes to making decisions you are constantly liaising. So, as such, you don’t need to worry too much or to think too much...When working without consulting doctors you have to plan things much more carefully, which is more difficult.*

- Simon, Formal Interview

*During our conversation about the timing of the consultant’s ward round, Sally states that discussing her concerns about the patient during the ward round puts her mind at rest much more than having to make the decisions herself.*

- Sally, Informal Interview

Indeed, the concepts of sharing and transferring risk were confirmed by several participants during the focus group sessions, as illustrated by these two data segments:

*[Referring is] also a form of support because if I am going to do something, I need the doctor to tell me ‘OK, do it’. Otherwise, if the consultant arrives and I hadn’t informed anyone about changes I would have made something with which he might not agree and that might put me in a very [awkward situation]. But if the doctor on duty agrees with my decisions, then I feel more confident. So if the consultant confronts me, the other doctor would say ‘I told her to do that because of these reasons’.*

- Susan, Focus Group 2

\textsuperscript{140} In a study about midwifery students’ recognition of and response to patient deterioration (Scholes et al., 2012), it was similarly noted that once they had called for medical help, the students’ response to the haemodynamic deterioration slowed considerably, suggesting that, like the nurses in the present study, the participants “relaxed” once help had been summoned. The former study, however, specifically dealt with midwifery students’ response to a rapid deterioration in the patient’s condition, while the present study looked at nurses’ decisions to seek medical help in general.
JACQUELINE: Yes, it’s like that...you transfer the risk

JACQUELINE: I would like to add something about risk sharing. I attended an advanced life support course, and there was an English anaesthesiologist and he said: “Rule number 1 in ICU is: share the blame...always share the blame...never leave it to yourself...it doesn’t matter [with] whom, but always share the blame...”

MODERATOR: So probably it’s not just for nurses...

JACQUELINE: No, for doctors as well...this is their rule: always share the blame; never to take decisions on your own.

- Excerpt from Focus Group 2

In other words, the responsibilities assumed by acting autonomously are invariably accompanied by additional risk. These risks often overwhelm the desire for autonomous practice making referral to another nurse or to a doctor inevitable, as illustrated by the following examples, related to referring to doctors during the setting up of a portable mechanical ventilator and prior to extubation respectively.

[With reference to an event observed during the previous observation session:] I have no doubt that I could have set it [the portable mechanical ventilator] appropriately, because it’s not exactly the first time that I am preparing for patient transport. However, had any problem cropped up – and it could easily have, as you are aware – I wouldn’t want anyone to say: ‘who set up the ventilator?’ And the anaesthetist would say: ‘they didn’t ask me about it’. I can’t tell them: ‘I arranged it’... I know I am able to do it, but, in order to cover ourselves and do things as should be, I prefer not to set it up on my own.

- Simon, Formal Interview

When extubating a person in ICU, I think you should have a doctor as a witness...because the decision to extubate is quite a major one confirming the patient’s stability...When a patient is freshly extubated, several things could happen. So the witness would confirm that I did proper suctioning, like I was doing, and that I put the patient on 15 litres non-rebreather mask, and that the extubation was carried out properly, so that then if something happens no one would say: ‘Listen, you didn’t suction the patient while he was being extubated’. If

141 Methodologically, this excerpt illustrates how I used focus groups for member checking and to gauge phenomenon recognition about concepts that I had come up with during the analysis of earlier data [in this case risk sharing and risk transfer]; refer to Section 3.6.2.

142 A portable ventilator is normally used to provide or assist a patient’s breathing while transporting him/her to a different unit; e.g. during the transfer of a patient from the ICU to the radiology department or to an operating theatre.
something goes wrong, the consultant might say: ‘This patient was doing well and now she went into CPR and she has brain damage. What happened?’ What are you going to tell him? Will you tell him that you extubated on your own? That is why I insist on having a doctor as a witness.

- Judith, Formal Interview

Such risk aversion\textsuperscript{143}, therefore, constitutes another important determinant in nurses’ decisions about whether to take certain actions without referring to doctors, particularly because referral enables nurses to share or, indeed, transfer some of the risks related to their actions to a member of the medical profession. Consequently, balancing the desire for autonomy with risk aversion constitutes another duality underpinning critical care nurses’ decisions about seeking help from doctors. The appeal of working independently motivates nurses not to seek help from doctors while the need to prevent risk, for themselves and the patient, stimulates them to refer.

5.3.7 Summary of factors promoting and hindering independent practice

This section has identified patient agency, altruism towards doctors, unavailability of medical help and, most significantly, nurses’ desire for individual and collective autonomy as principal determinants for nurses’ decisions not to seek help from doctors. Nonetheless, several structural constraints (most notably, nurses’ role of acting as medical practitioners’ agents), their acknowledgement of depending on doctors’ knowledge in specific aspects of critical care, as well as their need to share or transfer risk to another party make autonomous practice untenable in several areas of care. The amount of risk each nurse is ready to take subsequently determines whether the need for such risk aversion overwhelms the desire for acting autonomously. The factors enhancing and hindering independent practice discussed in the present section are summarised in Figure 5.8. The next section presents several factors which influence nurses’ decisions about which persons to seek help from.

\textsuperscript{143} Originally used in the investment sector, risk aversion refers to the “reluctance of a person to accept a bargain with an uncertain payoff rather than another bargain with a more certain, but possibly lower, expected payoff” (Wikipedia, 2013b). Likewise, several nurses prefer taking the less risky options of referring to another party, even though, as indicated in the previous subsections, autonomous decision making has a potentially higher professional satisfaction.
Figure 5.8 – Factors promoting (+) and limiting (-) independent nursing practice
5.4 DECIDING WHO TO SEEK HELP FROM

The previous section identified collective esteem and the desire for some degree of independent practice as factors which prompt nurses to seek the help of another nurse rather than a doctor. It was also made evident that a fairly clear distinction can be made between the type of knowledge and expertise held by nurses and doctors, and that, consequently, nurses partly decide whether to seek the help of a doctor or another nurse on the basis of the type of knowledge they are looking for (refer to Sections 5.3.5). The present section will discuss other factors which influence nurses’ decisions about who to make referrals to, including some motivators for seeking help from consultants, other doctors and other nurses. Attention will also be given to factors determining whether nurses attempt to influence decisions about treatment modalities and to nurses’ perceptions of the value that doctors ascribe to their input in decisions.

5.4.1 Type of problem

Whether help is sought from another nurse, any doctor or specifically the consultant partly depends on the type of problem encountered. Indeed, certain decisions, such as the transfer of patients to a less intensive setting, are taken almost exclusively by consultants and, as such, referrals related to such decisions are made directly to them:

There are some things which you must ask the consultant about and there are others which you can refer to one of the other doctors, not to the consultant. Regarding whether to remove a central line [which had been observed in the previous observation session], I knew that I wouldn’t have had a definite answer from the other doctors. There are other things which I would specifically ask a consultant. For example, sometimes I ask consultants why a patient who is improving is still here in ICU…to get to know what is the exact problem so as to help her improve. That is something which I have [often] asked consultants about, because they are the ones who hold the ultimate decision about transferring patients [from ICU] to another ward.

- Sally, Formal Interview

A particular example of seeking a consultant’s help in relation to a patient’s discharge from ICU, in this case involving a foreign patient being flown to his country of origin, was observed in practice. The following field notes refer:
At this point, the patient brings up a new subject by asking about when he would be able to fly back to his home country. Almost instantly, Sephora decides to ‘go and look for the doctors’ [her words] to discuss this issue. She explains the situation to one of the senior doctors [not the consultant] but he tells her: ‘I don’t know; I will speak to M [the consultant] about it’. At this point I ask Sephora whether she prefers to refer such problems to specific doctors. She states that in this case she would follow this up with the consultant because, in the case of the transfer of a patient to another country, the decision and arrangements would invariably have to be made by the consultant. Indeed, during visiting hours, while speaking to the patient and his relative about their wish to have him flown to his home country, Sephora decides to ask the consultant to speak to the relative about the possibility of a flight home. She phones him up [at the doctors’ room in the same unit] and explains the situation. In the subsequent formal interview, Sephora confirmed that the consultant had started making arrangements about this transfer soon afterwards.\textsuperscript{144}

- Field Notes + informal interview segments, Observation Session 1

Conversely, certain queries are specifically not referred to consultants because they are considered too ‘trivial’. For example, queries about the administration of medications would usually be referred to another doctor or to a more experienced nurse:

Sally also qualifies that if in doubt about potassium supplementation, she would ask for a doctor’s advice. Asked whom she would ask for help in such a circumstance, she said that she would definitely “not bother” the consultant with something “as trivial” as potassium replacement.

- Field Notes and Informal Interview, Observation Session 2

Table 5.5 uses data excerpts from this and previous sections to illustrate how nurses’ decisions about whether to seek help from consultants, from other doctors or from other nurses is partly based on the type of problem encountered, and the area of expertise of each.

\textsuperscript{144} This example further underscores the positional authority of the consultant in this setting (refer to Section 5.2.2).
### Transfer of Patients from ICU

There are other things which I would specifically ask a consultant. For example, sometimes I ask consultants why a patient is still in ICU and has not yet been transferred to another unit...only consultants decide that.

- Sally, Formal Interview

### Medication queries

If you have a doubt about potassium supplementation you can ask one of our doctors.

- Sally, Formal Interview

I would definitely not bother the consultant with queries about potassium supplementation.

- Sally, Formal Interview

### Queries about nursing procedures

For example, how to prepare a bag of heparinised saline, how many units of heparin should be added...there’s no problem in asking that to a junior colleague. And then, for example, I’m not so good in drugs, sometimes I would forget the generic name of certain drugs. Something like that you can actually ask to anybody, not necessarily to someone senior.

- Simon, Formal Interview

### Transfer of foreign patients to their home country

The relative came up to me and said: ‘Listen, what about transfer back to the UK?’ ... I would refer something like that to the consultant, even if I don’t feel comfortable doing so. I knew it had to pass through the consultant. Actually, I tried to pass it through a senior registrar but he told me that he has to ask the consultant. In fact, they immediately started making arrangements as soon as I spoke to the consultant about it.

- Sephora, Formal Interview

### Queries about ventilator settings

For example, you can ask one of the other doctors about oxygen reduction.

- Sally, Formal Interview

### Nursing care

In our course of studies we cover more of these aspects [wound management, mouth care, pressure sore prevention] than if we would have studied medicine. In medicine they have got their curriculum; it is what it is. Ours is different; I think that’s what makes us nurses after all...I think a nurse would have better judgement, for example, on how to perform wound care, rather than what the doctor could tell me.

- Jeremy, Formal Interview

### Removal of Invasive Lines

Regarding the removal of central lines, I knew that I wouldn’t have had a definite answer from the other doctors...so I decided to check it out with the consultant.

- Sally, Formal Interview

### Management of Invasive Lines

There are certain things that...are part of nursing care not doctor oriented ...for example, care of a central line...OK, doctors insert a central line, but in my opinion that’s as far as it goes...nurses would probably have a better answer then a doctor would, or a nurse will look at it from a different perspective.

- Jessica, Formal Interview

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**Table 5.5** – Type of problem and type of knowledge as determinants of nurses’ decisions about who to seek help from [based on data reported in this and earlier subsections].
This subsection has presented the type of problem as a determinant of nurses’ decisions about who to seek help from. The next subsection identifies other important issues in this decision, as well as factors determining whether doctors give value to nurses’ input in decisions.

5.4.2 Perceptions about the other party

It is evident from the data that doctors and nurses frequently judge the clinical competence, decision making skills and attitudes of other members of the team. For example:

_I think that just as we, nurses, make certain judgements about certain doctors – for example, sometimes we say: ‘hmm, that doctor is nice to us’ – likewise they, too, make judgements about nurses’ competence. It is part of human nature, I think._

- Judith, Formal Interview

_Doctors are not stupid; they know that some nurses are better than others. But ultimately, judging is something which we, nurses, do between us as well. When we’re allocating patients, for example, the outgoing head of shift would tell you: ‘Make sure you allocate someone sensible to this patient, because he’s difficult to manage’. So even we classify our own nursing colleagues according to who is competent and who is not so competent._

- Simon, Formal Interview

_JACQUELINE: I observe doctors asking ‘which [nursing] shift is coming on duty now?’_  

_SEPHORA: Even asking which nurse is in charge... it’s not right..._  

_JACQUELINE: It’s not right, but they feel it. They go and see which nurse, or which patient..._  

_SEPHORA: ...But we tend to label ... for example, I have an impression of you as a whole person, a label, a trustworthy professional etc. Then there is a person who is irresponsible, you know, careless...when you look at the person you can actually label the person. So doctors do label nurses for sure._

- Excerpt from Focus Group 2

In other words, there are different extents to which doctors and nurses trust each other in terms of patient management. In turn, trust is one of the factors which determine nurses’ decisions about who to seek help from. For example:
With him [making reference to a specific doctor], when I ask for advice, even though I haven’t been working here much, I can tell that I am going to get a really good answer, good advice, knowledge. But there are other junior doctors – I’m junior as well, mind you – about whom I say: ’I’m not going to gain much if I were to ask him; I am going to stay where I was’.

- Jeremy, Formal Interview

You do choose whom to ask for help. First of all because you would know that one person is more competent than another. For example, we have some junior doctors; it’s true, they are still doctors at the end of the day, but if you see a senior doctor, you would ask him first, mostly because you know that he or she is more competent. Then there are others whom you trust so much that you would automatically seek their advice because they put your mind at rest. Basically, their patient management is admirable and you would be certain that their advice would be sound.

- Simon, Formal Interview

JUDITH: In ICU you have to look for people who have really grasped certain concepts…they understand those concepts and understand what’s going on. You might have been working here for a long time but still haven’t grasped those.

JOHN: I think that you have to show that you know what you’re doing.

JUDITH: It works both ways, actually, because I have seen doctors who don’t appear to have a clue, and I would prefer not asking them for help.

- Excerpt from Focus Group 1

Hence, nurses prefer seeking advice from doctors whose clinical decision making skills they admire, not only because this is a source of learning, but especially because seeking help from someone whom they consider knowledgeable and competent ultimately benefits their patients. This type of judgement of another person’s knowledge and competence is also used when choosing whom to refer to from among nurse colleagues. For example:

Even when you are still inexperienced, you start to realise which nurses are more competent than others, I think. So you naturally would prefer to ask those nurses for help.

- Simon, Formal Interview
Whenever I find myself in situations in which I am not experienced and I don’t know what to do, I go to ask a senior nurse first...a senior nurse who is reliable, mind you!

- Judith, Formal Interview

Let’s say I have any problems with a machine; usually the only one to whom I ask questions is R [a nurse within the same shift], because he is the only one that I trust. So I go and ask him. He is the most competent regarding the ICU environment and how to care for ICU patients; he is the most reliable person in this regard.

- Jennifer, Formal Interview

The fact that nurses prefer to seek help from and refer to doctors and nurses whom they consider to be more competent can be considered to be driven by their role in acting as their patient’s agent (Section 5.2.6). Indeed, as suggested by the latter quote, in seeking advice from trustworthy colleagues, nurses believe that, ultimately, it is not only they but especially their patient who would be benefiting. Similarly, the extent to which doctors trust a nurse’s competence appears to affect the value that they give to nurses’ contributions to decisions about patient management, as evident from the following excerpts about junior nurses’ experiences of referral:

I told the doctor: ‘The patient full of secretions...we’re suctioning all the time’. I told him: ‘How are we going to suction if we take out the tube?’ The patient was weak as well, so I felt he was unable to expectorate. And I made it clear to the doctor that he was not ready for extubation, but he insisted. But that’s where the value of experience comes in. I called a colleague with whom I get along well – she’s a couple of years more senior – and I told her about the situation and she told the doctor: ‘He’s not ready’. And when she said it...the doctor decided not to extubate. That’s why experience is helpful, because when she said the same things that I had said, he didn’t extubate and said: ‘OK, we will not extubate’.

- Jeremy, Formal Interview

I had this very unstable patient who was meant to go to [the operating] theatre...At ten or half ten the patient started deteriorating. I told the consultant: ‘Listen, I don’t think she is fit for theatre’. But she was adamant: ‘We’re going to theatre; increase noradrenaline, do what you have to do, but this patient is going to theatre’. I prepared the bed and everything to go to theatre and I was saying to myself ‘this patient is going to die on the way’ and again I said: ‘Are you sure you want to go to theatre?’ The reply was the same as before: ‘Yes, we are going, bluh, bluh, bluh...’ Then another [more experienced] nurse came and said: ‘Are we really sending this patient to theatre?’ She didn’t say: ‘Listen, I don’t think ...’ She
just made a simple comment like: ‘Are you sure she’s not going to arrest on the way?’ Then the consultant immediately changed her mind. She phoned the relatives, explained to them what had happened and said: ‘We are not going to send the patient to the theatre; we’re going to leave her here’...so my word meant nothing...But this other nurse was a head of shift, so I’m sure it had something to do with it...And you feel like saying: ‘Haven’t I been telling you the same thing?’ OK, I haven’t been here so long but I knew; I could see it for myself. I didn’t need someone else to point out to me that this patient isn’t fit for theatre.

- Jessica, Formal Interview

In the examples above, these minimally experienced nurses were unsuccessful in convincing a doctor not to extubate a patient and not to immediately transfer a patient to the operating theatres, while more experienced nurses were successful, even though they based their arguments on the same reasons. Thus, it appears that doctors give more value to the input of experienced nurses. In the examples above, these minimally experienced nurses were unsuccessful in convincing a doctor not to extubate a patient and not to immediately transfer a patient to the operating theatres, while more experienced nurses were successful, even though they based their arguments on the same reasons. Thus, it appears that doctors give more value to the input of experienced nurses. A similar experience was shared in the informal interview with another participant with less than two years’ work experience in the unit:

She mentions a recent example in which, during night duty, her patient was deteriorating (poor breathing rate on CPAP mode and bradycardic on an amiodarone infusion). She suggested changing the ventilator to SIMV mode and also discontinuing the amiodarone infusion. However, the minimally experienced doctor on duty refused, urging her to leave things as they were until the consultant arrived for her midnight ward round, despite her insistence and the patient’s deterioration. Eventually, Jennifer informed the nurse in charge of the shift. The latter, informed the doctor that she was going to make some changes (the same ones which Jennifer herself had suggested!) and, actually, started making the changes herself. The doctor now agreed.

- Jennifer, Informal Interview

The actions of the senior nurse mentioned in this quote were elaborated upon in the subsequent formal interview with the same participant:

145 In a different context but using similar strategies, the critical care nurses in Chase’s (1995, p. 160) study involved more experienced nurses and eventually more senior doctors in an effort to influence medical practitioners’ decisions, a strategy which she calls “rallying the troops”, while in Henneman et al.’s (2010) “involving another nurse or physician” was used as a strategy in stopping or correcting errors made by doctors.

146 CPAP is a mode of mechanical ventilation which allows the patient to determine how many breaths to take every minute and how much air to exchange during each breath. It is normally used during the weaning process and requires a certain degree of haemodynamic stability.

147 Bradycardia is a heart rate which is lower than normal.
She [the senior nurse] just acted...she just changed the settings and infusion in the way I wanted to change them; she just did it. So, yes, experience helps to influence decisions taken by doctors because I think that if you have experience you feel more confident to insist on your own idea. If you have, let’s say, one year’s experience since you graduated, you won’t be so confident because if you suggest something you have to be ready to answer questions like: ‘Why do you think so?’ ‘Did you think of any complications?’ And you have to be ready to answer all these questions that can pop up in the doctors’ minds. So I do think that doctors trust experienced nurses more.

- Jennifer, Formal Interview

Indeed, as pointed out by an experienced practitioner:

Trust really matters. A doctor and a nurse who know each other communicate well, and they have developed a trusting relationship...the doctor is sure that this nurse will effectively manage the patient, but for a nurse who is not experienced, it’s different. New nurses are still forming their relationship...

- Susan, Focus Group 2

These incidents underscore the influence of nurses’ experience and positional authority in the extent to which doctors value their input in decisions about a patient’s treatment modalities. Yet, although very significant, experience is not the only factor which determines the extent to which doctors trust nurses and value their input. A minimally experienced nurse, for instance, explained how her input in decisions is valued because she generally feels trusted by doctors, despite being a junior nurse. According to this nurse, doctors are much more likely to value a nurse’s contribution if s/he has demonstrated that s/he can effectively implement management plans, is very well informed about the patient, speaks up if s/he has any concerns or suggestions about patient management, and engages in discussions about patient management:

I think what counts most in gaining a doctor’s trust is that we keep the patient as stable as possible, and that we really speak up for the patient when necessary. And when they [consultants] tell us to do this, we do it, rather than not taking any notice of what he [the consultant] is saying. If the consultant tells me: ‘You have to do this’, I just do it, you know? And I suppose he says: ‘Look, she is working well...she is doing what I’m telling her’. And then he will count on what I will be telling him. Also, in the ward round I never stay passive, letting them [doctors] speak without saying anything. I think that’s the worst thing to do. We have to take an active interest in what is being discussed. It’s true that they don’t always consider your input, but they frequently ask you, and I think we should always have an answer and if we don’t have an answer we look for it. I think that’s what determines whether they listen to you or not. And if you know that your patient is
very unstable, I think the first thing I do is read a bit how he was, his history, what
the patient has, so I would know what to expect, not blindly start taking care of the
patient without knowing what happened. In this way, I can participate in decisions
and the doctors would listen to me.

- Judith, Formal Interview

Apart from the fact that it came from a minimally experienced nurse who nonetheless feels
trusted by consultants, this quote is particularly significant because it suggests that
consultants give more value to the input from nurses who are not only effective in
implementing their management plans (the nurse as the consultant’s agent) but are also
assertive enough to participate in decisions by bringing up issues which directly affect the
patient (the nurse as the patient’s agent). Similarly, according to another participant:

*Maybe the doctor knows that this particular nurse is very good at work and he can
trust him, but there might be other nurses, maybe inexperienced ones like myself,
and they don’t do things exactly as he expects them. And then he starts to be
selective...he does not trust everybody. There were instances in which a consultant
arrives and starts some procedure. He looks around and he sees a much more
senior nurse whom he trusts and tells him: ‘Come here, please; let’s do this’. He
or she doesn’t simply ask the nurse who is taking care of the patient, but
specifically one whom he or she trusts. Or else he talks to that nurse but at the
same time he calls another nurse whom he trusts. Sometimes it happened with
senior nurses as well, not just with inexperienced ones.*

- John, Formal Interview

*It works both ways...especially till you get to know the consultant and until you
prove to the consultant that you know what you are doing. There is one consultant
who really disliked me at the beginning and she used to make me feel like I don’t
know anything. Then once I had a really critical patient and I knew what I was
doing and I was asking sensible questions, and whatever they told me to do I
handled well, and I managed the patient really well. So after that, little by little, I
was seeing that she said to herself: ‘Ah ok, she knows what she’s doing’. So then
automatically, little by little, you start gaining their respect, and vice versa.*

- Jessica, Formal Interview

The first quote above confirms that consultants prefer working with certain nurses on the
basis of how much they trust their competence in effecting their plans, and that this is only
partly related to the extent of the nurse’s experience. The second quote illustrates how doctors’ trust is gained through incidents in which nurses demonstrate their capability in patient management, even if they are still minimally experienced.

On the basis of nurses’ impressions, therefore, it can be argued that doctors are more likely to “reward” nurses who, in their view, can most effectively act on their behalf by implementing their plans for patient management by trusting them in subsequent occasions. This lends further support to the notion of the nurse as the medical practitioner’s agent by acting on his or her behalf and medical practitioners as the principal by rewarding or sanctioning nurses on the basis of their effectiveness in acting as their agent (see Section 5.2.5). Furthermore, there appears to be a cycle of opportunity: assertive nurses who participate in discussions are perceived to be more trustworthy by consultants, and are subsequently involved to a greater extent in decisions about a patient’s treatment modalities, which further improves their confidence and self-esteem. These and other determinants of the development of trust were discussed with an experienced participant, who confirmed that experience was important, but certainly not exclusive, in determining how much doctors trust individual nurses; a nurse’s “track record” (to use his words) of working effectively is even more important:

> How long you have been working here really helps to obtain a doctors’ trust. Also, through experience, they [doctors] would know how each individual works. They are aware that there are nurses who are really good and others who are less good. And it’s not just a matter of experience: I know of nurses who have been working here for ages and doctors still don’t trust them at all. I see this myself. Sometimes doctors tell me: ‘Was so and so taking care of this patient, by any chance?’ Or: ‘this patient has really deteriorated…was that nurse allocated to her?’ Sometimes they are more critical than nurses deserve, but sometimes they are spot on. And I’m sure that it’s about the individual’s track record in patient management as

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148 A similar finding is reported in Hancock and Easen’s (2006) study, in which the participants claimed that nurses’ involvement in decisions essentially “depends on who you are” (p.700).

149 Doctors’ evaluation of nurses’ input on the basis of trust is based on nurses’ perceptions of this evaluation, and, since the focus of the present study was on nurses’ decisions related to seeking help, the verification of these impressions with doctors themselves was, admittedly, beyond the scope of the present study. Nonetheless, as discussed in Section 6.3.4, studies like that by McDonald et al. (2005) strongly support the concept of doctors determining the value of nurses’ input on the basis of trust.

150 These findings resonate with those of a study about the development of confidence among a group of British nurses with different level of expertise (Eraut, 1995, cited in Eraut, 2004). According to the author, “much learning at work occurs through doing things and being proactive in seeking learning opportunities, and this requires confidence. Moreover, we noted that confidence arose from successfully meeting challenges in one’s work, while the confidence to take on such challenges depended on the extent to which learners felt supported in that endeavour” (Eraut, 2004, p. 269; emphasis in the original).
well. They [doctors] know, individually, how we [nurses] work. They certainly observe; no doubt about that. They know, or, rather, they think – whether it’s true or not is a different matter – that certain nurses are great and other nurses are hardly competent at all.

- Simon, Formal Interview

To summarise, this subsection presented trust as a crucial determinant of the two main aspects of nurses’ referrals to doctors, both of which are motivated by their desire to improve patient outcomes, namely referring to doctors to seek their help and to influence their decisions. In addition, trust is important in determining: (1) nurses’ decisions on which other nurse or doctor to seek help from, and (2) the extent to which doctors value different nurses’ contribution to treatment modality decisions. Both aspects can be explained by the central notion of dual agency. By giving more value to suggestions coming from nurses whom they perceive to be more competent, medical practitioners are essentially rewarding and sanctioning their agents on the basis of their effectiveness in implementing a plan. Concurrently, nurses tend to prefer to seek help from doctors and from other nurses who, in their view, are more capable of aiding them to implement their role as their patients’ agents, by advising them about how to improve patient outcomes. The components of each of these two aspects are summarised in Table 5.6. Subsequently, the next subsection considers the importance of doctors’ reactions to a nurse’s referral as a determinant of the latter’s decision about who to seek help from.

<table>
<thead>
<tr>
<th>TRUST AS A BASIS OF NURSES’ PREFERENCE FOR REFERRAL</th>
<th>TRUST AS A BASIS OF DOCTORS’ VALUE OF NURSES’ INPUT</th>
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<tbody>
<tr>
<td>Perceived competence of doctor</td>
<td>Nurse’s experience</td>
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<tr>
<td>Perceived technical knowledge and skills of another nurse</td>
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<td>Doctor’s experience</td>
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<td>Other nurse’s experience</td>
<td>Extent to which a nurse is informed about patients</td>
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<td>Past episodes in which the nurse effectively implemented management plans</td>
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Preference to seek help from doctor or nurse who can most effectively help nurses in their patient agency role

Table 5.6 – Dual agency and nurses’ construct of trust: Nurses prefer seeking help from persons who are more effective in helping them in their patient agency role while medical practitioners give more value to input from nurses whom they consider as effective agents.
5.4.3 Other party’s reaction to nurses’ request for help

Several nurses claimed that, when deciding whether to seek help from a doctor or from another nurse, they give substantial consideration to the anticipated reaction of the person from whom that help is sought. For example:

*As a nurse, I’m more comfortable talking to another nurse, because he or she would know what I do. Another nurse would know what our limitations are, what’s our advantage and everything. So I prefer talking to another nurse who is compatible with you and with whom you get along well. He or she would offer much more help, and not pressure you ... A doctor, even if he gets along well with you, might say something like: ‘Listen, why didn’t you do this? Why didn’t you do that?’ You know: pressure...adding pressure.*

- John, Formal Interview

*I think that you won’t feel so comfortable approaching doctors, especially at the beginning, because initially you would feel very inferior to them; your knowledge level would be a disaster while they’re so knowledgeable. Let’s face it: almost all of them are good doctors. In the beginning you would feel...at least I used to personally feel somewhat intimidated by doctors.*

- Simon, Formal Interview

This suggests that it is generally preferable to seek help from another nurse rather than from a doctor if the situation permits. Indeed, some nurses’ concern about doctors’ reaction to their requests for help compels them to make such referrals “through” another nurse:

*One other thing: sometimes nurses ask other nurses to ask the doctors. It happens to me a lot. Another nurse would say: ‘Jacqueline, you are OK with the foreign doctors...can you ask them this and this and this? Can you phone them?’ For example, with this particular doctor I get along quite well so I would ask him something on another nurse’s behalf. And similarly, when I am not OK with somebody, I ask my head of shift to approach a doctor with my query.*

- Jacqueline, Focus Group 2

However, it is not necessarily the professional grouping per se that determines this preference; in fact, some participants declared that they preferred to seek help from certain doctors rather than from certain nurses:
I generally feel much more comfortable discussing with a nurse, but I want to make it clear that this does not count for all doctors and all nurses either. For example, the colleagues that were near me today are the ones I feel most comfortable with; we are close even outside work...So we even speak on personal terms, so I feel comfortable in asking them for help. I don’t feel stupid when asking for their help; I feel I can ask anything I need to ask because I feel they are not going to intimidate me. With some other nurses, I learn and get advice, but I get it in a way which makes me feel degraded. I notice that when I ask some people for help they are thinking: ‘Do you really not know that?!’ And it makes me feel discouraged and uncomfortable. Then my confidence, the little I have, declines even more. And it depends which doctor is present as well, because with some doctors I don’t mind asking because I know they are going to help me...So it’s not only a matter of whether it’s a nurse or a doctor; it is a matter of the specific individual.

- Jeremy, Formal Interview

But there are some nurses that really make you feel really stupid so, as much as possible, if I can avoid them, I will definitely avoid them, and in that case I will ask a doctor before asking them.

- Jessica, Formal Interview

Thus, it is evidently the approachability of the other party, rather than the professional grouping per se, that is the stronger determinant of whether nurses’ prefer to seek help from a doctor or from another nurse. Indeed, as evident from the quotes in Box 5.9 nurses also make deliberate choices about which specific nurses to seek help from and which ones to avoid when in need of help.

In my early days at ICU, when nursing ventilated patients I used to continuously ask for help, for every single thing, both to doctors and to nurses, but especially to nurses first...not any nurse, but those whom I used to understand when they tried to explain things to me...those with whom I used to feel comfortable.

- Sally, Formal Interview

And even from among nurses, I choose who to talk to. There are certain colleagues [nurses] I don’t feel comfortable with, and others that have been working here as much as I have, but I don’t feel comfortable asking them. It depends on whom you ask.

- Sephora, Formal Interview
Their approach to you and how they respond makes a difference...because there is a way of responding: that you want to teach the person. Then there is another way of responding: ‘Are you actually asking that?!’ [sarcastically] Some people have a way of just making you feel [degraded]...extra comments that can really be avoided, that make you feel like...because they’ve been here longer than you they know everything...like you shouldn’t ask because you should know it by now.

- Jessica, Formal Interview

When asking certain nurses for help, I felt humiliated...all my questions were regarded as very stupid, as if I am an alien, and they don’t know which planet I’m coming from. So in my previous shift I preferred to ask only these five nurses who were approachable...you don’t need to be very experienced to see who is willing to help you and who is not willing to help you.

- Jacqueline, Formal Interview

Initially I try to ask those two, three, four people I feel most close to. And sometimes I would be working here, and they would be working in different rooms and areas, and I would still go over there to liaise with them, because I feel more comfortable with them.

- Jeremy, Formal Interview

I’d done it; I’ve done it!...I will be in one of the cubicles in the 12-bedded area151 and there is no one who is as approachable as I would like them to be nearby...so I ask someone to watch my patient and I go to the 8-bedded area and I ask someone who I know isn’t going to judge me for asking what I’m asking and isn’t going to treat me like I’m stupid...which sometimes is really frustrating if you have to go all the way to the 8-bedded area just to ask a question. At the same time it is also sad that you can’t feel confident to ask something to your own colleague.

- Jessica, Formal Interview

There are some nurses who just ask the person next to them, while there are others who come from the other side of the unit to ask you specifically. But everybody has his own buddy, with whom he or she feels comfortable. This happens mostly with certain nurses who are a bit timid, so if they are used to asking you for help, they come to look for you immediately. But that is what I used to do as well when I was less experienced.

- Sally, Formal Interview

BOX 5.9

Perceived approachability as a determinant of nurses’ decisions about which other nurses to seek help from

Thus, perceived approachability determines not only whether nurses seek help from a doctor or from another nurse, but also which specific nurse to seek help from. As evident from the latter three quotes, this consideration occasionally compels some nurses to go to another side of the unit specifically to seek the help of other nurses whom they perceive as more approachable.

151 As explained in Chapter 1, the study took place in a 20-bedded ICU made up of two areas (an 8-bedded and a 12-bedded section) facing each other, with a corridor in between.
Several nurses remarked that seeking help from doctors could have additional consequences, when compared to requesting help from other nurses. For example:

*I think we shouldn't ask very obvious silly questions to doctors. I think we should first clarify things a bit between ourselves.*

- Judith, Formal Interview

*I prefer [to ask nurses for help]...because I feel that doctors, especially consultants, in their mind they’re way above you so if you ask something that is really trivial they might say: ‘This one really doesn’t know a thing!’ But with a nurse it is much less of an issue because basically you are on the same level.*

- Jessica, Formal Interview

*Whenever I am in doubt about something, first I go and ask a senior nurse before going to the consultant, because that would hold my reputation, you know? [giggles]...I won’t ask him immediately...First I will ask an experienced colleague and she would tell me: ‘Listen, we manage this thing in this way’, like she told me this morning. In this way, when I ask the question to the consultant I would feel confident that it isn’t a silly question; I have already done my homework, sort of.*

- Judith, Formal Interview

This had, indeed, been observed during the observation session with the same participant:

*Judith asks the nurse in charge about whether she should drain the nasogastric tube through which activated charcoal had been administered earlier on. The senior nurse advises her to clarify this with the consultant.*

- Field Notes, Observation Session 9

Subsequently, nurses’ perceptions about doctors’ judgement of their competence on the basis of their referral is an important determinant in the decision about who to seek help from, particularly in areas in which nurses are expected to be knowledgeable and proficient, as evident from the quotes in Box 5.10.
If you are checking your patient’s blood results, for example, and you notice that the creatinine is a bit high, you ask yourself: ‘shall I supplement potassium?’ You wouldn’t ask the doctor about that, because you’re expected to know the answer. So I would look for Simon or Sally, for example, and ask one of them.

- Jeremy, Focus Group 1

There are young nurses who don’t want to take the risk to ruin their reputation in front of doctors by asking questions; they like to act autonomously on their own judgements, even without asking experienced nurses in ICU. They decide to act themselves, without any second thoughts...just because they don’t want to ruin the reputation, which is not safe at all.

- Jennifer, Focus Group 2

I used to suffer a lot from that: thinking about what my colleagues would say, what the consultants would say, what the doctors would say, what the patient would say. It’s from everywhere, you know? You often feel stupid, especially when they tell you ‘Can’t you take a decision? Don’t ask me stupid questions?’ We all have this risk.

- Jacqueline, Focus Group 2

So if you know that you get on very well with this colleague, you just ask him...he might still think that you are a bit stupid but you get along well with him so he’ll be ready to help. Even if he tells you: ‘Are you stupid? What are you doing?’ You wouldn’t get offended because you know him or her well. So going to the doctors immediately is not a good idea because then you might lose their trust...The consequences are much greater [than if you were to ask nurses]. Maybe everything occurs subconsciously but it’s there...because with your colleagues, doing the same work and sharing everything, you know that if you feel stupid with them it’s no big deal...

- John, Formal Interview

BOX 5.10

Reputation risk: Examples of nurses’ considerations of doctors’ judgement about their referral as a determinant of the decision about who to seek help from

The concerns expressed by these participants about doctors’ possible judgement of their questions can be interpreted in the context of consultants trusting nurses to act as their agent (discussed in the previous subsection). In fact, from these quotes it appears that nurses are actually considering the possible consequences of seeking help from doctors (and especially consultants) about certain ‘trivial’ issues on the latter’s impressions about their competence, and subsequently on the extent to which doctors would trust them and value their contribution to decisions about treatment modalities. In other words, seeking help from

152 These quotes confirm that seeking the help of another professional is accompanied by the “social cost” of acknowledging one’s limitations (Lee, 2002), a point which also emerged in Cioffi’s (2000) study about nurses’ decisions to call the medical emergency team in an Australian teaching hospital.
doctors carries a much higher reputation risk than seeking help from other nurses. Consequently, as indicated in several quotes above, rather than approach doctors immediately nurses often prefer filtering referral to doctors through other nurses, particularly through more experienced ones, so as to determine whether something would need to be referred to a doctor or not. More examples of such filtering are presented in Box 5.11.

When I was just starting [to work in ICU], I would ask a senior nurse: ‘What do you think?’…for example, just before the ward round comes.

- Susan, Formal Interview

I know it’s funny, but I wouldn’t want to look stupid in front of doctor [‘embarrassed’ giggle]. So first I ask my friend [another nurse]: ‘Listen, shall I ask the doctor about this or is it stupid if I ask?’ So, yes, I think twice before I ask certain things to doctors.

- Sephora, Formal Interview

Let’s say my patient has a wound: I am washing the patient and I see a pressure sore, or the patient has a rash after we start an antibiotic or another medication. First, I check it with my colleagues so that I’m sure…to confirm; and then I inform the doctor.

- Susan, Formal Interview

Obviously, with things like Prisma or dialysis, things that I really am not that experienced in, I prefer to have more support. But then I don’t ask the doctor directly; I ask an experienced nurse…if they are not able [to help me] I ask the doctor.

- Jacqueline, Formal Interview

When I was less experienced and had queries about mechanical ventilation, I always approached the nurse first. Then, if the nurse was unable to help, I would go to seek the doctor’s help.

- Sally, Formal Interview

I would ask the doctor, but first I prefer finding another nurse and ask him or her: ‘What do you think? Would you ask the doctor about it?’

- Jeremy, Focus Group 1
When you’re still green and you have only just started working here you wouldn’t want to give the impression that you’re incompetent. So, yes, you would filter your referrals through other nurses. For example, when I had just started working in ICU I would prefer to approach Simon, rather than immediately ask the doctor, because Simon is an experienced and competent nurse. And then maybe I’ll still ask the doctor at a later stage.

- John, Focus Group 1

At the beginning you don’t even ask the doctor; first you ask the nurse to make sure that you are asking the right thing so that you have the blessing that you should ask the doctor.

- Sephora, Focus Group 2

**BOX 5.11**

Examples of nurses ‘filtering’ referral through another nurse motivated by the need to protect their reputation with doctors.

It also appears that experienced nurses are even more conditioned by the consequences of seeking help from doctors in areas they are expected to be proficient. For example:

_I certainly don’t like bothering the doctor when it is something straightforward. Because I am afraid they would say: ‘She has been working for such a long time! Why should she ask? She should take action’. Do you know what I mean? ‘She should take action without even asking; it is a straightforward case!’ And I don’t want them to think I’m not capable._

- Sephora, Formal Interview

_It [not seeking a doctor’s help] could be because you might not feel comfortable asking doctors for help...Some nurses are very timid and keep back from asking doctors and others can’t care less. Some don’t like to look stupid, while for others, if they look stupid it’s as if nothing happened. I, for one, do not like to look stupid. For someone like me it’s even worse because I have been working here for a very long time._

- Simon, Formal Interview

**RESEARCHER:** Some participants told me that with more experience the reputation risk is even greater...

**SUSAN:** ...because doctors expect even more; that’s true.

- Excerpt from Focus Group 2
The quotes from these three experienced nurses, therefore, suggest that that the influence of reputation risk on the decision about whether to seek help from doctors is even more significant among experienced nurses, because ‘asking the wrong question’ might result in an erosion of the positive impression (trust) that doctors would have accumulated about the capabilities of that particular nurse.

In summary, perceived approachability emerged as a determinant of nurses’ decisions about whether to seek the help of a doctor or another nurse, and which specific doctor or nurse to seek help from. Furthermore, this subsection has presented two additional reasons why nurses’ generally prefer to seek help from another nurse rather than from doctors. First, notwithstanding some exceptions, they tend to find most nurses more approachable than most doctors. Second, in their view there is much more to lose when asking a doctor for help, mostly because of the consequences of that referral on doctors’ judgement of their competence. In other words, nurses are unwilling to tarnish the trust that doctors, by time, would have developed in their capabilities of acting as their agents by effectively managing critically ill patients. Table 5.7 lists the various factors, elicited in this and in earlier sections, which condition nurses’ preference to seek help from other nurses, and illustrates each reason with examples from the data. The next subsection will discuss other aspects related to a nurse’s decision about who to make referrals to, this time in terms of influencing doctors’ decisions about patients’ treatment modalities.

<table>
<thead>
<tr>
<th>REASON</th>
<th>EXAMPLE</th>
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<tr>
<td><strong>Type of Knowledge / Type of Problem</strong> [Sections 5.3.5 and 5.4.1]</td>
<td>Also because there are certain things that, not exactly we know better, but that are nursing care, not doctor oriented. For example, care of a central line...OK, doctors insert a central line, but in my opinion that’s as far as it goes, because sometimes I’ve uncovered it and it’s red, it looks really inflamed, I see how long it’s been in, I tell them and they say ‘no, it’s ok’ full stop. I think that such things are more nursing oriented rather than medical, so nurses would probably have a better answer then a doctor would...a nurse will look at it from a different perspective.</td>
</tr>
<tr>
<td>- Jessica, Formal Interview</td>
<td></td>
</tr>
<tr>
<td><strong>Filtering</strong> [Section 5.4.3]</td>
<td>In that case, I always approached the nurse first [to ask about mechanical ventilation], and then, if the nurse was unable to help, I would go to seek the doctor’s help.</td>
</tr>
<tr>
<td>- Sally, Formal Interview</td>
<td></td>
</tr>
</tbody>
</table>
| **Reputation Risk**  
*Section 5.4.3* | I certainly feel I don’t like bothering the doctor when it is something straightforward. Because I am afraid they would say: ‘She has been working here for a long time. Why should she ask? She should take action’. Do you know what I mean? ‘She should take action without even asking; it is a straightforward case!’...and I don’t want them to think I’m not capable.  
- Sephora, Formal Interview |
| **Approachability**  
*Sections 5.4.3 and 5.4.4* | First I would go and ask a senior nurse before going to the consultant, because that would hold my reputation...I won’t ask him immediately...  
- Judith, Formal Interview |
| **Collective Autonomy**  
*Section 5.3.5* | You’d feel more comfortable speaking to a colleague [because] she works with you; she is your level, basically. And...I wouldn’t want to look stupid in front of doctor  
- Sephora, Formal Interview |
|  | Maybe a doctor, even if he gets on well with you, he might say something like: ‘Listen, why didn’t you do this, why didn’t you...?’ You know: pressure...adding pressure. And even there is the cultural thing that, being a nurse and being a doctor, there is like a class distinction.  
- John, Formal Interview |
|  | First, we try to solve things between us. And that is why we are here, not to immediately ask the doctor; we should try to at least use our brains and try to solve problems ourselves.  
- Sally, Formal Interview |
|  | I still prefer asking a nurse because, if it is within the competence of nursing, why should we bother the doctor?  
- Jacqueline, Formal Interview |
|  | I think we [nurses] should first clarify some things a bit between ourselves, because there are nursing procedures which the experienced nurses would know; we don’t need to ask the consultant how [certain] things are done...  
- Judith, Formal Interview |

**Table 5.7 – Exemplars of reasons for preferring to seek help from nurses rather than from doctors**
5.4.4 Doctors’ reactions to nurses’ input in decisions

In the previous subsection, approachability emerged as an important factor in the decision about which person to seek help from. Likewise, the approachability of a doctor affects the extent to which nurses give their input in decisions about patient management. This is illustrated by the data excerpts below:

*With some doctors, like other colleagues, I feel more able to speak...to liaise...to fire a query or make a suggestion, than with others.*

- Sephora, Formal Interview

*If there is something with which I do not agree, with this particular doctor I will say: ‘No, I don’t like things this way...Let’s do it this way’. I would tell him so immediately...I wouldn’t mind. Maybe it’s because he’s young, and even the way he liaises with us makes me feel comfortable. His attitude with us is good in the sense that we work together as a team: in a real team, not nurses and doctors in a world of their own. What I say is as important as much as what the doctor would say. With some other doctors I still feel uncomfortable and unable to give my input, so I would try to avoid them because their attitude is different.*

- Jeremy, Formal Interview

*In the ward round, I would always give my input one way or another. However, with some consultants I manage to give more input than with others because I feel they are more approachable, and therefore I feel more comfortable with them.*

- Simon, Formal Interview

In particular, while several nurses feel free to contest a junior doctor’s decisions regarding a patient’s treatment modalities, they are much more hesitant to do so with a consultant:

*So at that point, yes, I insisted with the [junior] doctor not to extubate the patient. With the consultant, I would have brought up the issue once, just to make him aware of the problem, but I would not have insisted.*

- Jeremy, Formal Interview

*If it is the consultant who has told you something, then it’s definitely useless to object; I would accept his decision and will certainly not tell him: ‘I don’t agree’. To another doctor who is perhaps more approachable, or with whom I feel more comfortable, I might say: ‘listen, let’s wait for another hour’. There were occasions in which I did this; I would say: ‘Listen, I’m going to wait for another hour...before extubating the patient’, for example. Usually he would trust me and*
say: ‘All right; it’s up to you then’. So it varies; I would definitely not say that to a consultant, though; rarely...very rarely.

- Simon, Formal Interview

These quotes suggest two important aspects in relation to nurses’ principal-agent relationship with medical practitioners and patients. First, they consolidate the medical consultant’s positional authority in terms of the formulation of patients’ treatment modality plans. Second, nurses’ decisions about referral are not exclusively determined by their aim of improving patient outcomes. Rather, their concern about the doctors’ potential reactions to their referrals, and particularly their hesitance to express dissent to consultants’ decisions, imply that they also consider additional anxiety imposed to the self when making such referrals. In other words, nurses’ moral duty of acting as their patient’s agent is somewhat affected by their desire for self-preservation\(^{153}\).

In conjunction with the data about reputation risk (Section 5.4.3), these data confirm that decisions about referral are not exclusively determined by the type of problem encountered and the type of knowledge required to solve a problem. Conversely, human factors have a significant influence on nurses’ preferences about who to seek help from in the case of a problem they cannot solve, and whether and to which doctors they give their input when they identify the need of a change in their patients’ treatment modalities. Indeed, these considerations in contesting doctors, particularly those in a consultant position, are comparable to the risk management involved in approaching and challenging senior colleagues’ decisions reported in the aviation sector (e.g. Helmreich, 2000; Higton, 2005), which is where the term human factors originated. The implications of such human factors in nurses’ help seeking decisions are discussed in Chapter 7.

The last two subsections clearly indicate that nurses’ decisions about whether and from whom to seek help and whether and to whom to give input in decisions about treatment modalities are substantially motivated by the need for preventing personal risk. There appears to be an agreement that, given a choice, it is preferable to seek help from someone who is more approachable and who is less likely to reprimand the nurse for making such referrals, which implies the existence of an element of self-interest in nurses’ decisions about referring. Indeed, these considerations appear to have a significant influence, not only

\(^{153}\) In the context of this study, the figurative meaning of the term self-preservation is used, namely a coping mechanism which attempts to prevent emotional trauma from distorting the mind (Wikipedia, 2012).
on whether a nurse prefers to seek help from the consultant, a doctor or another nurse, but also about which specific doctor or nurse to refer to. Similarly, being mindful of such personal risk has an influence on whether nurses attempt to contribute to decisions about a patient’s treatment modalities and with whom. In other words, despite the importance of constantly acting as the patient’s agent, patients’ needs are not always the only, or indeed the central, consideration in nurses’ decision around referring, as confirmed by the following excerpts from the focus group discussions:

What I am trying to say is that here we are actually speaking about the patient so why should I stay worrying which doctor or nurse to ask for help, you know? But we still do it!

- Sephora, Focus Group 2

I am an advocate of the doctor’s decision, then I am an advocate of the patient and then of myself. So personally it’s not just the patient and the doctor that are important, but me as well. I have to explain why I did this action...why I took this decision. So it’s also about me...I am also an advocate for my own actions and decisions.

- Jacqueline, Focus Group 2

Nonetheless, nurses claimed that self-preservation and attempts at preventing personal risk are not the strongest determinants of their decisions about whether to make referrals on behalf of the patient, as is evident from these quotes:

If I’m stuck with that [unapproachable] person I’m not going to say: ‘OK, I’ll wait till the morning, rather than ask’. In that case, there’s no doubt about it: I’ll ask what I have to ask and then see what happens. So, I would never “not ask” something crucial for my patient because I don’t feel comfortable with the only persons who are available...if I think it is important for the patient I’m going to ask it anyway.

- Jessica, Formal Interview

Even if I normally feel more comfortable asking junior doctors, I would refer something like that [referring to the transfer of a foreign patient to his home country] to the consultant, because only he would be able to help my patient in certain circumstances.

- Sephora, Formal Interview
I saw that the X-ray was OK, which is what really matters for me, and when the patient told me ‘I am better’ and he slept comfortably I calmed down. There is no damage for the patient and this is what really matters for me...it doesn’t matter if I’m right or if I’m not right at the end of the day, or if the doctor thinks I skipped something or thinks I am not performing something well. As long as there is no damage to the patient and the patient is fine at the end, then I’m fine as well.

- Jacqueline, Formal Interview

It’s more on the lines of ‘should I call them’? ‘Should I not?’ But if I know that me calling them now, at this moment in time, is going to affect my patient, then I will do it, irrespective of their reaction.

- Jessica, Formal Interview

In these instances, nurses’ professional and moral duty of acting as their patient’s agent by preventing risks to the patient and attempting to improve their outcome clearly surpasses any factors discouraging immediate referral. Thus, not making referrals when patient outcomes necessitate them constitutes a **professional risk**, a risk that most nurses consider even stronger than the personal risk imposed by the inapproachability of colleagues. Hence, preference for referral is underpinned by another duality in nurses’ decisions about referral: the need for preventing **personal risk** (by avoiding referring to unapproachable persons) is weighed against, and frequently superseded by, the even stronger motivator of preventing the **professional** risk associated with poor patient outcomes.

**5.4.5 Summary of factors determining whether and to whom to refer**

This section has outlined several factors determining a nurse’s choice about who to refer to, either to seek help or to attempt to influence treatment modality decisions. Trust is influential in determining nurses’ decisions about which doctor or nurse to seek help from, and also in the extent to which doctors value the input of different nurses in decisions about a patient’s treatment modalities. The type of problem encountered is another determinant on which professional grouping and grade (consultant, doctors or nurses) a nurse seeks help from, whereas approachability is highly influential on whether nurses seek the help of a doctor or another nurse, from which specific doctor or nurse help is sought, and to which specific doctors referrals suggesting changes in treatment modality changes are made. The factors influencing these preferences for referral are summarised in Figure 5.9 below.
To summarise, the data suggest that when considering whether, at what point, and from whom to seek help, critical care nurses aim to find a balance between several opposing motivators [depicted as weighing pans in Figure 5.10]. In particular,

- Nurses’ **desire for autonomy** is balanced against the importance of sharing, transferring and **averting risk**, including the additional responsibility which accompanies independent practice [Section 5.3.6].

- Nurses’ attempts at enhancing their **collective esteem**, which motivates them to seek help from fellow nurses rather than seeking “external” help from members of another profession, are limited by their constant awareness of the culturally entrenched **power asymmetry** between the medical and nursing professions [Section 5.3.6].

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**Figure 5.9** – *Summary of factors affecting nurses’ preferences about who to seek help from and to whom to give their input about treatment modality decisions*
• **Personal risk** associated with seeking help and attempting to influence doctors’ decisions is balanced against the **professional risk** of deteriorating patient outcomes if such referrals are not made [Section 5.4.4].

• Nurses’ **moral agency**, which prompts nurses to act on behalf of the patient is frequently hindered by **structural constraints**, most notably their deferential decision making power with respect to medical practitioners [Section 5.2.8]. **Negotition strategies** are used enhance the former within the constraints of the latter.

• Several **personal and organisational factors** [represented by masses in Figure 5.10], such as experience, assertiveness, risk appetite, professional biography and the availability of peer and managerial moral support have a moderating effect in the resolution of these dualities.

• Central to all this is the notion of **dual agency** which involves nurses balancing their moral duty of safeguarding their patient’s interest with their legal obligations to respect the consultant’s preferences [Section 5.2.7]. The most crucial determinant of such decisions about referral is the perceived effect of that decision on patient outcomes.

*Figure 5.10 – Dualities surrounding critical care nurses’ decisions to seek help from doctors and individual / organisational factors which moderate these dualities*
5.5 CONCLUSION

This chapter has presented the principal findings of this study in relation to the motivations of critical care nurses to seek help from doctors, the strategies used during such referrals, the motivations for not seeking help from doctors and the factors influencing the decision about who to seek help from. As illustrated in Figure 5.11, the factors that promote and inhibit nurses’ referrals to doctors are embedded within the two aspects of their dual agency role, namely acting as an agent to the medical practitioner (consultant agency) while concurrently serving as the critically ill patient’s agent (patient agency).

Nurses’ referrals for consultant agency are underpinned by their deferential power in relation to medical practitioners, and often involve seeking authorisation for their actions and clarifying medical plans. The need for this type of referring varies according to the nurses’ and the medical practitioners’ characteristics and the nature of communication between the two. Nurses’ desire for autonomy prompts nurses not to refer to medical practitioners, but this is often overwhelmed by an even greater need to share or transfer risk with medical practitioners; risk aversion, therefore, encourages referral. Nurses’ unique knowledge, including their contextual information about individual patients, encourages them to refer to physicians in order to update them and inform and influence their decisions, thereby fulfilling their role as medical practitioners’ agents.

Concurrently, nurses’ moral agency motivates them to safeguard the interests of critically ill patients and to make referrals on their behalf in view of specific requests by the patient or his/her relatives, or, more often, on the basis of the nurses’ own assessment. This type of referral takes the form of either seeking help from doctors in areas in which they recognise their limited knowledge, skill or expertise (negative information asymmetry); or attempting to influence treatment modality decisions in order to improve patient outcomes, which is facilitated by nurses’ positive information asymmetry and hindered by their negative information asymmetry with respect to medical practitioners. Nurses’ desire to prevent risk to the self (including the risk of tarnishing doctors’ trust of their capabilities) occasionally discourages nurses from making referrals on behalf of their patients; however, this is balanced against, and often superseded by, the even stronger moral obligation to prevent deterioration in patient outcomes as a consequence of not making such referrals.
Figure 5.11 – Factors increasing (+) and decreasing (−) the likelihood of nurses’ referral to doctors in view of their principal-agent relationship with the medical consultant and the patient.
Several negotiation strategies are used by nurses to enact their moral agency in spite of its institutional constraints, and to balance the potentially conflicting priorities characterising their dual role in safeguarding patients’ interest while respecting medical consultants’ preferences. These strategies are mastered through socialisation into the norms of the critical care unit, by experience and on reflection of the success or otherwise of their and their colleagues’ referrals.

The next chapter abstracts the substantive theory presented in this chapter, engages in a comparison of the emergent theory with relevant theoretical and empirical literature, and underscores previously unexplored insights arising from these findings.
Chapter 6

DISCUSSION

6.1 INTRODUCTION

The previous chapter proposed an explanatory account of referral in which acting as dual agents emerged as a central organising dimension. This chapter discusses the emergent substantive theory in the context of extant formal theories. As explained in Section 4.6.5, the direction of the present integrative review was determined by my theoretical sensitivity – as enhanced by my prolonged interaction with the data – and by the emerging substantive theory itself, most notably the central dimension. Thus, whereas Chapter 2 provided an orientating review of the decision making literature and its value in the conception of the study, in the present chapter it is mainly the literature about agency and dual agency from a healthcare and non-healthcare perspective that is engaged with the emerging substantive theory. The chapter starts with an overview of the substantive theory on dual agency. It will then theoretically compare and contrast the substantive theory with formal agency theory, and particularly with the latter’s application to healthcare. Subsequently, a link is proposed between dual agency and nurses’ moral agency and this is located as a theoretical example of agency-structure integration. Engaging aspects of the emergent theory with the theoretical and empirical literature was considered important to counteract the criticism that grounded theory studies often produce substantive theories that are superficial in their theoretical roots and that, by giving too much prominence to the immediate contextual factors associated with a phenomenon, they overshadow the broad links with existing sociological theories (McCann & Clark, 2003b). The implications of the theory for nursing education, practice and management are subsequently discussed in Chapter 7.

6.2 THE SUBSTANTIVE THEORY

This substantive theory is based on an analysis of the observed actions and expressed claims and motivations of nurses working in the intensive care unit constituting the research setting. Cross references to sections in Chapter 5 with corresponding data evidence to saturate these concepts are presented in brackets.

154 A more detailed critique of grounded theory is provided in the next chapter (Section 7.2).
6.2.1 Consultant agency

Nurses’ frequent need for seeking verification and authorisation for their decisions from members of the medical profession (Section 5.2.1), underpinned by their deferential decision making power relative to doctors in this particular setting, establishes a principal-agent relationship between medical practitioners and nurses. Indeed, it is generally medical consultants (principals) who assume overall responsibility for deciding, planning, and mandating treatment modalities for critically ill patients, whereas nurses (agents) implement several aspects of this plan (Section 5.2.5). This leads to an informal contract between consultants and nurses about which actions the latter are authorised to perform in terms of a patient’s treatment modalities. Subsequently, several instances of referring are motivated by a need for clarifying this contract, particularly in the event of communication breakdown between medical practitioners and nurses about critically ill patients’ treatment modalities (Section 5.2.3). The need for such referral for contract clarity varies according to the characteristics of both the principal and the agent. In particular, referring for contract clarity is especially important when working with medical practitioners (principals) who exhibit significant scrutiny over nurses (agents) by expecting to be informed of minor changes in treatment modalities implemented by nurses. Additionally, nurses (agents) who are less experienced, who were trained in a different country, and who have a lower risk appetite tend to make more referrals for contract clarity (Section 5.2.3).

The agency relationship between medical and nursing practitioners is characterised by both power and information asymmetry. Nurses are constantly mindful of their inferior decision making authority in terms of several treatment modalities (power asymmetry). Nonetheless, their possession of unique information about the patient provides them with the opportunity of influencing and actively contributing to plans about critically ill patients’ treatment modalities (Section 5.2.8). Indeed, nurses claimed that their position of working closely with individual patients and the high nurse to patient ratio maintained in this critical care setting – in contrast to doctors’ need to divide their attention between all patients in the unit – places them in a position of “knowing more” about particular patients than medical practitioners. Consequently, medical practitioners depend on input from nurses in formulating treatment modality plans. Such positive information asymmetry enables nurses to inform and propose changes in treatment modality plans. Conversely,

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The principal-agent relationship described here also explains nurses’ relationship with other medical practitioners in more junior grades. The term consultant agency was selected because of the positional authority of the ICU consultant as the person who assumes ultimate responsibility for treatment modality decisions in the unit (refer to Section 5.4), a point which was repeatedly emphasised by the participants.
nurses acknowledge that there are several aspects in the management of critically ill patients in which doctors possess more knowledge, expertise or skill, such as the management of rapidly deteriorating patients and the insertion of invasive lines and tubes. This negative information asymmetry compels nurses to seek help from doctors. Thus, information asymmetry incorporates both the type of knowledge and the amount of information held by doctors and nurses (Sections 5.2.4 and 5.2.8). Subsequently, information asymmetry leads to a two-pronged referral system between doctors and nurses. Nurses need to refer several patient-related problems to doctors whom they perceive to be more knowledgeable in certain areas of patient management; conversely, doctors often depend on nurses’ unique knowledge about the patient to arrive at a clinical decision.

6.2.2 Patient agency

Concurrently, nurses feel a moral obligation to safeguard critically ill patients and their family – whom they consider as being entrusted to their care – and to act on their behalf, thereby moderating critically ill patients’ and their relatives’ deferential power in relation to medical practitioners. In fact, several referrals to doctors are motivated by what nurses perceive to be their patients’ and/or their relatives’ best interests, either because patients or relatives expressly voice their concerns and preferences, or, more frequently, because nurses elicit patients’ needs through their assessment while working closely with patients (Section 5.2.6). Acting on behalf of patients and their relatives creates another principal-agent relationship, this time with the patient as the principal and the nurse as the agent. Such patient agency is frequently intertwined with nurses’ agency relationship with medical practitioners, as it often involves seeking authorisation from doctors for actions which nurses feel their patients would benefit from, and empowers them to influence treatment modality changes on the basis of what they deem best for their patients. Also, by seeking help from doctors about areas in which they feel less competent (see Section 6.2.1 above), nurses are effectively acting as their patient’s agents by seeking advice about ways to improve patient outcomes.

6.2.3 Dual agency and its effect on moral agency

The critical care nurse, therefore, simultaneously acts as an agent to two different principals – namely the medical practitioner and the patient – placing the nurse in a position of dual agency. Occasionally, consultants’ preferences in terms of patient
management, such as the speed of weaning and the aggressiveness of treatment in end of life situations, appear incongruent with patients’ and their relatives’ interests as elicited by nurses. Thus, concurrent loyalty to medical practitioners and patients may lead to morally distressing situations with nurses having to respect the authority of the former while safeguarding the interests of the latter (Section 5.2.7). Indeed, nurses are frequently limited in the extent to which they manage to act as their patient’s agent because their moral agency is constantly conditioned by organisationally imposed and culturally tolerated constraints, particularly their inferior decision making power with respect to medical practitioners.

Dual agency is further complicated by the fact that nurses and doctors tend to draw upon different sources and types of knowledge to guide patient management, with medical practitioners perceiving ‘their’ type of knowledge as superior. Additionally, nurses’ legally or culturally motivated requirement to seek authorisation from medical practitioners for several aspects related to patient management impinges on their desire to practise autonomously. As a result, nurses often engage in several negotiating strategies, which enhance their ability to influence doctors’ decisions about critically ill patients’ treatment modalities (Section 5.2.9). Nurses learn such negotiation strategies as they gain experience; through socialisation into the norms and customs of the critical care unit; and by reflecting about the success or otherwise of their and their colleagues’ attempts at influencing decisions (Section 5.2.10).

Negotiation often enables nurses to compromise between the desire to prevent conflict with medical practitioners and their attempts to participate in patient-related decisions. For example, in their effort to influence treatment modality decisions, nurses frequently word referrals using the type of language which doctors find more convincing and in a manner which makes doctors feel that they, not nurses, are making the decisions (Section 5.2.9). Thus, being mindful of their inferior decision making authority conditions but does not inhibit nurses’ involvement in decisions affecting the patient. Rather, patient agency empowers nurses to prompt doctors to make decisions which they consider helpful in improving patient outcomes, but which only doctors can authorise. In other words, although nurses’ deferential decision making power acts as a structural constraint, acting on behalf of their patient significantly enhances their moral agency. Consequently, their dual agency role concurrently constrains and enhances nurses’ moral agency because patient agency helps to moderate the structural constraints imposed by consultant agency.
6.2.4 Preferences for referral

Trust is perceived by nurses as an important determining factor in their decisions about who to seek help from, and in the extent to which doctors value nurses’ contributions to decisions about patients’ treatment modalities (Section 5.4.2). Trust is, therefore, closely interlinked to the agency relationship between doctors, nurses and patients. By giving more value to suggestions coming from nurses whom they perceive to be more competent and efficient in patient management – such as promptly recognising and acting upon patient deterioration – doctors essentially reward and sanction their agents on the basis of their effectiveness in implementing a plan. Similarly, nurses prefer seeking the help of doctors and other nurses whom they perceive to be more capable of aiding them to implement their role as patients’ agents by advising them about how to improve patient outcomes.

Apart from trust, there are other considerations which affect nurses’ decisions about who to seek help from. First, the type of problem related to patient management, and, consequently, the type of knowledge required to solve a problem, partly determine whether nurses seek the help of a consultant, another doctor or another nurse (Section 5.4.1). Second, the perceived approachability of the nurse or doctor from whom help is sought also influences such preferences (Section 5.4.3). Likewise, the anticipated reaction of a medical practitioner to nurses’ suggestions about changes in treatment modalities determines whether and at which point nurses attempt to make these types of referral (Section 5.4.4).

The fact that nurses concurrently act as an agent to critically ill patients and to consultants is accompanied by a balance between several other opposing considerations associated with their decisions about referring. First, several nurses expressed a desire to implement at least some aspects of patient management entirely on their own, without needing to refer to, or be scrutinised by, doctors or other nurses (Section 5.3.4). Yet, this desire for independent practice is balanced by an equally important need for risk aversion. Indeed, by seeking the help of, and verification from, medical and/or nursing colleagues, nurses are able to transfer, or at least share, the risk associated with their decisions and actions. Also, in areas in which nurses feel that doctors or other nurses are more knowledgeable or experienced, acting in the patient’s best interest (patient agency) is considered to be a much stronger motivator than the desire for autonomy, thereby leading to a decision to seek help (Section 5.3.6).
Second, one of the factors encouraging a nurse to seek help from another nurse, rather than from a doctor, is the feeling of collective esteem acquired by managing to solve certain clinical problems without the need to refer them to a member of another profession. Indeed, when seeking help from a member of his/her professional group, an individual nurse might not be acting autonomously but nurses’ collective autonomy would be enhanced (Section 5.3.5). However, complete autonomy is unattainable. In fact, nurses’ attempts at enhancing such collective esteem are weighed against a constant mindfulness of the culturally entrenched power asymmetry between the medical and nursing professions, into which nurses are gradually socialised. Such power asymmetry is particularly conspicuous in areas in which nurses feel competent, but which still require medical authorisation prior to their implementation, such as the weaning of inotropic medication and ventilatory support in view of haemodynamic and respiratory improvement respectively (Section 5.2.1).

Third, preferences for referral are partly based on the need for preventing personal risk, including the prevention of reputation risk and avoiding referring to unapproachable persons. Indeed, nurses’ desire to protect themselves from anxiety affects the nature of their referrals, the extent to which they attempt to influence patients’ treatment modalities, and their decisions about who to seek help. These considerations for self-interest are, however, weighed against, and frequently superseded by, the even stronger motivator of preventing the professional risk associated with poor patient outcomes.

Several individual and organisational factors, such as experience, assertiveness, risk appetite, professional biography, and the availability of peer and managerial support have an impact on the frequency, timing and nature of referrals. Together with the adoption of negotiation strategies in nurses’ relationship with doctors, these characteristics have a determining effect in the resolution of these dualities. Dual agency, which involves nurses balancing their role in safeguarding their patient’s interest with their duty to respect consultants’ preferences, is the overarching duality with the most crucial determinant of such decisions about referral being the perceived effect of that decision on patient outcomes. Ultimately, according to nurses’ stated rationale, the strongest motivator of the decision about whether and at which point to make referrals – both to seek help and to attempt to influence treatment modalities – is the anticipated effect of that decision on patient outcomes (Section 5.4.4).
6.3 DUAL AGENCY IN THE CONTEXT OF CONVENTIONAL AGENCY THEORY\textsuperscript{156}

This section discusses the substantive theory presented above in the context of principal-agent relationships as they are normally understood in the literature. Following an overview of conventional agency theory and its application to healthcare and non-healthcare settings, it will explore the concepts of the critical care nurse as an agent and a dual agent. Subsequently, the significance of agent scrutiny and information asymmetry in formal agency theory and in the proposed substantive theory on dual agency will be discussed. The section concludes with a discussion about the centrality or otherwise of self-interest and conflict of interest in conventional principal-agent relationships and in the dual agency relationship proposed here.

6.3.1 Overview of Agency Theory and its applications\textsuperscript{157}

Agency theory (also known as the theory of agency or principal-agent theory) describes the relationship between two parties, whereby one party, referred to as the “principal”, delegates tasks or responsibilities to another party, designated as the “agent” (Eisenhardt, 1989; Kivisto, 2008; Ludwig, Van Merode, & Groot, 2010). Subsequently, the agent acts on behalf of the principal (Ross, 1973; Mackintosh, 1993; Sauerland, 2001; Heath, 2009; Petsoulas, Allen, Hughes, Vincent-Jones, & Roberts, 2011). The principal remains the ultimate claimant to the result of the agent’s actions and compensates or rewards the agent (Ludwig et al., 2010; Thompson & McKee, 2011), whereas the agent is expected to act in the principal’s best interest (Sauerland, 2001) and advance the principal’s objectives (Heath, 2009). However, the agent also has interests or utility functions\textsuperscript{158} of his/her own, and these are often incongruent with those of the principal (Ludwig et al., 2010). This self-

\textsuperscript{156} In this section, the term “agency” and “agent” are used in the context of the relationship between a principal and an agent, as explicated in conventional Principal-Agent (Agency) Theory and in the dual agency theory being proposed in the present work. A more philosophical and sociological approach to the terms will be explored in the next section, which also proposes a theoretical link between the two approaches.

\textsuperscript{157} This brief review is mostly based on theoretical and empirical papers from the economic, organisational, business ethics and health economics sectors. Empirical studies typically utilised the principal-agent model to explain data from health systems databases and audits, or a hypothesis testing approach on survey generated data to determine the feasibility of applying this model to healthcare and non-healthcare settings.

\textsuperscript{158} In economics, utility refers to the “usefulness of a product or service, the satisfaction which a consumer gets from a good or service he or she has bought, or the way in which a good or service contributes to a consumer’s welfare” (Dictionary Central, 2012, p. 1).
interested behaviour on the part of the agent may be partly addressed by establishing an explicit or implicit contract between the two parties, specifying what actions the agent is expected to perform and the remuneration the principal is expected to pay (Smith et al., 1997; Thompson & McKee, 2011). However, it is often too costly to monitor the agent’s actions in sufficient detail (Petsoulas et al., 2011). The characteristics of the principal-agent relationship and their applications in healthcare and non-healthcare settings are summarised in Box 6.1.

### KEY PROBLEMS

1. **Moral hazard** - it is often not possible for the principal to completely observe the agent’s actions or performance (Roberts & Dietrich, 1999; Sauerland, 2001; Abdalla, 2008).

2. **Information asymmetry** – the agent normally has more information about the task at hand than the principal (Mackintosh, 1993; Smith et al., 1997).

### CONSEQUENCES ON PRINCIPAL-AGENT RELATIONSHIP

- Impossible to judge whether the agent allows his/her own interests to prevail over those of the principal;
- Principal cannot ascertain whether the agent is actually acting in his or her (the principal’s) interest or whether the agent is simply trying to boost the indicators that suggest so;
- It is often possible for the agent to advance his/her own objectives, at the detriment of those of the principal (Ludwig et al., 2010).

### APPLICATIONS

The theory originated in the economic field, but can be applied to any liaison in which one party acts on behalf of another party. Indeed, “examples of agency are universal” (Ross, 1973, p. 134), e.g.

- **Political studies** – relationships between supranational agencies and member states, and between parties and ministers within a coalition government (Maloy, 2009).

- **Democratic electoral systems** – politicians and policy makers act as agents to often inadequately informed citizens who, therefore, rely on them to make certain choices (Maloy, 2009).

- **Health sector** – relationship between:
  - health providers and patients (e.g. Scott & Vick, 1999); hospital’s central administration and the different hospital departments (Ludwig et al., 2010);
  - national or regional health authorities and individual health institutions (Thompson & McKee, 2011);
  - hospital administrators and individual health professionals (Mellott, 2010).

- **Other applications**:
  - lawyer-client,
  - employer-employee and
  - buyer-supplier relationships (Eisenhardt, 1989).

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**BOX 6.1**

**Characteristics and applications of a principal-agent relationship**
6.3.2. The nurse as a trusted agent of critically ill patients and their relatives

The substantive theory about dual agency proposed in this work portrays the critically ill patient and the nurse engaging in a principal-agent relationship. Indeed, several instances of referral depicted in the previous chapter (especially in Section 5.2.6) are clearly motivated by attempts to safeguard patients and their relatives, particularly by proposing changes in patients’ treatment modalities which they feel their patient would benefit from, and seeking medical help in aspects which they feel that doctors are more competent about. Such referral for patient agency also involves nurses seeking authorisation from doctors for actions which they are convinced that patients would benefit from but which they do not feel authorised to implement autonomously. The common denominator of these referrals, according to the nurses concerned, is that they involve acting on behalf of, and therefore as an agent for, the patient. Of note, this fiduciary relationship takes place in a critical care environment which accentuates the power differentials between patients and their relatives on one side and healthcare professionals on the other (Silver & Winland-Brown, 2000; Blanchard & Alavi, 2008; O’Keefe-McCarthy, 2009). Thus, this caregiver-patient relationship is based on both power differences and trust, with the “more powerful party [the nurse]…entrusted to protect the best interest or well-being of the less powerful party [the patient]” (Lemmens & Singer, 1998, p. 961). On the basis of a detailed conceptual analysis, Lynn-McHale and Deatrick (2000) define trust between the health care provider and the family as “a process…that evolves over time and is based on mutual intention, reciprocity, and expectations” (p. 228). A relationship based on trust has, indeed, emerged as particularly important for patients and their family (Lynn-McHale & Deatrick, 2000), especially for the relatives of patients in end-of-life care (Andershed, 2006) and critical care (Rushton, Reina, & Reina, 2007).

Several authors have attempted to theoretically or empirically link the health professional-patient relationship to the principal-agent model. For instance, Roberts and Dietrich (1999) portray the consumer of health services as the principal and the health provider as the agent, and assert that it is difficult for the former to ensure that the latter is acting in his/her interest due to the information asymmetry favouring the health provider. Scott and Vick (1999) empirically tested several assumptions of the principal-agent theory by examining patients’ preferences for various attributes of the doctor-patient relationship and concluded that patients were happy for the doctor to choose on their behalf, as long as there was a clear exchange of information. Indeed, the doctor-patient relationship has frequently been depicted as the quintessential application of the principal-agent theory to the healthcare
setting (Mackintosh, 1993; Mooney & Ryan, 1993; Ryan, 1994; Smith et al., 1997; Hines, Ader, Chang, & Rundell, 1998; Scott & Vick, 1999; Jones & Zanola, 2001; Sauerland, 2001; Carr, 2005; Ludwig et al., 2010; Nguyen, 2011).

Occasionally, even the nurse-patient relationship is portrayed as an example of principal-agent liaison, but this has been done less frequently and less explicitly. An early reference, albeit indirect and possibly unintentional, to agency theory emerges from Kitson’s (1987; 2003) comparative analysis of nurses’ and lay-caregivers’ relationships with the patient. Kitson does use the term “agent” for the individual who is providing the (caring) service, and maintains that the nurse-patient relationship is based on the premise that the patient trusts the nurse (agent) in making decisions in his/her (the patient’s) best interest and respecting his/her integrity. In highlighting the features of the professional caring relationship between the nurse and the patient, Kitson (1987, p. 160) also alludes to two important characteristics of agency theory, namely its contractual nature (“the manifestation from the agent (or carer) to provide a sustained and continuous service until such time as it is no longer required”) and the information asymmetry between the two parties (“the possession [by the agent] of a sufficient level of knowledge and skills to ensure that the care being provided is adequate to meet the recipient’s need of care”). However, Kitson stays short of explicitly referring to the patient as a “principal”, preferring to label him/her as the “recipient” of care.

A more recent and more explicit comparison of the nurse-patient relationship with agency theory is proposed by Scott (2011) who unequivocally declares that:

*The nurse-patient relationship, like other principal-agent relationships, is characterised by an asymmetry of knowledge and capabilities. The patient as principal seeks the services of a nurse as agent because the nurse has knowledge or capabilities that he or she lacks (p.33).*

What the present study adds to the notion of the nurse as the patient’s agent is that this is particularly crucial in the technology-dominated critical care setting, which allegedly introduces barriers and reinforces the power imbalance between patients and health professionals (Blanchard & Alavi, 2008; O'Keefe-McCarthy, 2009; Eriksson, Lindahl, & Bergbom, 2010). In general, relationships between health professionals and patients tend to be underpinned by “an uneven distribution of power” tipping towards the health professionals (Delmar, 2012, p. 240); for instance, various studies have indicated that patients’ input in discussions about their own treatment modalities during hospital ward
rounds is, at best, minimal (Weber et al., 2007; Sweet & Wilson, 2010; Liu et al., 2012). Yet, there is some evidence suggesting that patients attempt to assert their own influence in their interaction with nurses, particularly through interrupting, questioning and extensive disclosure (Kettunen, Poskiparta, & Gerlander, 2002). However, this is not possible for most critically ill patients who cannot even speak (both physically and metaphorically), let alone influence conversations. Indeed, apart from having a compromised autonomy and a stifled ability to participate in decisions (Silver & Winland-Brown, 2000), several critically ill patients lose their capacity to breathe independently and other basic physiological functions, which induces anxiety and agitation (Tate, Devito Dabbs, Hoffman, Milbrandt, & Happ, 2012) and makes their dependence on health providers even more pronounced. Beth (2000) uses the term “voicelessness” to conceptualise this “process involving a variety of physiological, psychological and technological barriers that limit critically ill patients’ abilities to represent their thoughts, feelings, desires and needs fully to others” (p. 1253). Furthermore, in critical care there is a tendency to “read the body” from an almost exclusively anatomical and biochemical viewpoint and to focus on catering for the patient’s physical needs, possibly at the detriment of failing to adequately assess and address the critically ill patient’s emotional state (Jacobs, 1990; Foucault, 1977 as cited in Henderson, 1994).

The extent to which technology itself heightens the power asymmetry between the patient and the healthcare provider is contested. Barnard and Sandelowski (2001), for instance, dispute the allegedly dehumanising effects of technology, arguing that it is how health professionals use individual technologies in different settings and the meaning they attribute to them that can potentially lead to depersonalisation, and not technology itself. MacDonald (2008) concurs, arguing that technology is actually useful in assisting the nurse in becoming acquainted with the patient, not only by facilitating the gathering of physiological information but also by accelerating several other duties, thereby allowing more time to get to know the patient. Conversely, it has been argued that in care settings dominated by the use of technology it is only possible to know the patient to a superficial extent (Bundgaard, Nielsen, Delmar, & Sorensen, 2011). Furthermore, O’Keefe-McCarthy (2009, p. 786) contends that, when health professionals base their interpretation and evaluation of clinical outcomes exclusively on technologically derived data, technology “inserts itself between patients and nurses, thus distancing nurses from patients”. This augments the power differential between nurses and patients and potentially depersonalises
patients, rendering them “invisible” (Almerud, Alapack, Fridlund, & Ekeberg, 2007; Loscin, 2011).

Nonetheless, data reported in the previous chapter, together with other observed tacit instances which are quintessentially part of everyday critical care nursing practice, indicate that nurses do endeavour to moderate the disempowering effects induced upon patients and their relatives by the severity of the illness and the critical care environment itself. As illustrated in Section 5.2.6, acting as the patient’s agent involves activities such as speaking up to doctors on behalf of patients; attempting to facilitate patients’ and/or their relatives’ opportunities for communicating with medical practitioners; and “translating” medical language related to a critically ill patient’s progress and treatment modalities into terms which are easier for patients and/or their relatives to understand. This concurs with the construct of “interpretation” proposed by Happ (2000) in her study of clinicians working with critically ill older adults in an American medical intensive care unit. Interpretation involves nurses elucidating patients’ needs and wishes in several ways, and subsequently acting as their advocates by verbalising these needs to other clinicians, thereby “dampening the detrimental effects of voicelessness” (Happ, 2000, p. 1250). This also supports earlier studies reviewed by Ryan (1994) suggesting that, in the principal-agent type of relationship between the health care provider and the patient, reassurance is a very important utility function for the patient as principal and at times as important as health outcomes themselves. By acting as their patients’ intermediaries, therefore, critical care nurses are in a potential position of mediating the even greater power differential which exists between patients and medical practitioners (Porter, 2002), which resonates Nguyen’s (2011) argument that regulation and check from a “third party” (in this case, the critical care nurse) offers the consumer additional protection from potential abuse.

The previous chapter also suggests that nurses taking part in this study claimed to safeguard the interests of (and, therefore, act as agents for) the relatives of critically ill patients [see, for instance, Section 5.2.6 and Table 5.2 for some examples]. This is particularly important because families of critically and terminally ill patients are particularly vulnerable (Andershed, 2006), and prone to confusion, stress and uncertainty (Jamerson et al., 1996; Kosco & Warren, 2000), which nurses can potentially alleviate (Pryzby, 2005). Data in the present study and in the literature (Jamerson et al., 1996; Pryzby, 2005) suggest that critical care nurses’ perceived advocacy role includes addressing relatives’ crucial need for information and facilitating the opportunity for
communication between the family of the critically ill patient and medical practitioners. However, while it is encouraging to note that nurses consider it part of their role to act on behalf of their patients’ relatives, these findings should be viewed with caution because earlier research in Hong Kong (Tin, French, & Kai-kwong, 1999) and the United States (Kosco & Warren, 2000) indicated a significant discrepancy between the expressed needs of the relatives of critically ill patients and nurses’ perceptions of these needs. Thus, family-centred care in the adult critical care setting appears to be particularly challenging (Latour, 2005; Mitchell, 2005), not least because in this and several other intensive care units there are significant restrictions in the times during which relatives can stay next to patients and participate in their care. This drawback is particularly significant in view of research indicating that relatives of critically ill patients consider the possibility to visit the patient frequently and at any time of day to be among the most important but least met needs during their relative’s stay in intensive care (Tin et al., 1999). Also, while nurses apparently assume that family members entrust their critically ill relative to their and their colleagues’ care, it is important to note that trust is not automatically present in the health provider-family relationship; rather, it is built over time, involves efforts from both parties (Lynn-McHale & Deatrick, 2000; Rushton et al., 2007), and can easily be eroded when patients and/or their relatives are not adequately listened to (Francis, 2013).

6.3.3 The critical care nurse as a dual agent

Agency theory has been criticised for limiting its focus on interactions on only one principal-agent relationship at a time, without suggesting explanations about how this relationship can be intertwined within other possible agency relationships (Kivisto, 2008), even though, in reality, the same agent can be involved in different tasks (Holmstorm & Milgrom, 1991). The dual agency theory proposed in the present work is a step in this direction as it seeks to explain the relationship of one agent (the nurse) with two different principals (the medical practitioner and the patient) in the context of an intensive care unit. This subsection will discuss some previous uses of the dual agency concept and compare and contrast them with that proposed in the present work.

The term dual agency originated in the real estate brokerage sector with reference to persons who act as an agent to both the buyer and the seller, resulting in an inevitable (and often insoluble) conflict of interest between obtaining the lowest price for the buyer and the highest price for the seller (Teichner, 2005; Kadiyali et al., 2008). As explained in the
previous chapter, although nurses’ position of acting as an agent to both the consultant and the patient poses a different dichotomy, parallels can be drawn to the dual agency scenario because of the potentially conflicting priorities of their two principals (see especially Section 5.2.7).

In the health economics literature, a similar form of dual agency has been described whereby the clinician (for example, a physician working in a specific hospital) is an agent of two different principals, namely the governing body involved in funding the healthcare system and the administration board of the hospital itself. A potential source of conflict arises from this arrangement, with the first principal (the funder) seeking control through the revenue system and the second principal (the administrator) seeking control via cost restraints and management systems (Smith et al., 1997). This argument is extended even further by Angell (1993) who contends that while doctors have traditionally been considered as acting exclusively as their patients’ agents, due to relatively recent socio-economic changes they are nowadays expected to also act as agents for society’s needs and to be accountable to the taxpayer. Their traditional obligation to help the patient, therefore, competes with their newer duty to save resources for society, particularly with regards to the provision of costly treatment during periods of economic recession. In other words, doctors have become “double agents, expected to decide whether the benefits of treatment to their patients are worth the costs to society” (Angell, 1993, p. 279). Subsequently, “the physician is in danger of over-identifying with many possible agents – the employer, the patient, the state and the insurer” (Carr, 2005, p 58). From a non-financial perspective, Hines et al. (1998) cite several examples in which military psychiatrists act as a dual agent to their patient on the one hand and the organisation they work for on the other. In a recent Israeli ethnographic study, Keshet (2013) used the term “dual embedded agents” with reference to medical doctors who are also trained in some form of complementary and alternative medicine but practised in a mainstream biomedically-dominated healthcare organisation. Table 6.1 summarises the applications of the dual agency concept in the healthcare literature and uses clear and shaded rows respectively to identify similarities and differences with its use in the substantive theory emerging from the present study.
<table>
<thead>
<tr>
<th>SECTOR</th>
<th>LITERATURE</th>
<th>EMERGENT SUBSTANTIVE THEORY</th>
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<tbody>
<tr>
<td>HEALTH ECONOMICS</td>
<td>The physician as a dual agent between the funder/insurer and the patient (Smith et al., 1997; Sauerland, 2001).</td>
<td>The critical care nurse as an agent to two principals, namely the medical practitioner and the patient.</td>
</tr>
<tr>
<td></td>
<td>• Emphasis on financial aspect</td>
<td>• Finances do not feature explicitly in the proposed dual agency theory.</td>
</tr>
<tr>
<td></td>
<td>• Focus on the physician as the double or dual agent</td>
<td>• The critical care nurse as the dual agent and the medical practitioner as one of the principals.</td>
</tr>
<tr>
<td></td>
<td>• Goals of the two principals are opposite to each other</td>
<td>• Potential conflict between the agent (i.e. the nurse) and one of the principals (the consultant) because of disagreement in the methods of achieving the same aim, namely improving the patient’s outcomes (Section 5.2.7).</td>
</tr>
<tr>
<td>DUAL-TRAINED PHYSICIANS</td>
<td>Practitioners were constantly conscious of the dominance of one aspect of their dual agency, namely the traditional biomedical model, which conditioned but did not completely inhibit the application of alternative medicine principles and practices within the mainstream health organisation they worked for.</td>
<td>Critical care nurses’ constant mindfulness of their deferential power with respect to one of their principals conditions but does not inhibit their role as patient’s agents; rather they employ negotiation strategies to affirm their moral agency (Section 5.2.9).</td>
</tr>
<tr>
<td></td>
<td>• Potential conflict arose due to traditional and alternative medicine being underpinned by a different type of knowledge and way of thinking.</td>
<td>Medical and nursing practitioners are experts in different areas and make use of different types of knowledge (Sections 5.2.4 and 5.2.8).</td>
</tr>
<tr>
<td></td>
<td>• Essentially concerned with two modes of thinking and practice embraced and implemented by the same dual-trained physician.</td>
<td>Dual agency refers to critical care nurses’ loyalty to two different principals, namely the medical practitioner and the patient.</td>
</tr>
<tr>
<td></td>
<td>• Keshet’s choice of the term “dual embedded agency” appears to be mainly derived by the sociological notion of individual agency.</td>
<td>The present study makes use of the term agency as understood in principal-agent relationships, even though a link between the two will be proposed later in this chapter (Section 6.4.5).</td>
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MILITARY PSYCHIATRY

Conflicting priorities and/or confused loyalties for psychiatrists employed by the armed forces (Hines et al., 1998)

- Dilemma between clinical decisions concerning the patient and administrative decisions concerning the organisation.

- Critical care nurses often have to balance their moral obligation to safeguard the patient and the organisational requirement to respect consultants’ authority

- The “non-patient” agent in military psychiatry is the organisation in general

- Particularly different substantive area, e.g. due complexities associated with issues like post-traumatic stress disorder, battle fatigue and fitness to serve the armed forces.

- Critical care nurses as agents to one or more specific health professionals, most notably critical care consultants,

- Substantive area is critical care within a public general hospital

<table>
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Table 6.1 – Engaging the emergent substantive theory with the literature. *The clear rows provide examples of similarities between “dual agency” as portrayed in the emergent substantive theory and its use in the literature. Differences are highlighted in the shaded rows.*

Infrequent use of the terms “dual agency”, “double agency” or “mixed agency” has also been made in the nursing literature. This mostly includes situations in which nurses are involved in some form of potential or actual conflict of interest. Table 6.2 provides some examples of the use of these terms in nursing research, education, management and practice settings.
### Table 6.2 – Applications of the dual agency concept in the nursing literature

<table>
<thead>
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<th>AREA</th>
<th>POTENTIAL CONFLICT OF INTEREST</th>
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| Nursing research  
*Nurses concurrently acting as a researcher and a caregiver with the same person or group (Edwards & Chalmers, 2002)* | - Patients may hesitate to decline or withdraw participation for fear of compromising their relationship with the caregiver and, subsequently, their care;  
- Nurses have to struggle with their obligation to ensure optimal patient care while pursuing the additional interests associated with the discovery or construction of new knowledge through research. |
| Nurse education  
*Nurse educators who recruit their own students as research participants (Ferguson et al., 2006)* | - Nurse lecturers gathering data from the same students with whom they have a fiduciary relationship and to whom they have an obligation to facilitate learning toward their professional goals. |
| Management  
*Chief nurse executives who concurrently act as agents for society and agents for the organisation with which they are employed (Scott, 2011)* | - Potential conflict between the organisational-agency and professional-agency goals, which often results in balancing conflicting priorities, i.e.  
- Concurrently acting as agents for society (by ensuring that professional nursing care is delivered in a safe and effective manner) and as agents for the organisation (by acting on its behalf and delivering the contractual organisational outcomes). |
| Practice  
*Nurse practitioners working in a managed care environment (Johnson, 2005)* | - Nurses experienced tension while handling the conflicting demands of the business ethic and the professional ethic characterising their role;  
- While the former emphasises curtailing costs and improving efficiency, the latter emphasises patient centred holistic care. |

The papers by Edwards and Chalmers (2002) and Ferguson et al. (2006) [Table 6.2] bear some resemblance to the conflicting priorities of the critical care nurse having to act as an agent to both medical practitioners and patients (Section 5.2.7). Theoretically, however, although they both make use of the “dual agency” label, these examples differ from the notion of dual agency as understood in the present study because they discuss cases in which nurse researchers and nurse educators have a dual relationship with the *same* patients and students respectively. Conversely, in the present study nurses are considered to have a dual agency role because they are acting as an agent to two *different* principals,
namely medical practitioners and patients. This important distinction between a “dual relationship” (i.e. two different relationships with the same person or group) and “dual agency” (a similar relationship with two different parties) is also underscored by Hines et al. (1998). An example of “genuine” dual agency in nursing practice is explored in Scott’s (2011) paper about chief nurse executives and Johnson’s (2005) research about nurses working in a strict managed care environment. Although they involve different settings and different sets of principals from those of the current study, their portrayal of the nurse as having to reconcile conflicting priorities, obligations and loyalties “while keeping the advocacy of the patient as central” (Johnson, 2005, p.337) is congruent with the notion of dual agency as presented in this study. Indeed, data from the present study similarly involve nurses managing the occasionally conflicting priorities of acting on behalf of the critically ill patient while respecting the socio-culturally entrenched deferential power relative to medical practitioners. Like the present study, these examples suggest that such dual agency roles require the nurse to be proactive and use negotiation skills to enable him/her to concurrently “strengthen the profession of nursing and the organisation” (Scott, 2011, p. 34).

The common denominator of the present study and the situations discussed in this subsection is that, although nurses feel strongly motivated to act as their patient’s agent, their dual agency implies that several other factors impinge on their actions, because of which the patient is not their only, and at times their utmost, concern. To use Edwards and Chalmers’ (2002, p. 132) words, “these other interests have the potential to influence, or at least to be perceived as influencing, the caregiver’s professional judgement regarding the primary interest of patient well-being”. The dual agency role of critical care nurses emerging from the present study is further complicated by the imbalance of power between the two principals. Specifically, one of the principals (namely, the medical practitioner) is much more powerful than the other principal (namely, the patient), which partly explains why they are not always successful in acting as the latter’s agent. Indeed, Sauerland (2001) acknowledges that in such situations of dual agency a “dominant position emerges if one principal possesses better instruments to influence the agent’s behaviour than does the other principal” (p. 132). Subsequently, nurses’ dual agency role may divert their focus from keeping patients’ interest as their utmost priority, which is of concern when considering the negative consequences on patient safety and on the public’s trust in the

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159 Managed care is defined as “any method of health care designed to reduce unnecessary utilisation of services, contain costs, and measure performance, while providing accessible, quality, effective health care” (Rognehaugh, 1996, p. 109).
health system arising from the relegation of patients’ welfare below other competing interests, as eloquently portrayed in two recent inquiries into the delivery of care in certain parts of the English National Health Service (NHS) (Keogh, 2013; Francis, 2013).

6.3.4 Agent scrutiny and trust

An important feature of the Principal-Agent Theory is agent scrutiny. This involves the principal monitoring the agent (Abdalla, 2008) on the premise that “when the principal has information to verify agent behaviour, the agent is more likely to behave in the interests of the principal” (Eisenhardt, 1989, p. 60). Some form of agent scrutiny is also present in the principal-agent relationship between medical practitioners and nurses proposed in the present work. Indeed, several nurses “complained” about certain consultants’ expectations of nurses to inform them about minor events and minute changes in a patient’s condition, and to seek their authorisation for any change they implement in a patient’s treatment modalities. However, there are two important differences in terms of agent scrutiny between mainstream agency theory and the theory of dual agency proposed here. To begin with, in the present study the degree of agent scrutiny seems to vary extensively according to the characteristics of individual medical practitioners, with some doctors being more restrictive than others in terms of their scrutiny of nurses’ actions (Section 5.2.3). More importantly, agent scrutiny features in only one of the two sets of principal-agent relationships constituting dual agency. In fact, while one of the principals (the medical practitioner) is in a position of exercising scrutiny over their agents (nurses), the other principal, namely the critically ill patient, invariably cannot. As discussed next, this inability of the patient to exert a significant control over the agent is somewhat peculiar to, or at least particularly significant in, the critical care setting.

The principal agent relationship between the critical care nurse and the patient can be compared to the literature about doctor-patient relationships in which the doctor is depicted as the patient’s agent (Ryan, 1994; Scott & Vick, 1999; Jones & Zanola, 2001). Traditionally, the patient’s role was portrayed as passive, dependent and restricted to seeking the help of a competent physician (agent) to which he or she complied unquestioningly in order to improve their health status (Brody, 1980 as cited in Ryan, 1994), in a manner which is reminiscent of what Parsons (1951) had described as abiding by the “sick role”. Later on, however, the patient’s possibilities of exerting an influence on the doctor, and therefore scrutinising the agent, increased significantly, particularly
through the growing importance of informed consent as a guiding ethical and legal principle in medical practice. Subsequently, the doctor can “no longer make decisions on behalf of the patient, i.e. act as an agent, but becomes an advisor or counsellor who provides knowledge about both the benefits and risks of treatment so that the patient can make an informed choice” (Alaszewski & Brown, 2007, p.4). Indeed, Smith et al. (1997) contend that principals (i.e. patients) are enabled to recruit the health providers (agents) that they perceive to be the best to cater for their needs. However, such agent scrutiny by the patient is much less possible in a critical care setting. Critically ill patients’ frequent inability to communicate effectively with healthcare providers, as well as their and their relatives’ perceived or actual limited power relative to health professionals (Blanchard & Alavi, 2008) hinders their participation in decisions about their treatment modalities (see Section 6.3.2). This consolidates nurses’ role of acting as patients’ agents, but also makes it very difficult for the principal (i.e. the patient) to scrutinise agents (i.e. nurses) or choose a different agent according to his/her performance. On the contrary, data in the present study (Section 5.4.2) suggest that the other principal in nurses’ dual agency role (namely, the medical practitioner) can not only scrutinise the nurse as his/her agent but occasionally chooses which nurse (agent) to work with on the basis of trust and the perceived performance of the latter. This supports a central notion of mainstream agency theory whereby the principal is able to choose a different agent if the latter is unable or unwilling to act in the principal’s best interest (Sauerland, 2001).

Agent scrutiny is often achieved by means of establishing a contract between the principal and the agent (Ross, 1973). According to Smith et al. (1997), contracts which explicitly state the exact expectations of both parties are an important prerequisite in principal-agent relationships because if the agent is not scrutinised the principal’s objectives may be superseded by those of the agent, thereby leading to a breakdown in the relationship. Contracts also feature in the principal-agent relationship between critical care nurses and consultants. These normally involve consultants establishing a “plan” for a patient’s treatment modalities, which the nurse then implements. A major difference from conventional agency theory is that, in the context this critical care setting, principal-agent contracts tend to be informal in nature and often unwritten. In fact, there are different extents to which medical practitioners specify which exact actions and treatment modality changes they expect nurses to execute. Subsequently, as made evident from Section 5.2.2, the need for clarifying this contract constitutes an important motivation for referral,
confirming that both the principal and the agent are enticed to establish an “institutional agreement” because such an arrangement benefits the two parties (Sauerland, 2001).

In general, contracts may be *behaviour based* (whereby the agent’s actions are observed by the principal and rewarded accordingly) or *outcome based* (in which case agents are compensated by the principal according to their output) (Kivisto, 2008). Elements of both types occur, even if informally, in the relationship between consultants and nurses. In fact, data in the present study (particularly in Section 5.4.2) suggest that consultants tend to have more trust in nurses whom they perceive to be more effective in implementing treatment modality plans (behaviour based contract) and who have a track record of effectively helping patient outcomes to improve (outcome based contract). However, while behaviour based contracts are perceived by several nurses as stifling their preference to act with a certain degree of autonomy, outcome based contracts are more appealing because ultimately both parties are driven by the same goal of improving the patient’s health status. This is congruent with Smith et al.’s (1997) argument that in outcome-based contracts the agent is more likely to act in conformity with the principal’s preferences because the achievement of each one’s goals are dependent on the same outcome.

In standard agency theory, the remuneration of the agent partly depends on the degree to which they fulfil their contract with the principal (Mooney & Ryan, 1993). To use the words of Abdalla (2008), the agent’s compensation is often “tied…to the performance of the firm or a specific metric of that firm’s success or productivity” (p. 6). Conversely, in nurses’ agency relationship with doctors and patients, there is no direct link between nurses’ financial remuneration and their effectiveness as consultants’ or patients’ agent. However, nurses’ performance does appear to be linked to another non-financial form of remuneration, namely trust\(^{160}\). In fact, Section 5.4.2 showed that the extent to which medical practitioners trust nurses highly depends on how much they perceive different nurses to effectively act as their agents. In other words, consultants reward or sanction nurses on the basis of how proficient they perceive them in implementing treatment modality plans, and in helping them by suggesting improvements in such plans. Although this deviates from conventional agency theory through having a *non-financial* means of remuneration, in effect the development of trust tends to parallel improvements in an agent’s financial compensation. Just as companies initially hire workers at low wages and then increase them proportionally to the workers’ growing value to the company (Abdalla,

\(^{160}\) In this context, trust refers to what is normally termed clinical trustworthiness (see Section 5.4.2 for data about this).
2008), the present data suggest that nurses are initially only minimally trusted by their seniors and by doctors, but the latter’s trust in their effectiveness as their agents gradually improves on the basis of their performance and output (Section 5.4.2). Indeed, clinical credibility is not something that is automatically ascribed to a person, but has to be earned gradually through the effectiveness of one’s clinical practice (Ramage, 2004; McDonald et al., 2005; Ousey & Gallagher, 2010). Thus, trust can be considered as a type of non-legal sanction in the policing of contracts between principals and agents (Smith et al., 1997; Roberts & Dietrich, 1999; Jones & Zanola, 2001; Alaszewski & Brown, 2007). Furthermore, although non-financial in nature, trust constitutes a form of (non-financial) currency; as such, in the nursing literature, the term clinical credibility is occasionally used in interchangeably with clinical currency (Nursing and Midwifery Council, 2008; Ousey & Gallagher, 2010; Marshall et al., 2013).

Trust also features in the discussion about nurses’ preferred source of information, in both the present study and the international literature. Despite the emphasis on evidence based practice in the past two decades, the present study supports the substantial international evidence that clinicians in general (Dee, 1993; Gravios, Fisher, Patrick, & Bowen, 1995; Thompson, 1997; Thompson et al., 2001; Palfreyman, Tod, & Doyle, 2003; Thompson et al., 2004; Estabrooks et al., 2005c; McCaughan et al., 2005; Pravikoff et al., 2005; Kostenuik et al., 2006) and critical nurses in particular (McKnight, 2006; Marshall et al., 2011; O’Leary & Mhaolrunaigh, 2012) prefer to use of informal sources of information from fellow clinicians than formal published, printed or online sources. A recently published study in two Australian intensive care units (Marshall et al., 2013) further specified that information is not sought from any of their colleagues, but preferably from those who are perceived to be trustworthy161, experienced and approachable, characteristics which also apparently determine local critical care nurses’ preferences for referral (Sections 5.4.2 – 5.4.4). Indeed, apart from participants’ very sporadic references to “evidence based things” (Section 5.2.8) and assessing the patient physically and through reading his/her medical and nursing notes – which were deemed useful to increase their participation in patient-related decisions – observation and interview data suggest that critical nurses in the present study mostly seek the help of fellow nurses and doctors to address areas of uncertainty while on duty. In fact, even in areas which are guided by protocols, several participants preferred to verbally consult or seek authorisation from a

161 The fact that that nurses’ preferences for referral and doctors’ evaluation of nurses’ input partly depends on their perceptions of the other party’s competence, rather than to an objective measure, has been termed as an “allocation of competence” by Hancock and Easen (2006, p. 700)
medical practitioner prior to acting. One reason for this could be the fact that, as indicated by other data from the present study (Section 5.3.6) and from recent research among Italian (Villa et al., 2012), English (Hancock & Easen, 2006), Iranian (Ramezani-Badr et al., 2009) and Australian (Marshall et al., 2011; Marshall et al., 2013) critical care nurses, as well as Australian rural hospital nurses (Endacott et al., 2012) and midwifery students (Scholes et al., 2012), seeking reassurance about their decisions from colleagues enables clinicians to validate their judgement and share the accompanying risks and responsibilities. Another reason is the fact that, according to the nurses in the present study, there is considerable variation in consultants’ instructions despite the presence of protocols, suggesting unfavourable attitudes towards protocolled practice on the part of medical practitioners. Although verifying local physicians’ views was beyond the scope of the present study, research in the UK does indicate that several doctors tend to dismiss protocols as they perceive them to disregard their tacit knowledge and to stifle flexibility in dealing with variation and individual circumstances (Parker & Lawton, 2000; McDonald et al., 2005). Importantly, however, while being reluctant to follow “rules and guidelines” formulated by members of other professions, the surgeons and anaesthetists in McDonald et al.’s study did expect other professionals (nurses) to abide by their unwritten preferences, an expectation which is also evident in the present study (see, for example, Section 5.2.2).

As explicated in the substantive theory (Section 6.2), and as illustrated by several actions and statements by the participants (Section 5.4.2), trust appears crucial in nurses’ role as agents to both patients and medical practitioners. Indeed, trust, and also positional authority, serve not only as a criterion on the basis of which nurses decide who to seek help from in order to effectively act as their patient’s agent – a criterion which also influenced the nurses in Cioffi’s (2000) study’s about decisions to call the medical emergency team – but also as a benchmark on which medical practitioners value nurses’ effectiveness in working as their agents. In the context of this unit, therefore, trust and positional authority are comparable to what French sociologist Pierre Bourdieu conceptualises as symbolic capital. This is a form of power which is not necessarily explicit, but which is often characterised by rank or social position (e.g. doctors in the grade of consultant and, to a lesser extent, nurses in a head of shift position – see Section 5.2.1 and 5.4.2 respectively), and which leads to deference, obedience and demarcation of power (Rhynas, 2005; 2010). Conversely, the use of clinical guidelines, protocols or patient pathways as a means of clarifying uncertainty – which is tantamount to the heavy bureaucratisation of care
characterising North American health and social care delivery systems since the early nineties (Harrison & Smith, 2004; Johnson, 2005) – was rarely mentioned by the participants and practically never observed. Together with data indicating loyalty to the critical care consultant (Section 5.2.2), this suggests that trust remains a very prevalent form of currency in the local critical care setting. In this context, it is worth noting that clinicians’ exclusive dependence on protocols has been criticised, not only for the potentially dangerous consequences of blindly applying protocols without proper patient assessment (Endacott et al., 2012; Scholes et al., 2012), but also for its possible erosion of trust (Berwick, 2003; Harrison & Smith, 2004; McDonald et al., 2005).

Nevertheless, the fact that doctors assign more value to nurses whom they “trust”, and that nurses strive to gain such trust, is not necessarily empowering for nurses. McDonald et al.’s (2005) study among surgeons, anaesthetists and theatre nurses suggests that, for some medical practitioners in that study, “trust may be based more on nurses displaying an ability to fit in with doctors’ individual routines than on shared values and beliefs” (p. 239), which might also explain why inter-professional collaboration has been consistently perceived to be higher by doctors compared to nurses working within the same unit (Rosenstein & O’Daniel, 2002; Thomas, Sexton, & Helmreich, 2003; Ferrand et al., 2003; Hamric & Blackhall, 2007; Tang, Chan, Zhou, & Liaw, 2013). Some remarks by the participants of the present study suggest that this may also be the case in the present context. Subsequently, the fact that nurses strive to obtain this type of deferential trust ends up reinforcing the inter-professional power asymmetry between doctors and nurses, which lends support to the notion of nurses’ behaviour occasionally being similar to that of an oppressed group (Seago, 2006), an issue which shall be discussed further in Section 6.4.5. Furthermore, fear of eroding such trust occasionally hinders nurses from speaking up on behalf of the patient, due to their anticipation of doctors’ reaction to their referral (Sections 5.4.3 and 5.4.4), suggesting that the nurses’ efforts in terms of the development and maintenance of trust are partly motivated by their desire to protect themselves and not

162 For example:

When they tell us to do this, we do it, and not ignore what the consultant is saying...I would certainly do it. If the consultant tells me: ‘you have to do this’, I just do it. And I suppose he says [to himself]: ‘Look, she is working well...she is doing what I’m telling her’.

- Judith, Formal Interview
only their patients\textsuperscript{163}. Similarly, in McDonald et al.’s (2005) study, junior nurses’ concerns about gaining trust and acceptance stopped them from challenging doctors’ failure to comply with safety procedures, whereas recent inquiries in the UK found that frontline clinicians’ fear of and disempowerment in voicing their concerns about patient interests were an important antecedent of poor patient outcomes and led to an erosion of the public’s trust in the health service (Francis, 2013; Keogh, 2013). In the main, however, data in the present study (Section 5.4.2) confirm that, by gaining doctors’ trust, nurses enhance their effectiveness in influencing decisions about their patient’s treatment modalities, thereby confirming that trust is linked with their role of acting as an agent, not only with respect to medical practitioners but also with respect to patients. The present study, therefore, underscores the importance of not studying the relationship between medical and nursing practitioners in isolation, but rather in full view of the effects of this relationship on nurses’ effectiveness in safeguarding patient outcomes, a point which is crystallised in the intertwined nature of nurses’ principal-agent relationship with doctors and with patients.

\textbf{6.3.5 The significance of information asymmetry}

Another important assumption of the principal-agent theory is the presence of information asymmetry between the two parties; that is, the agent normally possesses better and more information about the specifics of the task than the principal (Kivisto, 2008). According to Ryan (1994), the economic theory of agency is, indeed, “characterised by a principal (ill-informed individual) and agent (informed individual), both of whom are attempting to maximise their independent utility functions” (p. 208), which may potentially give the agent scope for the fulfilment of his/her own interests, rather than those of the principal.

As indicated in Section 6.3.2, information asymmetry also features prominently when the theory of agency is applied to the health sector. Within a hospital, for instance, management boards hire medical specialists to provide their services to patients, but the managers (principals) do not normally have all the required information about the quality and effectiveness of the specialists’ treatment (Ludwig et al., 2010). However, such information asymmetry appears most explicitly in the principal-agent relationship between providers and consumers of health services, whereby the health provider (agent) normally has much more medical knowledge than the patient (principal) (Ryan, 1994; Scott & Vick,\textsuperscript{163} This self-interest element of nurses’ decisions about referral is discussed in terms of their dual agency relationship with doctors and patients in Section 6.3.6 and in the context of their moral agency in Section 6.4.4.

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In particular, health professionals are normally more knowledgeable about medical conditions, treatment options and the effectiveness of treatment (Jones & Zanola, 2001). To date, the main focus of this type of literature has been the relationship between physicians and their patients. Nonetheless, the principal-agent relationship between critically ill patients and critical care nurses depicted in the present dual agency model is also based on the assumption that patient care is entrusted to nurses, partly because the latter have received professional training and acquired sufficient knowledge to do so\textsuperscript{164}. The main difference is that in mainstream agency theory the emphasis is on the potential abuse resulting from information asymmetry, whereby the agent misuses his/her superior knowledge about the task to gain financial advantage over the principal, most notably through \textit{supplier-induced demand}\textsuperscript{165}. As elaborated in Section 6.3.6 below, this type of abuse does not feature prominently in the dual agency being proposed in the present work, mostly because the emphasis is on professional – rather than financial – relationships between nurses and their patients.

Information asymmetry also characterises the second type of principal-agent relationship, namely that between medical practitioners and critical care nurses: although nurses have less decision making power than doctors, just like agents in mainstream agency theory they are often in a position of information asymmetry relative to medical practitioners. Like the critical care nurses in Crocker and Scholes’ (2009) study about weaning mechanically ventilated patients, and those in Tate et al.’s (2012) study about the management of anxiety and agitation in mechanically ventilated patients, the participants in the present study believed that, through their position of working closely and extensively with individual critically ill patients, they are frequently in a position of knowing much more about individual patients than doctors (Section 5.2.4). This places nurses in the important position of \textit{updating doctors} about patient-related changes and \textit{attempting to influence decisions} about treatment modality changes. Subsequently, the ability of medical practitioners to make decisions about patients actually \textit{depends} on information about patients provided by nurses, thereby ensuring a more holistic approach to decision making. This is an important deviation from mainstream agency theory because in this case the

\textsuperscript{164} In this context, according to Roberts & Dietrich (1999, p. 990), from an \textit{economic} point of view nursing possesses all the characteristics to be considered a profession, specifically because its practice is based on a tacit knowledge base and because there is “considerable informational asymmetry between patient and nurse”, even though its professional status is sometimes contested from a \textit{sociological} perspective.

\textsuperscript{165} Supplier induced demand (SID) occurs when the suppliers of a product or service use their superior information to encourage consumers to demand a greater quantity of the product or services than they would have demanded had they been as informed as the supplier (Nguyen, 2011).
agent (i.e. the critical care nurse) is not using information asymmetry to gain advantage over the principal. Conversely, by informing, updating and proposing ideas to the principal, the agent is using information asymmetry to the advantage of both by effectively contributing to the achievement of a common aim, that of improving patient outcomes. This does not mean that this information asymmetry doesn’t also help nurses’ unique interests; indeed, possessing specific information about patients helps nurses to participate in decisions about treatment modalities which is intrinsically motivating and empowering (Section 5.2.8). However, these “personal” interests do not, in this case, act in any way against the patient’s (i.e. the other principal’s) interests.

Furthermore, the present study extends the meaning of the term information asymmetry, whereby it refers not only to the amount of information but also to the type of knowledge. Indeed, as apparent in this and other studies, there is a difference between doctors’ and nurses’ ways of gathering and assimilating information about critically ill patients. Nurses’ position of caring exclusively for one or two patients and working “closer to the bedside, literally and figuratively” places them in a unique position of knowing more about the idiosyncrasies of individual patients (Chase, 1995, p. 158). Conversely, doctors acquire snapshots of information as they shift their attention from one patient to another and then interpret those data on the basis of “their” body of medical knowledge. Patient outcomes, therefore, depend on decisions informed by two interdependent sets of knowledge, which lends support to the growing body of literature underscoring the co-dependence of knowledge underpinning effective patient care [see, for example, an ethnographic study by Chase (1995), a systematic review by Zwarenstein, Goldman and Reeves (2009) and a recent editorial by Papathanassoglou & Karanikola (2013)]. Indeed, the participants in both the present study (Section 5.2.4) and in Chase’s (1995) ethnographic study did not expect doctors to know certain data about the patient and in both studies doctors frequently asked for such details directly from the nurse. Nonetheless, while acknowledging the beneficial effects of such sharing of inter-professional information on the quality of team decision making, Janss, Rispens, Segers and Jehn (2012) warn that diversity in healthcare teams is double edged because it can also lead to intergroup bias and conflict, a point which will be addressed in Section 6.4.5. Furthermore, although the participants of the present study (Section 5.2.4) and the nursing literature (e.g. Tanner, Benner, Chelsa, & Gordon, 1993; Radwin, 1995; Radwin, 1996; Potter & Mueller, 2007; Mantzorou & Mastrogiannis, 2011) allude to “knowing the patient” as a quintessential characteristic of nursing which enhances good quality individualised care and empowers nurses’ advocacy role, the notion itself has
been contested. For instance, Radwin’s (1995) often cited definition describes knowing the patient as “a purposeful action whereby the nurse uses understanding of the patient’s experiences, behaviours, feelings and/or perceptions to select individualised interventions” (p. 364); yet, studies reported by Bundgaard et al. (2011) showed that nurses spent a significant amount of time gathering medical and instrumental information about the patient and much less in attempts at understanding patients’ unique caring needs. Similarly, in a study about knowing the patient in the context of weaning from mechanical ventilation, several of the participants relied on biomedical information derived from technological equipment, patient records and other documents with minimal or no attempts at getting to know patients by directly communicating with them (Crocker & Scholes, 2009).

Finally, another type of information asymmetry emerged in the study, namely in areas in which nurses feel less knowledgeable, skilled or experienced, and therefore about which they seek the help of medical practitioners (Section 5.2.8). Thus, while mainstream agency theory normally concentrates on the transfer – or otherwise – of information from the agent to the principal, through its analysis of the process and motivation of referral in a critical care context the present study also presents a flow of information in the opposite direction. Subsequently, information asymmetry is deeply interwoven in nurses’ dual agency role. By sharing what they perceive as their unique knowledge about patients, nurses keep doctors informed about patients (the nurse as the doctor’s agent) and propose treatment modality changes to doctors, thereby helping them improve patient outcomes (the nurse as the patient’s agent). Concurrently, nurses act as their patient’s agent when they seek help from doctors in aspects of management which they consider doctors to have better knowledge, information or expertise about, which help enhances their ability to improve patient outcomes.

6.3.6 Self-interest and conflict of interest

The literature about agency theory normally assumes that because the agent possesses more information than the principal (information asymmetry), and because the principal is unable to observe all the actions taken by the agent (known as moral hazard), it is only natural that the agent acts in a self-interested manner and is driven by his or her personal aims rather than those of the principal (Roberts & Dietrich, 1999; Kivisto, 2008). When applied to the healthcare sector, this potential for abuse manifests itself in situations of conflicting objectives between the suppliers and consumers of health services (Jones &
Zanola, 2001). In particular, due to their superior medical knowledge, health providers may artificially create a demand for their own services by recommending treatment in excess of what is actually required, which is normally referred to as supplier-induced demand (Ryan, 1994; Scott & Vick, 1999; Jones & Zanola, 2001). For instance, Nguyen’s (2011) study about drug prescription patterns in Vietnam demonstrated that physicians in the private sector prescribed significantly more drugs and were significantly more likely to prescribe injection drugs than their counterparts in the public sector. Besides being based on a study carried out in different setting (private general practice in South East Asia rather than critical care in a public hospital in southern Europe) and using a different methodological approach (hypothesis testing rather than theory generating), the latter finding constitutes an important difference from the present substantive theory. In the present study, most of the motivations of nurses’ decisions about seeking help from doctors and other nurses were deeply motivated by acting in the interest of critically ill patients and their relatives. This does not mean that nurses’ personal interests and concerns are totally suppressed in their interactions with doctors and patients; indeed, some of the present data do indicate that nurses’ decisions about referral are at least partly influenced by an element of protecting oneself from anxiety and from the risk of loss of trust. However, in the present substantive theory, self-interest is certainly not as central as portrayed in mainstream agency theory literature and, significantly, is not associated with financial gains.

This variation from the original agency theory somewhat reflects the very nature and aim of the public healthcare system when compared to the market sector. In fact, caring and altruism, which characterise the interpersonal relationship between health providers and patients, do not normally feature in other applications of the principal-agent model (Jones & Zanola, 2001). Likewise, the fact that cooperation and the inter-dependent objectives of different health providers and patients take precedence over self-interested bargaining, at least in theory, is atypical of principal-agent relationships in a competitive market (Scott & Vick, 1999). Ultimately, these uncharacteristic features reflect the peculiarity of a public healthcare system in several countries which, unlike commercial markets, is characterised by universal access (Smith et al., 1997), even though this situation is often challenged by socio-economic pressures.

In this context, the ‘traditional’ version of agency theory has been criticised for presenting an unnaturally restricted view of human motivation; indeed, its almost exclusive focus on self-interested and opportunistic behaviour overshadows the wider range of human motives
such as respect for others, altruism, and the intrinsic motivation of an inherently satisfying task (Kivisto, 2008). Even when applied to the health sector, the theory implies that health professionals and their clients have opposite motivations, despite sociological evidence to the contrary (Ryan, 1994; Roberts & Dietrich, 1999). While acknowledging the need for further research in this area, the present study does shed some light on the importance of individual characteristics of the agent and the principal in the context of the relationship between nurses and consultant, and subsequently in managing a dual agency role. Agent characteristics such as experience, assertiveness, and professional biography; characteristics of the principal such as their extent of agent scrutiny; organisational characteristics such as managerial and peer support; and inter-professional trust based on the perceived salience, competence and efficacy of the other party (see Section 6.3.4) are all influential in the relationship between medical and nursing practitioners in the critical care setting, as exemplified through their effect on the process of referral between the two parties.

The original agency theory also purports that goal conflict is an essential feature of all relationships between principals and agents (Kivisto, 2008; Heath, 2009). Indeed, Eisenhardt (1989, p. 63) contends that “the heart of agency theory is the goal conflict inherent when individuals with different preferences engage in a cooperative effort”. This is not entirely the case in the proposed dual agency theory. To begin with, the relationship between the nurse as the agent and the patient as the principal is characterised by the mutually beneficial goal of improved patient outcomes; indeed, the present data suggest that nurses feel professionally and morally motivated to act in the interests of the patient. This principal-agent relationship is, therefore, not typically characterised by conflict of interest, even though the literature does acknowledge the potential for conflict between nurses and patients’ relatives when the latter hold different views about a patient’s treatment modalities (O’Haire & Blackford, 2005). The other principal-agent relationship which critical care nurses are involved in, namely that with medical practitioners, does occasionally involve conflict between the two parties. However, unlike that characterising the original agency theory, such conflict is often not because of a dissimilarity in the principal’s and the agent’s aims per se; indeed, both medical and nursing practitioners strive for an improvement in patient outcomes. Rather, conflict typically occurs due to differences in what each party considers a priority and the different type of knowledge that informs the two parties. Conversely, as explicated by the central notion of dual agency, having to act as an agent to two different principals does involve some conflict of interest,
particularly when the preferences of one of the principals appear to be different from those of the other principal (Section 5.2.7). In the present theory, therefore, conflict of interest features most prominently in the dual aspect of nurses’ principal-agent relationship with medical practitioners and patients, rather than in their relationship with each of the two different principals, which again underscores the value of keeping patient outcomes in mind when investigating nurse-doctor relationships.

Another potential source of conflict of interest in the consultant-nurse branch of the dual agency model is related to the perceived or actual autonomy of critical care nursing practice. In this and several other studies (e.g. Fulton, 1997; Chaboyer & Patterson, 2001; Leonard et al., 2004; Hagbaghery et al., 2004; Hancock & Easen, 2006; Rose et al., 2008; Ramezani-Badr et al., 2009; Villa et al., 2012) nurses expressed a desire to practice with some degree of independence, at least in areas of practice which they consider themselves to be most confident and competent in, even though, as was the case in previous research (Endacott & Westley, 2006; Endacott, Kidd, Chaboyer, & Edington, 2007; Endacott et al., 2012), there was a considerable difference in the extent to which different participants were willing to act autonomously. Not being observed by another party is, indeed, considered to be one of the characteristics of professional activity (Roberts & Dietrich, 1999). Conversely, however, the very essence of a principal agent relationship involves agents’ actions being mandated by a principal (Eisenhardt, 1989; Abdalla, 2008). Subsequently, there is a conflict of interest between nurses’ professional desire for autonomous practice166 and their legal and organisational requirements to seek authorisation for their actions from physicians (Chase, 1995; Hancock & Easen, 2006; Villa et al., 2012).

This section discussed the salient elements of the substantive theory arising from the present study in the context of the literature about the principal-agent theory, particularly as applied to health care. It has also highlighted various aspects of the substantive theory which deviate from, or give added meaning to, the central notions of conventional agency and dual agency theory. The chapter proceeds by connecting critical care nurses’ dual agency relationship with medical practitioners and critically ill patients to their moral agency. It also considers nurses’ dual agency role in the light of the structure-agency debate.

166 The feasibility of the notion of autonomous practice, particularly in light of structural constrains on one’s agency, will be discussed in several parts of the next section, particularly in Sections 6.4.2 and 6.4.5.
6.4 THE PRINCIPAL-AGENT RELATIONSHIP IN THE CONTEXT OF NURSES’ MORAL AGENCY

6.4.1 Theoretical link between agency theory and moral agency

The substantive theory presented in this study portrays nurses’ role of acting on behalf of critically ill patients and their families in terms of a principal-agent relationship, with patients and/or their relatives as the principal and the nurse as their agent. While doctors have very frequently been described as having such a principal-agent relationship with their patients (see Section 6.3.2, above), the principal-agent theory has only rarely been applied to the nurse-patient relationship, even though patient advocacy has long been considered a cornerstone of nurse education and practice (Pask, 2003). Some notable exceptions include Kitson’s (1987) seminal work (discussed in Section 6.3.2 above) describing the patient as the recipient of care and the nurse as an “agent committed to looking after the recipient’s best interest” (p. 503, emphasis added), with decisions being made “by the agent…in the recipient’s best interest” (p. 503); and Johnson’s (2005) and Scott’s (2011) papers which respectively describe chief nurse executives and nurse practitioners as agents to both the patient and the organisation they work for (see Table 6.2 in Section 6.3.3). The present work, therefore, contributes to the abundant literature on patient advocacy by interpreting it in the context of a principal-agent relationship.

Nonetheless, during the past three decades, nurses’ role of acting on behalf of their patients and safeguarding their interest, which the present study labels as acting as the patient’s agent, has been strongly associated with nurses’ moral agency. From a philosophical standpoint, a moral agent is a person “who is capable of choosing and acting in accordance with judgements about what is right, wrong, good, bad, worthy, or unworthy” (Tietjens Meyers, 1998, p.374). According to Rodney, Brown and Liashenko (2004), moral agency is manifested in nurses’ relationships with, and professional responsibility towards, patients. In nursing, therefore, moral agency involves “working on another’s behalf and representing the concerns of the patient, the family and the community” (Hayes, 2000, p.90), which is congruent with the notion of the nurse acting in an agent-principal relationship with the patient as portrayed in the previous and present chapters. Also, Rodney et al. (2004), as well as O’Haire and Blackford (2005), postulate that nurses become moral agents when their actions are driven by their goal of protecting their patients’ rights and advocating for their best possible care. In a similar vein, Orem’s Self-
Care Deficit Nursing Theory defines nursing agency as “a formulation of insights about the power of nurses to deliberately interact with persons with legitimate needs for nursing to produce nursing for them and, when possible, with them” (Banfield, 2011, p. 42). Thus, the present work proposes a previously unexplored link between the concept of moral agency as presented in the nursing literature and the principal-agent theory discussed in the previous section. Indeed, although they make no explicit reference to the principal-agent theory in their work, Benner, Hooper-Kyriakidis, & Stannard’s (1999) definition of moral agency as “intervening to improve communication…by detecting a predictable but unnoticed problem, thereby bringing needed medical attention to the problem” (p. 444) mirrors quite closely what the present study defines as referral for patient agency (Section 5.2.6).

Findings from the present study (Section 5.2.4) also suggest that acting as the patient’s agent is made possible through nurses’ close and prolonged contact with patients. Likewise, the relationships that nurses form with patients, through their sustained presence during the latter’s suffering, is considered to be the basis of nurses’ moral agency (Peter, Lerch Lunardi, & Macfarlane, 2004; O’Keefe-McCarthy, 2009), while Pask (2001) affirms that moral agency can only occur if nurses are “sensitive to…the patient’s perspective and…able to grasp the whole picture”. Furthermore, as explicated in Section 6.3.2 above, nurses’ agent-principal relationship with patients is essentially based on a fiduciary association between the two; similarly, trust forms an essential cornerstone in the enactment of nurses’ moral agency (Rodney et al., 2004).

In summary, therefore, the very nature of nurses’ referrals on behalf of their critically ill patient; nurses’ assertion that this is made possible through their considerable knowledge about – and extended contact with – the patient (Section 5.2.4); and the fact that trust is a central feature of both the principal-agent relationship and moral agency constitute a rarely articulated connection between the principal-agent theory and moral agency. Data and the resultant substantive theory generated in the present study, therefore, embed nurses’ agent-principal relationship with patients and their family in the context of their profession’s moral agency. This section proceeds by discussing other aspects of the substantive theory which are related to moral agency and highlights further links to agency theory.
What the present study labels as referral for patient agency (Section 5.2.6; Section 6.3.2) is not only closely linked to, but actually a dimension which enhances, nurses’ moral agency. Curley (1998), for instance, proposes that a synergy develops between the characteristics of the patient and nurses’ qualities with beneficial outcomes for both. This was also the case in the present study, with several instances of referral demonstrating that acting in the patient’s interest has a major strengthening effect on nurses’ behaviour, as reflected in nurses’ attempts to give their input in decisions about patients’ treatment modalities. Indeed, in the present study, while the extent of participation in decisions was significantly affected by nurses’ character traits such as assertiveness – a point which also emerges from Wiegand and Funk’s (2012) paper – nurses claimed that patient outcomes usually outweigh other considerations in nurses’ decisions about referral. In fact, even minimally assertive nurses appear to be empowered to take action on behalf of the patient when the latter’s condition demands so. For example, one of the present study’s participants, who described herself as “not assertive at all”, explicitly stated that her lack of assertiveness inhibited her from speaking up for her own interests, but that she would invariably speak up for her patients (see Section 5.2.9). Such empowerment was also evident in Benner et al.’s (1999) research, which cites examples of expert critical care nurses’ ability to use their agency to ensure prompt medical attention in cases of subtle signs of deterioration, even when working in unfamiliar settings in which they didn’t enjoy much recognition.

The present study also presented a different type of principal-agent relationship involving critical care nurses, namely their relationship with medical practitioners. This relationship is marked by an acknowledged power asymmetry between the principal (medical practitioner) and the agents (nurses) (Section 5.2.1), which is diametrically opposed to nurses’ desire for some degree of autonomy (Sections 5.3.4 and 5.3.5). Indeed, as pointed out by Rodney et al. (2004), several kinds of relationships in society in general, and in healthcare in particular, are characterised by an asymmetry of power between the parties. Thus, such consultant agency may have a constraining effect on nurses’ moral agency, specifically because, as evident from the data (e.g. Section 5.2.1), there are several areas in

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167 This does not mean that there are no considerations for nurses’ self-interest in their decisions about referral, a point which was made in Section 6.3.6 above, and to which this chapter shall return in Section 6.4.4 below.

168 Jessica, Informal and Formal Interview.
which nurses cannot immediately implement what they consider best for their patient without seeking authorisation from a medical practitioner.

Inferior decision making power has already been underscored as a constraint of moral agency. Indeed, nurses’ efforts towards patient advocacy are frequently impeded when their concerns about the patient are not taken seriously (Benner et al., 1999; Wiegand & Funk, 2012). This is often due to nurses’ inferior status in the hierarchical structure constituting healthcare delivery (Bjorklund, 2004) which may inhibit nurses from speaking up despite witnessing wrong decisions and make it difficult for them to influence decisions in spite of their detailed assessment of, and information gathering from, patients (Oberle & Hughes, 2001). Similarly, in the present study, several participants spoke of their failure to influence medical decisions affecting their patients and their inability to participate in ward rounds due to their perceived or actual hierarchical inferiority relative to medical practitioners (see Section 5.2.8). In another study, nurses’ capability and willingness to interrupt and correct medical error was significantly impeded by being intimidated by certain medical and nursing colleagues (Henneman et al., 2010). According to Rodney and Starzomski (1993), such restraints on nurses’ moral agency are a result of “the disturbed relationships between nurses and the organised biomedical structure in which nursing is embedded” (p.24), leading to “situational constraints which make it difficult to translate moral choices into moral actions” (Varcoe & Rodney, 2002, p.115).

These constraints to nurses’ moral agency are clearly comparable to what in social science is normally referred to as structure. From a sociological perspective, structures incorporate several influential social, economic, political, organisational and cultural factors which confine or limit the capacity of a person to act according to his/her free will, i.e. human agency (Baker, 2005; Clifton, Repper, Banks, & Remnant, 2013). Indeed, people’s everyday lives, including their work, are considerably shaped by their gender, ethnicity, social class, customs and what Lynam et al. (2007, p. 26) call “the broader institutional framework”. In the present study, structure mostly manifested itself in nurses’ constant mindfulness of their deferential power with respect to medical practitioners, particularly consultants, but constraints of nurses’ autonomy may also include the managerial structure, the professional code of conduct, legislation and policies (Rowe, 2010). As indicated in the discourse around the principal’s scrutiny of the agent (Section 6.3.4), nurses’ requirement to seek the authorisation for several of their actions may be considered as an indirect way in which the organisation scrutinises its own members. Thus, as acknowledged by the
participants themselves (Section 5.3.6); in the substantive theory presented earlier in this chapter (Section 6.2.4); and in the literature (Seago, 2006), autonomous practice in its absolute sense is unachievable. Yet, structure and agency do not operate separately from each other; rather, social actors, either individually or as a group, can use aspects of structure to obtain a certain degree of autonomy, thereby enhancing their agency. This was also evident in the present study, as shall be discussed in Section 6.4.5.

An important implication of the structure and agency debate is that conflict may arise whenever there is disagreement between different parties about the extent of one’s agency (Baker, 2005). Indeed, in the present study several participants expressed their dissatisfaction about their being restricted from autonomously implementing certain interventions which their patient would benefit from before obtaining medical authorisation. The resultant powerlessness in acting in the interests of patients and their relatives is a source of moral distress which, according to Jameton (1984, p. 6), arises “when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action”. Although it has apparently not been explicitly linked to principal-agency theory, the causes and consequences of moral distress have been explored extensively in the nursing literature. According to McCarthy & Deady (2008), the term moral distress has developed into “an umbrella concept that captures the range of experiences of individuals who are morally constrained” (p. 245). The relevance of analysing the causes of moral distress emerges from its potential negative consequences on both nurses and the patients assigned to their care (Rodney et al., 2004; Pauly, Varcoe, & Storch, 2012). Nurses’ emotional responses to moral distress reportedly include anger, anxiety, depression, worry, frustration, helplessness, hopelessness, powerlessness, loss of confidence as well a sense of inadequacy and guilt (Wilmot, 1993; Bjorklund, 2004; Wiegand & Funk, 2012). Recent quantitative research among American (Hamric & Blackhall, 2007) and European critical care nurses (Papathanassoglou et al., 2012; Karanikola et al., 2013) showed a statistically significant association between the frequency and severity of nurses’ moral distress and their intention to resign. Effects of moral distress on patients include suffering, prolonged and/or undignified dying, inappropriate care, disrespect and false hope (Wiegand & Funk, 2012), while long term consequences on the nurse include serious moral compromise which alters the self and one’s sense of moral conscience (McCarthy & Deady, 2008). Moral support from peers and superiors is perceived to be helpful in buffering the constraints on moral agency imposed by the asymmetrical decision making power, as evident by the in the present
study and in the literature (Pask, 2001; Peter et al., 2004; Lutzen, Blom, Ewalds-Kvist, & Winch, 2010; Villa et al., 2012); yet, the participants of the present study complained that such peer and managerial support was not always present (Section 5.2.8). The latter point resonates with the findings from the recent review of fourteen English hospital trusts (Keogh, 2013) in which one of the causes of poor quality care was the “lack of focus on providing high quality supervision, mentoring and pastoral support” to frontline clinicians, especially junior doctors and nurses. This underscores the value of organisational efforts to counter sources of moral distress, not only for their inherent benefits to the staff members, but also because of their indirect effect on patient outcomes.

6.4.3 Dual agency as a source of moral distress

Some sources of moral distress comparable to those expressed by the participants of the present study (Section 5.2.7) include the prescription of investigations which are perceived by nurses to cause unnecessary suffering to the patient (McCarthy & Deady, 2008; Pauly, Varcoe, Storch, & Newton, 2009); insufficient autonomy (Papathanassoglu et al., 2012; Karanikola et al., 2013); poor collaboration with physicians (Hamric & Blackhall, 2007); as well as unsafe staffing levels and lack of confidence in nurses’ own, their colleagues’ and physicians’ competence (Pauly et al., 2009; Wiegand & Funk, 2012). However, the major cause of moral distress that emerged from the present study is associated with the conflicting priorities and divided loyalties imposed by nurses’ dual agency role. Having to act as an agent to two different principals, namely doctors and patients, frequently places nurses in a morally distressing situation, particularly when the preferences of the former appear to conflict with the interests of the latter. In other words, acting as a moral agent to the patient involves seeking help from doctors and attempting to influence decisions about patients’ treatment modalities (i.e. referral for patient agency), but this has to be done in a way which maintains a good working relationship with their other principal, namely the medical practitioner. Although they do not explicitly use the term dual agency, Lutzen & Schreiber (1998) sum up this potentially conflicting priority as “a conflict between the nursing value of respecting the patient’s integrity within the framework of a good, trust relationship and the demands made by other professionals” (p.308). The nurses observed in Varcoe and Rodney’s (2002) study were similarly “caught in conflicts between institutional and medical rules…and their own beliefs about what patients needed” (p. 116). The concept of nurses acting as dual agents, therefore, contributes to the current debate about factors which “divert attention from focusing on quality” (Keogh, 2013, p.
and proposes that these are partly explained by the interconnected nature of nurses’ relationship with both medical practitioners and patients.

In the present study, moral distress underpinned by nurses’ dual agency role was mainly manifested in cases of disagreement between doctors and nurses about which decisions are more suitable for critically ill patients and their relatives at a particular point in time, with decisions about the aggressiveness of intensive care in end of life situations being a prominent example (Table 5.3; Section 5.2.7). Similar examples are not uncommon in the literature; for instance, survey research in the United States and Europe has consistently reported a statistically significant association between nurses’ moral distress and poor nurse-physician collaboration (Gutierrez, 2005; Hamric & Blackhall, 2007; Papathanassoglou et al., 2012; Karanikola et al., 2013). Oberle and Hughes’ (2001) study, suggested that nurses’ moral distress typically rose in instances in which they felt that doctors’ decisions, with which they disagreed but to which they had to comply, contributed to dying patients’ suffering. Similarly, Peter et al.’s (2004) and Wiegand and Funk’s (2012) reviews of causes of moral distress among nurses identified the treatment modalities for dying patients as a source of nurses’ disagreement with doctors, and that nurses were particularly concerned about what they perceived as needless suffering and indignity. Other sources of inter-professional disagreement leading to moral distress among nurses which were reported by Peter et al. (2004) include maternity nurses’ attempts to avoid caesarean sections and medical induction of labour; disagreement about life support measures, emergency transfers and patient involvement in clinical research among neonatal nurses; and disagreement with instructions not to treat civilians with non-life threatening problems among military nurses. Of note, a similar source of moral distress may also occur when nurses disagree with relatives rather than with other health professionals. In O’Haire & Blackford’s (2005) study, for instance, paediatric nurses experienced moral distress whenever their views about which options are best for critically ill children assigned to their care differed from those of the children’s parents. This is comparable to the conflicting priorities experienced by the nurses in the present study in their dual principal-agent relationship with patients and medical practitioners. In fact, although O’Haire and Blackford stop short from using the term dual agency, they do acknowledge that in the paediatric acute care setting, nurses “act as moral agents for both the child and the parents” (p. 252; emphasis added), a situation which resonates with nurses’ position of acting as an agent to both the patient and the medical practitioner as depicted in the present study.
6.4.4 Moral agency versus self-preservation

One of the dualities surrounding critical nurses’ decisions to seek help from doctors emerging from the previous chapter involved nurses balancing their moral obligation to safeguard the patient with the need to protect their own selves from anxiety. For instance, although nurses claimed that they frequently disagreed with doctors on the importance of sedation because they (nurses) were more sensitive to patients’ need for comfort and rest (see Section 5.2.7), subtle clues in the data raise the possibility that such requests were partly motivated by nurses’ attempts to facilitate their work.\footnote{For instance: Some consultants are afraid to sedate, but then they go home and we are the ones who stay with the patient; not only because patient might self-extubate, but some might even get aggressive with us...you are the one who looks ugly in the relatives’ eyes because the patients are in a mess, literally, and we would have to arrange them every 2 minutes. - Sephora, Focus Group 2} This suggests that nurses’ decisions about requesting changes in a patient’s treatment modalities are not exclusively centred on their legal and moral obligations towards medical practitioners and patients, but also involve an element safeguarding their own interests. Similarly, the data suggest that mindfulness about their deferential positional authority with respect to medical consultants and the importance of maintaining their trust and averting reputation risk conditions the nature of nurses’ referral (Section 5.2.9); partly determines from whom they seek help (Section 5.4.3); and occasionally stops them from attempting to influence doctors’ decisions on the basis of the anticipated reaction of the latter to their referral (Sections 5.2.7 and 5.4.4). This finding also concurs with the notion of there being a “social cost” to seeking help from others (Lee, 2002), as this might be interpreted as acknowledging one’s incompetence, dependence or inferiority to another party (Janss et al., 2012). Indeed, in both the present study (Section 5.4.3) and in that by Cioffi (2000), nurses explicitly stated that they did not want to “look stupid” when requesting help, particularly from doctors. Subsequently, it can be argued that nurses’ self-preservation occasionally becomes so significant that it restricts them from effectively acting as their patients’ agents. Peter et al. (2004) review similar instances of nurses’ passivity in decisions about patients’ treatment modalities, while Kelly’s (1998) study reports that some junior nurses tended to compromise their moral agency by following the practices and norms of the hospital system in order to feel included in the team. Likewise, in McDonald et al.’s (2005) study, junior theatre nurses hesitated from confronting anaesthetists and surgeons who failed to comply with safety procedures because they feared that this would make it more difficult
to gain their trust and acceptance, which mirrors several other studies indicating that several clinicians are reluctant to directly confront senior colleagues about their concerns, partly due to the fear of retaliation (Helmreich, 2000; Tammelleo, 2002; American Association of Critical Care Nurses, 2005; Francis, 2013; Keogh, 2013). Similarly, rather than confronting parents whose care conflicted with what nurses considered best for the critically ill child, paediatric nurses in the previously cited study by O’Haire and Blackford’s (2005) preferred to avoid contact with them because such clashes were distressing. In these and similar instances, moral agency is limited by the need for self-preservation (i.e. the need to protect oneself from anxiety). In fact, it has already been suggested that nurses might distance themselves from their patients in an attempt to reduce their own anxiety (Pask, 2001), while McCarthy and Deady (2008) declare that “individuals may abandon their principles altogether and act only for pragmatic reasons based on fear, expedience or self-preservation” (p. 257).

This notwithstanding, nurses’ claims in the present study (e.g. Section 5.4.4) also indicate that, when weighing the balance, nurses perceive their duty of acting on behalf of the patient as more influential than most other considerations in their decisions about referral. Similarly, although they were aware that alerting a doctor to a patient’s problem placed them at a risk of verbal reprimand if their judgement was in error, the nurses in Chase’s (1995, p. 161) study claimed that such “risk is warranted if the patient’s condition depends on it” (even though the latter author does not relate this finding to nurses’ moral agency). In other words, although some egoistical concerns might have an influence on nurses’ decisions about referral, these do not typically overshadow nurses’ moral obligation to safeguard the patient’s interest, at least according to nurses’ own assertions, which goes on to support Tietjens Meyers’ (1998) affirmation that “self-interest may be among a moral agent’s concerns, but it cannot altogether eclipse consideration for other people” (p. 372; emphasis added). This also underscores a point made earlier on in this chapter (Section 6.3.6, above). While self-interest has a central role in conventional agency theory, in the dual agency theory proposed here its influence is more peripheral, mainly because it is allegedly superseded by altruistic and moral considerations of acting in the best interests of critically ill patients and their relatives.
Inter-professional disagreement may occur because of the different roles and priorities of nurses and doctors. Earlier research demonstrated that nurses give significant importance to respecting patients’ and their family’s dignity, comfort and wishes; whereas doctors tend to be more concerned with patients’ legal rights, quality of life and a predominantly scientific approach to disease and cure (Grundstein-Amado, 1992; Oberle & Hughes, 2001). The latter qualitative study, conducted among acute care physicians and nurses in Canada, also underscored the fact that such inter-professional disagreement is often not caused by actual differences in moral motivation or ethical reasoning, but by the complementary yet distinct professional roles played by the two parties. Specifically, “doctors are responsible for making decisions and nurses must live with these decisions” (Oberle & Hughes, 2001, p. 710). This essentially encapsulates the principal-agent relationship between doctors and nurses which emerged from the present study. Subsequently, in both the present study and in that by Oberle and Hughes, nurses were prone to moral distress due to an inability to adequately influence decisions about patients’ treatment modalities.

Another important reason for nurses’ failure to participate in treatment modality decisions, which, as seen in this study and in the literature, is a constraint of nurses’ moral agency and a source of moral distress, is the different type of knowledge held by doctors and nurses and each profession’s unfamiliarity and discomfort with the other party’s philosophy of care (Larson, 2011). According to Chase (1995, p. 158), “these two groups have different points of view on the same patient problems”, whereas Gordon argues that medicine focuses on fighting disease and nursing’s priority is to acknowledge illness and deal with its effects on patients’ lives. Consequently, some medical practitioners tend to consider the personal, aesthetic and ethical knowledge acquired by nurses (Carper, 2013) as “non-scientific”, and therefore as less legitimate than empirical medical knowledge (Bjorklund, 2004). In this context, Leonard et al.’s (2004) and Stein-Parbury & Liashenko’s (2007) research suggests that differences in nurses’ and doctors’ training and their expertise in different types of knowledge leads to their use of a different type of language, a situation which often hinders collaborative decision making, particularly when doctors dismiss nurses’ clinical assessments which do not fit in their preferred paradigm. Similarly, Andrews’ findings indicated that one difficulty nurses encounter in making successful referrals to physicians is that the former depend on “soft signs” in detecting deterioration in a patient’s condition while the latter rely on “hard signs” (Andrews &
Waterman, 2005; Andrews, 2011, p. 277). In the literature, these differences have even been compared to the distinct specialisations of the left and right hemispheres of the human brain, with the former’s coordination of expressive tasks, intuition, emotion and empathy being compared to the nursing role and the latter’s capability of logical and analytical processing being similar to doctors’ preferred modes of thinking (Papathanassoglou & Karanikola, 2013). Subsequently, although they work in the same teams, doctors’ and nurses’ socialisation into their respective professional grouping may prompt them to champion their profession’s (rather than the team’s) values (May & Fleming, 1997; McDonald et al., 2005).

In the present study, according to the nurses’ views, the extent to which doctors valued the uniqueness of nurses’ contribution varied considerably from one medical practitioner to another (Section 5.2.8). The fact that medical practitioners are increasingly recognising the contribution of different professionals’ knowledge to patient outcomes, at least on paper, is encouraging. For instance, in an editorial for a medical journal, Wu, Sexton and Pronovost (2006, p. 1291) criticise their fellow medical practitioners for “operating in their ‘own silos’, ignorant of crucial information known by other caregivers just feet away” and encourage “all members of the care team, particularly physicians, [to...] appreciate the value of different kinds of information, regardless of the source, whether it be physician, nurse or clerk, patient or family member”. Similarly, research in American critical care units is suggesting an increased understanding and recognition by physicians about the uniqueness of nurses’ contribution to improved patient outcomes (Schmalenberg & Kramer, 2009). Nonetheless, evidence from the present study suggests that this increased acknowledgement is not put into practice by all medical practitioners, at least locally.

The difference in the types of knowledge held by different health professions establishes another link with the principal-agent theory as normally understood in the economic sector. Apart from being a reported source of disagreement between medical and nursing practitioners, and subsequently a potential cause of moral distress, the difference between the knowledge held by medicine and nursing also characterises the principal-agent relationship between the two parties as portrayed in the present substantive theory (refer to Section 6.3.5 above). In this instance, however, information asymmetry is not restricted to the \textit{amount} but also incorporates the \textit{type} of information each holds about the patient. Indeed, while nurses acknowledged their need to refer several patient-related problems to doctors whom they perceive as more knowledgeable in certain areas of patient
management (Sections 5.2.8 and 5.4.1), they also claimed that doctors depend on nurses’ unique information about the patient to arrive at clinical decisions (Section 5.2.4). This also reflects the fact that, since knowledge is distributed among different members of society in general and the healthcare team in particular, nurses need to seek the help of other professionals in order to enact their moral agency (Rodney et al., 2004).

However, the type of knowledge held by doctors is frequently considered superior and, occasionally, the only relevant type. As a compromise, when attempting to get their point across, nurses frequently resort to using the type of knowledge and language that doctors prefer hearing, as reported in the present study (for example, by making careful reference to a patient’s physiological parameters – see Section 5.2.9), and in previous ones (e.g. Luker & Chalmers, 1989; Chaboyer & Creamer, 1999; Andrews & Waterman, 2005; Tjia et al., 2009). This is also congruent with Benner’s et al.’s (1999) assertion that acting on the patient’s behalf requires the nurse to present his/her clinical interpretations to medical colleagues through a “good logical presentation, and the ability to engage in thoughtful dialogue…presenting clinical cases with phrases that invite dialogue instead of resistance” (p. 451). Other approaches used by nurses in an attempt to enact their moral agency include what the previous chapter labelled as persuasion and negotiation strategies, such as using accommodating behaviour, asking neutral or leading questions, using reverse psychology, and, quite rarely, using confrontational strategies (Section 5.2.9). Several of these strategies are comparable to what other studies have termed as “responsible subversion” (Hutchinson, 1990, p. 7) and “bending the rules” (Varcoe & Rodney, 2002, p.116). Bourdieu also makes use of the “rule bending” metaphor to compare social action to the fact that languages are governed by an overarching grammar, but its speakers are free to choose which exact sentences to construct in particular situations as long as these lie within the overarching framework; and to a game whose detailed rules are known but often bent and occasionally broken (Bourdieu, 1990; Kemp, 2011). In the present study, nurses were similarly well aware of the “rule” that certain treatment modality decisions need to be discussed with and/or authorised by consultants, but, due to the perceived unapproachability of some of the latter, they occasionally made such referrals through another doctor rather than directly to the consultant thereby “bending”, rather than “breaking”, the rules (see “bypassing the consultant” in Section 5.2.9).

Nurses’ efforts to make use of the type of discourse preferred by the medical profession indicates a degree of “pluralistic professional logic” (Keshet, 2013, p. 14) and suggests that
they are equipped to deputise for their medical colleagues, thus supporting the notion of the nurse as the consultant’s agent. However, this also implies that nurses are prepared to devalue their own “sensorial and experiential knowledge” (Flaming, 2003, p. 235) in order to have their input acknowledged by doctors. In this context, Sandelowski (2000, p. 11) contends that, in their efforts to affirm the intellectual nature of their work and therefore reduce the disparity between their and doctors’ status, nurses “have inadvertently complied with the prevailing cultural practice of denigrating the very ‘body-knowledge’ that is the forte of the nurse”. This may be considered a form of what Bourdieu terms as symbolic violence, which he defines as “giving an action or a discourse the form which is recognised as suitable, legitimate [and] approved; that is, a form of a kind that allows the open production, in public view, of a wish or a practice that, if presented in any other way, would be unacceptable” (Bourdieu, 1990, p. 85). In fact, symbolic violence is a form of “violence which is exercised upon a social agent with his or her complicity” (Bourdieu & Wacquant, 1992, p. 167; emphasis added), which in turn lends support to the argument that nurses’ discourse and actions occasionally reflect oppressed group behaviour (Fulton, 1997; Seago, 2006). Indeed, several of the strategies observed or described by nurses to enhance their input in treatment modality decisions were essentially non-confrontational in nature (Section 5.2.9). To borrow some terminology from the labour studies sector, their efforts at enhancing their agency mostly constitute resilience (i.e. “small acts of ‘getting by’ that help individuals and groups cope with everyday realities but do not change [and indirectly accept] existing social relations”), rather than resistance (which directly challenges the hegemonic social system) (Coe & Jordhus-Lier, 2011, p. 216). Similarly, in Keshet’s (2013) study, medical doctors who were also trained in some form of complementary and alternative medicine used “non-adversarial, non-oppositional and non-competitive strategies” (p. 14) to increase the acceptance of such alternative practices among conventionally trained medical colleagues. What is particularly striking, though, is the fact that these dually trained doctors were a minority group within a healthcare system in which most of the clinicians were biomedically trained, whereas, by far, nurses constitute the largest professional group in the research setting of the present study. Yet, despite their outstanding numerical majority, nurses still had to resort to the strategies adopted by the former minority group, suggesting that it is not so much the size of the professional group but rather its socioculturally regulated hierarchical status which leads to power asymmetry and oppression.
Nonetheless, the frequent success of such negotiation strategies in enabling nurses to exercise their moral agency by influencing patient related decisions confirms that social structures constrain but do not completely inhibit nurses’ agency. In other words, like the dually trained physicians in Keshet’s (2013) study, critical care nurses utilise negotiation strategies to “manoeuvre among the constraints of institutional structures while using these very structures” (p. 13). This point is emphasised by sociologists like Pierre Bourdieu, who argues that social actors have a certain degree of autonomy within the boundaries of a social framework (Kemp, 2011); Anthony Giddens, who acknowledges the social constraints impinging upon individuals but maintains that these do not completely inhibit the individual from acting according to his/her free will (Giddens, 1984; Ritzer & Goodman, 2004); and Thomas Sewell, who affirms that “to be an agent means to be capable of exerting some degrees of control over the social relations in which one is enmeshed” (Sewell, 1992, p. 20). Indeed, several contemporary social theorists are reluctant to attribute complete dominance to either social structure or individual agency, acknowledging, instead, that structure influences human behaviour while humans are capable of bringing some change in social structures (Giddens, 1984; Ritzer & Goodman, 2004; Baker, 2005; Shove, Patzar, & Watson, 2012). Giddens’ Structuration Theory, for instance, proposes that structure and agency may be considered interdependent and complementary to each other (Giddens, 1984; Center for the Study of Inequality and Education, 2012); therefore, social structures can have both a constraining and an enabling effect on an individual’s actions (Bakewell, 2010).

In the present substantive theory this interaction between structure and agency is mirrored in several of the dualities surrounding nurses’ decisions around referral (summarised in Figure 5.10 and Sections 5.4.5 and 6.2.4). As depicted in this work, nurses’ decisions to refer are, in fact, underpinned by balancing structural constraints (such as their awareness of their deferential power with respect to physicians) with their desire to accomplish some degree of individual or collective autonomy, thereby expressing their moral agency. Most notably, nurses strive to achieve a balance between the two elements of their dual agency role, i.e. consultant agency and patient agency. Indeed, consultant agency imposes significant implicit and explicit constraints on nurses’ capacity to act independently, whereas patient agency potentially empowers nurses to increase their involvement in decisions, often through the use of negotiation strategies. Due to the interwoven nature of these two agencies, in the context of this specific setting it appears difficult to separate the structural aspect (represented by nurses’ deferential relationship with medical
practitioners) from the agency aspect (epitomised by nurses’ actions on behalf of the patient), even though, for the sake of clarity, this thesis occasionally discussed these two strands separately. This is clearly reminiscent of the literature about structure-agency integration, most notably *Structuration Theory*, which proposes that structure and agency do not constitute two separate phenomena (a dualism), but are similar to two sides of the same coin, and therefore, a duality (Giddens, 1984; Hardcastle & Holmes, 2005). Similarly, nurses act as the critically ill patient’s moral agent within the constraints imposed by consultant agency, with both aspects forming part of the same central duality (dual agency) influencing nurses’ decisions about referring.

This also lends support to the notion, introduced earlier in this chapter (Section 6.4.2), that autonomy is not a singular or absolute concept but a relative one which is complementary to its opposite element, i.e. dependence (Giddens, 1984; Hardcastle & Holmes, 2005). In other words, a social actor or group is not *either* autonomous *or* dependent; rather, there are different *extents* of autonomy and dependence in different situations and at different moments. In this context, Giddens (1984, p. 15-16) proposes a “dialectic of control in social systems” whereby “all forms of dependence offer some resources whereby those who are subordinated can influence the activities of their superiors”. Subsequently, it is through social structures (i.e. the rules and regulations of the organisations) themselves that the party with less power tries to achieve some control and that the more powerful party attempts to maintain it (Hardcastle & Holmes, 2005, p. 226). Similarly, it was through their use of negotiation strategies that nurses in the present study attempted (and often managed) to enhance their participation in treatment modality decisions, thereby “bending but not breaking the rules” to use Bourdieu’s words, and “using the resources offered by the social system itself” to use Giddens’ terminology.

Nurses’ use of such negotiation strategies to enhance their moral agency in view of institutional structural constraints can also be discussed in terms of another social aspect. The present study suggests that these strategies and other aspects of referral are essentially learnt and mastered through experience, reflection and socialisation into the “norms” of the critical care unit (see Section 5.2.10). In other words, by learning from their own and their colleagues’ experiences of referral, nurses gradually integrate the structural rules into their own agency and modify their practice accordingly. Similarly, Bourdieu explains that, through socialisation, structure is brought ‘into’ agency and manifests as a set of habits, thereby developing what he calls *habitus* (Bourdieu, 1990; Bourdieu & Wacquant, 1992).
Habitus, therefore, includes the development of practical consciousness, norms, and rules of conduct which are influential but often implicit or tacit (Rhynas, 2010; Shove et al., 2012). According to Bourdieu’s Theory of Practice, an individual’s habitus is developed by experience and through socialisation, initially in the context of the home and subsequently in several social settings such as the workplace (Lynam, Browne, Reimer Kirkham, & Anderson, 2007), but not in formal academic settings (Rhynas, 2010). In the nursing literature, the development of habitus has also been compared to the way nursing students and newly qualified nurses use role modelling to observe how their more experienced colleagues get to know, interact with, and express their caring attitude towards patients (Rhynas, 2005; Moule & Goodman, 2009), and is also used in Savage’s (2003) exploration of the embodiment of nurses’ work. This also confirms that a significant portion of nursing knowledge is passed on through oral and experiential, rather than written, means (Flaming, 2003) and that the knowledge nurses use in their decision making is significantly influenced by their “cultural competence” (Hancock & Easen, 2006, p. 702). In the present study, the need to develop this cultural aspect of competence emerged quite significantly from data provided by non-national nurses. For instance, one participant related how, despite her substantial critical care nursing experience in her country of origin, she still needed to learn the ropes of referral in the local critical care setting, particularly because what should and should not be referred to, and authorised by, doctors differed significantly from that in her country of origin (refer to the effect of professional biography on the need for referral towards the end of Section 5.2.3).

In the context of relative autonomy, the participants also spoke about instances in which they preferred to seek help from their fellow nurses, rather than from doctors, not only because of their perceived superior competence in certain aspects of care “within their domain”, but also because this promoted a sense of collective esteem through being able to solve problems autonomously as a professional group (Section 5.3.5; Section 6.2.4). In these circumstances, it is nurses’ collective, rather than individual, agency that is being enhanced. Indeed, in the social sciences, while the term agency normally refers to the micro-level (i.e. the agency of individual social actors), it has occasionally been applied to social or professional groups, organisations and even entire nations (Ritzer & Goodman, 2004). In the latter situations, agency is applied at the macro-level, a situation which is comparable to the collective agency that is enhanced when nurses seek help from within their professional group rather than from physicians.
In summary, there several aspects related to nurses’ efforts to attain a degree of (relative) autonomy in the proposed substantive theory which are comparable to formal sociological theories about structure and agency and their interaction. First, nurses’ attempts at achieving some degree of autonomy, either individually or as a professional group, bear a resemblance to the discourse about there being different extents of dependence and autonomy, rather than either of them being a singular concept. Second, nurses’ use of several negotiating strategies to manoeuvre their participation in treatment modality decisions confirms that the expression of (some degree of) human agency requires several interpersonal competencies, including the ability to use “negotiation and diplomacy” (Williams & Sullivan, 2009, p. 10). Third, the manner in which nurses learn and master such strategies is comparable to the notion of developing habitus (Bourdieu, 1990; Bourdieu & Wacquant, 1992). Finally, dualities surrounding nurses’ decisions around referral, most notably the central organising phenomenon of dual agency, constitute an example of structure-agency interaction in the context of a critical care unit.

6.5 CONCLUSION

This chapter has presented a substantive theory in which nurses concurrently act as an agent to two different principals – medical practitioners and critically ill patients – and attempted to discuss it in the context of other empirical research and formal theories. Although there is considerable overlap, the proposed substantive theory deviates from conventional agency theory in several ways. First, agent scrutiny is only possible in the nurse-doctor strand of nurses’ dual agency relationship with medical practitioners and critically ill patients. Second, although nurses’ actions are formally regulated by a code of professional conduct, the day to day enactment of their relationships with their two principals is essentially governed by informal and unwritten culturally entrenched rules. Third, finances do not directly feature in the proposed theory; conversely, trust serves as a very significant means of non-financial remuneration. Fourth, in the proposed theory, the role of self-interest and goal conflict is much less central than that played in formal agency theory; indeed, the ultimate aims of nurses, critically ill patients and medical practitioners are usually similar. Yet, conflict frequently arises around the priorities and methods of achieving mutually beneficial aims. Fifth, the proposed substantive theory extends the meaning of information asymmetry to incorporate different types of knowledge – apart from different amounts of information – between the principal and the agent. Sixth,
although formal agency theory focuses on the potential misuse by agents of their information asymmetry with respect to principals, in the present study information asymmetry emerges as a means of enhancing nurses’ participation in decisions aimed at improving patient outcomes, a goal which they share with both medical practitioners and critically ill patients. Seventh, due to nurses’ state of both positive and negative information asymmetry with respect to medical practitioners, in the present substantive theory there is a flow of information between principals and agents in both directions; in conventional agency theory, on the other hand, information asymmetry is typically depicted exclusively in terms of agents’ superior amount of information relative to principals.

This discussion has also proposed a virtually unexplored link between nurses’ moral agency and their dual principal-agent relationship with patients and medical practitioners. Dual agency both enhances and impinges on nurses’ moral agency and is a potential source of moral distress due to the divided loyalty and conflicting priorities that characterise it. One aspect of dual agency, namely consultant agency, is characterised by power asymmetry and potentially restricts nurses’ moral agency. Concomitantly, acting on behalf of the patient empowers nurses to enact their moral agency and partly counteracts the constraints imposed by the power asymmetry between nurses and medical practitioners. By depicting nurses’ role of acting on behalf of their patients as intertwined with their obligation to act as consultants’ agents, the study contributes to the current debate about factors which deviate clinicians’ attention from being exclusively focused on promoting patients’ welfare, and underscores the importance of studying inter-professional healthcare relationships in the context of their potential effects on patients’ outcomes rather than in isolation.

In conclusion, the present work extends the applications of agency theory to healthcare in a number of relatively unexplored directions. First, while the health economics literature has often considered the doctor-patient relationship as the classic example of the principal-agent relationship in the healthcare sector, the present study suggests that this is also applicable to the nurse-patient relationship. Second, by portraying this type of relationship in a critical care context, the present substantive theory helps to underscore the significance of the nurse’s role in acting on behalf of the patient in a scenario of significant patient vulnerability, as well as the factors that enhance, mediate and potentially suppress this advocacy role. In particular, although nurses’ contributions to decisions about critically ill
patients’ treatment modalities have a potential of improving patient outcomes, their mindfulness of their deferential power relative to medical practitioners occasionally conditions nurses’ ability to safeguard the patient. Finally, this study explained nurses’ decisions about whether, at what point, and in what manner they seek help from doctors and/or attempt to participate in their patients’ treatment modality decisions as a series of dualities; it also elicited a balance between their concurrent roles of acting as their patient’s and the medical practitioner’s agent. In so doing, the generated substantive theory updates and extends the concept of dual agency in the health sector. Subsequently, nurses’ dual agency role as proposed in this work provides an application, in the context of a critical care unit, of the inseparability of the moral agency forces which enhance, and the structural forces which constrain, individual practitioners’ and their social group’s agency.

The next chapter discusses the implications for practice, management, education and further research arising from these contributions, with particular emphasis on critical care nurses’ role in improving critically ill patients’ outcomes. It also reflects on the limitations of the study and on my learning from these limitations and throughout the entire research journey.
Chapter 7

REFLECTIONS AND IMPLICATIONS

7.1 INTRODUCTION

This final chapter discusses the limitations within the study and my efforts at mitigating them, supported with references to authors advocating similar measures. Learning from these limitations and from other aspects of this research is made explicit and informs a number of implications for nurse education, practice, management and further research. The thesis concludes with a reflective summary of the study and its contributions.

7.2 LIMITATIONS OF THE STUDY AND SUBSEQUENT PERSONAL LEARNING

Despite my efforts at ensuring methodological rigour (Section 3.6), this study is impacted by a number of limitations. Several of these are related to the methodological decisions, while others are related to the general scope of the research study and my own inexperience in conducting this type of research at the onset of the project. First I address a methodological critique of grounded theory and the implications this raises for my own work.

7.2.1 Critique of grounded theory research

According to Bryant and Charmaz (2007a, p. 36), grounded theory has been criticised for its purported “epistemological naïveté, slipshod attention to data collection, questionable justification of small samples, presumed incompatibility of macro-questions, and hints of being unscientific”. The present subsection discusses such criticism in the context of the present study.

A frequent accusation levelled at grounded theory is that its “epistemological assumptions have not been clearly explicated” and that its “links with existing social theory have been decreased” (McCann & Clark, 2003b, p. 20). Conscious of this criticism, Chapter 3 of this thesis started by expounding the ontological, epistemological and theoretical perspectives
underpinning the study, while in Chapter 6 the generated substantive theory was extensively compared and contrasted with the extant empirical and theoretical literature about agency and dual agency from an economic, philosophical and sociological perspective. The latter point also helps to mitigate the criticism that grounded theory studies tend to emphasise the immediate contextual factors impinging on a phenomenon with little attention being given to the broader structural influences (McCann & Clark, 2003b). Indeed, structural influences on the social process of referral, as well as their interaction with individual agency, did emerge from the present data (Chapter 5) and in their engagement with the literature (see Chapter 6). In this context, Charmaz (2006) rebuts the criticism that grounded theory is incapable of addressing macro-sociological questions by arguing that this was an omission of early grounded theory authors when explaining methodological procedure, rather than a limitation inherent in the approach.

An important limitation of grounded theory which I acknowledge is its tendency to produce low-level theories providing detailed explanations of an area but with questionable ability to generically extend that explanation to other places and times (Charmaz, 2006; Buroway, 1991 cited in Urquhart, 2007). Admittedly, the scope of the project was to generate a substantive theory that explains “a tangible phenomenon in a clearly defined situation” (Glaser & Strauss, 1967, p. 156; Birks & Mills, 2011), even though efforts were made to “scale-up the theory” by relating it to the literature (Urquhart, 2013, p. 136). Despite this limitation, however, I would argue that the substantive theory generated through the present study has the potential to be elevated to a higher conceptual level of a formal theory, which therefore constitutes a notable implication for future research (see Section 7.5).

Birks and Mills (2011) observe that grounded theory projects are often (unjustly) criticised from their outset because they may initially lack a clear research question, do not attempt to verify a hypothesis or existing theory and are not clear on their sample size. Whilst this was the case at the beginning of this project as well, the present thesis attempted to be transparent about how the initial research question was conceived (in Chapter 1), about its eventual refinement and expansion on the basis of my reflections on the initial data (see Chapter 2), and about the sampling decisions in the different stages of the project (see Chapter 4). The fact that both purposive and theoretical sampling were adopted also helped to enhance the conceptual depth of the resultant theory as the exclusive use of purposive sampling tends to produce essentially descriptive findings (McCann & Clark, 2003a).
Conceptual depth was also enhanced by starting data analysis concurrently with data collection and by the use of successive inductive-deductive cycles, which helped to prevent premature closure (McCann & Clark, 2003b). Additionally, the use of a combination of data collection methods – observation and informal, formal and focus-group interviews – was indispensable in gaining insight to both the social process of referral and participants’ experiences of it (Chenitz, 1986b; Benton, 1996).

Doubt is sometimes cast on the nature and quality of the evidence generated by grounded theory research, particularly in view of the current evidence-based practice milieu which glorifies systematic reviews of randomised controlled trials as the gold standard of health related research and relegates grounded theory and several other forms of non-experimental research to lower levels in the hierarchy of evidence (Dawes, Davies, Gray, Mant, & Seers, 2005; Straus, Richardson, Glasziou, & Haynes, 2011). While acknowledging the value of double-blind randomised controlled trials and their systematic reviews in answering particular types of research questions, I would argue that different types of research questions necessitate different research approaches and methodologies, and that, for several reasons presented in Chapter 3, grounded theory was particularly applicable to the purpose of the present research study.

The constructivist approach to grounded theory has been criticised for allegedly imposing particular views on the data instead of generating theory from the data (Glaser, 2002). As explained in Chapters 3 and 4, several measures were adopted to prevent such “forcing”, including reflecting and writing about how my background might have influenced my views on the subject and how my perspective shifted along the research journey; my prolonged engagement with the data, during which I constantly attempted to keep an open mind to different interpretations; exposing my interpretations to the feedback of relative outsiders to the data and setting (namely, my academic supervisors and conference audiences); and sharing the emerging theory with the participants themselves to assess the relevance of the theory to the nurses from whom it was generated and their recognition of its constituent constructs.

7.2.2 Limitations in participant observation
Although, during fieldwork, every effort was made to engage in “persistent observation” (Lincoln & Guba, 1985), I am aware of the limitations of human observation in capturing all relevant events going on in a research setting. This is particularly so in a critical care
area in which multiple events and interactions occur simultaneously, potentially exposing the field researcher to observer fatigue (Latvala, Vuokila-Oikkonen, & Janhonen, 2000; Happ & Kagan, 2001; Caldwell & Atwal, 2005). The use of video recording (Scholes, 1996; Latvala et al., 2000; Caldwell & Atwal, 2005; Carroll et al., 2008) and/or photography (Riley & Manias, 2003; Riley & Manias, 2004) as an additional method of data collection might have mitigated a significant part of this limitation. In a series of recent studies investigating decision making during patient deterioration in several simulated settings, for instance, reviewing a video recording of the participants’ performance during subsequent interviews enhanced the participants’ reflective account of their decisions and the researchers’ elicitation of how theoretical knowledge and past clinical experience inform clinical judgement (Cooper et al., 2010; Endacott et al., 2010; Cooper et al., 2012; Endacott et al., 2012; Scholes et al., 2012).

Yet, although originally considered, this approach was not adopted because of its technical demands, financial constraints, and especially because of the difficulties to obtain ethical clearance (Olsen, 1998; Latvala et al., 1998). While I acknowledge that video “provides access to important and otherwise difficult to examine aspects of human interaction” (Büscher, 2005, p. 1), on reflection I also feel that the presence of one or more video cameras in an actual clinical area (rather than in a simulated one) might have affected the ease and speed with which an honest rapport was built with the research participants and other members of the research setting. Moreover, observer fatigue was partly addressed by discontinuing observation while the participant was on break, approximately half way through each observation session, which is in line with Happ and Kagan’s (2001) recommendations about conducting grounded theory research in critical care settings.

### 7.2.3 Limitations in recording informal interviews

The added value of audio and/or visual recordings has also been underscored by grounded theory authors, such as Urquhart (2013, p. 69), who argues that “a text loses the context when we cannot see the video or hear the tone of voice” and that “in the digital age, the importance of visual images, as opposed to text, cannot be denied”. Similarly, in order to capture the exact nature of conversations between nurses and doctors during referral and my own conversations (informal interviews) with the participants, the observation sessions should have ideally been audio and/or video recorded. For instance, in a study using fairly similar data collection methods, the researcher used a head mounted audio recorder (Bucknall, 2003). The use of head mounted video cameras during clinical decision making
research has also been proposed and implemented (Unsworth, 2008). This approach was, however, discarded due to its obtrusive and intrusive nature, and especially due to the ethical implications of unintentionally capturing conversations and/or footage of people who had not consented to take part in the study; of intimate caring interventions; and of the distress and anxiety of patients and their relatives. To compensate for this shortcoming, I took copious field notes about my observations of and conversations with participants, and separate memos were used to document my initial and subsequent reactions to them. Furthermore, as explained in Section 4.5.1, field notes from observation sessions and informal interviews were expanded as soon as possible, during or immediately after each participant observation session.

7.2.4 Blurred boundaries between observer and participant role

Although I feel that I generally managed to establish a balance between my ‘observer’ and ‘participant’ roles (refer to Section 4.5.1), my nursing background might have occasionally tipped this balance towards the ‘participant’ side, with the possibility of missing out on important observation data. For example, in some rare instances, during the observation sessions I accommodated requests for my assistance from nurses who were not taking part in the study when no such help from other nurses was immediately available. Thus, like Bailey (2007, p. 23), I had to constantly reflect and “struggle to see where my nursing role ends and where my researcher role beings”. Several methodological memos on the nature and extent of my participation (Davis, 1986), and constant reflection on whether the quality and quantity of the data I was gathering were addressing my research purpose (Schatzman & Strauss, 1973) were very helpful in this regard. Also, while acknowledging this as a possible methodological limitation, in retrospect I feel that momentarily suspending my researcher role in order to assist other nurses helped in fulfilling the ethical principle of respect for communities (Section 4.7.3); in enhancing my sensitivity to the issues related to the participants’ everyday life; and, indirectly, in facilitating the nurses’ acceptance of my presence in their setting to a greater degree than an exclusively “voyeuristic” observer approach would have, especially in view of the many sensitivities that this field holds.

7.2.5 Limitations due to self-reporting and observer effect

A substantial component of the findings on which the generated substantive theory was grounded was derived from interviews with the participants. Like all other forms of self-reporting, it is possible that the participants might have given me the answers which,
according to their perspective, I would have liked to hear (Barker, 1996a; Barker, 1996c; Polit & Hungler, 1998). Additionally, their behaviour during the participant observation sessions might have been somewhat affected by my presence (Barker, 1996b). It has been pointed out, however, that clinical personnel who are being observed while on duty are normally too busy with their work to feel self-conscious about being observed (Schatzman & Strauss, 1973). Also, as Frankeberg (1982) points out, it is unlikely that a single observer can change custom and practice built up over several years.

Several measures were taken in an effort to mitigate the potential distortions due self-reporting and observer effect on the participants’ behaviours. First, I ensured that all of my actions during the data collection sessions were documented so as to acknowledge their potential impact on the participants’ actions and answers (Davis, 1986; Erlandson et al., 1993). Secondly, the first part of each formal interview was specifically dedicated to debriefing about the preceding observation session and a discussion about the effects, if any, my presence might have made on the respective participant’s actions. In addition, I constantly reminded the participants that the aim of the interviews was to gather their perspective and that the aim of the observations was that of watching their actual everyday actions and interactions, and not to perform any form of judgement on their actions or perspectives. I feel that, to a large degree, this was valuable in obtaining the participants’ honest views about the issue at hand, as were my attempts to involve the participants themselves in decisions about the logistics of data collection, and eventually their involvement in enhancing verification and theoretical sufficiency of the emerging theory.

7.2.6 The implications of insider research

The fact that I was researching an aspect of my own profession might have led me to take certain aspects for granted, both in terms of interpreting what I observed and in the type of questions I asked (or did not ask) the participants. In view of this, one of the aims of the preliminary observation sessions was specifically that of learning how to look at familiar activities from a stranger’s position. In addition, during my informal, formal and focus group interviews, I frequently reminded the participants to express their views as they would to an outsider to the area of critical care. Subsequently, during the iterative process of collecting and analysing data, measures were taken to enhance my theoretical sensitivity, including the use of peer debriefing (through academic supervision), feedback from a wider audience of critical care practitioners (through conference posters and presentations) and the literature as conceptual levers. This was discussed in Sections 3.4
and 4.6.2. Finally, to ensure that the substantive theory emerging from the study actually reflected the participants’ views and experiences (rather than my own) the participants were involved in member checking, thereby ascertaining that they “recognised” the main concepts presented in the substantive theory and their relevance to their daily clinical practice (Schatzman & Strauss, 1973, p. 135). A detailed audit trail of these and several other research decisions was presented in Chapters 3 and 4, with particular attention to the methods used to enhance and maintain rigour (Section 3.6).

7.2.7 Limitations due to the self-selection of participants into the sampling pool
As explained in Sections 4.2.2 and 4.2.3, the participants in this study were selected by means of purposive and theoretical sampling. However, because of the ethical reasons discussed in Sections 4.2.1 and 4.7.1, nurses in this ICU were not directly individually asked to participate; rather, an invitation was made to all nurses, and those who were willing to participate opted in. Subsequently, purposive and theoretical sampling was performed from within this pool of “volunteer” potential participants, and not from the entire nursing workforce of the unit. Although the considerably large pool of 38 volunteers from which participants were sampled suggests a substantial range in the biographical and professional characteristics of the potential participants, it is still possible that the variation in motivations, strategies and preferences for referral are, in fact, even larger than those presented in this study, as the nurses who did not volunteer to participate and the volunteers who were not selected might hold significantly different perspectives from those of the nurses who were sampled. It must be pointed out, however, that even though theoretical sampling was guided by the emergent theory (not by representativeness), the biographical data of the participants does mirror that of their non-selected colleagues fairly closely in terms of age distribution, educational background, level of experience and nationality.

7.2.8 Limitations in transferability
The fact that this study is based on the perspectives of a relatively limited number of critical care nurses in one setting makes it difficult to generalise and transfer the findings beyond the context in which the data were elicited. Indeed, the aims underlying the present study were concerned with gaining a deeper understanding about this type of decision within the specific context of a local general intensive care unit. Due to the contextual differences between the critical care setting in this and other countries and between critical
care and other areas, even within the same hospital, wider generalisations undoubtedly require additional research.

7.2.9 **Failure to include doctors’ voice**

The purpose of this project and the research question guiding this study were essentially geared at eliciting the factors related to critical care nurses’ decisions to seek help from doctors; as such, data were gathered by observing and interviewing nurses working in an intensive care unit. Indirectly, nurses’ perceptions of doctors’ reactions to their referrals were elicited, as well as their impressions about some factors affecting nurses’ relationships with doctors and their effects on collaborative decision making. While the data and the resulting substantive theory appear sufficient in addressing the research question, I acknowledge that an even more complete picture about referring in critical care might have been depicted had data also been collected from medical practitioners themselves. As such, this constitutes an important implication for further research arising from the present study (refer to Section 7.5).

7.2.10 **Focus on one aspect of inter-professional collaboration**

The present study provides a deep exploration about the process of nurses seeking help from doctors and also from fellow nurses. However, there are other aspects of inter-professional collaboration in which nurses in this unit are involved, most notably their long established partnership with physiotherapists, medical technicians and, more recently, pharmacists. It was mainly the data elicited from the participants’ own actions and perceptions that gave overwhelming importance to their help seeking behaviours with regards to doctors and other nurses, rather than from colleagues in other professions. Furthermore, broadening the data to cater for additional types of referring might have compromised the depth of analysis. Nonetheless, I acknowledge that such data would have provided an even more complete picture of referring.

7.2.11 **Personal inexperience in naturalistic inquiry**

This was my very first experience in field research. Never before had I conducted interviews or engaged in participant observation as part of a research project, which, naturally, affected the quality of the data collected. Efforts to mitigate this limitation included in-depth reading about data collection methods and strategies, and attending educational activities for novice researchers. Most of my learning, however, occurred in the field itself. Looking back, Davis’s (1986, p. 64) declaration that “the best way to learn
how to observe in natural settings is to go out and do it” was certainly applicable to this study. Such learning was documented in a reflexive journal, excerpts of which were reproduced in Chapters 3 and 4.

7.2.12 Inexperience in managing qualitative data
This was also my first ever attempt at conducting qualitative research. The only other research studies I had conducted, as part of my undergraduate and master’s degree, had utilised a quantitative survey design with self-administered questionnaires and statistical analysis, and were essentially underpinned by a positivist / post-positivist perspective. Qualitative research – particularly its concurrent collection and analysis of data, the combination of purposive and theoretical sampling, and the importance it ascribes to the interaction between the researcher and the participants – was indeed a paradigm shift. While guidance from the literature and academic supervision helped tremendously to increase my confidence, I still acknowledge my limitation in handling qualitative data. Interpreting (rather than merely reporting) data, thinking abstractly and writing creatively were particularly challenging aspects, especially towards the beginning. Undoubtedly, however, this steep learning curve has contributed tremendously towards my personal and academic development, and as I approach the conclusion of this research journey I feel much more comfortable, cognitively and emotively, with the interpretative research paradigm.

7.2.13 Limitations due to word count constraints
Chapter 2 of this thesis placed the present study within the context of the decision making literature and highlighted what is known and what is not in the area under study. Furthermore, in Chapter 5, aspects of the present study’s findings were compared with those from earlier studies, while Chapter 6 conceptually compared and contrasted the emerging substantive theory with formal theories and their application to the health and other sectors. However, due to word count constraints, it was not possible to provide a critical appraisal of individual research studies, which, therefore, constitutes another limitation of the present thesis.

7.2.14 Perspective shifting and additional personal learning
As explained in several sections of this thesis, several methodological measures, including the adoption of a reflective stance and an open mind during the collection and interpretation of data, were used to ensure that the generated substantive theory adequately
reflects the realities of the participants. Yet, my own perceptions, beliefs, and values, have undoubtedly had an impact on the different stages of the present study, an aspect which is congruent with the dimensional analysis approach to generating grounded theory from the data (Bowers & Schatzman, 2009; Section 3.2.2). As such, my own professional biography and my views and prejudices about the phenomenon under study have been articulated in Chapter 1 and in several reflexive memos, examples of which were presented in Chapter 3. Also, besides eliciting several professional and empirical justifications for research in this area, the first two chapters presented some personal motivations for conducting this study and how these shaped the research question. Subsequently, in Chapters 3 and 4, an effort was made to provide a detailed audit trail of my research decisions and their rationale. While reflexivity was indispensable to ensure that I did not impose my views on the participants and their data, my reflections towards the end of this project indicate that my perspectives have actually been impacted by the data. Despite being a former practitioner within the same setting and having experienced referral first hand, my previous impressions about seeking help were that of a much more straightforward process. As explained in Chapter 4, the manner in which I looked at referral in critical care changed along the research journey from that of a critical care nursing practitioner and educator to that of a novice researcher. This made me ask questions the way an outsider would about an area with which I had previously considered myself acquainted. Only by looking at these familiar areas with a different lens did I start to realise how and why other nurses’ experiences, views and strategies related to referral could be substantially different from mine. Had I not endeavoured to shed my clinician / educator perspective, I would probably have been unable to capture several nuances and complex dualities underpinning referral and to subsequently identify the links within and beyond the substantive area I was investigating.

This project has also helped me appreciate the interpersonal and educational aspects of research and the surprisingly beneficial effects it may have for the participants and the researcher alike. While preparing my applications for institutional permissions and ethical approvals I naturally had to think of several potentially harmful effects of research on its participants and ways to prevent them, which led me to presume that any persons opting in the study would be doing so out of their generosity without getting much in return. While I am, indeed, extremely grateful to the nurses who took part in the study, I couldn’t help noticing that practically all of them stated that they actually enjoyed their participation, and that expressing their views and speaking about their experiences was an unusual
opportunity to reflect on their practice and a unique learning exercise. Even more significantly, I was surprised at how much I starting learning from the participants’ actions and stories. At the end of most data collection sessions, my feelings were quite similar to those at the conclusion of a particularly insightful lecture, mainly because I started to realise the differences in perspectives between people with a similar professional background to mine.

The latter insight was particularly significant in view of my move to a full time role in nurse education that had just preceded my registration into this doctoral programme. Indeed, as soon as I had started to grapple with my new role in teaching others, I had to face the steep learning curve associated with planning and conducting research in an unfamiliar paradigm. In addition, the fact that I was learning so much from my participants made me reflect on my role in, and approach to, teaching. I realised that the dictum that educators can learn from their students was not simply a cliché, and tried to apply it in my relations with the students with whom I work.

This research journey was accompanied by several challenges, such as having to balance the sheer amount of work, stamina and resilience it required with work, family and other commitments, as well as that of being a split-site student. Yet, my encounters and sharing of ideas with, and learning from, supervisors, lecturers and fellow doctoral students have undoubtedly helped to foster my academic development. Apart from developing competence and gaining confidence in a research approach with which I was totally inexperienced, the PhD programme, particularly the nature of academic supervision, has also prompted me reflect upon and attempt to improve the way in which I provide feedback to my students, particularly by encouraging their growth rather than simply correcting their work.

Notwithstanding the limitations discussed in this section, the findings from the present study should be helpful to practitioners, managers, and educators in facilitating the factors that support, and addressing those that hinder, nurses from implementing their important role in improving patient outcomes. As pointed out in Chapter 1, a nurse’s decision to seek help from doctors, which this study has explored in depth, is an important decision in its own right, specifically because the welfare of critically ill patients partly depends on nurses’ ability to determine whether and when to take certain actions, including that of
seeking help from other members of the multidisciplinary team. Furthermore, some of the limitations of the present study might be addressed through future work. These implications for management, practice, education and research are discussed in the rest of this chapter.

7.3 IMPLICATIONS FOR MANAGEMENT AND PRACTICE

Findings from this study portray local\(^{170}\) critical care nurses as being constantly mindful of their inferior decision making authority relative to senior medical practitioners, which partly explains why some of them occasionally fail to speak up for their patient. Indeed, nurses’ referrals – both to seek help and to suggest changes in patients’ treatment modalities – are conditioned by their concern that these might tarnish doctors’ trust in their ability to act as their agent (Sections 5.4.3 and 5.4.4). This somewhat resonates with the findings from the recent Mid Staffordshire NHS Foundation Trust public inquiry\(^{171}\) – which reported a “culture of fear in which staff did not feel able to report concerns” (Francis, 2013, p. 10) – and the review into the quality of care and treatment provided by 14 hospital trusts in England – in which “staff did not feel empowered to take action when they had identified an issue” (Keogh, 2013, p. 29) – with negative effects on patient outcomes in both scenarios. Local hospital managers should, therefore, introduce, encourage and sustain opportunities for organisational and peer support for all ICU healthcare providers, particularly those who, like the nurses in the present study, are vulnerable to moral distress due to frequent instances of being constrained from implementing what they consider best for their patients.

The finding that nurses’ moral agency is occasionally restrained by their desire to prevent conflict with medical practitioners, particularly consultants, has also been reported in other countries (see Section 6.4.4). However, the potential consequences are even greater in a small country in which opportunities for seeking other paths within the same clinical area are extremely restricted, and where a conflict with one’s colleagues, particularly those considered to have considerable power, might lead the nurse to leave that clinical area.

\(^{170}\) Given that this is the only fully fledged intensive care unit in this country (see Chapter 1), the term “local” as applied in this chapter mostly refers to the unit in which the study took place.

\(^{171}\) Although this and other reports which this chapter draws upon originated in a different country, it is still relevant to identify their connections with the present study, not only because several aspects are internationally overarching but also because, due to its smallness, the local healthcare system tends to seek insight from trends in other countries.
Nurse managers and healthcare administrators should, therefore, create systems and structures through which nurses can seek support and appeal in a formal manner, since at present only informal sources of such support are available. The significance of such efforts at a local level increases in view of the recent findings that a widespread “lack of value and support being given to frontline clinicians, particularly junior nurses and doctors” constituted a common barrier to the delivery of high quality care in several hospital trusts (Keogh, 2013, p. 5).

In view of nurses’ role in safeguarding critically ill patients, which the present study helped to shed more light on, it is indispensable that local hospital managers promote and maintain a clinical atmosphere which provides nurses with “the psychological safety to speak up if something has gone wrong” through the adoption of collegial, rather than hierarchical, attitudes (Gordon, cited in Larson, 2011, p. 2). Similar recommendations have been proposed in the often cited To Err Is Human document by the Commission on Quality of Health Care in America (Kohn, Corrigan, & Donaldson, 2000); in the Institute of Medicine’s Keeping Patients Safe document (Page, 2004); and, more recently, in the English NHS inquiries by Keogh (2013) and Francis (2013). The latter report, in particular, recommended that the oppressive “culture of fear…[is replaced] by a culture of openness, honesty and transparency, where the only fear is the failure to uphold the fundamental standards and the caring culture” (Francis, 2013, p. 75). What is particularly significant is the fact that in the present study this recommendation is based on data indicating that nurses’ effectiveness at, and at times willingness to, contribute to decisions affecting the patient are considerably affected by the perceived or actual reaction of doctors to their input, which is of concern given their well-documented responsibility to “rescue” their patients (see Chapter 1).

In this regard, important insights for collaboration, team building and effective inter-professional communication within this critical care unit can be drawn from the work on human factors training pioneered by the aviation industry, and subsequently applied to healthcare settings (Helmreich, 2000; Higton, 2005). Essentially, the difficulty in approaching and challenging senior colleagues’ decisions reported in the present and previous studies (e.g. Rodney & Starzomski, 1993; Henneman et al., 2010), which this thesis discussed in the context of the structural constraints to nurses’ moral agency (Section 6.4.2), are comparable to those experienced by junior or minimally experienced aviation staff in challenging flight captains’ decisions. The realisation that such “flaws or
characteristics of the human condition” (Higton, 2005, p. 781) were associated with the occurrence of accidents, with massive financial and human costs, led the aviation industry to institute crew resource management training, aimed at enhancing teamwork, improving communication and emphasising the acknowledgement of fallibility and ways of managing it. The effectiveness of such programmes in facilitating behavioural and attitudinal change, and subsequently improving safety, led to the promotion of Team Resource Management in several non-aviation sectors, including healthcare (Helmreich, 2000; Higton, 2005). It is envisaged that similar initiatives aimed at empowering the staff members of this unit to put safety concerns before other considerations would be helpful, not only in addressing the constraints to moral agency reported in the present study but also in improving staff morale and, indirectly, patient outcomes, given the latter’s association with collaborative practice (see Chapter 1). To borrow words from the Keogh report, health organisations, including the hospital in which the present study took place, need to “understand the positive impact that happy and engaged staff have on patient outcomes, including mortality rates” (Keogh, 2013, p. 12). Holding regular forums in which physicians and nurses can share unpleasant experiences related to collaboration and attempt to resolve differences (Tang et al., 2013) could be a step in the right direction.

This study lends support to the growing body of literature about the co-dependence of medical and nursing knowledge in making decisions about patients’ treatment modalities. Yet, the findings of this and other studies (see Section 6.4.5) also suggest that nurses occasionally have to downplay “their own” knowledge and discourse and “imitate” physicians’ preferred means of knowing and communicating in order to convince them about the need for treatment modality changes. Consequently, mutual appreciation of each profession’s knowledge should be placed higher on the education and leadership agenda, through measures geared at enhancing inter-professional collaboration and by increasing opportunities for shared learning at pre and post registration levels. In this sense, I fully concur with Gordon’s (1997, p. 1) argument that “doctors should learn a lot more about nursing in medical school; they should learn what nurses do…and should learn with nursing students at some instances”, because for health professionals to fully appreciate the contribution of other professions to patient outcomes collaboration needs to start from the very beginning of their socialisation into their profession. Starting to collaborate and to become familiar with each other’s role before qualification enhances subsequent inter-professional collaboration and trust (Larson, 2011), which is fundamental given that, according to the nurses in the present study, trust is as an important determinant of nurses’
decisions about who to seek help from and of doctors’ evaluation of nurses’ input in decisions (Section 6.3.4).

One tangible way in which inter-professional collaboration could be enhanced is through the nature of the ICU ward round. Internationally, physicians have acknowledged that “nurses provide the hub of patient care, and their involvement in the daily bedside clinical review is central to the effectiveness of the ward round” (Royal College of Physicians & Royal College of Nursing, 2012, p. 12); yet, nurses’ input, and sometimes even their presence, in ward rounds is inconsistent (Weber et al., 2007; Liu et al., 2012). Observational data from the present study indicate that the nurses working in this unit are invariably present at the bedside during ward rounds; however, according to the participants, the nature and extent of their participation varies substantially depending on the consultant’s characteristics. Subsequently, hospital managers should facilitate nurses’ (and other health professionals’) input in ward rounds and ensure that opportunities are in place for such contribution to be given consistently rather than haphazardly. Only in this manner can ward rounds become truly multidisciplinary and their “crucial communicative purpose” (Moroney & Knowles, 2013, p. 28) be tapped.

ICU nurses’ prolonged proximity to critically ill patients and their relatives, as well as a high nurse to patient ratio, emerged as important factors in nurses’ role of gathering contextual details about individual patients. This enhances their ability to make decisions, on their own and in conjunction with members of other professions, and potentially contributes to the improvement of patient outcomes. It is, therefore, recommended that these findings are taken into consideration should any reviews of the nurse-patient ratios in this unit be contemplated, particularly in view of recent evidence about the negative effects on patient outcomes when staff reductions are not preceded by a comprehensive risk assessment (Francis, 2013).

7.4 IMPLICATIONS FOR NURSE EDUCATION

An important motivation for nurses’ decisions to seek help from doctors emerging from the data is their own acknowledgement of their limitations in knowledge, skills and expertise in certain aspects of critical care when compared to medical practitioners, which this thesis has termed as negative information asymmetry (Section 5.2.8). This may partly stem from
the fact that most medical practitioners in this setting have to undergo continuous training, while opportunities for **continuing professional development for local critical care nurses** are more limited and voluntary in nature. Steps in the right direction have already been made through several continuing education initiatives for nurses organised by the intensive care unit itself – especially by the practice development nurse – and by the university to which the hospital is attached. Nonetheless, the scope and nature of these initiatives should be expanded, and nurse managers should consider making some aspects of nurses’ continuing professional development mandatory.

The study supports international research indicating that, like their counterparts in several other countries, local critical care nurses retrieve a significant portion of the information they require during clinical practice from human (informal) sources – namely their medical and nursing colleagues – rather than from published (formal) sources. It is, therefore, the onus of managers and educators to ensure that the best use is made of clinicians working in this unit who are regarded as highly knowledgeable and competent by their colleagues by providing them with adequate training to conduct **peer education** with fellow nurses. In this manner, role-modelling could be used as an important link between nurse education and practice. This is particularly important in view of the participants’ acknowledgement that they tend to choose such human sources of information on the basis of their assessment of the **person** from whom the information is sought, rather than on the **quality** of the information retrieved (see Sections 5.4.2 and 6.3.4).

The data revealed situations (discussed in Section 6.4.2) in which nurses’ moral agency is severely challenged by institutional constraints, most notably their deferential decision making power and the positional authority of medical consultants. Subsequently, nurse education should continue endeavouring to facilitate not only the academic and intellectual improvement but also the **moral development of nursing students and qualified nurses**. This would place nurses in the critical care and other settings in a better position to address such moral challenges, particularly that of concurrently acting as an agent to both the critically ill patient and the medical practitioner. The planning of such training in decision making and moral positioning could use insights from the findings to help nursing students and practitioners “recognise the many constraining (and sometimes enabling) structures in which they work” (Clifton et al., 2013, p. 517), and subsequently use the latter to moderate the effects of the former. In this thesis, this was exemplified in the use of negotiation strategies reported in Section 5.2.9 and discussed in Section 6.4.5. Ultimately, the aim of these educational initiatives should be that of instilling, with even greater intensity, “a
relentless focus on the patient’s interests and the obligation to keep patients safe and protected from substandard care”, even when this involves healthcare providers having to “put patients before themselves” (Francis, 2013, p. 66 and p. 86). The latter point is congruent with the UK Chief Nursing Officer’s current vision and strategy document which identifies courage as one of the values required in fostering a culture of compassionate care (NHS Confederation, 2012).

Nurse educators should also expand their efforts at **equipping current and future nurses with communication skills**. Local undergraduate programmes appear to focus on developing and enhancing communication techniques which aid nurse-patient interaction, particularly in terms of informing, educating, listening to, and empathising with patients and their relatives. While these are undoubtedly essential skills to master, there is room for improvement in training local nursing students and qualified nurses to communicate effectively with members of their own and other professions, including persons who are considered higher in the hierarchy. As such, findings from the present study should be particularly helpful in the planning of training programmes on making referrals, both to seek doctors’ help and to convincingly advise them to authorise changes in patients’ treatment modalities. In view of their positive information asymmetry (Section 5.2.4), special attention should be given to the manner in which the unique information which nurses often hold about their patients – including aspects of patient progress and deterioration – is communicated to other members of the healthcare team. The latter should be done in full awareness of the human factors affecting inter-professional referrals, which this study helped to cast more light on.

In summary, the management, practice and education implications at a local level arising from the findings of the present study include:

- Providing adequate organisational support in view of the morally distressing decisions facing the nurses working in this unit, particularly in view of their dual agency role;
- Empowering these nurses to consistently give their input in treatment modality decisions, and to speak up on behalf of critically ill patients in a psychologically safe atmosphere;
- Increasing the frequency of teambuilding activities aimed at fostering effective inter-professional communication and collaboration;
Providing more opportunities for inter-professional education at both pre- and post-qualification levels, not only to enhance clinical competence but also to increase each profession’s appreciation of the contribution by members of other professions to clinical decisions and outcomes;

Expanding the frequency, scope and nature of the existing continuing professional education programmes available for the critical care nurses working in this unit;

Formalising and supporting the peer-education which is presently occurring in an informal and spontaneous manner;

Enriching the moral development of critical care nurses and nursing students, thus enhancing their ability to address the dilemmas they encounter in clinical practice;

Intensifying and extending nursing students’ and qualified nurses’ training in communication and negotiation strategies, particularly in terms of approaching members of the multidisciplinary team whom they consider higher in the organisational hierarchy.

7.5 IMPLICATIONS FOR FURTHER RESEARCH

This study has contributed to knowledge about local critical care nurses’ decisions and motivations when seeking help from doctors. Essentially, however, this was based on data related to nurses’ perceptions, actions, and interpretations of those actions. It is now timely to gather and analyse data from the perspective of the other party involved in this type of referral, namely medical practitioners.

Future research might also focus on different health providers’ perceptions of the value of trust in intra- and inter-professional collaboration and joint clinical decision making. In particular, it would be worthwhile exploring doctors’ perceptions about critical care nurses’ clinical trustworthiness. This would build upon the present study’s contribution of eliciting trust as an important factor in nurses’ decisions about who to seek help from and in doctors’ evaluation of nurses’ input in treatment modality decisions.

A recurring duality in the data is the balance between the nurses’ desire for some degree of independent practice and their legal requirements to seek authorisation for their decisions. This can be problematic since it is often not entirely clear which exact actions can be performed with and without seeking medical authorisation (see, for example, the data in
parts of Section 5.2.2). It is, therefore, timely to attempt to evaluate the extent to which the local legal framework is comprehensive in accommodating the realities of these blurred roles. The current weighting, in legal or other terms, of the local nursing code of professional conduct should also be assessed, since practically no reference to it was made by any of the participants; in contrast, informal rules governing nurses’ inter-professional relationship with doctors were a constant undercurrent.

The present study has identified several individual characteristics of the nurse that have a moderating role in nurses’ decisions about whether, at what point and from whom they seek help, and the strategies they use to give their input to treatment modality decisions. However, the extent to which each is involved needs further exploration, possibly through the use of quantitative research.

This study confirmed international trends indicating that several of the decisions and actions implemented by nurses depend on information or advice provided by their medical and nursing colleagues. However, an assessment of the quality and salience of this information and knowledge shared within and between the professions was not within the remit of the present study, which indicates the need for conducting research or audit to evaluate this aspect.

According to the participants, a natural extension of nurses’ patient agency role is that of also safeguarding the interests of the relatives of critically ill patients. It is, therefore, worthwhile to explore the contemporary needs of these relatives in the local critical care context. This is important in view of the lack of recent local studies in this regard and because international research suggests a discrepancy between relatives’ expressed needs and critical care nurses’ perceptions of relatives’ needs (see Section 6.3.2).

Several instances in the data involve nurses in situations in which their ability to implement what they consider best for their patients is impeded by institutional requirements, suggesting the occurrence of moral distress. As yet, however, no studies have been conducted to formally assess the presence and extent of moral distress, professional satisfaction, intent to stay and their causes and moderating factors among local critical care nurses. Findings from such research and their comparison to those among nurses working in different clinical areas and critical care nurses working in other countries would be valuable, given the documented association of moral distress with
negative outcomes, both for nurses and for the patients assigned to their care (see Section 6.4.2). This is also timely in view of the growing body of evidence suggesting that perceived and actual inter-professional collaboration improves nurses’ professional satisfaction and subsequently their retention in the critical care setting (see Chapter 1).

While the present study did attempt to represent the voice of the non-national nurses working in the present critical care unit, it is recommended that studies similar to the present one are conducted in more cosmopolitan contexts in which nurses coming from even more mixed backgrounds work together. Findings from such studies would be relevant even locally, in view of the increasing mobility of health and other professionals from outside, and especially within, the European Union (Directive 2005/36/EC), which makes international communities of health professionals working in the same place increasingly likely, and indeed common.

This study focused on one facet of referring in a local critical care setting. Other aspects of referring worth exploring include different types of referrals involving nurses (e.g. nurses’ referrals to physiotherapists, medical technicians, and pharmacists), as well as referrals not directly involving nurses (such as referrals between junior doctors and consultants and those between ICU consultants and medical practitioners from another specialty). Eventually, the emerging substantive theory may be conceptually compared to data from such studies and from similar studies conducted in different countries. In this manner, by searching for new comparisons outside the substantive area, theoretically sampling the literature and using the latter as data, the substantive theory presented in this thesis might be generalised and conceptually elevated even further to generate a formal grounded theory (Glaser & Strauss, 1967; Glaser, 2011; Andrews, 2011). Indeed, generating a formal grounded theory may be considered as “the next logical step” after generating a substantive grounded theory (Andrews, 2011, p. 277).

7.6 CONCLUDING REMARKS

Prior to this study, it had been established that seeking help from colleagues within their own and other professions was one of nurses’ most frequent decisions. Yet, little was known about the personal, professional and contextual aspects related to the process of such referring in the critical care setting. Additionally, there was very minimal research on any aspect of local critical care nurses’ clinical decisions. The present study sought to
address these gaps by observing ICU nurses while on duty, conducting informal and formal interviews with them, and generating a substantive theory based on the findings.

Despite several limitations, the study contributes insight into inter-professional collaboration by providing an in-depth exploration of the phenomenon of referring within the critical care context. In so doing, it makes nurses’ potential and actual role in improving the outcomes of critically ill patients more explicit. This role is manifested not only through caring for and safeguarding critically ill patients and their relatives but also by contributing to decisions about their treatment modalities, either independently or in conjunction with ICU doctors. Indeed, the study underscores the interdependence of medical and nursing practitioners in improving patients’ outcomes and celebrates their complementary, yet distinct, knowledge. In particular, nurses depend on doctors’ authorisation and/or confirmation for several of their actions and need to seek their help to solve certain problems in patient management; concurrently, doctors’ decisions often rely on nurses’ extensive contextual information about the patients assigned to their care and on nurses’ specific knowledge and skills which enable them to implement the treatment modalities which doctors authorise.

By extending the applications of agency theory to the critical care setting, the study provides an original explanation of ICU nurses’ relationship with doctors and its effects on their ability to safeguard critically ill patients. While the literature has focused on the doctor-patient interaction as the quintessential example of a principal-agent relationship in the healthcare sector, the present study suggests that this is also applicable to both the nurse-doctor and the nurse-patient relationship. By illustrating the latter in a critical care context, the present substantive theory helps to underscore the significance of the nurse’s role in acting on behalf of the patient in a scenario of significant patient vulnerability, but also identifies important factors which inhibit them from this advocacy role. Additionally, the study contributes to the literature about the value of trust in health care relationships because it features as a non-financial form of remuneration and a prominent factor which influences both nurses’ decisions about who to seek help from and doctors’ evaluation of nurses’ contribution to treatment modality decisions.

The substantive theory generated from the findings, for the first time, explicitly portrays the critical care nurse as an agent to both the patient and his/her relatives on the one hand and the medical practitioner on the other. This suggests that inter-professional relations
between nurses and doctors should not be studied in isolation, but rather with due consideration of their effects on patient outcomes. This thesis also proposes a previously unexplored link between nurses’ moral agency and their dual principal-agent relationship with patients and doctors. Nurses’ moral agency is manifested through acting on behalf of their patients, but is often conditioned by the other principal in their dual agency role, namely the medical practitioner, a situation which makes negotiation and persuasion skills indispensable. Subsequently, the findings depict a contemporary representation of the various negotiation strategies used by critical care nurses in enhancing their involvement in decisions affecting the patient while acknowledging the positional authority of ICU consultants and protecting themselves from unnecessary risk. In this context, during my reading I recently stumbled on the introduction to a book called *When chicken soup is not enough: Stories of nurses standing up for themselves, their patients, and their profession* in which the author, Suzanne Gordon, laments that nursing is inundated with literature which, in its good intention of raising nurses’ morale, ends up reinforcing the traditional stereotypes about nurses’ work while downplaying the importance of some of the required interpersonal skills and activities which also emerged from the present study:

> Typically, these books refer to workplace challenges and issues but gloss right over the crucial tools needed to deal with them: bureaucratic manoeuvring...negotiating with doctors and hospital administrators, and conflict resolution (Gordon, 2010, p. xi).

I hope that this study is a step in the right direction in addressing this omission.

In conclusion, this study should provide valuable insight into the type of leadership and education that is required to enhance nurses’ courage to place patients’ interest at the forefront of their actions and interactions, without eroding the existing collaborative aspects within multidisciplinary teams. Its findings shed more light on how nurses decide whether, under what circumstances and from whom they seek help; increase our understanding of the motivations and nature of referring within a critical care setting; and help to explain the dilemmas which occasionally keep nurses from fulfilling what they consider to be the essence of their professional values – namely, protecting the patient. It emerged that nurses’ decisions about referral involve them weighing up several occasionally conflicting motivators, including a desire to act with some degree of independence; attempting to prevent personal and professional risk; and being constantly mindful of their asymmetrical decision making power relative to doctors. A central
consideration is that of balancing their moral obligation to safeguard critically ill patients’ interests with their duty to respect medical practitioners’ preferences. Although this suggests that patient safety is not always the only consideration underpinning their decisions about referral, it is encouraging to note that most nurses declared that they do intend to tip this balance in the patient’s favour, as embodied through this affirmation by one of the participants:

“As a nurse you constantly find yourself between the doctor and the patient, and the most important thing is that you have to keep a balance between pleasing the doctors and safeguarding the patient…saving the life of the patient! Ultimately, I prefer to save the life of the patient than pleasing the doctor.”

- Jennifer, Focus Group 2
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## Appendix I

### LITERATURE USE THROUGHOUT THE STUDY

<table>
<thead>
<tr>
<th>STARTING POINT</th>
<th>BODY OF LITERATURE (SELECTION)</th>
<th>AIMS</th>
<th>LOCATION IN THESIS</th>
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<td>Preliminary literature review</td>
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<td>Chapters 1 &amp; 2</td>
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<td>• Identifying gaps in the literature</td>
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<td>• Referral</td>
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<td>Chapters 3 &amp; 4</td>
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<td>• Grounded theory methodology</td>
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<td>• Symbolic interactionism</td>
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<td>Winter 2011</td>
<td>Ongoing literature review</td>
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<td>[Rationale and process described in Sections 3.4 and 4.6]</td>
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<td>• Viewing data with increasing levels of abstraction</td>
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Table A.1 – Aims of and sources for reviewing the literature during different stages of the study, with the corresponding timeline and the chapters in which the respective literature is reviewed.
Appendix II

PERMISSION FROM THE HOSPITAL CHIEF EXECUTIVE OFFICER

Ms. Marion Rizzo
Chief Executive Officer
Mater Dei Hospital

14th December, 2009

RE: PERMISSION FOR RESEARCH PROJECT

Dear Ms. Rizzo,

I am currently reading for a PhD (Nursing) with the University of Brighton. As part of my studies, I am proposing to carry out a research study which aims to explore the phenomenon of referral in critical care nursing. The working title guiding this project is: ‘Referral in Critical Care: Factors associated with nurses’ decisions to seek help from doctors’. This project is being supervised by Professor Julie Scholes, Professor of Nursing at the University of Brighton and Dr. Maria Cassar, Lecturer at the University of Malta’s Nursing Division.

It is envisaged that the sample for this study will consist of approximately fifteen nurses and five doctors working in the Intensive Therapy Unit. Data will be collected by means of observation and individual interviews. The project will be guided by the principles of grounded theory methodology. Participation will be entirely voluntary and will proceed only if the participants give their verbal and written informed consent. Should permission be granted, I plan to commence data collection in the spring of 2010.

I would like to inform you that the study has been academically approved by an independent Thesis Panel at the University of Brighton. Ethical approval has already been granted from the University of Brighton’s Research Ethics and Governance Committee and is currently being sought from the University of Malta’s Research Ethics Committee. Permission to carry out the study is also being requested from the Chairman of the Anaesthesia Department, the Medical Administrator and the Director Nursing Services, Mater Dei Hospital.

I would be extremely grateful if you give me your permission to carry out this study. Should you require further information about the proposed research project, do not hesitate to contact me by phone or email. Should you wish to contact my supervisors, their email addresses are J.Scholes@bton.ac.uk (Prof. Scholes) and maria.cassar@um.edu.mt (Dr. Cassar).

Many thanks in advance for your co-operation.

Sincerely yours,

JOSEF TRAPANI
Assistant Lecturer, Nursing Division
University of Malta
Appendix III

PERMISSION FROM THE HOSPITAL MEDICAL ADMINISTRATOR

Dr. Lina Janelova
Medical Administrator
Mater Dei Hospital

14th December, 2009

RE: PERMISSION FOR RESEARCH PROJECT

Dear Dr. Janelova,

I am currently reading for a PhD (Nursing) with the University of Brighton. As part of my studies, I am proposing to carry out a research study which aims to explore the phenomenon of referral in critical care nursing. The working title guiding this project is: ‘Referral in Critical Care: Factors associated with nurses’ decisions to seek help from doctors’. This project is being supervised by Professor Julie Scholes, Professor of Nursing at the University of Brighton and Dr. Maria Cassar, Lecturer at the University of Malta’s Nursing Division.

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I would be extremely grateful if you give me your permission to carry out this study. Should you require further information about the proposed research project, do not hesitate to contact me by phone or email. Should you wish to contact my supervisors, their email addresses are jscholes@bbn.ac.uk (Prof. Scholes) and maria.cassar@um.edu.mt (Dr. Cassar).

Many thanks in advance for your co-operation.

Sincerely yours,

Josef Trapani
Assistant Lecturer, Nursing Division
University of Malta

\[\text{I have no objection on condition you inform the Chairman Anaesthetics Dr. J. Scholes.}
\text{I seek his approval.}\]
\[\text{May I also ask you to ensure that all the laws of data protection are adhered to.}\]
\[\text{Josef Trapani 18/12/09}\]
Appendix IV

PERMISSION FROM THE HOSPITAL’S DIRECTOR OF NURSING SERVICES

Ms. Charmaine Attard
Director Nursing Services
Mater Dei Hospital

Through: Mr. John Cassar, Departmental Nursing Manager
         Mr. Peter Sant, Nursing Officer – ITU
         Mr. Joseph Fenech, Nursing Officer – ITU

14th December, 2009

RE: PERMISSION FOR RESEARCH PROJECT

Dear Ms. Attard,

I am currently reading for a PhD (Nursing) with the University of Brighton. As part of this project, I am proposing to carry out a research study which aims to explore the phenomenon of referral in critical care nursing. The working title guiding this project is: ‘Referral in Critical Care: Factors associated with nurses’ decisions to seek help from doctors’. This project is being supervised by Professor Julie Scholes, Professor of Nursing at the University of Brighton and Dr. Maria Cassar, Lecturer at the University of Malta’s Nursing Division.

It is envisaged that the sample for this study will include approximately 15 nurses working in the Intensive Therapy Unit. Data will be collected by means of an observation session (approx. 2 hours) and an individual interview (approx. 45 minutes) with each of the participants. The project will be guided by the principles of grounded theory methodology. Participation will be entirely voluntary and will proceed only if the participants give their verbal and written informed consent. Should permission be granted, I plan to commence data collection in the spring of 2010.

I would like to inform you that the study has been academically approved by an independent Thesis Panel at the University of Brighton. Ethical approval has already been granted from the University of Brighton’s Research Ethics and Governance Committee and is currently being sought from the University of Malta’s Research Ethics Committee. Permission to carry out the study is also being requested from the Medical Administrator and from the Chairman of the Anaesthesia Department.

I would be extremely grateful if you give me your permission to recruit nurses from the Intensive Therapy Unit to participate in this project. Should you require further information about the proposed research project, do not hesitate to contact me by phone or email. Should you wish to contact my supervisors, their email addresses are jscholes@brcm.ac.uk (Prof. Scholes) and maria.cassar@um.edu.mt (Dr. Cassar).

Many thanks in advance for your co-operation.

Sincerely yours,

JOSEF TRAPANI
Appendix V

DATA PROTECTION CLEARANCE

Subject: Study: "Referral in critical care: Factors associated with nurses' decisions to seek help from doctors"
From: "Agius Muscat Hugo at MDH" <hugo.agius-muscat@gov.mt>
Date: 20/01/2010 15:48
To: "Josef Trapani" <josef.trapani@um.edu.mt>

20th January 2010

Josef Trapani

Dear Josef,

With reference to the above-named study and previous correspondence on it, this is to confirm that, on the basis of the comprehensive documentation you submitted, from the MDH management data protection point of view you have been cleared to proceed with your study.

Good luck with your study.

Kind regards,
Hugo Agius Muscat

Dr H Agius Muscat MD MSc
Consultant
Data Protection Officer
Mater Dei Hospital
Tel: (00356) 2545 5334
INVITATION LETTER

‘Awwissu’
121, Triq Ħal Warda,
Ħ’Attard ATD 1409

Dear Colleague,

As part of my studies, I am conducting a research study in the Intensive Therapy Unit. I would hereby like to invite you to take part in this study.

The main aim of this study is that of exploring critical care nurses’ decisions to seek help from doctors during the course of their duty. To achieve this aim I would like to carry out observations of nurses at work at the Intensive Therapy Unit and then discuss in depth with them what I would have observed, through one to one interviews.

If you choose to participate in this study, your involvement will mainly consist of the following:

1. Allowing me to observe you, for not more than three hours, while working at the ITU.

2. Participating in an individual discussion (interview) with me following the observation session. The interview should not take more than one hour and will be audio recorded.

I would be very grateful if you choose to participate. Your participation in this study is, however, entirely voluntary. If you choose to participate, you will be free to withdraw from the study at any time without giving a reason. All information obtained from the observation sessions and interviews will be treated confidentially and will only be shared with my two academic supervisors once anonymised.

I would also like to inform you that this proposal has been reviewed and approved by the Research Ethics Committees of the University of Brighton and the University of Malta. Permission to conduct the study has also been obtained from the hospital administration.

If you accept to participate, will you please inform me, at your earliest convenience, by phoning me or sending me a message on 79211149 or by sending me an email on josef.trapani@um.edu.mt or else by informing your head of shift.

Many thanks for your co-operation.

JOSEF TRAPANI
Appendix VII

THANK YOU NOTE

‘Awwissu’
121, Triq Ḥal Wara, H’Attard ATD 1409

Dear

I would sincerely like to thank you for taking part in this study. Your participation is greatly appreciated.

Further to our conversation, should anything else come to mind, please do not hesitate to contact me by phone or email and I will be more than happy to meet you again.

Thanks again.

JOSEF TRAPANI

Tel: 79211149
Email: josef.trapani@um.edu.mt
Appendix VIII
EXAMPLE OF EARLY DIMENSIONALISING

This is an example of labelling data segments in an early attempt to identify dimensions. The left hand column shows segments from an interview transcript. The middle column includes labels for corresponding data chunks, some of which were eventually renamed more conceptually in later inductive-deductive cycles (refer to Section 4.6.2). The column on the right includes analytical and coding memos in which I record additional reactions to the data, and in which I compare and contrast the data from the present participant to similar or different ones obtained from earlier participants. A similar approach was adopted with observation field notes and focus group transcripts.

<table>
<thead>
<tr>
<th>DATA SEGMENTS (INTERVIEW TRANSCRIPT)</th>
<th>LABELS (EARLY DIMENSIONS)</th>
<th>MEMOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>[RESEARCHER:] We were discussing reasons for seeking help from doctors…</td>
<td>Communication breakdown</td>
<td>Clarifying what is expected…possibly different from verification (elicited in previous interview)</td>
</tr>
<tr>
<td>[JESSICA:] In the ward round, very often they discuss things between them and they don’t tell you straight forwardly “this is our plan”. So you need clarification. Most of the time you need to ask them to clarify what they have decided, or, rather than clarification, to inform you because they would discuss it between them sometimes and decide on things and don’t even tell you as the nurse. But then, other than that, if for example a patient is deteriorating, I will call for help. Or if I believe something should be changed I will approach a doctor as well. Because even though we have a protocol for NG feeding, different consultants want different things. So some of them, even if the patient isn’t absorbing, they tell you to continue for another few hours and then see; others will tell you to stop so kind of. For these sorts of decisions that you feel you cannot just take the decision and stick to it yourself. Or changes in the patient’s condition for the better or for worse that you feel something should be changed. You mentioned several reasons. Do you mind me clarifying what you mean by each? You mentioned deterioration for example. Imagine I’m an outsider to ICU; could you elaborate…? For example, a patient’s blood pressure starts to drop all of a sudden. Even if the patient is on noradrenaline, for example, sometimes you would need to know what the plan is because for some patients they may decide not to escalate treatment, for others the plan might be different. So you need to ask what the plan is. In such a case I would ask: “Am I going to keep increasing according to the blood pressure or am I going to leave everything as it is?”</td>
<td>Need for clarification</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Referral to seek help</td>
<td>Confirms the main reasons for referral from previous interviews</td>
</tr>
<tr>
<td></td>
<td>Referral to influence decisions</td>
<td>Protocols do not appear to reduce the need for referral</td>
</tr>
<tr>
<td></td>
<td>Different views of consultants, despite protocol.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Need for medical authorisation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Updating doctors</td>
<td></td>
</tr>
</tbody>
</table>
Or ventilator wise, for example, because sometimes if the PO₄s are really good we just go down ourselves on the FiO₂. But it depends as well on which doctor is on duty because some of them make you feel you have to ask everything before you touch anything. In that case, you have to make sure. Then some others really leave things up to you.

So, if I am understanding you well, there isn’t a clear cut decision about what you would need to refer or not?

No, not at all because it depends a lot on the consultant or the doctor. So it’s very up to who likes what…so if I’m not sure I ask. But there isn’t anything like rigid clear cut saying these are the decisions I can make, anything outside that circle I need to ask. It gets quite frustrating sometimes because you don’t know whether you are supposed to take this decision yourself or if is it better if I double check.

How does that make you feel?

Very frustrated. It makes me feel annoyed because there are certain things, I believe, that as a nurse you should be able to have a certain amount of responsibility. Otherwise what’s the point of working here, having a one-to-one nurse-patient ratio? Mind you, I understand my limitations hundred per cent; I’m not doubting my limitations and I know that there are things I can’t take into my own hands. But then, with other things like FiO₂, adjusting ventilator settings and other stuff like that, why shouldn’t I be able to take that decision myself?

You had also mentioned other situations in which you approach doctors…

First of all, I feel that if I am the one who is 12 hours by the patient, I think that what I have seen for example in five hours could influence what the plan is. For example, two of our consultants actually address you or ask you what you’ve seen. Sometimes they would ask “What do you think about …?” And they really make you feel you are really part of the team. With others during the ward round you sometimes feel you’re at the side to answer whatever questions they may ask and that’s as far as it goes.

So sometimes I do intervene because I say this is my patient, and if I don’t ask and leave it up to them, they’re never going to come and tell me anything. So in a way you feel more involved and you are having an influence in what’s being done for your patient.

Right! And how would you deal with these different scenarios? Let’s take the two extremes. How would you act in the case of a consultant who wouldn’t normally involve you?

It depends. There are certain consultants with whom if you know they’re in a hurry, or in a bad mood, they will make...
you feel this small in the ward round. If it is that case, I let it pass, and then I speak to one of the doctors, and whatever I have to say I say it to another doctor not the consultant. When I know they’re in one of those moods I avoid getting involved to the extent that I won’t get involved directly with the consultant, I’ll ask another more approachable doctor.

And if it’s a consultant who is asking your opinion, then of course I will say anything and everything I have to say, and I don’t hold back; they might not agree, but whatever I have to say I say it. But it depends a lot on their approach with you, and their mood. Sometimes they come in the morning and, you know, they’re going to pick on every single thing. So I keep my words with the consultant to a bare minimum and then I deal with somebody else, another doctor, but not the consultant. And it’s not a very nice feeling.

**I believe you also mentioned suggesting things yourself. Can you give me some examples?**

Yes, I do suggest changes. An example, which happens quite a lot. You keep aspirating from the NG, and they still tell you to continue the feed. They don’t tell you to start Maxalon. Then you aspirate another 220mls and you ask a second time and they still tell you not to give. And then last week, the third time, instead of saying like: “Shall I start Maxalon?” I said “Listen, this is the third time I have aspirated 200, I’m going to give Maxalon.” And then you say like “OK?” You just add something to show like you’re still waiting for their approval... but you don’t say “Shall I give?” because that in a way prompts them to say “no”.

**This morning I think you also mentioned this point about not provoking a “no” answer, but the context was a bit different...**

Yes. There’s a particular consultant who will never want to wean anything; you could have a patient with a systolic of 200, and noradrenaline is at 20, and, for example, in the handover for example the night nurse will says “Don’t wean; they don’t want us to wean”. And then, instead of saying: “Shall I wean?” I would tell her: “Listen the systolic has been 200 all night, I’m going to start weaning slowly, what do you think?” So I’m not telling her “Listen, this is my decision; that’s what I’m doing” because at the end of the day she is the consultant, you know? But try to put it in a kind or way where she says yes while feeling its her decision

<table>
<thead>
<tr>
<th>Bypassing the consultant</th>
<th>Avoidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>This STRATEGY was already mentioned by Jacqueline, but the former uses it consistently for one specific consultant, while Jessica apparently uses it according to the specific situation</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Asking leading questions</th>
<th>-Making the consultant feel she is taking the decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultants’ (negative) characteristics condition, but do not completely stifle, nurses’ input</td>
<td></td>
</tr>
</tbody>
</table>

This is a NEW strategy used in referral

<table>
<thead>
<tr>
<th>Asking leading questions</th>
<th>Making the consultant feel she is taking the decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is reminding me of the Doctor-Nurse Game!</td>
<td></td>
</tr>
</tbody>
</table>
Appendix IX

APPROVAL FROM THE UNIVERSITY OF BRIGHTON'S FACULTY OF HEALTH AND SOCIAL SCIENCE RESEARCH ETHICS & GOVERNANCE COMMITTEE

<table>
<thead>
<tr>
<th>Faculty of Health and Social Science Research Ethics &amp; Governance Proposal Review Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date: 03 December 2009</td>
</tr>
<tr>
<td><strong>Title of project:</strong> Referral in Critical Care: Factors associated with nurses' decisions to seek help from doctors.</td>
</tr>
<tr>
<td><strong>FREGC Application No:</strong> 09/45</td>
</tr>
<tr>
<td><strong>Name of Principal Investigator/Supervisor:</strong> Prof Julie Scholes</td>
</tr>
<tr>
<td><strong>Name of All Other Researchers/Students:</strong> Josef Trapani</td>
</tr>
<tr>
<td><strong>Reviewer's Names:</strong></td>
</tr>
<tr>
<td>1st Reviewer Dr Hannah Frith</td>
</tr>
<tr>
<td>2nd Reviewer Dr Catherine Caballero</td>
</tr>
<tr>
<td><strong>Outcome:</strong></td>
</tr>
<tr>
<td>Approved ..................................................................................................................</td>
</tr>
<tr>
<td>Approved with minor changes, the chief investigator or the supervisor should confirm in writing to the administrator of FREGC that the changes have been undertaken ...........................................................................................................</td>
</tr>
<tr>
<td>Return to researchers for major changes and resubmission to FREGC ..................................</td>
</tr>
<tr>
<td>Not approved ...............................................................................................................</td>
</tr>
<tr>
<td>NHS Sponsorship Recommended? Yes □ No □ N/A □</td>
</tr>
</tbody>
</table>
Appendix X

APPROVAL FROM THE LOCAL UNIVERSITY RESEARCH ETHICS COMMITTEE

To be completed by Faculty Research Ethics Committee

We have examined the above proposal and advise

Acceptance  Refusal  Conditional acceptance

For the following reason/s:

Signature  Date 14.04.10

To be completed by University Research Ethics Committee

We have examined the above proposal and grant

Acceptance  Refusal  Conditional acceptance

For the following reason/s:

Signature  Date 15.02.10
Appendix XI

INFORMATION LETTER TO PARTICIPANTS
( OBSERVATION AND INTERVIEWS )

‘Awwissu’
121, Triq Hal Warda,
H’Attard ATD 1409

Dear Participant,

Thank you for your interest in participating in this research study.

The main aim of this study is that of exploring critical care nurses’ decisions to seek help from doctors during the course of their duty. To achieve this aim I would like to carry out observations of nurses at work at the Intensive Therapy Unit and then discuss in depth with them what I would have observed, through one to one interviews.

If you choose to participate in this study, your involvement will mainly consist of the following:

1. Allowing me to observe you, for not more than four hours, while working at the ITU.

2. Participating in an individual discussion (interview) with me following the observation session. The interview should not take more than one and a half hours and will be audio recorded.

Your participation in this study is entirely voluntary and you are free to withdraw from the study at any time without giving a reason. If you choose to withdraw from the study, it might not be possible to remove all the data which you would have contributed up to that point in time, but your participation will stop immediately without any negative consequences whatsoever.

All information obtained from the observation sessions and interviews will be treated confidentially and will only be shared with my two academic supervisors once anonymised. If, during the observation sessions, you and/or the patient/s you are taking care of are placed at risk, I will stop the data collection and seek the help of the nurse in charge. The interviews will be transcribed and stored in my personal computer in password protected files. No data will be stored in the university’s mainframe computer. Any papers with information related to the research will be kept secure at all times.

Please be informed that the findings from this study may be shared with colleagues in conferences and/or published in journals. However, the identity of the individual participants will be not be revealed. Upon completion of the research study, you will be more than welcome to view the findings. The completed dissertation will also be available at the libraries of the University of Malta and the University of Brighton.
I would also like to inform you that the proposal for this study has been reviewed and approved by the Research Ethics Committees of the University of Brighton and the University of Malta. Permission to conduct the study has also been obtained from the hospital, department and unit administration.

Should you have any queries or require further information about the study, do not hesitate to contact me on 23401166 or 79211149. You may also send me an email on josef.trapani@um.edu.mt. Should you have any complaints in relation to the study, please feel free to contact my research supervisors. Their details can be found below.

Many thanks for your co-operation.

JOSEF TRAPANI

Research Supervisors

Professor Julie Scholes
Centre for Nursing and Midwifery Research
University of Brighton
Mayfield House, Room 263
Village Way
Falmer, Brighton
BN1 9RT
Tel: (0044) 1273 644078
Email: j.scholes@bton.ac.uk

Dr Maria Cassar
Nursing Division
Institute of Health Care
University of Malta
Tel: 2340 1139
Email: maria.cassar@um.edu.mt
Appendix XII

PARTICIPANT CONSENT FORM
(OBSERVATION & INTERVIEWS)

Participant Consent Form

Referral in Critical Care: Factors associated with nurses’ decisions to seek help from doctors

♦ I agree to take part in this research study which seeks to explore the factors related to critical care nurses’ decisions to refer to doctors when they want treatment modality changes for their patients.

♦ The researcher has explained, to my satisfaction, the purpose of the study and the possible risks involved.

♦ I am aware that the researcher is authorised by all respective parties, to carry out this research study within the ITU that I work in.

♦ The researcher has explained to me how data will be collected in this study. I have also read the information sheet. I understand the procedures of the research study fully.

♦ I am aware that I will be required to be observed by the researcher while working as a qualified nurse at the ITU, and to participate in an audio recorded interview carried out by the researcher.

♦ I understand that any confidential information will only be seen by the researcher and his academic supervisors. However, I am aware that in case I or the patients I am taking care of are placed at risk during the observation session, the researcher will stop collecting data and seek the help of the nurse in charge.

♦ I am aware that the findings of this study may be published or presented in conferences.

♦ I understand that I am free to withdraw from the research study at any time. I am also aware that, if I withdraw from the study, it might not be possible to remove data which I would have contributed up to that point.
Participant’s Signature:  
Researcher’s signature:  
Approved by:  

……………………………  ………………………………  ………………………………

Participant’s Name:  
JOSEF TRAPANI  
PROFESSOR JULIE SCHOLES  
Research Supervisor

Date:  
Date:  

……………………………  ………………………………

Researcher’s contact details – Mobile Phone: 79211149  
Email: josef.trapani@um.edu.mt
Appendix XIII

INFORMATION LETTER FOR FOCUS GROUPS

‘Awwissu’
121, Triq Ħal Warda,
H’Attard ATD 1409

Dear Participant,

Thank you for your continued interest in this research study.

The main aim of this study is that of exploring critical care nurses’ decisions to seek help from doctors during the course of their duty. To achieve this aim I have already conducted observations and individual interviews with nurses at working at the Intensive Therapy Unit. At this point, I would like to share my interpretation of the findings with the participants to gather their feedback.

If you choose to participate in this phase of the study, your involvement will mainly consist of participating in one or more group discussion lasting about two hours.

Your participation in this study is once again entirely voluntary and you are free to withdraw from the study at any time without giving a reason. If you choose to withdraw from the study, it might not be possible to remove all the data which you would have contributed up to that point in time, but your participation will stop immediately without any negative consequences whatsoever.

All information obtained from this discussion/s will be treated confidentially and will only be shared with my two academic supervisors once anonymised. These sessions will be audio-taped and stored in my personal computer in password protected files. Any papers with information related to the research will be kept secure at all times.

I would also like to inform you that the proposal for this study has been reviewed and approved by the Research Ethics Committees of the University of Brighton and the University of Malta. Permission to conduct the study has also been obtained from the hospital, department and unit administration.

Should you have any queries or require further information about the study, do not hesitate to contact me on 23401166 or 79211149. You may also send me an email on josef.trapani@um.edu.mt. Should you have any complaints in relation to the study, please feel free to contact my research supervisors. There details can be found below.

Many thanks for your co-operation.

JOSEF TRAPANI
Research Supervisors

Professor Julie Scholes  
Doctoral College – Falmer Campus  
Mayfield House  
University of Brighton  
Village Way  
Falmer, Brighton BN1 9RT  
Tel: (0044) 1273 644078  
Email: j.scholes@brighton.ac.uk

Dr Maria Cassar  
Department of Nursing  
Faculty of Health Sciences  
University of Malta  
Tel: 2340 1139  
Email: maria.cassar@um.edu.mt
Appendix XIV

FOCUS GROUP PARTICIPANT CONSENT FORM

Participant Consent Form

Referral in Critical Care: Factors associated with nurses’ decisions to seek help from doctors

- I agree to extend my participation in this research project.

- The researcher has explained, to my satisfaction, the purpose of the study and my role in it.

- I am aware that the researcher is authorised by all respective parties, to carry out this research study.

- The researcher has explained to me the nature of my participation in the study. I have also read the information sheet. I fully understand the procedures of the research study.

- I am aware that I am requested to take part one or more audio-recorded discussions.

- I understand that the researcher will not divulge any confidential information with anyone, except his research supervisors.

- I am aware that the findings of this study may be published or presented in conferences.
Participant’s Signature: ....................................  
Researcher’s signature: ..............................................  

Participant’s Name: ....................................  
JOSEF TRAPANI  

Date: ....................................  
....................................  

Researcher’s contact details – Mobile Phone: 79211149  
Email: josef.trapani@um.edu.mt  

Supervisors’ details:  

- Professor Julie Scholes – j.scholes@brighton.ac.uk  
- Dr Maria Cassar – maria.cassar@um.edu.mt
Appendix XV

RESEARCH STUDY POSTER

Josef Trapani, a PhD student at the University of Brighton, is carrying out a research study on critical care nurses' decision making.

As part of this study, he is observing specific nurses while on duty. Should you come in contact with the nurse he is currently observing, he would come to you and ask for your verbal consent.

josef.trapani@um.edu.mt
Appendix XVI

EDITING OF VERBATIM QUOTES FOR EASE OF READING

Individual and focus group interviews were transcribed verbatim in the few days after each data collection session. To facilitate reading, some of the quotes excerpted in Chapter 5 underwent minor (linguistic) editing without changing the meaning. To enhance transparency, an example of such editing is provided below:

Verbatim quote from Interview

There’s the social...because as a culture, we have a culture that the consultant everywhere has the biggest decision. So how come I, you know, the nurse of ITU would like to break all this culture one day? You can’t...we have to abide by culture, so if the culture is that we have to abide by what the consultants say...we have to... because the medical profession is up there and the nursing profession, culturally, was down there...there’s a divide...in our ITU it is present, it is. The juniors are more approachable, but some consultants...they have some...I think from their education, they were educated in a way that they are the one and only.

Edited quote presented in Chapter 5

There’s a social aspect as well...because, as a culture, we consider that the consultant always has the biggest decision. So how can I, an ICU nurse, break all this culture in one day? You simply can’t...we have to abide by this culture. So if the culture dictates that we have to abide by what the consultants say, we have to [seek their authorisation]...because the medical profession is up there and the nursing profession, culturally, was down there...there’s a divide in our ICU. Some doctors show it and some don’t. The junior doctors are more approachable, but some consultants...I think it’s from their education: they were educated in a way that makes them think they are the one and only.

- Judith, Formal Interview