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Nurse Perceptions of Physician-Nurse Collaboration in the Home Health Setting: A Pilot Study

Tameki Mongo
Gardner-Webb University

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Nurse Perceptions of Physician-Nurse Collaboration in the Home Health Setting: A Pilot
Study

by

Tameki Lavette Mongo

A thesis submitted to the faculty of Gardner-Webb University School of Nursing in
partial fulfillment of the requirements for the Degree of Master of Science in Nursing

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Submitted by:

Tameki Lavette Mongo

Approved by:

Dr. Janie Carlton

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Abstract

This quantitative, descriptive study surveyed 20 registered nurses in a single home health setting for the purpose of uncovering nurse attitudes toward physician-nurse collaboration. Particularly, the researcher was interested in whether the nurses held “positive” or “negative” attitudes. The data collection instrument was the Jefferson Scale of Attitudes toward Physician-Nurse Collaboration (JSAPNC). Study data was analyzed via means of descriptive and inferential statistics.

Although non-significant, the findings of this study indicate that nurses in this particular home health setting demonstrated positive attitudes toward physician-nurse collaboration. Age and number of years in nursing practice had no effect on total scores on the JSAPNC. The type of nursing degree did not seem to have an effect on total scores. Trends showed that those with the baccalaureate and master’s in nursing showed more positive attitudes toward physician-nurse collaboration than those with the diploma and associate degree. Nurses tended to demonstrate positive attitudes in each underlying factor category score of the JSAPNC, just as they did in total scores on the JSAPNC.

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Chapter I

Introduction

Defining Collaboration

Collaboration has been defined by many different authors. Morris (1973) called collaboration “working together, especially in a joint intellectual effort”. Most nursing attempts to define collaboration are with respect to interdisciplinary collaboration (Baggs & Ryan, 1990). As it relates to healthcare, collaboration has been defined as a process of joint communication and decision-making with a goal focused on satisfying the patient’s wellness and illness needs, while respecting the unique qualities and abilities of each professional (Coluccio & Marguire, 1983).

Some of the critical attributes of collaboration that have been established include “shared” planning, decision-making, problem-solving, goal-setting and responsibility (All-White, Charns, & Strayer, 1983). After reviewing the literature, Henneman (1995) identified some antecedents that must be present before collaboration can occur. These include a readiness to collaborate on the behalf of both parties, a sense of equality, an adequate understanding of each party’s contribution, and mutual respect and trust (Henneman, 1995).

Collaboration can occur in long-term relationships, as well as in fleeting encounters. Long-term collaborative relationships offer the opportunity for growth in collaborative relationships (Lindeke & Sieckert, 2005). On the contrary, short-term or fleeting opportunities for collaboration offer the opportunity for success in collaboration only once (Lindeke & Sieckert, 2005). Both have the capacity to cause lasting outcomes,

either positive or negative, on those collaborating and most importantly on those the collaboration is to benefit, the recipients of healthcare (Lindeke & Sieckert, 2005).

Collaboration can occur face-to-face or electronically (Lindeke & Sieckert, 2005). Regardless of the venue, the process must involve the exchange of views and ideas that consider the perspectives of all collaborators (Lindeke & Sieckert, 2005). Again, in order for this to take place, there must be a mutual respect and trust. This will lend itself to the most optimal outcomes for patients.

Significance of Physician-Nurse Collaboration

For some time now, the importance of effective physician-nurse collaboration has been widely documented in the literature. One study noted that a significant decrease in patient death rates in an intensive care unit was credited to excellence in physician-nurse collaboration (Knaus, Draper, Wagner & Zimmerman, 1986). The results of another study of 14 Magnet Hospitals indicated that there was a positive correlation between effective physician-nurse collaborative relationships and positive patient outcomes (Thomson, 2004). Other benefits include less fragmented care and less wasting of resources (Tschannen, 2004).

Effective collaboration is not only beneficial to patients, it also benefits the professionals involved in the process. Recently, The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) has also cited the building of collaborative relationships between physicians and nurses as crucial to positive patient outcomes (JCAHO, 2008). They are specifically targeting non-collaborative behaviors such as intimidation and other disruptive behaviors by physicians (JCAHO, 2008). JCAHO indicates that these behaviors are associated with poor patient satisfaction,

increased adverse outcomes and cost of care, as well as migration of nurses away from the nursing profession (JCAHO, 2008). As one method to combat these issues, JCAHO is calling on organizations and educational institutions to educate members of the healthcare profession on strategies to improve collaboration (JCAHO, 2008). All members of the healthcare team are dependent upon each other for information that will allow them to perform their individual jobs to the best of their abilities. As such, all that can be done must be done, in an effort to ensure effective collaborative relationships in healthcare organizations.

It is estimated that by 2020, the nursing profession will be deficient to the tune of 400,000 in the number of registered nurses (RN's) required for patient care delivery (Tschannen, 2004). The shortage of nurses is due to a number of factors, however, ineffective collaborative relations between physicians and nurses has been noted as one of the main causes. This is because ineffective or non-existent collaborative relationships leads to decreased job satisfaction, decreased empowerment, increased turnover, and increased burnout among members of the nursing profession (Tschannen, 2004). Other variables that can be positively affected include nurse recruitment/retention and increased morale (Tschannen, 2004).

Because physician-nurse collaboration affects patient outcomes significantly, the healthcare profession needs to get to work on increasing collaboration among physicians and nurses. Without doing so, a vision of quality in healthcare cannot and will not be realized. Now that problems with physician-nurse collaboration are evident, there must first be an attempt to understand each of the disciplines' perceptions about the issue. This study will attempt to delve into the perspectives of nurses in the home health setting on

this issue. Particularly, do the nurses hold positive or negative attitudes toward physician-nurse collaboration? Collaboration between nurses and physicians in the home health setting is of particular importance simply because of the physical distance between the two.

Theoretical Framework

Conceptual Model of Conflict Behavior

The theoretical framework used in this study comes from a conceptual model of conflict behavior. Evolution of the model has come from the work of Deutsch, Ruble & Thomas, and Kilman & Thomas. Deutsch and Ruble & Thomas conceptualized conflict management in one and two dimensions respectively (Kilman & Thomas, 1977). These dimensions are assertiveness and cooperativeness (Kilman & Thomas, 1977).

Assertiveness is defined as attempting to satisfy the concerns of one party, while cooperativeness is defined as attempting to satisfy the other party's concerns (Ruble & Thomas, 1977).

Through the work of Kilman & Thomas, a combination of the two above dimensions of conflict management led to the identification of five predominate intentions to which people defer in a conflict situation (Kilman & Thomas, 1977). These intentions include competing, collaborating, avoiding, accommodating, and compromising (Kilman & Thomas, 1977).

Competing describes when one is assertive and uncooperative. When one collaborates, they display assertiveness and cooperativeness (Kilman & Thomas, 1977). There is a desire to satisfy the concerns of each party, which leads to a mutually beneficial outcome (Robbins & Judge, 2009). The avoiding behavior yields unassertive

and uncooperative behaviors (Kilman & Thomas, 1977). Accommodating means one is unassertive and cooperative (Kilman & Thomas, 1977). Finally, compromising is defined as being intermediate in both assertiveness and cooperativeness (Kilman & Thomas, 1977).

Although the research indicates that people have predispositions to deal with conflict through a given one of the intentions described above, collaboration is thought to yield the best outcome (Robbins & Judge, 2009). The collaborating behavior is most optimal in the healthcare setting because healthcare professionals should be both assertive and cooperative in striving for the most positive patient and professional outcomes. Collaborating allows for all parties involved in a conflict to ultimately have their concerns satisfied.

Conflict between physicians and nurses exists for a number of different reasons. These include, but are not limited to, differences in practice functions, culture, gender, and perceived differences in power base (Nelson, King, & Brodine, 2008). Though conflicts will arise and are thought by some to be necessary for optimal outcomes, the goal of conflict management should be its resolution (Nelson, King, & Brodine, 2008).

Conflict as the Cause of Differences

Mary Parker Follet, an early industrialist and one of the first to study organizational conflict, suggested that conflict should be used to find the root cause of differences (Nelson, King, & Brodine, 2008). She noted that dealing with conflict involves domination, compromise, or integration (Nelson, King, & Brodine, 2008). Domination denotes that one party wins over the other (Nelson, King, & Brodine, 2008). In compromise, one party gives up something for the sake of keeping the peace (Nelson,

King, & Brodine, 2008). Domination and compromise should be avoided. The most effective of the three, integration, involves the integration of the desires of all parties involved (Nelson, King, & Brodine, 2008). Thus, both desires are in place and neither party has to give up anything.

The key to integration is communication (Nelson, King, & Brodine, 2008). As such, it is imperative that nurses and physicians communicate effectively.

Communication, along with assertiveness, cooperation, and integration lend themselves to optimal collaborations in healthcare.

Chapter II

Literature Review

A broad literature search was conducted through a search of academic databases. The databases searched included Academic OneFile, Academic Search Premier, Business Source Premier, CINHALL with FULL TEXT, Health Source: Nursing/Academic Edition, PsycARTICLES, and PubMed. Organizational websites such as that of JCAHO were also searched. The search yielded a wealth of information, however, only articles with the most relevance to the topic of this study are included.

Presentation of Studies

A 1990 descriptive study by Baggs and Ryan, researchers affiliated with the University of Rochester, NY, looked at the relationship between physician-nurse collaboration and nursing job satisfaction in the intensive care setting. They also sought to show how collaboration relates to nursing education, experience, and advanced practice. The results of the study were drawn from a sample of 68 intensive care (ICU) registered nurses (RN's) using questionnaires analyzed via regression analysis (Baggs & Ryan, 1990). The results were as follows. ICU nurses who practice more collaboratively were not found to be more satisfied with their jobs as evidenced by $r = 0.08$. However, a significant positive correlation (0.67) was found between collaboration and satisfaction in specific decision-making situations (Baggs & Ryan, 1990). Finally, it was concluded that older, more experienced nurses were less satisfied with collaborative practice experiences (Baggs & Ryan, 1990). Limitations of the study include the fact that the results may not be able to be generalized because the sample was taken from one ICU in one hospital

(Baggs & Ryan, 1990). Also, the variables of the study need to be studied in a broader variety of healthcare settings (Baggs & Ryan, 1990).

Tschannen, a nursing doctoral student at the University of Michigan completed research on the effect of individual characteristics on perceptions of collaboration in the work environment. The researcher used a cross-sectional, nonexperimental, retrospective design. The hypothesis that high levels of team orientation and organizational commitment (individual characteristics) result in higher levels of physician-nurse collaboration was supported at $r = 0.028$ for physicians and $r = 0.03$ for nurses (Tschannen, 2004). The size of the sample and also the absence of variation of work settings was also a limitation of this study (Tschannen, 2004).

A 2007 study by researcher Stacy Thomson, affiliated with the Wake Forest University Baptist Medical Center in Winston Salem, NC, compared the attitudes of physicians and nurses on collaboration in the medical-surgical patient care setting. This descriptive, prospective study used the Jefferson Scale of Attitudes toward Physician-Nurse Collaboration to obtain data. The results were not found to be clinically significant at $p > 0.05$, however, a trend was noted (Thomson, 2007). In general, nurses were found to have more positive attitudes toward physician-nurse collaboration than physicians (Thomson, 2007). Mean total scores were 52.7 and 47.6 for nurses and physicians respectively (Thomson, 2007). Limitations of the study included a small sample size, the use of only one sample setting, and the disproportionate participation of physicians and nurses in the survey (Thomson, 2007).

Nelson, King, & Brodine completed a study in 2008 on the perceptions of collaborative relationships between physicians and nurses on medical-surgical units. The

researchers used a convenience sample of physicians and nurses in collecting data using the Collaborative Practice Scale (CPS). Through univariate analysis, it was found that physicians had higher mean scores than nurses at 4.3 and 3.5 respectively (Nelson, King, & Brodine, 2008). Thus, physicians perceived more of a collaborative work environment than nurses. Also, an increase in collaborative perceptions was noted for physicians and nurses with more education and experience (Nelson, King, & Brodine, 2008). The education variable was significant at $p = 0.010$ and the experience variable was significant at $p = 0.0001$ (Nelson, King, & Brodine, 2008). Nurses with a job title and advanced certification was significant at $p = 0.044$ and $p = 0.0001$ (Nelson, King, & Brodine, 2008). Limitations of the study included a small sample size and data collection from only one medical-surgical setting (Nelson, King, & Brodine, 2008).

Another study sought to determine the attitudes of physician-nurse collaboration in the surgical setting. The researcher also sought to determine if there was a difference in the perceptions based on gender, nursing specialty, or length of experience. This study also showed that nurses had more positive attitudes toward collaboration than did physicians (Sterchi, 2007). Nurses mean total scores on the Jefferson Scale of Attitudes were significantly higher than that of physicians at $p < .000$ (Sterchi, 2007). Gender and nursing specialty were found not to be significant factors; however, length of experience was a significant factor affecting attitudes. In general, as physicians' years of experience increased, they demonstrated more positive attitudes toward collaboration and as nurses' years of experience increased; they demonstrated more negative attitudes toward collaboration (Sterchi, 2007). Limitations included a convenience sample, data collection from one setting, as well as disproportionate gender sample sizes (Sterchi, 2007).

The only piece of literature found targeting the home health setting had a purpose of describing strategies to facilitate effective physician-nurse collaboration. In the article, a registered nurse and a physician gave their personal perceptions on how physician-nurse collaboration can be increased. The nursing perspective suggested the implementation of delivery system strategies and interventions designed to improve communication (Markley & Winberry, 2008). The strategies included introducing the agency to the physician community, developing written agency procedures/guidelines for physician-nurse communication, and the establishment of standing orders to be implemented before a patient's condition worsens (Markley & Winberry, 2008).

The physician perspective suggested more continuity and follow up from home health agencies, increased physician participation in the home health plan of care, and improving general communication and collaboration between the physician and the home health agency (Markley & Winberry, 2008). The physician perspective also called for home health agencies to include the views of certain groups when attempting to improve communication and collaboration (Markley & Winberry, 2008). These groups included administrative personnel from both the agency and the physician group, the main physicians who order home health services, as well as secondary physicians who are also involved in the patient's care (Markley & Winberry, 2008).

A 2003 cross-cultural study by Hojat and colleagues compared the attitudes of physicians and nurses toward physician-nurse collaboration in America, Italy, Israel, and Mexico. Use of the Jefferson Scale of Attitudes toward Physician-Nurse collaboration uncovered differences and similarities among the above listed groups (Hojat, et al., 2003). The highest mean scores were found in American physicians and nurses (Hojat, et

al., 2003). Regardless of country, nurses demonstrated significantly higher attitudes than physicians regarding physician-nurse collaboration (Hojat, et al., 2003). Total mean scores were 51.5 for nurses and 46.3 for physicians (Hojat, et al., 2003).

In another study, the JSAPNC was administered to nursing undergraduate students to obtain attitudes on physician-nurse collaboration. Significant results were found that (1) women scored higher than men (2) scores were higher for students with healthcare work experience (3) scores were higher for students with higher levels of education prior to entry into nursing school (Ward, et al., 2008). These results were significant a $p < 0.05$ (Ward, et al., 2008). This study was also used in validation efforts for the JSAPNC.

Summary of the Literature

The literature review mostly contained interesting and in some cases conflicting evidence on the perceptions of physician-nurse collaboration from both the physician and nurse perspective. In light of this, more rigorous studies need to be done that include larger sample sizes using a variety of healthcare settings. This may create a better picture of physician-nurse perceptions of collaboration on which to base the development and implementation of strategies to improve physician-nurse collaboration.

With regard to the home health setting in particular, research needs to be done on the perspectives of collaboration in this setting. This is because collaboration plays a major role in healthcare outcomes in this setting. Only then can nurses reach out to members of other healthcare professions in an effort to improve the whole of intraprofessional healthcare collaborations.

Chapter III

Methodology

Research Design

This study used a quantitative descriptive research design. This type of design proved suitable because descriptive research designs are used to identify problems in current practice (Burns & Grove, 2005). It is also an important design for acquiring knowledge in areas where little research has been conducted (Burns & Grove, 2005). This study fit both of the above mentioned circumstances. The information gleaned from the study may identify a possible problem in the collaborative practice between physicians and nurses in the home health setting. Also, there has been virtually no research done on the perceptions of collaborative practice between physicians and nurses in the home health setting.

Sample and Selection Procedures

Participants for this study came from a population of nurses employed at one of the offices of a large home health specialty agency. These nurses only work in the home health setting. Registered nurses and licensed practical nurses that regularly interact with physicians in the provision of care to the home health patient were included in the study. The minimum sample size for the study was 20, with the goal being 30. According to Burns & Grove (2005), power analysis is only used in correlation, quasi-experimental, and experimental studies. This study is neither, thus power analysis was not used in determining appropriate sample size. The sampling method consisted of a combination of purposive, network, and convenience sampling. Purposive sampling was used because nurses who work regularly in home health will be able to offer a great deal of information

about the nurse/physician collaborative relationship in the home health setting. Home health nursing requires a great deal of collaboration and communication between physicians and nurses in order to coordinate patient care optimally. Network/convenience sampling was used in an attempt to add to the study sample size, as nurses involved in the study put the researcher in touch with others who met study inclusion criteria (Burns & Grove, 2005). Advertisement for participation in the study included flyers which were distributed in the office, announcements via company intranet, and verbal summoning methods.

Ethical Considerations

Each participant signed a consent form approved by the Gardner-Webb University Institutional Review Board. The consent form indicated the purpose of the study and explained the data collection process. It also noted that participation in the study was voluntary and could be revoked at anytime without fear of retaliation. In addition, the completion of the survey indicated consent to participate in the study. Risks and benefits of participation in the study were also explained to prospective participants. There were no foreseeable risks to participation in the study. A benefit of participation in the study was the attainment of valuable information regarding physician-nurse collaboration. Approval for the study from the agency from which data was collected was obtained through written approval from the office's Director of Nursing (under direction of the company's legal consultant, as the company did not have a formal internal review board (IRB) process). Data obtained during the study was kept confidential through the use of numerical codes instead of names to identify participants. These codes are stored in a secure place.

Measurement Method

The measurement method was the Jefferson Scale of Attitudes toward Physician – Nurse Collaboration. This tool is a survey. This method of data collection is thought to generate the most usable nursing knowledge regarding nurse “perceptions” or “attitudes” toward physician-nurse collaboration in the home health setting because issues in this area will be seen through the eyes of nurses, who are such a vital link in this process. (Mayo & Duncan, 2004) The instrument measures the attitudes of physicians and nurses toward authority, autonomy, responsibility for patient monitoring, collaborative decision-making, role expectations, as well as collaborative education (Dougherty & Larson, 2005). Identified underlying factors of the scale include shared education and teamwork (7 items), caring as opposed to curing (3 items), nurse autonomy (3 items), and physician dominance (2 items) (Hojat, et al., 2003). The instrument contains a total of 15 items scored on a 4-point Likert-type scale.

The instrument has established validity and reliability. In 2005, Dougherty and Larson completed a review of instruments used to measure nurse/physician collaboration and compared each for potential opportunities and strengths. In this review, it was found that the Jefferson Scale of Attitudes toward Physician-Nurse Collaboration demonstrated construct and content validity, as well as reliability. The instrument was initially tested by administration to a group of 208 first-year medical students and 86 nursing students in the upper-division of a baccalaureate program (Dougherty & Larson, 2005) The group represented 93% of their class (Dougherty & Larson, 2005).

Content validity was found via factor analysis with orthogonal varimax rotation in which six extracted factors had Eigen values greater than 1 (Dougherty & Larson,

2005). In regards to reliability, the Cronbach's alpha was 0.84 for medical students and 0.85 for nursing students (Dougherty & Larson, 2005). Total score correlations ranged from 0.65-0.40 with a median of 0.61 (Dougherty & Larson, 2005).

The fact that the instrument can be administered to both physicians and nurses is a noted strength (Dougherty & Larson, 2005). Further validity and reliability testing on the instrument was recommended to assess criterion-related validity (Dougherty & Larson, 2005). Limitations noted included the use of students with little practice experience to run tests of validity and reliability and that the instrument has been used primarily to measure the attitudes of physicians and nurses on the concept of collaboration across international and transcultural lines (Dougherty & Larson, 2005).

With respect to this study, it is important to note that the instrument was originally developed for use in the hospital setting. Approval to use and modify the data collection instrument for use in the home health setting was obtained from its developer via e-mail communications. See the appendix to view a copy of the data collection instrument.

Data Collection

The study data was collected over a two week period. Data collection tool packets were placed in the mailboxes of all nurses in the office of the home health agency in which data were collected. These packets included the measurement tool with demographic information and consent forms. Those who completed the packet were asked to return these in sealed envelopes, provided by the researcher, to the work mailbox of the nurse researcher in their office. Halfway through the data collection period, a reminder for questionnaire completion was sent via company intranet. Completed data

collection packets were collected daily by the investigator until the end of the data collection period.

Data Analysis

Data collected during the study was coded and entered into the computer for analysis. The data was analyzed using the PSAW statistical analysis application, version 18. The accuracy of the coding and data entry process was double checked by the investigator.

Chapter IV

Results

Descriptive Statistics

Surveys were distributed to 33 nurses in a Bayada Nurses Home Care office. A return rate of 60% was obtained. Twenty nurses completed and returned the survey. All nurses completing the survey were registered nurses and were female. All of the participants were specialized in home health nursing. The mean age for respondents was 42.6 with a standard deviation (SD) of 11.77. The age of participants ranged from 22-60. The mean value for number of years in nursing practice was 18.6, SD = 12.30. Number of years in nursing practice ranged from 2-40. See table 4.0.

Table 4.0 Descriptive Statistics of Participants According to Gender, Age, and Number of Years in Nursing Practice

	Gender of Participant	Age of Participant	Number of Years in Nursing Practice
N Valid	20	20	20
Missing	0	0	0
Mean	1.00	42.6000	18.6000
Std. Deviation	.000	11.76704	12.30490
Range	0	38.00	40.00
Minimum	1	22.00	.00
Maximum	1	60.00	40.0

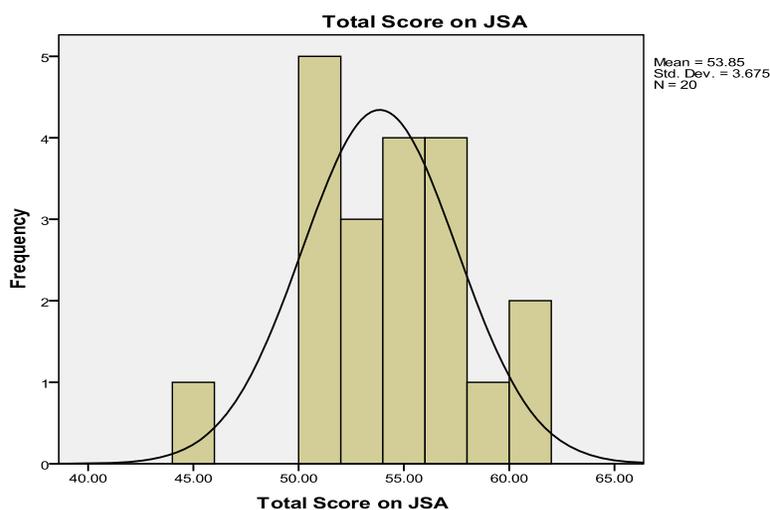
Table 4.1 shows the breakdown for degree type as follows: diploma = 20%, associate = 40%, bachelors = 25% and masters = 10%. Five percent of respondents did not specify their degree type.

Table 4.1 Participants by Type of Nursing Degree

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid .00	1	5.0	5.0	5.0
Diploma	4	20.0	20.0	25.0
Associates	8	40.0	40.0	65.0
Bachelors	5	25.0	25.0	90.0
Masters	2	10.0	10.0	100.0
Total	20	100.0	100.0	

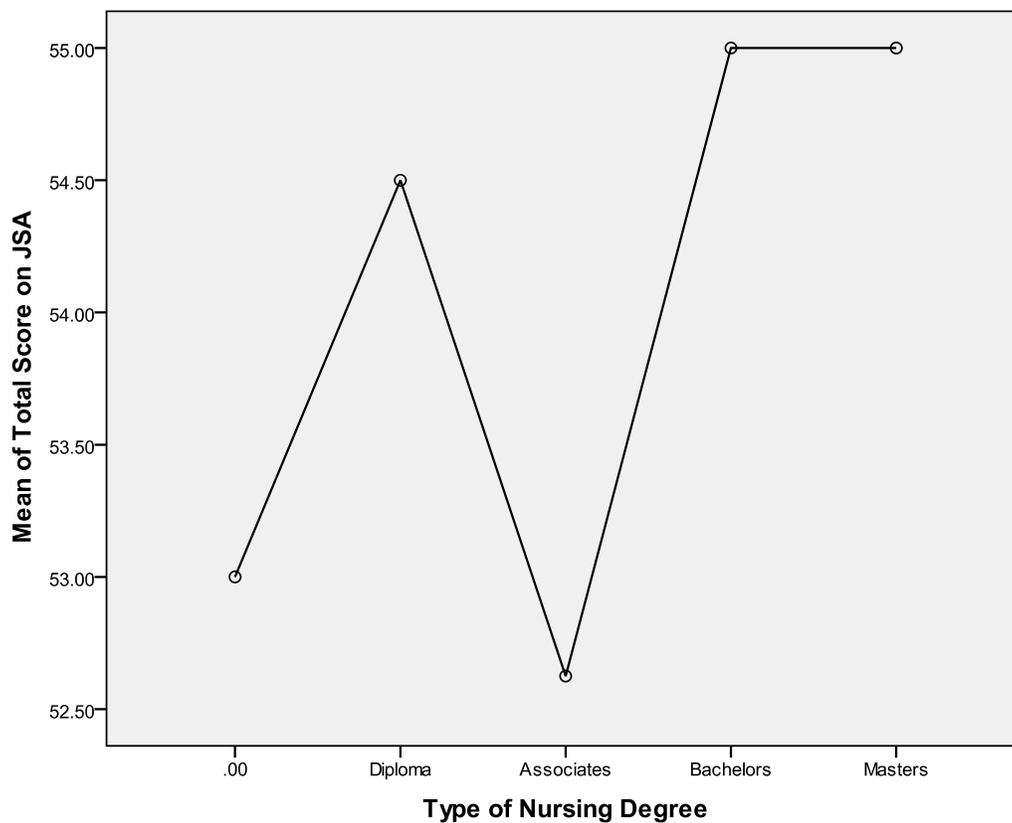
The total mean score for participants on the JSAPNC was 53.85, SD = 3.67. Mean scores ranged from 45.0-60.0. Figure 4.0 shows the total distribution of the nurse scores.

Figure 4.0 Distribution of Participants' Total Scores on the JSAPNC



Mean scores by degree type was 54.50, SD = 1.29 for diploma nurses, 52.63, SD = 3.81 for associate degree nurses, 55.0, SD = 7.07 for baccalaureate nurses, and 55.0, SD = 3.67 for master's prepared nurses. Refer to Figure 4.1.

Figure 4.1 Graph of Effect of Nursing Degree on Mean Total Score on JSAPNC



Factor scores were as follows: shared education and collaboration = 26.55, SD 1.96, caring vs. curing = 10.70, SD 1.34, nurse autonomy = 11.50, SD 1.15, and physician dominance = 5.1, SD 1.57. Refer to Table 4.2.

Table 4.2 Underlying Factor Score Means

	Shares Education and Collaboration	Caring vs. Curing	Nurse's Autonomy	Physician's Autonomy
N Valid	20	20	20	20
Missing	0	0	0	0
Mean	26.5500	10.7000	11.5000	5.1000
Std. Deviation	1.95946	1.34164	1.14708	1.58612
Range	7.00	5.00	4.00	6.00
Minimum	21.00	7.00	8.00	2.00
Maximum	28.00	12.00	12.00	8.00

Inferential Statistics

Bivariate correlation was used to determine if there were differences in total scores on the JSAPNC based on age or number of years in nursing practice. There was no correlation noted between age and total score on the JSAPNC $p = 0.382$, $r = 0.207$. There was also no correlation noted between number of years in nursing practice and total scores on the JSAPNC $p = 0.290$, $r = 0.249$. Refer to tables 4.3 and 4.4.

Table 4.3 Correlation Between Age and JSAPNC Total Score

	Age of Participant	Total Score on JSAPNC

Age of Participant	Pearson	1	.207
	Correlation		
	Sig. (2-tailed)		.382
	N	20	20
Total Score on JSAPNC	Pearson	.207	1
	Correlation		
	Sig. (2-tailed)	.382	
	N	20	20

Table 4.4 Correlation Between Number of Years in Practice and JSAPNC Total Score

		Number of Years in Nursing Practice	Total Score on JSAPNC
Number of Years in Nursing Practice	Pearson	1	.249
	Correlation		
	Sig. (2-tailed)		.290
	N	20	20
Total Score on JSAPNC	Pearson	.249	1
	Correlation		
	Sig. (2-tailed)	.290	
	N	20	20

One-way analysis of variance (ANOVA) was used to detect differences in total score based on degree type. The results were non-significant at $p > 0.05$. Refer to table 4.5.

Table 4.5 ANOVA: Total Score on JSAPNC and Degree Type

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	23.675	4	5.919	.381	.819
Within Groups	232.875	15	15.525		
Total	256.550	19			

Chapter V

Discussion

Study Findings/Limitations

Although results were non-significant, the findings of this study indicate that nurses in this particular home health setting demonstrated positive attitudes toward physician-nurse collaboration. Age and number of years in nursing practice had no effect on total scores on the JSAPNC. Likewise, the type of nursing degree did not have an effect on total scores. However, the trend showed that those with the baccalaureate and master's in nursing showed more positive attitudes toward physician-nurse collaboration than those with the diploma and associate degrees. These findings were consistent with previous studies by Ward and colleagues, as well as Nelson and colleagues. Also, nurses tended to demonstrate positive attitudes in each underlying factor category score just as they did in total scores on the JSAPNC.

Limitations rendering the study results unable to be generalized include the following: no male nurse representation in, the use of a small sample of convenience, data collection from only one setting, physicians not being included in data collection/analysis, and a non-diverse group of nurses in terms of background. The fact that the researcher had direct working relationships with survey respondents proved to be a limitation. Lastly, the researcher is a novice researcher.

The use of male representation would have allowed for comparison of score differences between male and female nurses. In future studies, more rigorous research methods need to be applied in the selection of the sample. Also, studies should be completed across a variety of healthcare settings using data collected from physicians as

well as nurses. The principal investigator need not share direct relationships with study participants so as to decrease bias in survey responses. Finally, the researcher being a novice could have contributed to methodological mistakes that could have affected the studies outcome negatively.

Communication of Findings

The findings of the study were presented to nurses, other healthcare workers, and peers at Bayada Nurses, as well as to School of Nursing Faculty at Gardner-Webb University. Utilization of oral presentation accompanied by power point presentation was used to communicate findings. These presentations took place at office team meetings and in the academic setting. Study findings were disseminated as requested.

Implications for Nursing

The dynamic changes occurring in health reform efforts in the United States call for healthcare as a whole to increase collaboration. Accomplishment of collaboration among healthcare professionals will require that each discipline understand and appreciate what it is they contribute to the whole. Effective collaborative relationships are imperative to positive patient outcomes, decreasing healthcare costs, and increasing healthcare professionals' job satisfaction. Thus, it is in the best interest of healthcare to perform more scholarly research in an effort to increase knowledge in the area and ultimately discover methods of improving collaborative relationships.

As the findings of this study are disseminated, there will hopefully be increased interest in research efforts examining the issues surrounding physician-nurse collaboration. As mentioned before, physician-nurse collaboration must be examined in a

variety of settings using a variety of differing research methods. If researchers can accomplish this, much will be done for the quality of healthcare.

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Appendix A
Institutional Review Board (IRB) Approval Form

Gardner-Webb University
Institutional Research Board

Application to Conduct Research with Human Subjects

(Researcher must complete this form before request can be submitted to IRB)

Name of Researcher: Tameki Lavette Mongo

Date: 10/06/10

Mailing Address: 2706 Black Cherry Dr., Charlotte, NC, 28262

Email Address: tmongo@gardner-webb.edu

Phone: 704-921-3029

Department: School of Nursing, MSN

Faculty Sponsor (if student research): Dr. Janie M. Carlton

Title of Research Project: Nurse perceptions of Nurse/Physician Collaboration in the Home Health Setting

What is your hypothesis/research questions(s): What are the nurse perceptions of the nurse/physician collaboration in the home health setting?

How many subjects do you expect to use, and how will you obtain this sample? The number of subjects will be 20-30, with 30 being the goal. A purposive/network sampling plan will be utilized.

What is your research methodology? Attach any tests to this form with the appropriate references. The research methodology that will be used is a quantitative research design. The Jefferson Scale of Attitudes will be used to collect data (see attached scale). Descriptive statistics will be used to present the data.

Describe the research procedure. Attach a copy of the consent form and a copy of the debriefing statement. Describe how and when these will be used. Data will be collected from nurses working in the home health setting. The questionnaires and consent forms will be placed in large, sealable, mailing envelopes and placed in individual nurse mailboxes in the Bayada Nurses office. The nurses will complete the questionnaire, seal the envelope, and return the envelope to the nurse mailbox of the researcher (Tameki Mongo) where she will collect them in 1-2 weeks.

Does this research pose risk to the subject? If so, what protocol will be enacted to protect the subject? There are no risks to the subjects.

Does this research involve deception of any kind? (If applicable, please explain.)

There is no deception involved.

Will any incentives be used? If so, please explain. No incentives will be used.

How will you protect the subject's right NOT to participate in your research?

Subjects will be informed that participation in the research study is voluntary and that the completion of the questionnaire will serve as their consent to participate in the study. If they do not wish to participate, they will not complete the questionnaire. There will be no ramifications if they choose not to participate-there will be no information collected that will identify who completed the questionnaire.

How will you protect the subject's confidentiality of results? No names will be placed on the completed questionnaire. Only the researcher will have access to the completed questionnaires. Summary of the results will be presented.

How, when, and where will the research results be reported? Results will be reported in the thesis paper and in the oral/visual presentation to the SON faculty. Results will also be made available to the participants and others from the home health agency who is interested in knowing the outcome.

If this changes, be sure to contact the IRB with an update. If, for example, a faculty member publishes research results, he/she should forward this information to the IRB.

When do you anticipate completing this research? December, 2010

Signatures:

Researcher _____ **Date** _____

Print Above Name _____

Faculty Sponsor _____ **Date** _____

(if student research)

Print Above Name _____

Required attachments:

- **Copy of Informed Consent Form**
- **Copy of Course Completion Certificate**

- **Permission to use published instruments (if applicable)**
- **Signed institutional permission or IRB application (if applicable)**

Appendix B

Approval for Research from Bayada Nurses, Inc.



p 21 10 09:13a

Tameki Mongo

704-921-3029

p. 1



September 14, 2010

To Whom It May Concern:

Tameki Mongo has been approved to conduct her thesis research for Gardner-Webb at Bayada Nurses' Cabarrus Visits office.

Sincerely,

Jo Ann Reed
Jo Ann Reed, RN MSN
Director
Bayada Nurses

Appendix C

Permission to Use Data Collection Instrument

Dear Tameki:

In response to your request, I am sending you a copy of the Jefferson Scale of Attitudes toward Physician-Nurse Collaboration, its scoring instructions, and a few relevant articles. You have my permission to use the scale in your not for profit research given that Jefferson Copyright sign printed at the bottom of the scale will appear in any copy you will be using in your project.

Good luck with your project and inform me of your progress,

(-:

Hojat

* Mohammadreza Hojat, Ph.D.

* Research Professor of Psychiatry and Human Behavior

* Director of Jefferson Longitudinal Study

* Center for Research in Medical Education and Health Care

* Jefferson Medical College

* 1025 Walnut Street

* Philadelphia, PA 19107, USA

*

* Voice-mail: (215) 955-9459

* Fax: (215) 923-6939

* E-mail: Mohammadreza.Hojat@Jefferson.edu

* Website: www.tju.edu/jmc/crmehc

*Webpage: http://www.tju.edu/jmc/crmehc/faculty_profile.cfm?key=mxh146

Dr. Hojat,

You recently granted me permission to use your Jefferson Scale of Attitudes as the data collection instrument in my thesis research examining the perceptions of nurses in the home health setting regarding nurse-physician collaboration. As your scale was originally intended for use in the hospital setting, I have been asked by my thesis advisor to ask you if the scale can be adapted for use in the home health setting. Basically, I just want to use the wording home health where you use hospital. Specifics are as follows:

(1) Instructions: For the purposes of this survey, a nurse is defined as a registered nurse (RN) who is engaged in providing or directly supervising the care of home health patients.

(2) #9. Physicians and nurses should contribute to decisions regarding the home health discharge of patients.

(3) #11. Nurses should be involved in making policy decisions concerning the home health support services upon which their work depends.

(4) Also, just wanted to ask if I can add other demographic information such as number of years in practice.

If you would grant me permission to do this, I will owe you everything as I am down to the wire trying to finish in December.

Dear Tomeki:

You have our permission to make those 4 changes described in your following e-mail message. Please specify clearly in your report all the changes made from the original scale. Did I send you the scoring instructions?

Good luck with your project and please inform me of your progress.

(-:

Hojat

Appendix D

Copy of Jefferson Scale of Attitudes toward Physician-Nurse Collaboration

c:\user\hmg\app\stat\local\mimso\off\in\index\temp\internet_files\flow\content_id51\trm\scf\physician-nurse%20collaboration[1].doc

JEFFERSON SCALE OF ATTITUDES TOWARD PHYSICIAN-NURSE COLLABORATION

INSTRUCTIONS: Please indicate the extent of your *agreement* or *disagreement* with each of the following statements by circling the appropriate number. For the purposes of this study, a *nurse*, is defined as one who participates in the care of patient(s) in the home setting.

Gender: _____ **Age:** _____ **Number of Years in Practice:** _____

Degree Type: _____ **Specialization:** _____

	Strongly Agree	Tend to Agree	Tend to Disagree	Strongly Disagree
1. A nurse should be viewed as a collaborator and colleague with a physician rather than his/her assistant....	4	3	2	1
2. Nurses are qualified to assess and respond to psychological aspects of patients' needs.....	4	3	2	1
3. During their education, medical and nursing students should be involved in teamwork in order to understand their respective roles.....	4	3	2	1
4. Nurses should be involved in making policy decisions affecting their working conditions.....	4	3	2	1
5. Nurses should be accountable to patients for the nursing care they provide.....	4	3	2	1
6. There are many overlapping areas of responsibility between physicians and nurses.....	4	3	2	1
7. Nurses have special expertise in patient education and psychological counseling.....	4	3	2	1
8. Doctors should be the dominant authority in all health care matters.....	4	3	2	1
9. Physicians and nurses should contribute to decisions regarding the hospital discharge of patients.....	4	3	2	1
10. The primary function of the nurse is to carry out the physician's orders.....	4	3	2	1
11. Nurses should be involved in making policy decisions concerning the hospital support services upon which their work depends.....	4	3	2	1
12. Nurses should also have responsibility for monitoring the effects of medical treatment.....	4	3	2	1
13. Nurses should clarify a physician's order when they feel that it might have the potential for detrimental effects on the patient.....	4	3	2	1
14. Physicians should be educated to establish collaborative relationships with nurses.....	4	3	2	1
15. Interprofessional relationships between physicians and nurses should be included in their educational programs.....	4	3	2	1

Appendix E

Jefferson Scale of Attitudes toward Physician-Nurse Collaboration

Scoring Algorithm

A respondent must answer at least 12 items (80%) of the 15 items; otherwise, the form should be regarded as incomplete and excluded from the data analyses. In the case of a respondent with 3 or fewer unanswered items, missing values should be replaced with the mean score calculated from items completed by the respondent.

To score the scale, items 8 and 10 are reverse scored items (Strongly agree=1... Strongly disagree=4). Other items are directly scored based on their Likert weights (Strongly agree=4... Strongly disagree=1). Total score is the sum of all item scores. The higher the score, the more positive attitudes toward physician-nurse collaboration.

Items in each of the four factors are as follows:

1. Shares education & collaboration: 1,3,6,9,12,14,15.
2. Caring vs. curing: 2,4,7.
3. Nurse's autonomy: 5,11,13.
4. Physician's authority: 8,10.

Appendix F

Consent for Study Participation

Study Title: Nurse Perceptions of Nurse-Physician Collaboration in the Home Health Setting

Investigator: Tameki Mongo, RN, BSN, (Gardner-Webb University-MSN candidate)

Should you choose to participate in this study, you will provide valuable information that may lead to improvements in the collaborative relationship between nurses and physicians in the home health setting, ultimately, improving the quality of patient care.

The study procedures have been approved by the Institutional Review Board at Gardner-Webb University, as well as a designated representative of Bayada Nurses. The study

procedure poses no known risks to participants. Participation in this study will take

approximately 5-10 minutes. Should you have any questions about the study you may

contact Tameki Mongo at 704-921-3029 (H) or 704-491-3556 (M). For information about

research participant rights or research related injury you may contact the Gardner-Webb

University Institutional Review Board at 704-406-6000.

Your participation in this study is completely voluntary. You may refuse to participate or withdraw from the study at any time without penalty.

Information you provide during the study will be kept confidential. Your name will not

be on the questionnaire you complete. Thus, at no time during the conduct, reporting, or

publication of the study will your identity be revealed. All study data will be collected

solely by the investigator and will be kept in a secure place.

I have read and understand the content of this consent form and voluntarily give my consent to participate in this study.

Subject's Signature

Date

I have thoroughly explained this research study to the above subject and have sought his/her understanding for informed consent.

Investigator's Signature

Date