INTERPROFESSIONAL MISPERCEPTIONS
AMONG PHYSICIANS AND NURSES
IN LONG-TERM CARE FACILITIES

by

ALBERTUS GUSTAAF ROSKAM

B.A., University of British Columbia, 1982
B.N., University of Calgary, 1986

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF SCIENCE
in
THE FACULTY OF GRADUATE STUDIES

(Department of Health Care and Epidemiology)

We accept this thesis as conforming
to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA

August, 1993

© Albertus Gustaaf Roskam, 1993
In presenting this thesis in partial fulfilment of the requirements for an advanced degree at the University of British Columbia, I agree that the Library shall make it freely available for reference and study. I further agree that permission for extensive copying of this thesis for scholarly purposes may be granted by the head of my department or by his or her representatives. It is understood that copying or publication of this thesis for financial gain shall not be allowed without my written permission.

Department of Health Care and Epidemiology

The University of British Columbia
Vancouver, Canada

Date August 31, 1993
Today’s comprehensive system of health care delivery requires knowledge and skills of physicians and nurses that neither profession can provide without collaboration from the other. Without this interprofessional collaboration, patient care will suffer from fragmentation, resulting in confusion and apprehension on the part of the patient. It appears that many benefits can be gained from appropriate collaborative team work between physicians and nurses. A systematic review of the literature shows that collaboration has led to improved patient outcomes such as decreased morbidity and mortality, and increased patient satisfaction. An increase in job satisfaction, as well as a decrease in health care costs are indicated in the literature as additional benefits.

Unfortunately, many barriers can stand in the way of the development of the realization of the collaborative team concept and its many potential benefits. Interprofessional misperceptions has been indicated in the literature as a barrier. It has been suggested that misperceptions can seriously interfere with any collaborative effort between health professionals.

Currently there is no research available on the levels of interprofessional misperceptions among the physicians and the nurses in long-term care facilities. To partially fill this void, this exploratory study has examined the interprofessional misperceptions among physicians and nurses in 13 long-term care facilities in Vancouver, British Columbia. For the purpose of this study interprofessional misperception has been defined as the difference between one professional’s perception on how the other professional would view an issue, and the viewpoint actually expressed by the other professional on the same issue. The interpersonal perception method has been used as the conceptual framework for the study.
A survey has been conducted among 28 physicians and 66 nurses. They volunteered to fill out a questionnaire called the Interprofessional Perception Scale, which has provided some insight into the subjects’ misperceptions.

Only small degrees of misperceptions were found among the two professions. In fact, the highest degree of misperception among 15 issues was still only 36%, and was found among the nurses regarding physicians’ views on whether nurses expect too much of the physicians. It was also found that significant numbers of physicians and nurses perceived that they have difficulties with the issues of professional territoriality, the under-utilization of their professional capabilities, and their lack of professional autonomy.

Thus, despite the failure to find substantial interprofessional misperception, the findings of the study suggest that there are issues between the physicians and the nurses in long-term care facilities that could be barriers to collaboration. There is a need for both professions to work toward an improved form of collaborative team work. To this end, several strategies for change are suggested as part of this study.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>ii</td>
</tr>
<tr>
<td>TABLE OF CONTENTS</td>
<td>iv</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>vii</td>
</tr>
<tr>
<td>ACKNOWLEDGMENTS</td>
<td>viii</td>
</tr>
<tr>
<td>CHAPTER 1 Introduction</td>
<td>1</td>
</tr>
<tr>
<td>The Purpose</td>
<td>1</td>
</tr>
<tr>
<td>The Definitions</td>
<td>1</td>
</tr>
<tr>
<td>The Problem</td>
<td>2</td>
</tr>
<tr>
<td>The Significance of the Study</td>
<td>3</td>
</tr>
<tr>
<td>The Data Source</td>
<td>4</td>
</tr>
<tr>
<td>A Profile of the Study</td>
<td>4</td>
</tr>
<tr>
<td>CHAPTER 2 A Review of the Literature</td>
<td>6</td>
</tr>
<tr>
<td>Introduction</td>
<td>6</td>
</tr>
<tr>
<td>Collaborative Team Work</td>
<td>7</td>
</tr>
<tr>
<td>Benefits of Collaborative Team Work</td>
<td>10</td>
</tr>
<tr>
<td>Barriers to Implementing Collaborative Team Work</td>
<td>15</td>
</tr>
<tr>
<td>The Barrier Created by Interprofessional Misperceptions among Physicians and Nurses</td>
<td>23</td>
</tr>
<tr>
<td>Make-or-Break Issues in Interprofessional Collaboration</td>
<td>25</td>
</tr>
<tr>
<td>Issue No. 1 - Professional Competency</td>
<td>27</td>
</tr>
<tr>
<td>Issue No. 2 - Professional Autonomy</td>
<td>30</td>
</tr>
<tr>
<td>Issue No. 3 - Professional Capabilities</td>
<td>33</td>
</tr>
<tr>
<td>Issue No. 4 - Professional Concern with Patient Welfare</td>
<td>34</td>
</tr>
<tr>
<td>Issue No. 5 - Professional Territoriality</td>
<td>35</td>
</tr>
<tr>
<td>Issue No. 6 - Professional Ethics</td>
<td>38</td>
</tr>
<tr>
<td>Issue No. 7 - Interprofessional Role Expectations</td>
<td>40</td>
</tr>
<tr>
<td>Issue No. 8 - Professional Status</td>
<td>43</td>
</tr>
<tr>
<td>Issue No. 9 - Professional Ethnocentrism</td>
<td>45</td>
</tr>
<tr>
<td>Issue No. 10 - Interprofessional Trust</td>
<td>47</td>
</tr>
<tr>
<td>Issue No. 11 - Interprofessional Advice</td>
<td>48</td>
</tr>
<tr>
<td>Issue No. 12 - Interprofessional Utilization of Capabilities</td>
<td>49</td>
</tr>
<tr>
<td>Issue No. 13 - Interprofessional Cooperation</td>
<td>51</td>
</tr>
<tr>
<td>Issue No. 14 - Professional Training</td>
<td>53</td>
</tr>
<tr>
<td>Issue No. 15 - Interprofessional Relationships</td>
<td>54</td>
</tr>
<tr>
<td>Demographic Correlates of Interprofessional Misperceptions and Team Work</td>
<td>57</td>
</tr>
<tr>
<td>Interprofessional Collaboration in Long-Term Care Facilities</td>
<td>61</td>
</tr>
<tr>
<td>Summary</td>
<td>63</td>
</tr>
</tbody>
</table>
### CHAPTER 3 The Research Methodology

Introduction 65
The Development of the Research Proposal 65
The Study Design 66
The Instrument Used for the Survey 66
The Research Procedures 69
The Methods of Data Analysis 72
Summary 74

### CHAPTER 4 The Findings

Introduction 75
Profiles of the Subjects in the Study 75
Findings on Each of the Fifteen Issues Measured by the Interprofessional Perception Scale 77
Issue No. 1 - Professional Competency 79
Issue No. 2 - Professional Autonomy 81
Issue No. 3 - Professional Capabilities 83
Issue No. 4 - Professional Concern with Patient Welfare 85
Issue No. 5 - Professional Territoriality 87
Issue No. 6 - Professional Ethics 88
Issue No. 7 - Interprofessional Role Expectations 90
Issue No. 8 - Professional Status 92
Issue No. 9 - Professional Ethnocentrism 94
Issue No. 10 - Interprofessional Trust 96
Issue No. 11 - Interprofessional Advice 98
Issue No. 12 - Interprofessional Utilization of Capabilities 100
Issue No. 13 - Interprofessional Cooperation 101
Issue No. 14 - Professional Training 103
Issue No. 15 - Interprofessional Relationships 105
Summary of the Degrees of Misperceptions Found among the Physicians and the Nurses in Long-Term Care Facilities 107

### CHAPTER 5 Discussion of the Findings

Introduction 112
Misperceptions among the Physicians and the Nurses 112
Discussions of the Findings for Each of the Fifteen Professional Issues 114
Issue No. 1 - Professional Competency 114
Issue No. 2 - Professional Autonomy 115
Issue No. 3 - Professional Capabilities 116
Issue No. 4 - Professional Concern with Patient Welfare 117
Issue No. 5 - Professional Territoriality 118
Issue No. 6 - Professional Ethics 119
Issue No. 7 - Interprofessional Role Expectations 121
Issue No. 8 - Professional Status 123
Issue No. 9 - Professional Ethnocentrism 125
Issue No. 10 - Interprofessional Trust 126
<table>
<thead>
<tr>
<th>Issue No. 11 - Interprofessional Advice</th>
<th>126</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issue No. 12 - Interprofessional Utilization of Capabilities</td>
<td>127</td>
</tr>
<tr>
<td>Issue No. 13 - Interprofessional Cooperation</td>
<td>128</td>
</tr>
<tr>
<td>Issue No. 14 - Professional Training</td>
<td>129</td>
</tr>
<tr>
<td>Issue No. 15 - Interprofessional Relationships</td>
<td>130</td>
</tr>
<tr>
<td>Summary of the Findings</td>
<td>133</td>
</tr>
</tbody>
</table>

**CHAPTER 6**

Conclusion | 138 |
--- | --- |
Introduction | 138 |
Summary of the Study | 138 |
Limitations of the Study | 142 |
Strategies toward Improved Team Collaboration | 144 |
Suggestions for Further Study | 153 |
Conclusion | 158 |

**REFERENCES** | 160 |

**APPENDIX A**

Interprofessional Perception Scale for the Physicians | 164 |

**APPENDIX B**

Interprofessional Perception Scale for the Nurses | 165 |

**APPENDIX C**

Agency Consent Form | 166 |

**APPENDIX D**

Introductory Letter to the Physicians | 167 |

**APPENDIX E**

Introductory Letter to the Nurses | 168 |

**APPENDIX F**

Poster | 169 |

**APPENDIX G**

Follow-up Letter to the Physicians | 170 |

**APPENDIX H**

Follow-up Letter to the Nurses | 171 |
<table>
<thead>
<tr>
<th>TABLE</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Demographic Data of all the Participating Physicians in the Study on Interprofessional Misperceptions</td>
<td>76</td>
</tr>
<tr>
<td>2</td>
<td>Demographic Data of All the Participating Nurses in the Study on Interprofessional Misperceptions</td>
<td>78</td>
</tr>
<tr>
<td>3</td>
<td>Response Rates of the Staff Nurses Across the Three Professional Designations</td>
<td>79</td>
</tr>
<tr>
<td>4</td>
<td>List of the Degrees of Misperceptions Represented by Percentages Found Among the Physicians and the Nurses in Long-Term Care Facilities</td>
<td>107</td>
</tr>
<tr>
<td>5</td>
<td>List of Issues Around Which There is No Misperception Found Among Either the Physicians or the Nurses in Long-Term Care Facilities</td>
<td>111</td>
</tr>
<tr>
<td>6</td>
<td>Demographic Data of the 29% Nurses Who Say that Physicians in Long-Term Care Facilities Are Not Highly Ethical</td>
<td>120</td>
</tr>
<tr>
<td>7</td>
<td>Demographic Data of the 44% Nurses Who Say that Physicians Do Expect Too Much of Nurses in Long-Term Care Facilities</td>
<td>122</td>
</tr>
<tr>
<td>8</td>
<td>Demographic Data of the 9% Nurses Who Say that Nurses Do Have a Higher Status than Physicians in Long-Term Care Facilities</td>
<td>124</td>
</tr>
<tr>
<td>9</td>
<td>Demographic Data of the 18% Nurses Who Say that Physicians Do Not Have Good Relations With Nurses in Long-Term Care Facilities</td>
<td>132</td>
</tr>
</tbody>
</table>
ACKNOWLEDGMENTS

My thanks are extended to the Administrators and Directors of Care, who have given me their consent to include their respective long-term care facility in the study. I also am very grateful to the physicians and the nurses who volunteered to participate in the study.

I particularly would like to thank Dr. Lawrence Green for directing the course of this study, and Dr. Anna Marie Hughes and Ms. Ruth Milner for serving on my committee.

To my family and friends who gave me encouragement and support throughout my Master’s Program, I extend my sincere thanks.
CHAPTER 1

Introduction

Today’s challenges in health care consist of rapid technological changes, ethical and moral dilemmas, and cost constraints (Ornstein, 1990; Fagin, 1992). These challenges have made it necessary for health professionals to function as members of a collaborative health care team. The necessity for collaborative team work definitely applies to the physicians and the nurses in long-term care facilities, which is the group of professionals addressed by this study.

Historically it appears to have been a rather difficult task for physicians and nurses truly to work collaboratively with each other. In fact, in the eyes of some, the concept of collaborative team work might be only an illusion (Nason, 1983). There appear to be many barriers between physicians and nurses, which stand in the way of the collaborative team concept.

One barrier is created by misperceptions between physicians and nurses. Banta and Fox (1972), Jacobson (1974), and Ducanis and Golin (1979) point out that misperceptions will seriously interfere with any collaborative effort between health professionals.

The Purpose

The purpose of this study is to investigate the degrees of misperceptions that physicians and nurses in long-term care facilities may have about each other.

The Definitions

For the purpose of this exploratory study the following definitions are used.
Collaborative Team Work.

Collaborative team work is "a joint communication and decision-making process between medical staff and nurses with the goal of meeting the patient’s wellness and illness needs as best as possible, while respecting the unique qualities and abilities of both professions" (Ornstein, 1990, p. 10).

Interprofessional Misperception.

Interprofessional misperception is the difference between one professional's perception on how the other professional would view an issue, and the viewpoint actually expressed by the other professional on the same issue.

Physicians.

Physicians are the professionals who provide medical care to the patients in any of the 13 long-term care facilities that have been included in the survey.

Nurses.

Nurses are professionals who provide nursing care to the patients in any of the 13 long-term care facilities that have been included in the survey. They work either as regular full-time or part-time staff nurses, and they are registered nurses, registered psychiatric nurses, or licensed graduate nurses.

The Problem.

Recent developments in long term care have made the issue of collaboration between physicians and nurses in this sector of our health care system a more urgent matter then it has been ever before (Ornstein, 1990; Samuelson, 1992). Ornstein (1990) points out that changes in
demographics have placed new demands on physicians and nurses in long term care. Larger numbers of elderly patients are admitted to long-term care facilities. Not only are the numbers larger, the patients that are admitted also present with health problems that require more complicated care than ever before. Faced with these new demands the physicians and the nurses in long term care are urged to take a closer look at how well they collaborate with each other (Samuelson, 1992). How one profession views another is a crucial factor contributing to the degree to which interprofessional collaboration occurs. Examining the extent to which physicians and nurses in long-term care facilities do not share perceptions with one another can provide an important measure of potential conflict areas in the long term care setting.

The Significance of the Study

The poor collaborative status of today’s health care teams is a serious matter. Especially if the significant benefits of collaborative team work are being considered, it becomes quite apparent that the genuine implementation of collaborative teams is long overdue. Research evidence has linked appropriate collaborative practice to improved patient outcome and increased levels of job satisfaction, as well as a decrease in overall health care costs (Beloff and Korper, 1972; Ducanis and Golin, 1979; Anderson and Finn, 1983; Ritter, 1989; Ornstein, 1990; Fagin, 1992). When these consequences are the benefits of collaborative team work between physicians and nurses, no time should be wasted to analyze the divisive forces that somehow prevent the two professions to mutually commit to the collaborative team concept.

As pointed out already the study focuses specifically on physicians and nurses in long-term care facilities. Many of the challenges that today’s health care system is facing are found right in the domain of long term care. These challenges stress the need to specifically explore possible barriers to the current collaborative team work in long-term care facilities.
The results of this study show how the physicians and the nurses in long-term care facilities in Vancouver view one another. The research findings on interprofessional misperceptions provide helpful insight to today's health care managers in long term care. The managers can use the information to further guide the interprofessional relationship between physicians and nurses in long-term care facilities toward a more collaborative experience.

The findings can be used as a point of departure to develop educational experiences in collaborative skill building for physicians and nurses in long term care. Samuelson (1992) points out that at the moment such skill building is a rarity in long-term care facilities.

The Data Source

Thirteen long-term care facilities have been randomly selected from a universe of 22 facilities in the city of Vancouver, British Columbia, which has given access to a data source of one hundred and thirty eight physicians (n = 138) and one hundred and ten nurses (n = 110).

The subjects have been invited to participate voluntarily in the survey by filling out a questionnaire called the Interprofessional Perception Scale.

A Profile of the Study

This study is reported in six chapters. The first chapter presents the introduction to the study. Brief discussions of the purpose, the problem, the significance of the study, and the data source are presented.

In the second chapter a review can be found of the research literature on the theoretical concepts that define collaborative practice in health care. Misperceptions that physicians and nurses have of each other also are explored in this chapter by discussing the related research done on several interprofessional issues. Research on specific demographic correlates of interprofessional misperceptions and team work is included in the review. Finally, additional
research is reviewed on collaboration between physicians and nurses specifically in the long-term care segment of health care.

The research methodology of this study, including a description of the instrument used for the survey, is described in chapter three. Chapter four presents an overview of the findings, which are further discussed in chapter five.

Chapter six, finally, summarizes the study and concluding remarks are made about the findings of the survey. The limitations of the study also are discussed in this chapter. In addition, strategies are included in this chapter that may be implemented in order to lessen the perceptual obstructions between physicians and nurses in long-term care facilities, which ultimately will enhance the concept of collaborative team work among the two professions. Suggestions for further study are made at the end of chapter six.
Introduction

Research and non-research literature was reviewed to determine what has been written regarding interprofessional collaboration between physicians and nurses. Special emphases in the review was placed on literature that examined the benefits of collaboration between the two professions, and also additional literature that outlined the barriers in the way of their collaborative practice, especially the reciprocal misperception barrier. Misperceptions between physicians and nurses are reviewed on a number of important interprofessional issues.

The sources of literature that formed the basis for the study were found in medicine, nursing, management sciences, psychology, and sociology. In this chapter, first the review of the literature will outline the theoretical concepts that define collaborative practice in health care. Second, literature findings will be discussed on the benefits of collaborative team work. Third, literature on the barriers to collaborative practice will be explored, including misperceptions that physicians and nurses have of each other. Fourth, a discussion will be provided of the related research done on several interprofessional issues identified as key to collaborative practice.

Fifth, literature on specific demographic data of physicians and nurses will be reviewed, with a special emphasis on the impact of these demographics on the collaboration between the two professions. The final section in this chapter will review additional research on collaboration between physicians and nurses specifically in the long-term care segment of health care.
Collaborative Team Work

Fagin (1992) points out that today's comprehensive system of health care delivery requires knowledge and skills of physicians and nurses that neither profession can provide without collaboration from the other. It appears that today's challenges in health care have made it a necessity for physicians and nurses to become members of a collaborative health care team. The question arises, when does a team of physicians and nurses truly become a collaborative team, rather than just a group of health professionals who happen to work in the same building or with the same patients?

The literature provides many descriptions of what elements must be found in a team of physicians and nurses, before one can refer to the team as a collaborative team. In a report from the American Medical Association, a good collaborative team is described as patient-centered and as incorporating medical protocols through the cooperative efforts of physicians and nurses (as cited in Fagin, 1992).

Ducanis and Golin (1979), who have studied the functioning of interprofessional teams extensively in health care, also refer to the cooperative effort as a major characteristic of collaborative team work. They refer to the process of synergism on a collaborative team and explain that the diverse skills and expertise of the different professionals on a team must be combined to provide solutions to specific patient care problems. In essence, collaborative team work is an intangible phenomena that allows a team to function synergistically as more than the sum of its parts.

Ducanis and Golin (1979) also stress that team members will experience a real sense of team identity, but only if they participate collaboratively in the entire team process. Ornstein (1990) also describes collaborative team work as a process by referring to it as "a joint communication and decision-making process between medical staff and nurses with the goal of
meeting the patient's wellness and illness needs as best as possible, while respecting the unique qualities and abilities of both professions" (p. 10).

Ornstein's definition of collaborative team work includes the characteristics that are necessary elements for the work relation between physicians and nurses to be truly collaborative. These characteristics must be fully understood by the physicians and the nurses, if they are to contribute to the development of collaboration.

Mutual respect is one such characteristic, which can have great impact on the development of a collaborative practice between physicians and nurses. Hughes and Mackenzie (1990) make the point that physicians and nurses must accept and respect each other for their unique professional knowledge and expertise. If the one professional has no respect for the other, chances are very slim that an effort will be made to work collaboratively with each other.

Many authors, who have written about interprofessional collaboration, have stressed the need for parity among the members of a collaborative team (Ornstein, 1990; Fagin, 1992; Baldwin, 1993). The sense of equality between physicians and nurses is a major interprofessional issue that will enhance the collaboration between the two professions. The traditional work relationship between physicians and nurses, that has been physician dominated no longer fits the collaborative model (Baggs and Schmitt, 1988). As noted earlier, Ornstein (1990) talked about the joint participation in decision making that must be observed in members of a collaborative team. Baldwin (1993) also feels that an interdisciplinary team can only be described as a collaborative team if it operates on the basis of a partnership model. She points out that members of a collaborative team develop a work relationship primarily based on the principle of linking with each other rather than ranking each other. Fagin (1992) makes a similar point by describing collaboration as a professional relationship of interdependence. The members of a team depend on each other's unique skills and knowledge, if they want to provide comprehensive health care.
Ornstein (1990) also includes the need for joint communication and decision making between physicians and nurses as a necessary element of collaborative team work. Fagin (1992) agrees that mutual communication must occur between physicians and nurses. Both authors point out that poor communication between the doctors and the nurses will preclude the development of a collaborative practice and, in fact, will even result in potential peril to patient care. Hughes and Mackenzie (1990) also state that frequent open joint communication is necessary in a collaborative practice.

There are many additional characteristics that have the potential to define the degree of collaboration attainable for physicians and nurses. Several of these have been made a focus of this study and match the issues addressed by the Interprofessional Perception Scale (Ducanis and Golin, 1979). They include:

- the belief in the other professional’s competency
- the acknowledgment of the other professional’s autonomy
- the understanding of the other professional’s capabilities
- the recognition of the other professional’s concern with patient welfare
- the sense of professional territoriality
- the differences in each other’s professional ethics
- the role expectations of each other
- the difference in professional status
- the sense of professional ethnocentrism
- the mutual trust in each other’s professional judgement
- the soliciting of each other’s professional advice
- the full utilization of each other’s capabilities
- the degree of interprofessional cooperation
- the recognition of each other’s professional training
- the perceived quality of the interprofessional relation.

Each of these interprofessional issues are separately discussed in greater detail in subsequent sections of this chapter.

Literature will be reviewed first that has stressed the necessity for collaborative team work by pointing out all the benefits appropriate collaboration can bring to the patients, the health professionals, and the health care system.

Benefits of Collaborative Team Work

The research literature summarized in this section elaborates on the reasons why physicians and nurses must collaborate with each other in their delivery of health care. Many authors have stressed the importance of promoting collaborative team work between these two professions, because of the many important benefits it brings to all the interested parties in the health care system (Ducanis and Golin, 1979; Mechanic and Aiken, 1982; Keddy, Gillis, Jacobs, Burton and Rogers, 1986; Baggs and Schmitt, 1988; Ornstein, 1990; Fagin, 1992). Fagin (1992) actually makes a much stronger statement by indicating that collaboration between physicians and nurses is no longer a choice.

There have been numerous changes in our society, our economy, and our health care system, as well as within the professions of medicine and nursing, which have made it necessary to shift from a physician dominated relationship to a collaborative practice between physicians and nurses (Baggs and Schmitt, 1988; Ornstein, 1990).

A very important survey, conducted in 1971 by the National Joint Practice Commission in the United States, has provided a significant research basis for interprofessional collaborative practice (Ornstein, 1990; Fagin, 1992). The commission's report describes benefits that are specific to the patients, to the health professionals, and to the overall health care system reported in this survey. These specific benefits and related research literature are discussed next.
Benefits for the Patients

Ducanis and Golin (1979) state that appropriate collaboration between physicians and nurses avoids fragmentation of medical and nursing care, and prevents confusion and apprehension on the part of the patients. Ornstein (1990) makes it quite clear that for patients to continue to receive high quality of care, collaborative practice between physicians and nurses is essential. She indicates that in a collaborative work relation physicians and nurses develop more effective communication skills. Ornstein (1990) explains that one outcome of this improved communication pattern between the two professions, is that less errors in patient care are being committed. She further explains that the improved communication between the two professions enhances the coordination and comprehensiveness of patient care resulting in greater patient satisfaction. Other authors reach a similar conclusion and stress that patients receive better nursing care when the nurses participate in a collaborative practice with physicians (Beloff and Korper, 1972; Fagin, 1992).

Professional associations seem to agree that patients are better served by physicians and nurses who collaborate with each other. In a recent document prepared by the Registered Nurses Association of British Columbia the point is stressed that to serve the patient well, interprofessional team work has to involve ongoing collaboration (Registered Nurses Association, 1992).

Governments are equally convinced that collaborative practice between physicians and nurses will benefit the patients. The government of British Columbia recently has taken an initiative to promote interprofessional collaboration between physicians and nurses with the ultimate goal to serve patients better (Hutchison, 1993). The author reports that nurse midwives and physicians in the province of British Columbia will work together providing pregnant women with a new approach to childbirth. Women who want to have midwife-assisted birth will have to
consult a physician during the first trimester of pregnancy, but for the remainder of their pregnancy have the option to be cared for by a midwife.

Recently, very concrete and far reaching benefits for patients have been reported in the literature as an outcome of good collaborative practices by health care teams. Fagin (1992) reports that mortality rates for patients in intensive care units and other specialty areas are significantly lower than expected as a result of good collaborative team work. Fried, Leatt, Deber, and Wilson (1988) rightfully remark that little is understood to date how exactly these mortality rates are improved by collaborative practice. The fact, however, remains that favorable changes are noted in mortality rates in clinical areas where collaborative teams provide the patient care.

Benefits for the Physicians and the Nurses

Authors have made the point that today’s comprehensive health care, with its ever increasing sophistication in new technology, procedures, medications, and services, requires the broad spectrum of knowledge and skills that practitioners no longer can provide on their own (Fried et al., 1988; Ornstein, 1990; Fagin, 1992). Just trying to keep up with the ever increasing body of knowledge specific to one’s own profession is quite a challenge for the physicians and the nurses and requires much of their time and energy (Ornstein, 1990). Given the demands on each profession, reciprocal information sharing is a great benefit of interprofessional collaboration.

Based on her literature research Fagin (1992) concludes that with all the complexities and constraints in today’s health care system, the traditional approach of a physician dominated care team does no longer function well for any of the team members. Ornstein (1990) argues that it is no longer realistic to look only at the group of physicians for prescribing and supervising all the patient care activities. Stein, Watts and Howell (1990) observed the relationships between
physicians and nurses for more than two decades. They report on the changes affecting these relationships over time and comment that physicians will have to depend on nurses' expertise, if the doctors want to remain the technical experts in patient care while also maintaining a human attitude toward their patients.

In her editorial, Oulton (1989) makes the point that alliances between physicians and nurses must be forged in achieving common goals in patient care, and she encourages the professionals to develop a creative approach toward the achievement of these common goals. Only through a collaborative team approach will physicians and nurses be able to continue to apply effectively all their unique professional expertise to the difficult challenges in patient care.

An additional major benefit of collaborative practice comes to the physicians and the nurses in the form of increased job satisfaction. Ornstein (1990) and Fagin (1992) explain that both professions enjoy greater respect and mutual trust, as well as autonomy, and more freedom to apply their knowledge, skills and judgment in patient care if they commit to a collaborative model of care delivery. Both authors have based their views on the findings of a survey conducted by the National Joint Practice Commission in the United States in 1971. The commission has indicated that many nurses are very dissatisfied with their work, because they do not feel respected or trusted, they do not feel included in the decision-process of patient care management, and they feel that there are no opportunities to apply fully all their expert nursing skills.

Nurses, who experience higher degrees of job satisfaction, also will be at lower risks for burnout and related illnesses (Anderson and Finn, 1983; Ritter, 1989). Although many sources contribute to job satisfaction, if collaborative practice is one of them, and in turn, contributes to the health of the health professionals, every effort must be made to create lasting conditions that will cultivate the collaborative teams.
Benefits for the Health Care System

Several authors have referred to the tremendous rising costs in health care (Ritter, 1989; Ornstein, 1990; Fagin, 1992). The need for interprofessional collaboration has increasingly become an urgent matter for the survival of the health care system at the level of quality as we know it today. It has been shown that the tremendous rising costs of health care can be reduced by utilizing nurses in a consultative relationship with physicians (Fagin, 1992). Quite clearly, for nurses to be utilized in a consultative role to the physicians, an open and ongoing communication between the two professions is imperative.

There is a decrease noted in total patient days in hospital when the care is provided by a collaborative team of physicians and nurses (Ritter, 1989; Fagin, 1992). Ritter (1989) also indicates a decrease in number of hours worked by the physicians and nurses. Improved communication and joint decision making provide more efficient, coordinated and comprehensive patient care (Ornstein, 1990). Such findings are indicative of greater staff efficiency and productivity and ultimately lead to a decrease in health care costs.

As noted earlier, nurses experience higher degrees of job satisfaction if they participate in a collaborative team (Ornstein, 1990). As these nurses experience higher degrees of job satisfaction, they are less likely to resign from their positions. The turnover rates, therefore, are noted to be significantly less under collaborative work conditions as compared to health care settings that operate with non-collaborative teams (Anderson and Finn, 1983; Ritter, 1989). Lower turnover rates translate into less need for new staff, and therefore, lead to lower costs for orientation programs. Any reduction in costs is a welcome benefit to a health care system that is coping with tremendous cost constraints.

With all these exciting benefits to patients, to health care professionals, and to the health care system, it is disappointing to see so little reported in the literature on how well physicians
and nurses actually are working in a collaborative practice. The next section in this literature review will discuss the reasons why much of the discussion given to the concept of collaborative team work is only lip-service.

**Barriers to Implementing Collaborative Team Work**

Many health professionals are quick to commit verbally to collaborative team work, and yet, these same professionals are very slow to follow through with this commitment in actual practice. Nason (1983) explains that the collaborative team concept is only an illusion held by the more powerless care givers on the team. Physicians, on the other hand, have been reported to have limited interest in the administrative functioning of a team (Hanlon and Gladstein, 1984).

Many reasons have been cited in the literature for this lip-service to collaborative team work. The reasons are characterized in the literature as barriers to collaboration, and they are reviewed in the following sections of this chapter.

**The Barrier Created by Historical Developments**

As far back as the early 19th century, when physicians and nurses were at the bedsides in their patients’ homes, the two professions have not collaborated well with each other (Ornstein, 1990; Fagin, 1992). A period in which many physicians and nurses have been reportedly able to work well as a team has been under circumstances such as during World War II. During this war, collaborative team work received a major impetus, and physicians and nurses experienced good colleagueship, while facing their common problems for which they found shared solutions (Ducanis and Golin, 1979; Fagin, 1992). Fagin (1992) states, however, that as soon as the war was over both professions somehow were unable to continue their collaborative practice.

The implications of the collaborative team concept have not always been fully understood, and the initial enthusiasm for the concept has been followed by disillusionment (Ducanis and
Golin, 1979). The authors explain that the concept of collaborative practice was seen even as obsolete by some health professionals in the late 1950s.

The Barrier Created by Clinical Uncertainty in Health Care

Horder (1992) notes that the more stressful the challenge in patient care is, the more difficult it appears to be for professionals to collaborate. This observation is rather paradoxical. Consider, for instance, the stress of World War II. As noted earlier, under these trying circumstances of war, physicians and nurses have been reported as having worked very well with each other (Ducanis and Golin, 1979; Fagin, 1992).

One actually expects that professionals would be more motivated to work collaboratively if the task on hand is very difficult. Fried et al. (1988) argue this same point and say that when there is an increase of clinical uncertainty in a patient’s case, the chance for successfully treating the patient is largely dependent on how well the involved health professionals collaborate with each other.

Horder (1992) admits to the paradoxical nature of his observation, but still supports it by referring to a number of systematic studies which suggest that only 20% of physicians and nurses are working in partial or full collaboration. Horder (1992) maintains that the uncertainties in health care, as well as the insecurities and the anxieties, are the exact reasons why there are low success-rates with the interprofessional collaborative team concept. The author perceives that the unpleasant feeling of uncertainty is creating a barrier to collaboration. He argues that health professionals want to avoid collaboration when they feel uncertain and anxious. However, Fried et al. (1988) in their indepth study conducted on units treating renal disease and cancer clinics, present a counter argument. They conclude that the clinical uncertainties in renal and cancer patients has lead to the deliberate choice of physicians and nurses to work collaboratively.
The Barrier Created by Dominance in the Work Place

Many work relations between physicians and nurses are dominated by physicians (Baggs and Schmitt, 1988; Ornstein, 1990). This condition of dominance in the work place by physicians is seen as a major barrier to interprofessional collaboration. It is now believed that it is highly inadvisable for a patient care team to follow blindly what ever has been stipulated by one of the professionals on the team. Fagin (1992) strongly warns that a single-discipline view of health care in the future will be destructive to the patients, the health professionals, and the health care system. This warning is of real significance especially when seen together with a report prepared by Kurtz (1980). The author has examined the views of 800 physicians to assess their preferences in interprofessional interactions. From the report it appears that physicians generally prefer not to be interactive. Physicians prefer to avoid group involvement. With such preferences for individual action on the part of the physicians, the development of collaboration with nurses has a very slim chance of success.

Baldwin (1993), associate professor in the Counseling and Educational Psychology Department at the University of Nevada, examines the element of dominance in the work setting from a psychological view point. She explains that dominance in the work-place finds its origin in the North- American society's orientation toward a dominator model of interaction. Ornstein (1990) classifies this form of interaction as oppressed group behavior. She identifies the nurses as the members of the oppressed group, and the physicians as the oppressors. Baldwin (1993) adds that until very recently, scholarly research and developmental theories generated within the dominator model has sent women the message that they are somehow not equal in any meaningful way to men. This message definitely has reinforced the feelings of oppression among nurses, who are predominantly female. Already, in 1967, the oppression and the dominance model of interaction between physicians and nurses have been recognized and have been called elements of the doctor-nurse game, and a recent review of the rules of this game shows that little
has changed in the interplay between the physicians and nurses (Stein et al., 1990). The authors indicate that still much tension appears to exist between the two professions. Based on Baldwin’s review (1993) of the history of the dominator model, it appears that these tensions partially are the result of struggles with models of dominance and hierarchy. Baldwin (1993) urges that instead, the professionals should work towards models of partnership and cooperation in order to achieve collaboration.

The Barrier Created by Poor Communication Patterns

Poor communication patterns between the physicians and the nurses form serious barriers in the way of collaborative practice. Both professionals are at fault in this instance. Nurses frequently express their dissatisfactions in very indirect and covert behavior (Fagin, 1992). Unfortunately, this poor communication habit of nurses is only reinforced by physicians. Many physicians are reported to disapprove of any open expression of dissatisfaction among nurses, and this disapproval, in turn, results in an inability for the physicians to see clearly what is distressing to the nurses (Fagin, 1992). Indeed, the physicians are reported generally to be puzzled and confused by nurses’ behavior (Stein et al., 1990). The same authors report that physicians even feel betrayed and are angered by the nurses’ behavior.

Without an open, ongoing communication between the two professions, they will continue not to be able to understand each others’ point of view. Physicians and nurses will continue to be ignorant of each others’ roles, and they will have a very slim chance to find remedies for their problems. Nor will they ever be able to collaborate well with each other when these bad habits of communication are maintained.
The Barrier Created by Limited Available Time

Another reason for seeing little evidence of successful collaborative team work, is the enormous amount of time it takes to develop such a work method. Baggs and Schmitt (1988) explain that there is a greater demand on the physicians' and the nurses' time, because collaborative practice requires the professionals to participate in many joint committee meetings. Ornstein (1990) feels that as long as physicians' meeting time is not compensated for, it is unlikely that physicians are willing to spend the extra time in meetings in order to develop a collaborative relationship with nurses. She also explains the dilemma of time constraints that nurses are facing, who already are trying to cope with very high patient workloads.

The Barrier Created by Limited Financial Resources

The impact of collaborative practice on health care costs also is indicated as a barrier. Anderson and Finn (1983) point out that implicit to collaborative team work is the introduction of primary nursing models at a high cost. As noted earlier, however, patient care eventually is delivered more efficiently, and is less costly, if it is provided by a team of physicians and nurses who collaborate well with each other (Ornstein, 1990). This barrier, therefore, seems to be an issue mainly during the initial stages of preparing the nurses to work as primary nurses and in collaborative practice with physicians.

The Barrier Created by the Lack of Institutional Support

A look at the above barriers partially explains why physicians and nurses have been struggling with each other ever since they have cared for the same patients at the same time. Nason (1983) draws a similar conclusion and points out that patient care teams have seldomly run smoothly. Fried et al. (1988) suggest that the lack of guidance by management thought and practices partially explains the long record of poor team performance. Considering the
tremendous complexity of today’s health care system, it is easily understood why there is a need for expert management advice to guide all parties through the difficult challenges. It does take someone with expert management skills and administrative knowledge to integrate patient needs with the institution’s need for fiscal solvency, while at the same time also having to consider the conflicting interests of different employee groups (Nason, 1983; Hanlon and Gladstein, 1984). The balancing of all these different needs is not an easy task, but can be achieved partially by guiding the professionals toward good collaborative practice. Fried et al. (1988), however, point out that health services managers have not been serious enough about this guidance and the need to inject group management practices into the teams of physicians and nurses. Ducanis and Golin (1979) make a similar point. They conclude that physicians and nurses have not been made aware of the factors that have an impact upon team collaboration. Epton, Payne and Pearson (1984) elaborate on some of these factors. They say that team members must be informed about the process of team management and team building. In particular, team members should be told about the procedures for resolving conflicts and ways on how to obtain agreement on controversial issues. This educational approach, indeed, has proven to be very effective in those instances where it has been used. In an interview Joyce Clifford, Vice-President for Nursing and Nurse-in-Chief at Beth Israel Hospital in Boston, Massachusetts, tells how she, and the other members of the senior management team at the hospital, have provided directions to the physicians and the nurses in resolving potential conflict situations (Bocchino, 1991). They have stressed the importance to avoid the classic we/they syndrome in attempts to resolve controversial issues and to remain always focussed on patient centered care. The management at Beth Israel Hospital has placed emphasis on conflict resolution, not conflict avoidance. To this end, the administration has seen to it that the nurses at Beth Israel are represented on the Medical Executive Committee and all its subcommittees with equal participation and voting powers as the physicians (Bocchino, 1991). Bocchino (1991) reports that this interprofessional collaboration at
Beth Israel Hospital has been a success for over 15 years. Koerner and Armstrong (1983) report on another successful implementation of collaborative practice. At the Hartford Hospital in Hartford, Connecticut, the administration has recognized the need for collaboration between physicians and nurses and they have implemented a Joint Practice Committee to enhance the quality of the interface between the two professions. The administration at Hartford Hospital has supported the collaborative team concept and has seen to it that equal numbers of physicians and nurses are on this joint committee.

It seems from this review of the literature, that the administrative support to the collaborative team concept seen at Beth Israel Hospital and at Hartford Hospital still is perceived to be more the exception than the rule in today’s health care system. Repeatedly the administrators are encouraged to increase the guidance of the physicians and the nurses in their attempts to collaborate well with each other and to provide these professionals with the necessary educational resources. Yet, Nason (1983) points out that many of today’s health care teams still do not have the advantage of team training. Administrators themselves also will have to become fully aware on how the internal workings of their health organizations can become a constraint to the development of collaborative teams (Epton et al., 1984).

Administrators can create an additional barrier to collaborative practice if they are not truly committed to the collaborative team concept (Nason, 1983; Epton et al., 1984; Hanlon and Gladstein, 1984). Their commitment will show only through insightful leadership and often very time consuming and hard work. Hanlon and Gladstein (1984) make it clear that managers must be committed to the goals of a collaborative team. Nason (1983) stresses the importance for administrators to commit themselves to the difficult task of analyzing the devise forces on the teams. Nason (1983) and Epton et al. (1984) point out how important it is for administrators to know exactly how team members relate to each other. It is vitally important that administrators become aware of the exact degree of collaboration that exists among team members, because a
lack of collaboration reflects both system and patient care problems (Nason, 1983). Epton et al. (1984) stress that, most importantly, administrators should spend time appropriately controlling, co-ordinating and motivating the members of the teams to work together. Without such leadership on the part of the administrator, the health organization will not see the development of collaborative teams. Nason (1983) thinks that institutional support for collaborative teams will depend on how much those in power will come to rely themselves on the collaborative process as an administrative style. As long as collaborative practice is not being recognized as a means to achieving their own administrative goals, administrators might be slow in genuinely supporting the collaborative team concept.

In summary, the lack of guidance in team management by administrators of physicians and nurses potentially can be a barrier in the way of developing well functioning collaborative teams. An equally significant administrative barrier is the lack of involvement and genuine interest in collaborative teams on the part of health care administrators. A third administrative barrier is a lack of awareness of barriers to interprofessional collaboration.

The Barrier Created by Resistance to Change

The above barriers have all been barriers specifically identified or suggested as standing in the way of collaborative team work. There is also a more general form of barrier described in the literature, which is the mere resistance to change itself. Keddy et al. (1986) make the point that the present work relationship between physicians and nurses has existed for more than a century. The authors explain that physicians and nurses are threatened by the introduction of the new work method of collaborative practice. Both professions react to this threat by resisting any development towards collaborative practice. Keddy et al. (1986) further clarify that both professions may not have been prepared for this change in their work method. They explain that physicians and nurses have not been educated nor socialized to work collaboratively with each
other. This may contribute to another major barrier, that of misperceptions of one another by physicians and nurses.

**The Barrier Created by Interprofessional Misperceptions Among Physicians and Nurses**

In addition to the forementioned barriers there is one additional barrier to collaborative practice cited in the literature, which has been made the focus of this study. Interprofessional misperception has been identified as a major barrier in the way of collaborative work between physicians and nurses (Banta and Fox, 1972; Jacobson, 1974; Ducanis and Golin, 1979). These authors point out that misperceptions will seriously interfere with any collaborative effort between health professionals. Interprofessional misperception has been defined as the difference between one professional's perception on how the other professional would view an issue, and the viewpoint actually expressed by the other professional on the same issue.

**The Interpersonal Perception Method**

The interpersonal perception method developed by Laing, Phillipson, and Lee (described in Ducanis and Golin, 1979) is used as the conceptual framework for this study on interprofessional misperceptions between physicians and nurses in long term care facilities.

The interpersonal perception method asserts that each member in a dyadic relationship develops different levels of perspectives. At one level, the professional develops a direct perspective on an issue. At a different level, the same professional also develops a perspective on how an other professional would respond to the same issue. The interpersonal perception method is adaptable to a variety of investigations, including group perceptions.

Based on the interpersonal perception method, Ducanis and Golin (1979) suggest that physicians and nurses enter their work relationship with certain preconceptions about each other. These preconceptions can consist of expectations that one has of one's own professional role in
the work relationship with others, and also can consist of expectations one has of the role and responsibilities of the other profession. What is of interest, is to note that these preconceptions appear not always to reflect reality. In essence, these preconceptions could be misperceptions. Jenny (1990) provides an account of a physician who required hospitalization following a cardiac arrest, and who had preconceptions about nurses which turned out to be definite misperceptions. The doctor thought nurses were a sort of executive secretary, who took orders and gave the right pill. Through his experience as a patient, the physician realized that nurses were doing much more than following orders and giving pills. The same physician who referred to nurses as executive secretaries perceived them now as his lifesavers.

Using the framework of the interpersonal perception method two scenarios of perceptions can be described, which have become the focus of this study.

Scenario 1 - Members of one profession perceive themselves in a certain way (level I), and they perceive that members of another profession either agree with them or not agree with them (level II).

Scenario 2 - Members of one profession perceive the members of another profession in a certain way (level I), and they perceive that the members of the other profession either agree with them or do not agree with them (level II).

Scenario 1 indicates how professionals see their own profession and whether they think the members of an other profession will agree with them or not. Scenario 2 shows how professionals view the members of another profession, and whether they think these members will agree with this view or not.

To determine whether or not these preconceptions are misperceptions, a comparison needs to be made between the level II perception of scenario 1 and the level I perception of scenario 2.
Similarly, a comparison needs to be made between level II perception of scenario 2 and the level I perception of scenario 1. In essence, a comparison is made between a perceived viewpoint on an issue and an actually existing viewpoint on the same issue in order to determine whether the perceived viewpoint is a misperception.

The focus of this study has been interprofessional misperceptions rather than intraprofessional misperceptions, because the potential misperceptions are usually more serious between members of different professions than between members of the same profession (Ducanis and Golin, 1979). The focus of the study has been further delineated by looking specifically at the physicians and the nurses, because historically these two professions have been at odds with each other longer than any other profession in health care (Ornstein, 1990; Fagin, 1992).

Fried et al. (1988) stress the importance for health professionals of sharing their perceptions of each other. Only through open and honest sharing of these perceptions will physicians and nurses be able to move a step closer to collaborative practice. They will be in a position to identify any existing misperceptions there may be amongst the members of the team.

Ducanis and Golin (1979) have developed an instrument that measures the existing degrees of misperception among health professionals. This instrument asks the professionals to share their perceptions on a number of interprofessional issues. These interprofessional issues are considered the "make-or-break" issues in interprofessional collaboration, and are discussed in the next sections of this chapter.

Make-or-Break Issues in Interprofessional Collaboration

Of the many issues described in the literature that have major influence on collaborative team building, there are make-or-break issues in professional collaboration. These issues are
considered make-or-break issues, because they seem to have as much potential to contribute to
the formation of a well functioning team as they seem to have the potential to stand in the way of
any collaborative team effort.

Ducanis and Golin (1979) apply the interpersonal perception method to misperceptions
among physicians and nurses by focussing on 15 interprofessional issues that are supported in the
literature. They include:

- the belief in the other professional’s competency
- the acknowledgment of the other professional’s autonomy
- the understanding of the other professional’s capabilities
- the recognition of the other professional’s concern with patient welfare
- the sense of professional territoriality
- the differences in each other’s professional ethics
- the role expectations of each other
- the difference in professional status
- the sense of professional ethnocentrism
- the mutual trust in each other’s professional judgement
- the soliciting of each other’s professional advice
- the full utilization of each other’s capabilities
- the degree of interprofessional cooperation
- the recognition of each other’s professional training
- the perceived quality of the interprofessional relation.

In the next sections each of the 15 issues will be separately reviewed to assess prior
research on each. Their potential to be either a contributor or a hindrance in interprofessional
collaboration will become quite apparent through each of the separate discussions. This dual
potential stresses the importance for all health care professionals to understand fully these issues
and use them to their advantage. Hughes and Mackenzie (1990) suggest that knowledge of the necessary elements of collaboration can assist nurses and physicians toward an enhanced collaborative relationship. Through complete understanding of these make-or-break issues is there an increased chance for successful interprofessional collaboration.

**Issue No. 1 - Professional Competency**

It is easy to see how the issue of professional competency can have the potential to be a make-or-break issue in interprofessional collaboration. Afterall, one could hardly expect a professional to work collaboratively with another professional who is perceived to be incompetent. If on the other hand the one professional believes the other professional to be competent, chances are high that the two will want to work together collaboratively in the provision of patient care.

How does one come to the conclusion that the other professional on the team is competent or not? What is it about the other professional that makes him or her perceived to be competent? Prescott and Bowen (1985) have deliberated about these questions. As part of a larger study examining organizational factors in hospitals, these authors have studied physician-nurse relationships. They have interviewed 187 physicians and 264 staff nurses and have been able to verify that the competency of physicians is often assumed, the nurses, on the other hand, often have to prove their competency. Fagin (1992) indicates that this fundamental difference in acquiring credibility as a competent health professional definitely can stand in the way of building a collaborative relationship between the two professionals. The literature provides a number of additional insights on how people appear to make up their minds about an other person's level of competency.

The more experience and exposure a person has to a certain clinical area, the more the person is thought of as competent. Jenny (1990) contends that nurses who have chosen to remain
in the same clinical area for longer than five years are often the only ones with the finite
knowledge of typical patient responses seen in that area, and are often very skillful in handling
the very specialized technology available to treat these patients. Of course, one should be
cautioned and realize that the mere longevity of a person’s exposure to one clinical area does not
guarantee that person’s competency. In fact, bad habits and stagnation in acquiring knowledge
may very well have lead to the development of less than competent skills in the professional.

Ducanis and Golin (1979) reported on a different method used by some people to assess an
other person’s level of competency. They allude to the basic assumption made by many health
professionals that those who are higher in the hierarchy of a health organization possess all of the
knowledge and skills of those lower in the system, in addition to their own uniquely acquired
knowledge and skills. The authors are quick to add, however, that such an assumption no longer
can be defended given the tremendous specialization that has been observed in each of the
separate disciplines on a health care team. No longer can a "higher" professional know all the
specialized knowledge of a "lower" professional. Despite this reality some health professionals
still live by this assumption, and perceive other professionals as competent solely because they
are "higher" in the organization.

Educational status of the professional often determines how "high" the person is in the
organization. The more education the person has the more competent he or she is perceived to
be. For instance, traditionally physicians have always outnumbered the nurses in terms of years
of education, and have enjoyed a higher place in the hierarchy. However, changes are occurring
in the educational status of nurses (Nurse-Physician, 1989). More nurses are prepared at the
university level, both the undergraduate and graduate levels. With this change in educational
status the nurses are being perceived as more competent by many other health professionals,
including the physicians. The order of who is perceived as higher or lower in the organization
based on education is constantly changing as health professionals require more education in their respective fields.

Unfortunately, there are professionals who see this change in educational status and competency as a threat to their own position in the organization. These professionals believe that their own skills and knowledge will become obsolete as the other professionals become increasingly more competent. Ducanis and Golin (1979) point out that such situations are often fraught with acrimony and rancor and may lead to interprofessional strife and rivalry. Fagin and Diers (1983) add that such situations can produce anxiety. They feel that the anxiety is the end result of a chain of reactions, which starts with the nurses. Because of their 24-hour position at the bed side, nurses see all that happens with the patients. The nurses see the cures, but also the neglect. As the nurses increase their competency and knowledge, they will develop a framework within which they can scrutinize better all the work produced by the physicians. Fagin and Diers (1983) speculate that some physicians may feel rather anxious about this heightened form of scrutiny.

A 1988 study brought out another alarming point concerning professional competency (cited in Nurse-Physician, 1989). Based on interview results the study reports, that some nurses perceive they are a scapegoat for medical incompetency. Such a perception on the part of nurses is indeed very alarming and requires further investigation, which goes beyond the current scope of this study. It is, however, important to note that a nurse who perceives herself or himself to be a scapegoat of medical incompetency is very unlikely to engage in collaborative team work with physicians.

Hopefully not too many professionals would feel threatened by an other professional’s competency. It also is hoped, that each professions’ monitoring of its members’ competencies will lessen the circumstances where one professional may be seen as a scapegoat for another’s incompetency. It is hoped that we would see more and more professionals agree with Samuelson
He made the important point that if each professional would be allowed and encouraged to function more efficiently within his or her area of greatest competency, an environment of mutual respect could be fostered for health care teams rather than an atmosphere of rivalry.

**Issue No. 2 - Professional Autonomy**

Nason (1983) points out that physicians and nurses have a need to be autonomous and become a self-regulating profession. To obtain professional autonomy is seen as a confirmation of one's unique expertise and professional knowledge. Ducanis and Golin (1979) explain that society's willingness to confer autonomy on a health professional serves as a recognition of the professional's unique contribution to health care. The authors point out that such recognition, in turn, is seen as a source of professional power, which explains why professionals appear to be eager to have autonomy. Jenny (1990) agrees with this point and feels that the route to nursing power lies in autonomous nursing acts.

It is easily seen how the issue of professional autonomy becomes a make-or-break issue in collaborative practice, when one considers how autonomy is equated to professional power. One profession can easily misperceive the viewpoints of an other profession on professional autonomy. Ornstein (1990) illustrates this point by citing how physicians have reacted to the recommendations nurses have made to make nurses the gatekeepers to community-based primary health care services. She explains that physicians have perceived these recommendations as a threat to the doctors' clinical autonomy. Such a perception of threat hardly makes a physician want to contribute to the concept of collaboration with a nurse. Yet, the success of community-based primary health care services relies on the collaboration between the nurse and the physician.

The fact remains, however, that physicians see their professional autonomy increasingly changing. Fagin (1992) points out that more physicians are becoming salaried employees. No
longer are the physicians entirely autonomous under these new work conditions. They now are accountable for their actions to an employer. The autonomous characteristic of being a self-regulating profession is changed for the physicians, now that an employer partially provides regulations on how the physicians will perform their duties. Ducanis and Golin (1979) point out that some physicians might perceive such changes as evidence that some of their professional autonomy is being eroded. The authors explain how the bureaucratically prescribed functions of physicians may be in direct conflict with the orientations to the professional role as formulated by the physicians themselves.

As for the nurses, they have been very interested in the issue of their own professional autonomy for quite some time (Stein et al., 1990). The nurses strongly feel they need to increase their autonomy for reasons, which Stein elaborates on, discussed in an earlier article written in 1967 (as cited by Fagin, 1992). In this 1967 article Stein describes the interaction between physicians and nurses as a game. Even in today’s health care settings part of the doctor-nurse game still consists of physicians managing nurses’ initiatives and recommendations on care interventions without giving the nurses autonomy over the final decisions. Ornstein (1990) makes a similar observation and states that the responsibility of care is left to the nurses, but without the authority to act in the absence of the physicians. Under these circumstances it is easy to see how nurses perceive their autonomy to be in need of more substance. The nurses are gaining ground in this respect, because they increasingly are receiving recognition for their professional autonomy. In a recent interview British Columbia’s current Minister of Health expressed interest in exploring the future role of nurses (Bruce Wells, 1992). Based on the report of the province’s Royal Commission on Health Care and Costs, the Minister believes that nurses will acquire an even stronger role than they already have as advocates for patients. It seems that, particularly in the areas of community care, health promotion, and the prevention of illness, the nurses can look forward to an increase in their clinical and professional autonomy.
Both professions see their professional autonomy also change by the rise of consumerism (Ducanis and Golin, 1979). The consumer movement strongly influences the current autonomy of physicians and nurses. Today, the public is much more knowledgeable and aware of and are demanding services that can be rendered by a team of physicians and nurses. No longer do the professionals have free reign over what services they will provide. To this end, the professionals also face more governmental interventions especially tied to cost containment. The change to professional and clinical autonomy, as driven by consumerism, is a change for the better. There has been a longstanding lack of real team accountability for the care the different members on the team provide. Butterill, O’Hanlon, and Book (1992) have identified this poorly defined accountability of a care team as a common problem faced by the public. The authors have come to this conclusion after reviewing the literature on organizational structure, power, communication, and boundaries within the organization. The increasingly more knowledgeable public now demands more accountability and no longer blindly confers complete clinical autonomy to the physicians and the nurses.

These shifts, however, in professional autonomy should be perceived as positive movements toward a more efficient and effective health care system that is provided by a collaborative team of physicians and nurses. If both professions can acknowledge each other’s professional autonomy purely as a reflection of each one’s unique professional expertise and knowledge, rather than only a reflection of professional power, then the issue of professional autonomy has the potential to contribute to the collaborative team concept. It is encouraging, therefore, to see that some of the physicians of tomorrow already seem to have formulated a positive viewpoint of nurses in this respect. Anvaripour et al. (1991) report on the results of a workshop for second-year medical students on collegiality and find that medical students do recognize nurses as autonomous professionals.
Another important factor contributing to poor collaboration between physicians and nurses is the lack of understanding the capabilities of the other professional (Ducanis and Golin, 1979; Mechanic and Aiken, 1982). One profession appears to have certain perceptions about another profession’s capabilities to handle the problems in patient care. A recent reaction from physicians to the legalization of midwifery for home births in the province of British Columbia serves as a good illustration of a profession’s perception about the capabilities of an other profession (Hutchison, 1993). The legalization has been met with resistance from the province’s Medical Association. The physicians argue that home births have great potential for risks and that midwives should not be legalized for home births (Hutchison, 1993). Such a viewpoint is a clear illustration of the physicians’ lack of understanding the capabilities of midwives. All evidence points to the fact that home births under supervision of midwives are extremely safe for low-risk birthing women. The midwives are specialists who have been very well trained and who have a proven track record as capable care-givers for pregnant women (Rooks, 1990).

If the other professional is perceived as not capable of solving, or significantly contributing to solving problems, chances for the development of interprofessional collaborations are rather slim. It is important, therefore, to create a proper understanding of each other’s capabilities and to eliminate any misperceptions about such an important issue.

It is suggested that both professions should be educated about each other’s capabilities. Horder (1992) notes that it is a widespread assumption that education about the work of other professions can contribute to better collaboration between these professions. Even though the impact of education on team collaboration is only an assumption, Horder (1992) does stress that ignorance definitely is a barrier to collaboration. It appears, therefore, to be important that efforts are made by physicians and nurses to learn about each other’s capabilities. It takes more
than education, however, to create the mutual understanding for each other’s capabilities. Nason (1983) explains that it takes experience and empathy for each other’s capabilities, as well as limitations, for a team of professionals to appreciate how each profession deals with the problems in patient care. Hughes and Mackenzie (1990) make a similar point. They add that physicians and nurses must accept and respect each other for their unique expertise.

From this review on professional capabilities, it appears that for several decades the literature has stressed that collaboration between physicians and nurses requires knowledge, empathy, acceptance, and respect for each discipline’s scope of unique capabilities.

**Issue No. 4 - Professional Concern with Patient Welfare**

While at times it may appear that interprofessional collaboration is promoted for the sake of the professionals on the team or the health care organizations, the main reason for developing collaborative practice is to serve the patients. Clifford, Vice-President at Beth Israel Hospital in Boston explains in her interview, that throughout the entire process of fully integrating the collaborative team concept at her hospital, the focus has been kept on the essential reasons for the institution’s being, which are patients, their families and how to provide excellent care to them (Bocchino, 1991). Ducanis and Golin (1979) also stress, that the patient is the focus of the team’s efforts and the reason for the team’s existence. Furthermore, Fried et al. (1988) argue, based on their literature review and study results, that the patient actively should be included as a member of the collaborative team. With all their self-confessed altruistic intent, physicians and nurses certainly will not argue with this point. On the other hand, Nason (1983) notes that these same professionals are known to pursue professional priorities that appear to have no relevance to patient care.

Members of both professions frequently perceive the members of the other profession to be preoccupied with self-serving priorities rather than the welfare of the patients. These perceived
self-serving priorities can become a source of tension between the physicians and nurses impeding the collaborative functioning of the team (Nason, 1983). There is a reluctance to spend time on collaborative effort with another professional, when this professional is perceived to be more concerned with the enhancement of self-serving goals rather than the welfare of the patients. To illustrate, some physicians have been reported to be concerned about the priority that nurses persistently have set for themselves in recent years, to see the baccalaureate degree as the entry level to nursing (Nurse-physician relationships, 1989). The physicians are concerned that nurses will become less interested in direct nursing care, as the nurses enter their profession with university degrees. The physicians ask the question, who will do the basic patient care? This perception on the part of the physicians sharply differs from the actual reasons that have been given by nursing leaders for their attempts to make the baccalaureate degree a requirement to enter the practice of nursing. In fact, nurses feel they need to be prepared at the university levels precisely in order to serve the patients better in today’s complex health care system. The two professions appear at odds with each other on the issue, which does not add to the development of the collaborative team concept.

A better understanding of rationale for actions taken by a profession will prevent possible misperceptions on the true intent of that profession to continue to have the welfare of the patient first and foremost in mind.

Issue No. 5 - Professional Territoriality

Of all the issues discussed in this literature review, professional territoriality is one of the most sensitive issues causing great amounts of tension between physicians and nurses. Fagin (1992) argues that this issue looms large as a barrier in the way of collaborative practice. For any collaboration to occur the two professions first must work out their perceptions of each other’s sense of professional territoriality and encroachment. The sensitivity around the issue is
well described by Ducanis and Golin (1979). The authors explain that as soon as one profession claims the right to solve a problem, which formerly has been solved by an other profession, the latter profession will perceive that claim as an accusation of its incompetency or a threat to their unique scope of practice. The latter profession will react, in turn, by accusing the other profession of professional encroachment.

Both the medical and the nursing profession have been noted to engage in the habit of accusing each other of professional encroachment. Fagin and Diers (1983) explain that dominant groups always are very reluctant to yield any professional ground. Both the physicians and the nurses are dominant players in the health care system. Historically the physicians have been the upper and controlling class in the health care system. As for the nurses, their dominance is found purely in their great numbers. They are the largest professional group in the health care system (Fagin and Diers, 1983). It is no surprise, therefore, to find both professions at odds with each other over issues relating directly to their sense of professional territoriality.

The physicians’ and nurses’ concern over their professional territory also has been heightened by the actions of other health professionals. Beloff and Korper (1972) explain that with the ever growing number of new health professionals, who are ready and able to serve the patients, the physicians and the nurses can spend less actual time with patients. Not only are the two professions of medicine and nursing, therefore, in competition with each other, they also are competing for patient time with social workers, dieticians, neighborhood health aides, and other members of the care team. Ducanis and Golin (1979) come to similar conclusions and note that each profession has a tendency to become increasingly more protective of its domain.

Fagin (1992) reports that the American Medical Association appears to have been obsessed with the competition and the threats from nurses. Rooks (1990) states that the American physicians have attacked and nearly obliterated midwifery. Nurse anesthetists also have been kept from doing their work by anesthesiologists groups, who have used such unfair means to attack
the nurses that antitrust action appeared to have been necessary against the physicians (Maine aims antitrust blow at MDs and saves the day for CRNAs, 1985). In Canada similar strong reactions are seen amongst the physicians, whenever nurses appear to be inching in on the physicians territory. Ornstein (1990) reports on the uneasy feelings physicians in Ontario have about nurses’ involvement in community-based primary health care services. The Ontario physicians feel their professional territory threatened and very reluctantly want to share their turf. In the province of British Columbia the situation around professional territoriality is not much different. As noted earlier, the province’s Medical Association is quoted to be against home births under the supervision of midwives (Hutchison, 1993). From these illustrations, it becomes clear that professional territoriality truly is a very sensitive issue.

Fortunately, many authors have tried to put the issue of professional territoriality in the right perspective by suggesting positive and effective approaches to maintain one’s uniqueness as a profession, but without becoming territorial. (Hughes and Mackenzie, 1990; Fagin, 1992; Samuelson, 1992).

Increasingly more physicians and nurses are reported to be saying that their physical territories are overlapping, but that their clinical territory can be uniquely maintained (Nurse-Physician, 1989). Physicians and nurses each have their own perspectives on patient care from their own professional knowledge base, but collectively both professions can add to the overall quality of patient care. Physicians have been reported to say that there is nothing wrong in itself with nurses taking over tasks, which have been performed previously by the physicians, but this take-over can be done in conjunction with the physicians rather than independently of the doctors (Nurse-physician, 1989).

Hughes and Mackenzie (1990) point out as well that physicians and nurses are in a position to complement each other’s roles through recognition and appreciation of each other’s uniqueness. Fagin (1992) stresses that physicians and nurses should not have to be in competition
for patients’ time. She explains that each profession certainly can have its own territory. Nurses can devote their expertise and skills to patient services which require highly interpersonal interactions, whereas physicians can engage in services for which substantial scientific and technological expertise is needed.

Team collaboration is most likely to occur when physicians and nurses accept each other’s input in the overall care to the patients without perceiving that input as a threat to their own professional territory (Samuelson, 1992).

**Issue No. 6 - Professional Ethics**

Medical and nursing professional associations have developed codes of ethics regulating the behaviors of their respective members. These associations have given much careful thought to the development of their respective codes of ethics in order to provide assurance to their own membership and the general public, that each member in the association behaves in a manner appropriate for either a physician or a nurse. Ducanis and Golin (1979) explain that a code of ethics is necessary for the physicians and the nurses, because each of these professions enjoys a great degree of freedom and autonomy. They argue that the greater the freedom of a profession, the more chance there is for improper conduct by a member. The associations, therefore, must have codes of ethics and strictly enforce them.

A code of ethics is based on the norms and values that a profession has adopted through a socialization process (Ducanis and Golin, 1979). Dr. Marsha Fowler, a nurse and professor in the school of nursing and graduate school of theology at Azusa Pacific University in California, points out that the value systems of physicians and nurses differ from each other (Ethics For Nurses, 1991). Given again that these different value systems form the basis for the codes of ethics, the ethical standards for physicians and nurses are different as well. Because of this difference, the issue of professional ethics is included in this discussion of make- or-break issues in collaborative practice. The differences are not always well understood and may lead to
misperceptions about each other's code of ethics, which in turn, will stand in the way of any collaborative effort. Huntington and Shores (1983) agree with this observation and point out that conflict always seems to arise from differences in value systems and moral distress.

Gramelspacher, Howell, and Young (1986) have conducted structured interviews with 26 nurses and 24 physicians and have found that physicians and nurses often disagree about ethical decisions. Especially if the differences between the two professions are perceived to be too far apart, chances for developing any form of collaborative team work are slim.

Dr. Fowler provides an illustration of an important difference in the value systems between physicians and nurses (Ethics For Nurses, 1991). She tells of the way physicians and nurses often differ in what they seek as the end result for the dying patient. Physicians tend to use all available medical technology to preserve life for as long as possible. Nurses, on the other hand, are more inclined to allow the patient to complete his death rather than complete his life. Both professionals are intensely involved in the process of the dying patient, but the physicians and the nurses come from different value systems in their approach to the dying patient. Under these circumstances, true interprofessional collaboration will be much harder to achieve.

Dr. Fowler's illustration is only one of the many ethical dilemmas that physicians and nurses face in today's health care system. The many uncertainties in health care have brought on a multitude of moral and ethical dilemmas for the physicians and the nurses (Ornstein, 1990). The uncertainty and the constant changes in medical technology have made it necessary for the physicians and the nurses to respond to new ethical dilemmas. The various professional associations have guided their members through the thorny ethical dilemmas by setting strict standards of professional ethics. The focus, however, has been only on members of their own respective associations. Physicians and nurses increasingly need to approach collectively the ethical dilemmas in health care. Before any collaboration can take place between the physicians
and the nurses, both professions must create a mutual understanding of their respective value
systems and mutually solve ethical issues by maintaining an open dialogue on the related topics.

**Issue No. 7 - Interprofessional Role Expectations**

Most discussions on barriers to collaborative team work seem to include details on the
issue of interprofessional role expectations. The issue certainly has caused much tension between
physicians and nurses. Butterill et al. (1992) confirm this notion and describe the problem around
role expectations as a definite contentious issue.

It appears that a considerable amount of confusion exists among the physicians and the
nurses on how each of them should contribute to the overall care. Fagin (1992) explains the
reason for all the confusion. She points out that medicine and nursing overlap in many areas of
their service to patients, which has contributed greatly to the confusion and the lack of effective
collaboration between the two professions.

In this confusion physicians and nurses have developed different perceptions and
expectations about each other’s roles on the team, which are often misperceptions (Ducanis and
Golin, 1979; Fried et al., 1988; Samuelson, 1992). Fried et al. (1988) further point out a related
and very alarming detail. Physicians and nurses apparently are not sharing their perceptions.
There is no ongoing discussion about what they think each other’s role and functions should be.
Without this sharing the confusion will go on and misperceptions can continue to develop, which
in turn, will stand in the way of any collaboration between the two professions. Ducanis and
Golin (1979) also stress that health professionals must learn what they can expect of the other
members on the team. Only through ongoing communication can physicians and nurses become
more familiar with each other’s roles.

The constant change in the roles of physicians and nurses, needless to say, has not made
things any easier. Physicians have seen their role change from unchallenged master to
bureaucratic functionary (Ducanis and Golin, 1979). The physicians are constantly reminded that they no longer can assume the role of the charismatic dominating leader of the team, instead they are to become a team player like any of the other members on the team.

The role of the nurses is changing constantly as well. The role of the nurses, in fact, has changed dramatically from past years (Nurse-Physician, 1989). There are still a few individuals who continue to stereotype nurses as temperature takers with small brains and big hearts (Keddy et al., 1986). Others even might still perceive the role of nurses to be that of the handmaidens to physicians (Nurse-Physician, 1989). Fortunately, these misperceptions are on their way out. It is very encouraging to see Dr. John Anderson, in his function as president of the British Columbia Medical Association, being quoted to say that nurses no longer are the handmaidens to physicians (Nurse-Physician, 1989). In a discussion paper by the Registered Nurses Association of British Columbia (1990) Dr. Halfdan Mahler, in his capacity as the director-general of the World Health Organization, is quoted to be saying that nurses will become more the resources of people rather than resources to physicians. Dr. Mahler also feels that nurses increasingly will take on greater responsibility for the decision-making in our health care system.

Many role changes for the physicians and the nurses have been the result of a direct shift of responsibility and actual work from the physicians to the nurses (Jenny, 1990). She maintains, however, that this steady shift of responsibilities often has been conducted in an unplanned manner and without appreciation or proper compensation to the nurses. Jenny (1990) clearly conveys the sense of frustration among nurses about this particular aspect of their role change in health care. The physicians are not too happy either. The real issue here seems to be whether the shift results in a purposeful delegation by the physicians or an assumpton of duties by nurses without physician delegation. They perceive these shifts of responsibilities and actual work as a case of boundary violations and a threat to their professional territory (Butterill et al., 1992).
The physicians definitely have voiced their concerns and confusions about what the role of nursing actually is (Ornstein, 1990). Even though the physicians express their confusion, there appears to be a strange reluctance to take it a step further, however, and engage the nurses into a discussion about what is making everybody unhappy. Fagin (1992) describes this strange situation as an informal conspiracy, which keeps the frustrations from being discussed out in the open. She explains that physicians and administrators fear that such open discussions would only shake the boat even more. This fear, however, could not be farther removed from the truth. In order to calm matters between physicians and nurses, an open dialogue must take place. Only through such communication can the two professions be brought together in a collaborative team. Fagin (1992) stresses that without open ongoing communication the relationships between physicians and nurses will remain dishonest and even demeaning. No professional will ever get to see clearly what the role of the other professional is, if they do not talk with each other.

Effective team collaboration is enhanced further when the parties involved accept the different role changes, and clarify each others’ new roles (Samuelson, 1992). The record to date shows that this acceptance and clarification may not be an easy task. Samuelson (1992) warns, however, that the team members should not become discouraged in their attempts to develop better collaboration, just because of futile attempts that have been made in the past. These past failures resulted from role conflicts and role ambiguities. Samuelson (1992), therefore, repeatedly stresses the importance of professional role clarity, which will permit the professionals to accept others and their input non-defensively.

Ducanis and Golin (1979) also warn the physicians and the nurses not to become overly rigid in their role expectations. They explain that a certain amount of role flexibility is necessary for effective team collaboration to occur. With such flexibility, opportunities will be created for the physicians and the nurses to engage in role negotiations that can be important to the smooth functioning of their collaborative teams. Fried et al. (1988) argue a similar point. They stress
that physicians and nurses must recognize that individuals may serve in different roles on the
team depending on their level of time commitment.

It is clear, for collaborative team building to be successful, each player on the team must understand the different roles of everyone. Only with such full understanding can the professional formulate appropriate role expectations and avoid falling in the trap of misperceiving what the other professional is doing.

**Issue No. 8 - Professional Status**

The issue of professional status has definite potential to become a thorny barrier in the way of collaboration between the physicians and the nurses (Horder, 1992). The reason for this high potential is simple. The difference in professional status between physicians and nurses is real. As already has been discussed, historically nurses always have assumed a position of lower status to the physicians (Ducanis and Golin, 1979; Ornstein, 1990).

There are a number of factors that contribute to this difference in professional status between the physicians and the nurses. Fagin (1992) indicates that the difference partially is based on class differences. She points out that most nurses come from the middle class or the working class, whereas physicians tend to come from the upper middle and the upper classes. In an earlier article Fagin and Diers (1983) describe nursing even as a metaphor for class struggle. The authors believe that nurses represent the classic underdogs in the world of health care, who are struggling to be heard, approved, and recognized.

Fagin (1992) indicates an additional factor that contributes to the difference in status of the two professions. She points out that the majority of the nurses are salaried employees, and therefore, fit in a different professional status than the physicians. This factor, however, gradually will have less impact on the issue of professional status as the physicians’ employment
arrangement is changing. Fagin (1992) points out that increasingly more physicians become salaried employees as well and, therefore, to some extent status differences with the nurses are lessened. In the eyes of some physicians this changing trend in their employment arrangement, is seen to have caused a deterioration in the physicians’ professional status. Stein et al. (1990) indicate that the public esteem for physicians actually has deteriorated in recent years. The authors further explain that physicians are no longer seen as omnipotent, instead the public recognizes that physicians can be fallible.

At the same time that the physicians are upset to see their professional status change, the nurses are upset that their professional status has remained the same. Ornstein (1990) explains that nurses have taken on additional tasks and responsibilities, but their professional status has not changed accordingly. The public esteem of the nurses has not increased. Nurses still are viewed by some members of the public as physician’s hand-maidens (Ornstein, 1990).

The traditional hierarchical authority of health care organizations also has contributed to the difference in the two professions’ status (Ornstein, 1990). The impact of this factor has been felt in particular by the nurses. Ornstein (1990) maintains that health care organizations have found it economically advantageous to keep nurses at the lower end of the hierarchy. Lower wages can be paid to those who are at the lower end of the totem pole.

A major factor that contributes to the status difference is the fact that the nursing profession is predominantly practiced by women. Porter (1991) explains that historically nurses have been subordinated to physicians along the lines of the sexual division of labour. With the rise in the women movement, however, and the concurrent change in women’s status, nurses are no longer interested in being placed in the health care hierarchy at a lower level than physicians (Stein et al., 1990).

Given that the difference in status between the two professions is well established, Fried et al. (1988) wonder to what extend there can be equal participation in decision making. They
question whether the goal of achieving parity on the team is realistic. Nason (1983) also questions whether effective negotiation is achievable for the physicians and the nurses, given that it requires equal power among the participants. In essence, these authors question whether the collaborative team concept has any chance at all to ever be successful. The nurses certainly believe that all certainly is achievable. The nurses think that they actually are taking their places as full and equal members on the team with definitely something to contribute (Nurse-Physician, 1989).

Indeed, the issue of professional status does not have to be a barrier, provided that the professionals handle the issue wisely. The physicians and the nurses must be sensitive to the differences in status (Ducanis and Golin, 1979). It is very important for the physicians and the nurses to acknowledge the difference between their professional status as a reality. As Fagin (1992) points out it is foolish, for instance, to ignore the power of social status on professional interactions and its impact on the parity implied in a collaborative team concept. A professional, however, should refrain from pulling rank simply because of his or her status. At the same time, one must remember that the status of a professional is deserving of courteous respect. Ornstein (1990) explains that interprofessional collaboration involves both physicians and nurses respecting each other. Under these circumstances the potential is there for professionals of different status to work well in good collaboration.

Issue No. 9 - Professional Ethnocentrism

Professional ethnocentrism is cited as a primary barrier to collaborative team work (Ducanis and Golin, 1979). In an environment where team collaboration is genuinely practiced, a professional can not perceive his or her own profession to be the most important one on the team. Such a view is very detrimental to the collaborative team concept. Neither can a profession truly feel committed to collaborate with another profession, when the latter one is perceived to be
more important. It is fundamental to the survival of the collaborative team that one acknowledges
that all its members are equally important.

The reality, however, is that such an acknowledgment does not always appear to exist.
Medical students have given witness to the fact that physicians often appear condescending to
nurses (Anvaripour et al., 1991). Such an attitude is extremely destructive to any collaborative
effort. Samuelson (1992) agrees with this notion. He maintains that there is no place for
arrogance or professional chauvinism on collaborative teams.

Professional chauvinism, however, does appear on the scene, in particular, when one
profession sees its prerogatives eroded by another profession. Under these circumstances the
profession will try to gain back its prerogatives by exerting control over the other profession’s
practice (Ducanis and Golin, 1979). The authors further explain that professions will try to
legally define the boundaries of their own profession and also of the other profession. Such an
attempt is seen as a preventative measure to assure that the profession will retain exclusive rights
to as many professional prerogatives as possible. Huntington and Shores (1983) provide an
illustration of one such attempt made by physicians. In the state of Washington nurses have tried
to include the term 'diagnosis' in the state nurse practice act. The physicians, however, have
asserted that the term, and all its implied judgments and action, belongs to them, and them only.

These type of attempts to retain exclusive rights become difficult barriers to collaborative
team work. In particular, when the focus is on the conflicting prerogatives of the different
professions, the professionals can build formidable barriers to effective collaboration (Hanlon and
Gladstein, 1984)

Whenever conflicting prerogatives emerge, effective leadership is required to prevent the
team from falling apart. There always seems to be one person on the team, who will emerge as
the team leader. If this professional, however, has taken on the leadership role solely based on
his or her feeling of professional ethnocentrism, the team obviously is being lead by the wrong
person. To take on the leadership role only because one feels more important than the other members on the team often leads to a dictatorial leadership and a reluctance to share power, rather than a balanced leadership which will guide the team toward achieving its common goal (Baldwin, 1993).

Good leadership will encourage physicians and nurses to refrain from seeing only themselves as the most vital member on the team with all the know-how. Instead, both professionals will be encouraged to respect each discipline’s scope of knowledge and uniqueness of functions. They must acknowledge that the uniqueness of both professions make each of them a vital member of the team.

**Issue No. 10 - Interprofessional Trust**

Interprofessional trust is essential for collaboration to be successful (Ornstein, 1990). It is the key to a positive relationship between physicians and nurses (Nurse-Physician, 1989; Fagin, 1992). Afterall, one can hardly expect a professional to collaborate with an other professional, whose professional judgment is perceived to be rather shaky and can not be trusted. Caution must be taken, however, not to come too quickly to the conclusion that the other professional can not be trusted. There is a high chance this conclusion is a misperception of the true facts. There should be concrete evidence, before a professional concludes that an other professional is not trust worthy. It takes time to collect enough evidence on which professionals can build their mutual trust. Fagin (1992) agrees and reports that it has been shown that the longer two professionals work together, the better the opportunity is to build trust.

Ornstein (1990) also reports that physicians and nurses develop more trust as they work collaboratively. These observations of Ornstein (1990) and Fagin (1992) bring out an interesting detail about interprofessional trust. Their observations beg the question, what develops first, trust or collaboration. It is beyond the current scope of this study to delve deeper into this question,
but suffice it to say that obviously interprofessional collaboration and interprofessional trust go hand in hand.

As a final comment, it bears repeating that trust is also linked to competency, as discussed earlier under issue number 3 - professional capabilities.

**Issue No. 11 - Interprofessional Advice**

A fundamental element of collaboration between professionals is the ability to depend on each other for advice. The issue of interprofessional advice, however, does seem to have the potential to cause tension among the members of the team.

Samuelson (1990) indicates one form of tension brought on by the issue of interprofessional advice. He argues that the act of asking an other professional for advice may be perceived as evidence of one’s professional weakness. No professional wants to appear weak. To those professionals who think that asking for advice reflects a weakness, it must be pointed out that the rapid expansion of knowledge in health care necessitates the division of tasks and functions along different lines of expertise (Ducanis and Golin, 1979). No longer can one professional be expected to know everything, and consequently, the professional will have to depend on others for advice and this dependency should not be perceived as a form of weakness. Such a perception clearly is a misperception.

It seems that nurses have talked much about the dependency aspect of interprofessional advice (Nurse-Physician, 1989). This is, because nurses constantly ask physicians for advice. The nurses stress, however, that this dependency on physicians for advice does not mean that nurses are subservient to the doctors.

As much as the nurses depend on the physicians, the doctors depend on the nurses for advice as well. This advice, however, is cloaked often in suggestions to the physicians, which the doctors either may accept or may not accept (Jenny, 1990). If they do accept the suggestions, the
physicians often also take credit for them, which creates a lot of tension among the nurses. The nurses feel that credit should go where credit is due. Jenny (1990) further explains that as soon as the nurses’ suggestions appear to challenge medical authority, they face automatic rejection. This reaction from the physicians adds to the tension among the team members, and certainly distracts from the collaborative aspect of the team.

Porter (1992) points out that ideally team interactions around interprofessional advice between physicians and nurses are to be perceived as complimentary rather than contradictory. It should be made clear that someone’s advice is just that - advice. It is not a command. Porter (1992) maintains that nurses appear to have captured well the complimentary nature of the interprofessional advice exchange. He explains that nurses increasingly feel no longer constrained from frequently making overt suggestions to the physicians about patient care issues. In fact, the nurses increasingly feel comfortable to argue in support of their given advice.

If interprofessional advice can not be exchanged, not only is there really no collaboration between the professionals, but patient care may suffer from lack of input from both professions. The dynamics behind the issue of interprofessional advice should be well understood. A good understanding will help a professional to overcome the perceived problems with interprofessional advice. As the problems are resolved, the professional will be able to enjoy a much better sense of interprofessional collaboration.

Issue No. 12 - Interprofessional Utilization of Capabilities

The issue of professional capabilities already has been discussed in an earlier section of this review under the heading of issue number 3 - professional capabilities. What is stressed in this earlier section is the difficulties that may arise when professionals misperceive each other’s capabilities. Many frustrations are caused by this lack of understanding. The frustrations,
however, become even more pronounced, when a profession's capabilities are known, but are not properly used.

Cartwright (1991) has conducted a survey among the members of a team that care for the terminally ill patient. The author finds that the most frequent criticism made by the nurses of physicians is that they do not ask for nursing help early enough in the care of the terminally ill patient. This under-utilization of nurses happens despite the fact that the physicians in the survey are convinced that the nurses' contribution is very helpful to the program of terminal care services. The sooner nursing gets involved with the care of the terminally ill patient, the more nursing can contribute to the decision making around any diagnostic and preventative measure. It appears that in this instance, the utilization of nursing expertise mostly is limited to providing the task oriented direct care to the terminally ill patient. The capabilities of these nurses clearly are being under-utilized.

The issue of under-utilization, however, is changing. Ornstein (1990) points out that physicians increasingly are accepting of delegating to nurses tasks which have been at one time solely the physicians' responsibility. This development contributes well to the collaborative team concept. Caution must be taken, however, to use the full gamut of nurses' capabilities and to have nurses involved when decisions are being made about what functions are delegated to the nurses or incorporated into nursing practice. Again, strictly limiting the nurses to tasks of direct care leaves a whole arsenal of diagnostic and preventative capabilities under-utilized.

As much as under-utilization is a concern, the "spread-to-thin" phenomena using a professional's capabilities appears to be a problem as well. Jenny (1990) warns that nurses are being asked to stretch their capabilities too far. She argues that increasingly the nurses are asked to do more with less resources. Such conditions are very detrimental to the nurses' self-esteem and create moral outrage (Pike, 1991). The author describes moral outrage as an emotional response seen in nurses, who are not able to carry out moral choices in patient care due to
constraints. Based on her observations of physicians and nurses on a patient care unit dedicated to the study and development of interprofessional collaboration, the author reports a decline in incidents of moral outrage among the nurses on the unit as a favorable outcome of their collaboration with physicians. There has to be a balance between what one can do and what one is asked to do. Professionals do feel better if they fully can use their capabilities and are properly provided with the necessary resources. Samuelson (1992) explains that professionals’ self-esteem is enhanced further, when their contributions and capabilities are genuinely recognized by their colleagues. Pike (1991) attributes the decline in moral outrage to mutual trust and respect between nurses and physicians, and an appreciation that the two professions are dependent on the utilization of each other’s professional capabilities.

It is important for physicians and nurses to properly utilize each other’s capabilities. This review shows that the issue of interprofessional utilization of capabilities must be handled with care. Misperceptions appear to develop easily among the physicians and the nurses on how much each of them is capable of contributing to the overall care. Administrators play a key role in proper utilization and appropriate resource allocation as well as ensuring physicians and nurses recognition and appreciation of one another’s capabilities.

**Issue No. 13 - Interprofessional Cooperation**

Samuelson (1992) stresses that meaningful collaboration depends heavily upon interpersonal dynamics. These dynamics must reflect interprofessional cooperation. If there is no interprofessional cooperation, then collaboration between physicians and nurses definitely is unachievable. Samuelson (1992) further points out that it takes practice to work cooperatively in groups. It requires skill to cooperate with another profession, especially if one is new at the issue of interprofessional cooperation.
However, even if one has learned to cooperate, it still does not guarantee interprofessional collaboration. Hughes and Mackenzie (1990) state that physicians and nurses must have an on-going commitment to cooperate with each other. The two professions genuinely must want to collaborate. Ornstein (1990) maintains that even if physicians and nurses are coerced to cooperate, or forced to do so by law, there still may be no collaboration. Her point is that the two professions can never be coerced to collaborate. As seen from the discussion at the beginning of this chapter on what constitutes collaborative team work, coercing physicians and nurses to collaborate is extremely ineffective. Feelings of mutual trust and respect, as well as collegiality, are at the core of collaboration. One can not force these feelings upon the professionals. There has to be a real desire to collaborate, and in order to achieve this goal, the professionals must effectively cooperate with each other, rather than just going through the motions. Professionals who are perceived to be going only through the motions will not likely be approached for any collaborative effort. The higher the degree of genuine interprofessional cooperation the more chance there is to see physicians and nurses work well collaboratively.

Interprofessional cooperation is a desirable goal in health care, because of its by-products. Efficiency and appropriate resource allocation are the by-products of cooperation (Registered Nurses Association of British Columbia, 1992). The Registered Nurses Association of British Columbia endorses the idea of interprofessional cooperation, and points out that when physicians and nurses work in cooperation, the resulting plan of care can be implemented by the most appropriate member of the team. The appropriateness is determined by the skills required for the care to be given, as well as the degree of efficiency with which the care can be given. Through good cooperation physicians and nurses collectively can decide which professional is most appropriate to provide the service.
In summary, it is clear that a real commitment to the issue of interprofessional cooperation will enhance the chances of successful collaboration between physicians and nurses, and in turn, will lead to all the different benefits that interprofessional collaboration brings.

**Issue No. 14 - Professional Training**

As much as professional training has the potential to add to a professions’ ability to provide high quality of care, it also has great potential to be a barrier between different professions (Horder, 1992). Ducanis and Golin (1979) point out that professional education involves adopting a certain professional lingo, developing certain assumptions, and learning to work within a unique conceptual framework. While all this training enhances intraprofessional communication, it tends to create barriers between professions.

The issue of professional training has been the cause of many interprofessional misperceptions. The professional training issue closely relates to the issue of professional competency. The related misperceptions around competency already has been discussed earlier in this chapter. Nurses are reported to believe that physicians feel threatened by the increased education levels in the nursing profession (Nurse-Physician, 1989). For the most part this tends to be a misperception. While some physicians may feel threatened indeed by the increase in university prepared nurses, most are reported to say that it is not an issue of feeling threatened at all, they perceive it to be more a matter of concern that university prepared nurses may become less interested in providing bedside care. These concerned physicians beg the question - who will continue to provide quality bedside care? The physicians’ concern, in turn, is based also on a misperception. Many degree nurses prefer to stay right at the bedside. In time, given that university preparation is the entry level for nursing, all nurses at the bedside will be university prepared.
Physicians also are concerned that nurses make judgments about medical practice for which they do not have the background training (Nurse-Physician, 1989). As discussed earlier in this chapter this concern more often than not is also based on a misperception. Some nurses are very well trained to make judgments about medical practice (Jenny, 1990). The author supports her argument by pointing to nurses who have chosen to remain in the same clinical area for a number of years. These nurses are often the only ones with the finite knowledge of typical patient responses seen in that clinical area, and are often very well trained to handle the very specialized technology available to treat these patients. Some of these nurses, in fact, have prepared themselves as clinical specialists with masters and doctorate degrees. Ornstein (1990) hopes that these academic credentials will add credibility to nursing in the eyes of medicine. Baldwin et al. (1992) say that nurses will see their relationships with physicians improve as the nurses increase their education.

One way to deal with the misperceptions around professional training is to promote interprofessional training (Glendon and Ulrich, 1992; Horder, 1992). Glendon and Ulrich (1992) argue that medical and nursing students need to be taught together on how to interact skillfully with each other. Opportunities for these interactions will also allow physicians and nurses to appreciate the similarities and uniquenesses of each profession. Currently, the University of British Columbia offers an interdisciplinary ethics course that provides such learning, but such courses are rare (A. M. Hughes, personal communication, August 20, 1993). Through interprofessional training, interprofessional collaboration will have a better chance to succeed.

**Issue No. 15 - Interprofessional Relationships**

The issue of interprofessional relationships is an important determinant of collaborative team effectiveness (Ducanis and Golin, 1979). Most physicians and nurses perceive their relationships with each other as positive, however, when asked to substantiate their view point
the professionals are hard pressed for examples of existing collaborative behaviors (Fagin, 1992). In fact, a review of the literature provides details of some serious difficulties with the relationships between physicians and nurses that have caused a major barrier to the development of collaborative team work.

A quick look at the difference in basic terminology used by either profession to describe their relationship shows already that the physicians and the nurses are far apart on the issue (Huntington and Shores, 1983). While nurses talk of collegial relationships with physicians, the physicians continue to talk of supervisory relationships with nurses. With such a difference in perception on what form the relationship should take, it is no surprise to see that the relationships between the two professions are sometimes adversarial and often guarded (Nurse-Physician, 1989).

Fagin (1992) continues to describe the relationships between the two professions to be a hierarchical one, where the nurse is subordinate to the physician. She even maintains that some relationships between physicians and nurses are actually dishonest and demeaning. Not surprisingly, the author is concerned about the current status of the interprofessional relationships. She strongly advocates that the physicians and the nurses relate more interdependently with each other, where both professionals have complimentary roles.

It is interesting, however, to see that some nurses are not keen to see the status quo changed at all. Ornstein (1990) points out that many nurses feel threatened by the idea of an increased interdependence with physicians. She explains that these nurses equate such a change in the relationship with an unwanted increase in their responsibility and accountability. It seems that these nurses are not ready, or lack the knowledge to adjust to a relationship with physicians that is characterized by interdependence.

Ornstein (1990) reports that physicians are not too keen either to move toward an increased form of interdependence in their relationships with nurses. In fact, the author explains that the
physicians also feel threatened. To remedy these uneasy feelings among the physicians, Ornstein (1990) suggests that the nurses should develop skills in leadership, as well as skills in bargaining and negotiating. She argues that with these skills nurses can approach the physicians without being perceived as threatening the doctors with their suggestions to change their work relationships. This argument, of course, seems to be equally valid for the physicians. If both professions have improved their negotiating skills then perhaps the physicians and the nurses can move toward a more collaborative relationship.

The nurses have a real interest to see their relationship with the physicians change, because without a more collaborative relationship the nurses see one important part of their job almost made impossible. Mechanic and Aiken (1982) explain that without collaboration the nurses are often left in the dark about the physicians intent of care. The nurses will not have full knowledge about what the physicians intend to do with their patients. Nurses, therefore, will not be in a position to provide insightful emotional support to the patients, who are trying to cope with the many uncertainties brought on by their illnesses. In addition, without nursing input, physicians may be unaware of the patients’ or the families’ inability to cope with these uncertainties.

There is hope, however, that the interprofessional relationships will improve. A document prepared by the Registered Nurses Association of British Columbia and endorsed by the British Columbia Medical Association stresses that "medical and nursing team work is enhanced by a relationship that respects the uniqueness and interdependency of the respective services of each discipline" (Registered Nurses Association of British Columbia, 1992, p. 7). These are encouraging words, which hopefully will be followed by confirming actions on the part of the physicians and the nurses.

The fifteen issues that have been reviewed in this chapter have all been included in a survey conducted among physicians and nurses in long term care facilities in the city of
Vancouver, British Columbia. With the survey an attempt has been made to assess what perceptions the two professions have developed on each of these fifteen important issues in collaborative practice. The results of this survey can be found in chapter three and are further discussed in chapter four of this study.

Demographics that have been collected on the subjects in this study have been chosen specifically because of their potential to influence physicians and nurses in their development of different perceptions and attitudes about collaborative practice. The following section provides a literature review describing the potential influences.

Demographic Correlates of Interprofessional Misperception and Team Work

The subjects have been asked to share personal information on a number of pertinent data. The demographics include age, gender, education, ethnic background, and work experience. They are discussed separately in the following sections.

**Age.**

It seems that the age of a professional might have an impact on that persons outlook on collaborative practice. Ducanis and Golin (1979) argue that professionals develop attitudes toward certain role behaviors already early on in life. Through real-life experiences with physicians and nurses people develop a set of role expectations that they perceive to be true of physicians and nurses. Ducanis and Golin (1979) explain that these attitudes and perceptions are shaped further throughout life through the process of socialization. The older person, of course, is exposed to a longer period of socialization than the younger person. The older professional, therefore, has more real-life experiences from which to develop an attitude toward collaborative team work.
The exact effect of a longer socialization process on a professional’s attitude toward collaboration is extremely difficult to assess. There are so many additional factors that contribute to the formation of one’s feelings about interprofessional collaboration that it is impossible to single out the effect of just one factor. However, the type of socialization process within professional education can often be identified by age. Nonetheless, it was thought to be interesting to see whether more positive or more negative attitudes toward interprofessional collaboration would be found in one particular age group among the subjects in the survey.

**Gender**

Keddy et al. (1986) point out that the attempts on developing collaborative relationships between physicians and nurses have been characterized by an enduring pattern of physician dominance and nurse deference, paralleling the male-female societal relationships. Baldwin (1993) points out that these intergender relationships have been woven into the fabric of our history for aeons. She argues that dominance is a style of interaction based on ranking of one gender, and she explains that within the dominator model women are sent the message that they are somehow not equal in any meaningful way to men. With this perception ingrained in people’s minds, together with the fact that nursing predominantly is practiced by women, it appears to be an almost insurmountable challenge to develop a truly collaborative practice between physicians and nurses.

Baldwin (1993) believes that this dominator bias is trapping both men and women in a narrow configuration of humanity. Men perceive they constantly must try to develop their sense of professional success by being dominant. Based on this perception the men will not likely sign up for any form of interprofessional relationship that takes away their sense of dominance. Women, on the other hand, perceive they constantly must way their professional goals with their responsibilities as housewifes and mothers. This perception is changing, however, as more men
get involved with the maintenance role of house and family. The male-female societal relationship is changing, which may hold promise for the collaborative team concept.

Fagin (1992) also believes that the issue of gender difference between physicians and nurses and its impact on the collaborative team concept is starting to become an issue of the past. Ornstein (1990) agrees and states that the women’s movement is forcing the nurses to reexamine their relationships with the physicians. No longer are nurses prepared to play the role of physicians’ handmaidens (Keddy et al., 1986).

The gender demographic has been included in the survey to see if any impact is evidenced on the perceptions among physicians and nurses about their collaborative relationships.

Education

Data on the subjects’ educational background has been included, because professionals with higher education are said to be often better prepared for collaborative team work than those with less education (Ornstein, 1990). The author explains that the higher educated professionals are perceived to be more capable as team members than the lower educated professionals, because they have a better understanding for committee work, they have better problem-solving skills, and they also are better at making decisions.

It was thought to be interesting to see whether or not more positive attitudes toward collaborative team work would be seen among those subjects in the survey with higher educational levels than those with less education.

Ethnic Background

Multiculturalism is at the heart of Canadian society and that fact holds true for the health care system as well. Physicians and nurses come from a variety of ethnic backgrounds. They
bring with them different values and norms, as well as different levels of command over Canada's two official languages.

Horder (1992) has pointed out that the use of different languages can form a definite barrier to the development of collaborative teams. The author specifically makes reference to the differences in professional lingo, but the point is equally well taken when it comes to the differences in command over the English or the French language. If one professional can not understand an other professional because their mother-tongues are different, it will be very hard for the two to work collaboratively. Fundamental to any form of collaboration is good communication, which is hard to achieve if the members on the team do not speak the same conversational language.

Ethnic background, therefore, was thought to be a very crucial piece of demographic data that needed to be included in the survey. Of course, it is not assumed that a difference in ethnic background automatically indicates a difference in command over the English language. To determine such a difference other tests should be conducted. The intent for this study is to indicate only the possibility that language and culture differences might be at the root of the problems faced by collaborative teams.

**Work Experience**

The length of work experience appears to have an impact on professionals' perceptions about collaborative team work.

Vance (1992) comments that professionals in their first year of practice need to learn the organizational savvy. As new comers to the team, they have to learn the norms and the patterns of their work team. In fact, they may have to adjust their own perceptions on how team collaboration ought to work to how things are actually working, which might have quite a bearing on their continued attitude towards the collaborative team concept.
Fagin (1992) also makes a point about a professional's length of work experience and the person's inclination to trust the other team members. She points out that the longer professionals work together the better the opportunity is for them to build a mutual trust, which will enhance the collaboration on the team.

With these points kept in mind, it was thought to be of interest to include data on the subjects’ years of work experience and see whether or not more positive perceptions about team collaboration are found among those professionals in the survey with considerable amounts of more work experience.

This study specifically has been focused on long-term care facilities. The recent developments in this sector of the health care system together with the unique circumstances under which physicians and nurses in long-term care facilities have to work have prompted a closer look at collaborative team work in long-term care facilities.

Interprofessional Collaboration in Long-Term Care Facilities

There are a number of unique circumstances and elements in the organizational setting of long-term care facilities that have a major impact on the development of collaboration between physicians and nurses.

One very significant element is the frequency of face-to-face contact between the two professions. On average, physicians spend less than two hours per month in long-term care facilities (Mechanic and Aiken, 1982; Fagin, 1992). Consequently, physicians are most often not there in person to collaborate with the nurses on patient care issues. Fagin (1992) points out that the care in long-term care facilities is predominantly provided by nurses. It appears that the nurses have no choice. Ornstein (1990) points out that the physicians simply are not easily accessible to the nurses for consultation. It appears to be difficult for the nurses in long-term care
facilities to have timely access to physicians. The physicians’ time is scheduled with their patients in hospitals and in their offices, which often are located far away from the long-term care facilities. Ducanis and Golin (1979) point out that physical location is an important aspect of how professionals will function as a team. They argue that it is more likely that collaboration will take place if the team members are housed in the same building. If both professions are present to see the problems first hand, chances are increased that physicians and nurses will collaborate in their efforts to solve the problems in a timely manner.

Increasingly the inaccessibility to physicians is becoming a dilemma for the nurses, who find themselves having to care for a geriatric patient population that is getting older and sicker and requiring considerably more complicated care than ever before (Ornstein, 1990; Samuelson, 1992). Ornstein (1990) explains the dilemma of the nurses. She points out that the nurses are left with the responsibility of providing complicated care without the presence of a physician, and yet the nurses have no authority to act in the absence of a physician. Samuelson (1992) is concerned about this dilemma faced by the nurses and points out that the challenges of long term care have become increasingly more complex in nature for one profession to resolve. He argues, therefore, that team collaboration has to be more strongly promoted in long term care facilities than currently is the case. He points out, in fact, that very little is known about the levels of interprofessional collaboration in long term care facilities. One thing Samuelson (1992) does know is that, especially in long term care, attempts to build collaborative skills among the physicians and the nurses is a rarity.

However, opportunities do exist for the professionals in long term care to develop a good collaborative relationship. The collaborative team concept does not necessarily exclude groups that rarely or never meet face-to-face (Ducanis and Golin, 1979). As long as the professionals communicate there is a chance to collaborate. For the moment, the physicians and the nurses in long-term care facilities primarily have to use the telephone for their communication needs. This
method of communicating is fraught with problems, but the fact remains, the professionals are in a position to communicate.

To further increase their chances of developing collaborative teams, the physicians and the nurses in long term care facilities have to learn to work within the unique circumstances of their work environment. Physicians have to rely more on nurses and nurses have to become more autonomous in daily decision making (Nurse-Physician, 1989).

It would be in the best of interest to the elderly patients to see both professions adapt to their new work relation as soon as possible. Mechanic and Aiken (1982) point out that nurses need to increase their efforts in becoming clinically skilled enough to make the autonomous decisions. The authors point out that with skilled nursing care in long term care facilities, the elderly patients will require less admissions to costly emergency-rooms and in-patient services of acute care hospitals. As for the physicians, Fagin (1992) points out that they should start viewing their role as collaborative and consultative with nurses, rather than seeing their role as that of direct care-givers. It is encouraging to see that in those instances where physicians and nurses have adapted to their new roles in long-term care facilities, improvements have been noted in the care of the elderly patients (Fagin, 1992).

Summary

This chapter has reviewed the literature regarding the need for, benefits of and barriers to collaborative team work. It also has reviewed 15 issues used as a basis by Ducanis and Golin (1979) for their instrument, which is the main data collection instrument for this study. As can be seen from this discussion, much appears to be gained from appropriate collaborative team work in long-term care facilities. As Samuelson (1992) has pointed out, however, not much is known about how well the physicians and the nurses in long-term care facilities are under way with their collaborative efforts. This study has tried to shed some light on the issue.
The remainder of this report is devoted to a description of the design and methods used to conduct a survey among the physicians and the nurses in 13 long-term care facilities in Vancouver, British Columbia, and to present and discuss the findings. The professionals were surveyed for their misperceptions on the make-and-break issues of interprofessional collaboration. Even though the various degrees of misperceptions form only a very small part of the total dynamics that surrounds the collaborative team concept, the findings of the survey still may serve as an indicator of how well the concept is perceived by physicians and nurses in long term care facilities.
CHAPTER 3

The Research Methodology

Introduction

This chapter discusses the research methodology chosen for this study of interprofessional misperceptions among physicians and nurses in long-term care facilities. Where applicable, rationale is given for the particular choices.

For clarity the chapter has been divided into six different sections. The first section provides details concerning the development of the research proposal. The design specifically chosen for the study is outlined in the second section, and the instrument used for the survey is described in the third section of the chapter. The next section provides details on each of the procedures followed in conducting the survey. This section includes a description of the procedures used for selecting the long-term care facilities, and the respective samples of the physicians and the nurses, as well as a description of the methods used for distributing the questionnaire. Ethical considerations are incorporated.

In the fifth section of this chapter the methods used for the data analysis are presented. A summary is provided in the final section of this chapter.

The Development of the Research Proposal

In order to assess the feasibility of exploring interprofessional misperceptions among physicians and nurses in long-term care facilities, and to assess the potential for any practical application in the long term care setting, the nature and the purpose of the research was discussed with various individuals, including physicians and nurses in long term care. The topic
of the research was met with great enthusiasm by the different individuals and definitely seen as a very timely issue. This response was very encouraging and led to the development of a research proposal.

The research proposal was submitted to the members of the Thesis Screening Panel of the Department of Health Care and Epidemiology at the University of British Columbia. The members' permission and support for the research was obtained, as well as the approval of the university's Behavioral Sciences Screening Committee for Research and Other Studies Involving Human Subjects.

The Study Design

A descriptive study design was selected for this research. The purpose of the study was to investigate the degrees of misperception that physicians and nurses in long-term care facilities may have about each other. The intent was not to engage in any hypotheses testing.

The conceptual framework for this research was based on the interpersonal perception method described by Ducanis and Golin (1979).

The Instrument Used for the Survey

An adapted form of a previously validated instrument was used for the data collection in this study (see Appendix A for the instrument used for the physicians and see Appendix B for the instrument used for the nurses). Ducanis and Golin (1979) developed this instrument in the late 1970s, and called it the Interprofessional Perception Scale.

The scale was specifically designed to examine how professionals viewed themselves, viewed members of other professions, and perceived how the members of these other professions viewed them (Ducanis and Golin, 1979). The scale, therefore, yielded a great deal of data
concerning the way in which one group of professionals viewed relationships with another group of professionals.

The Interprofessional Perception Scale was used for the present research because of its diagnostic and descriptive capabilities related to existing degrees of perceptions among physicians and nurses in long-term care facilities. By comparing these perceptions conclusions could be made with respect to any degrees of misperception among the two professions.

Ducanis and Golin (1979) included a total of 15 issues on the scale. The 15 items were concerned with interprofessional issues:

- the belief in each other's professional competency
- the acknowledgment of each other's professional autonomy
- the understanding of the other professional's capabilities
- the recognition of the other professional's concern with patient welfare
- the sense of professional territoriality
- the differences in each other's professional ethics
- the role expectations of each other
- the difference in professional status
- the sense of professional ethnocentrism
- the mutual trust in each other's professional judgement
- the soliciting of each other's professional advice
- the full utilization of each other's capabilities
- the degree of interprofessional cooperation
- the recognition of each other's professional training
- the perceived quality of the interprofessional relation.
All these 15 issues, selected for the scale, have been described in the literature as having great impact on interprofessional relationships. The literature base and the exact potential for these issues to contribute to interprofessional collaboration have been discussed in detail in chapter two of this study.

Ducanis and Golin (1979) designed the scale to elicit a response from their subjects at three different levels. First the subjects were asked to give an opinion of the other profession (level I) with respect to these 15 issues. Then the subjects were asked to tell how the other professionals would respond to the same issues (level II). Finally the subjects were asked to assess how the other professionals would say that the subjects had answered the questions on each of the issues (level III). With this method a direct view was obtained on how one profession perceived another (level I), whether one profession thought the other would agree or disagree with that direct perception (level II), and whether the other profession would understand or misunderstand that perception (level III).

For the purpose of this study, it was sufficient to collect data only on level I and II responses. The Interprofessional Perception Scale, therefore, was adapted to include only those two levels. The scale was further adapted by using more specific labeling to clearly denote either the physicians or the staff nurses in long-term care facilities, rather than using the more generic labels of 'your own profession' and 'the other profession'.

Ducanis and Golin (1979) maintained that content validity of the instrument was established by the direct nature of the questions on the scale. They also reported that the instrument's reliability was established through a test-retest procedure over a specific period of time. The reliabilities were measured by percent of exact agreement. An 80 percent mean across several professions, who were included in the test-retest procedure, was obtained for level I responses. The percent of exact agreement ranged from 74 percent to 86 percent for level I responses. The
level II responses showed a mean of 79 percent exact agreement, with a range of 74 percent to 81 percent.

An additional adaptation was made to the instrument by adding specific details to the respondent data in order to obtain a more complete and pertinent profile of the subjects in the study. The original instrument included information on the subjects’ age, gender, years of experience, and education. The specific details added to the instrument included information on the subjects’ ethnic background, and the detail on years of experience was expanded by specifically asking for the number of years the subjects had cared for patients in long-term care facilities. The nurses' professional designation as well as the nurses’ ratings of their job satisfaction were added to the nurses’ version. The detail concerning the area of practice was added to the physicians’ version. These specific demographic data were included in the package based on findings in the literature, which stressed the potential of these demographics to significantly influence physicians and nurses in their development of perceptions of each other. The pertinent literature on these demographic data is discussed in Chapter Two.

The Research Procedures

The Procedure for Selecting the Long-Term Care Facilities

No evidence was found in the literature of any exploratory or descriptive study previously done on misperceptions among physicians and nurses in long-term care facilities. There was, therefore, no specific guidance available on how many long-term care facilities, or how many subjects of each of the two disciplines, ideally should be included in the sampling in order for this exploratory study to be truly reflective of physicians and nurses in long-term care facilities. However, a study done by Katzman (1989) on physicians’ and nurses’ perception of nursing authority reflected much of the intent of this study in that both focus on perceptions of physicians and nurses. Katzman’s study, therefore, provided some guidance in determining how many
physicians and nurses were ideally to be included in the sampling. Katzman used responses of 53 physicians and 110 nurses.

From a preliminary study it was estimated, that by including 13 long-term care facilities access could be obtained to approximately 75 physicians and 120 staff nurses. Even with the expected difficulties associated with possible low response rates to a voluntary questionnaire, these target numbers for each of the two disciplines were seen as appropriate for the purpose of this study. Accordingly 13 long-term care facilities were randomly selected from a universe of 22 facilities in the city of Vancouver, British Columbia.

Meetings were arranged with officials of each of the 13 facilities. These meetings were held to inform the officials of the purpose of the study, as well as the scope of involvement required on the part of the facility, its nursing staff, and its physicians. Most of the officials were functioning either as the Director of Care or the Administrator of the facility. Once the officials had expressed their interest to see their facility included in the study, they were asked to sign an Agency Consent form. A copy of this consent form is found in Appendix C. The Agency Consents were sent along with the request for ethical review to the University of British Columbia Behavioral Sciences Screening Committee for Research and Other Studies Involving Human Subjects.

The Procedure and Ethical Considerations for Selecting the Sample of Physicians and the Sample of Nurses

None of the 13 long-term care facilities had a standing committee for ethical reviews or research. All the ethical considerations for the selection of the subjects, therefore, were discussed with the Administrator, or the Director of Care, or in some instances with both officials. The confidential nature of the survey was stressed with the officials, and it was explained that the voluntary return of a completed questionnaire would imply the subject’s consent to participate.
After carefully reviewing all the ethical considerations, the officials allowed for the study to proceed and they assisted with the selection of the samples by providing lists of eligible medical and nursing subjects. Only physicians who had patients at one or more of the 13 long-term care facilities were considered as eligible to participate in the study. The nurses were only eligible to participate if they worked as regular full-time or part-time staff nurses in these same facilities.

The lists for the physicians had to include their name as well as the address of their office. The address was needed to assure that physicians, who were associated with more than one of the thirteen facilities, only were approached once for their participation in the study. The list of eligible staff nurses included their name and professional designation of either registered nurse, registered psychiatric nurse, or licensed graduate nurse. The exact number of nurses in each of these professional designations was needed in order to compare the actual response rates for each of these categories of nurses.

A package was distributed to all the eligible physicians and nurses. The physicians received their packages in the mail at their respective offices. The packages for the nurses were either distributed together with the nurses’ pay cheque, hand-delivered to the nurses by the agency’s official, or placed in the nurses’ respective mailbox.

The package included a copy of the questionnaire, called the Interprofessional Perception Scale, together with detailed instructions on how to fill in this questionnaire.

The package also included an introductory letter, which stressed that the return of the completed questionnaire would imply the subjects’ consent. The letter further explained the merits of the study, the confidential and voluntary nature of the questionnaire, information about the author of the study, as well as instructions on how to return the completed questionnaire. The physicians were asked to return the questionnaire to the author in an addressed and stamped envelope, which was also enclosed in the physicians’ package. The nurses were asked to return
the questionnaire to an envelope, which was located in the staff room of each of their respective facilities. Because of the difference in instructions on how to return the questionnaire, the introductory letters differed slightly for each of the two professions (see Appendix D for the introductory letter to the physicians and Appendix E for the introductory letter to the nurses).

Throughout the duration of the data collection, colorful posters were put on display in each of the consenting facilities. The posters conveyed information similar to the content of the introductory letters and were encouraging the subjects to participate in the survey (see Appendix F).

In order to maximize the response rates, each of the questionnaires were coded allowing for a second distribution two weeks later to subjects who did not respond the first time. The content of the package for the second distribution was exactly the same as the package send out the first time, with the exception of the introductory letters. The introductory letters enclosed with the package for the second distribution served as a thank-you for those subjects, who had responded, and a reminder for those who had not yet completed the questionnaire (see Appendix G for the letter to the physicians and Appendix H for the letter to the nurses). Enclosed with the second package was also a replacement questionnaire in the event the first copy inadvertently had been misplaced. The subjects, who received the second package, were prompted to disregard the reminder and the second copy of the questionnaire, if they already had returned the first copy.

Of the 138 questionnaires distributed to the physicians, 28 questionnaires (20%) were returned as completed. A total of 66 completed questionnaires (60%) were returned of the 110 distributed to the nurses.

The Methods of Data Analysis.

The data obtained were to be analyzed for any existing degrees of interprofessional misperception among the physicians and the nurses in long-term care facilities. For the purpose
of the study, interprofessional misperception had been defined as the difference between one professional’s perception on how the other professional would view an issue, and the viewpoint actually expressed by the other professional on the same issue. What was being measured, therefore, was the degree of agreement between the two professions on a particular viewpoint.

The literature shows that the easiest and most frequently used index of agreement is the overall proportion of agreement (Fleiss, 1981; Sackett et al., 1985). It was decided that the same index of agreement would be used for the present research. Accordingly proportions were computed for the different degrees of perceptions found to be present among the physicians and the nurses on each of the 15 issues on the Interprofessional Perception Scale.

From these computations on proportions, it was determined what perception per issue was found in the majority of the physicians and the nurses, respectively. After these particular perceptions were identified, a comparison was made with the proportion of members of the other profession, who actually had expressed similar viewpoints on the same issues. Through these comparisons different degrees of misperception came to light.

In order to determine the severity of the misperceptions each of the professions actually had about the other one, different ranges of values were used for the computed differences between the applicable proportions. Once again, what had been measured, was the degree of agreement between the two professions on a particular viewpoint. Fleiss (1981) indicated that for the purpose of indicating degrees of agreement, in most cases the values of 75 percent and 40 percent have been used to divide the full range from 0 percent to 100 percent ranges of values for degrees of agreement. The same values have been used for the present study. Values below 40 percent were taken to represent excellent agreement, or very little misperception, values greater than 75 percent were taken to represent poor agreement, or a high degree of misperception, while values between 40 percent and 75 percent were taken to represent fair to
good agreement, or a fair amount of misperception. The computed misperceptions were tabulated and ranked in order of severity, from the most severe misperception to the least severe one.

Finally, profiles of the subjects were compiled. Separate profiles were created for each group of subjects according to their true or false responses reflecting either their direct views on an issue or their perceptions of the views held by the members of the other profession on the same issue. Through this method conclusions could be made as to whether there was a difference in profiles of subjects who had very little misperception on a given issue as compared to subjects who had a high degree of misperception on a given issue about the members of the other profession.

Summary

Twenty eight physicians and 66 nurses participated in this descriptive and exploratory survey, which examined the degrees of interprofessional misperception among physicians and staff nurses in long-term care facilities on 15 interprofessional issues. The data was collected via a questionnaire adapted from the Interprofessional Perception Scale (Ducanis and Golin, 1979). Pertinent demographic data was obtained as well. Proportions of perceptions were computed and compared between the two professions to determine the existing degrees of misperceptions across the 15 issues. Through this method of data analyses it was possible to develop a view of the total pattern of interprofessional misperceptions between the physicians and the nurses in long-term care facilities.
CHAPTER 4

The Findings

Introduction

The data collection resulted in descriptive information about the different misperceptions the physicians and the nurses had of each other. The information has been tabulated to provide a clear presentation of all the findings. This chapter has been divided into three sections.

The first section presents the profiles of the subjects in the study. The second section presents the findings on each of the 15 issues measured by the Interprofessional Perception Scale. This is followed by a percentage calculation of misperceptions held by the physicians and a calculation of misperceptions found among the nurses. The last section in the chapter presents a list of the degrees of misperceptions as represented by percentages found among the physicians and the nurses in long-term care facilities. The misperceptions are ranked in order of their percentage, from the highest percentage of misperception to the lowest percentage. A second list is presented in this section indicating the issues around which neither the physicians nor the nurses appear to have misperceptions of the views held by the members of the other profession.

Profiles of the Subjects in the Study

Table 1 provides a profile of all the physicians, who participated in the study. The physicians are mostly male family practitioners, who are over 40 years old and are Caucasian. It also shows that most of the physicians have worked for more than 15 years in long-term care facilities. Of note is the predominance of male respondents in this group of physicians. Very significant is the finding that all the physicians, who participated in the survey, are family
practitioners. None of the respondents claimed to have expertise in gerontology. The lack of
ethnic diversity also is noteworthy.

Table 1  Demographic Data of all the Participating Physicians in the Study on Interprofessional Misperceptions

<table>
<thead>
<tr>
<th></th>
<th>N = 28 = 100%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GENDER:</strong></td>
<td></td>
</tr>
<tr>
<td>FEMALE</td>
<td>N = 5 = 18%</td>
</tr>
<tr>
<td>MALE</td>
<td>N = 23 = 82%</td>
</tr>
<tr>
<td><strong>AGE (*)&amp;:</strong></td>
<td></td>
</tr>
<tr>
<td>20-30</td>
<td>N = 0 = 0%</td>
</tr>
<tr>
<td>31-40</td>
<td>N = 8 = 29%</td>
</tr>
<tr>
<td>41-50</td>
<td>N = 1 = 36%</td>
</tr>
<tr>
<td>Over 50</td>
<td>N = 10 = 36%</td>
</tr>
<tr>
<td><strong>NUMBER OF YEARS THE PHYSICIANS HAVE CARED FOR PATIENTS IN LONG-TERM CARE FACILITIES (*)&amp;:</strong></td>
<td></td>
</tr>
<tr>
<td>1-5 YEARS</td>
<td>N = 2 = 7%</td>
</tr>
<tr>
<td>6-10 YEARS</td>
<td>N = 6 = 21%</td>
</tr>
<tr>
<td>11-15 YEARS</td>
<td>N = 4 = 14%</td>
</tr>
<tr>
<td>OVER 15 YEARS</td>
<td>N = 16 = 57%</td>
</tr>
<tr>
<td><strong>AREA OF PRACTICE:</strong></td>
<td></td>
</tr>
<tr>
<td>FAMILY PRACTICE</td>
<td>N = 28 = 100%</td>
</tr>
<tr>
<td>OTHER</td>
<td>N = 0 = 0%</td>
</tr>
<tr>
<td><strong>ETHNIC BACKGROUND (*)&amp;:</strong></td>
<td></td>
</tr>
<tr>
<td>CAUCASIAN</td>
<td>N = 26 = 93%</td>
</tr>
<tr>
<td>ORIENTAL</td>
<td>N = 1 = 4%</td>
</tr>
<tr>
<td>NATIVE INDIAN</td>
<td>N = 0 = 0%</td>
</tr>
<tr>
<td>EAST INDIAN</td>
<td>N = 0 = 0%</td>
</tr>
<tr>
<td>OTHER</td>
<td>N = 1 = 4%</td>
</tr>
</tbody>
</table>

(*) The percentages are rounded off, so they do not always add up to 100%.
Table 2 provides a profile of the nurses in the study. Most of the nurses, who participated in the survey are female registered nurses, who are in their 40s and are diploma trained. All of the nurses rate their job satisfaction as good to excellent. Of note is the even percentage of Caucasian and Oriental nurses in the survey. All the nurses are employed in long-term care facilities and all items are worded with respect to their perceptions and experiences in long-term care facilities. The words "long-term care facilities", therefore, will be omitted in the reporting of some of the findings in the interest of space and readability.

Table 3 provides an overview of the staff nurses from 13 long-term care facilities, all of whom were invited to participate in the survey. The nurses are divided into three separate groups as per their professional designation. The data has been tabulated to compare response rates and non-response rates of the nurses across the three different professional designations. Registered nurses have the lowest response rate, although it is still over 50% and they constitute 59% of all respondents.

Findings on Each of the Fifteen Issues Measured by the Interprofessional Perception Scale

In this section the findings are presented on each of the 15 issues measured by the Interprofessional Perception Scale. The presentation of the findings on each issue follows a consistent format. The findings on each issue are presented in two parts. Part A looks at the issue as it reflects on the nursing profession. Part B shifts the focus of the issue to the medical profession. Under each part, first the views of the physicians are presented followed by the views of the nurses. The expressed views, in turn, are followed by a percentage calculation of misperception held by the physicians and a percentage calculation of misperception found among the nurses. In order to determine the severity of the misperceptions each of the professions
| Table 2 | Demographic Data of all the Participating Nurses in the Study on Interprofessional Misperceptions |
| N = 66 = 100% |
| GENDER: | | 
| FEMALE | N = 65 = 98% |
| MALE | N = 1 = 2% |
| AGE: | | 
| 20-30 | N = 2 = 3% |
| 31-40 | N = 15 = 23% |
| 41-50 | N = 30 = 45% |
| Over 50 | N = 19 = 29% |
| NUMBER OF YEARS THE NURSES HAVE CARED FOR PATIENTS IN LONG-TERM CARE FACILITIES (*): | | 
| 1-5 YEARS | N = 16 = 24% |
| 6-10 YEARS | N = 14 = 21% |
| 11-15 YEARS | N = 20 = 30% |
| OVER 15 YEARS | N = 16 = 24% |
| EDUCATIONAL PREPARATION: | | 
| DIPLOMA | N = 51 = 77% |
| SPECIALTY CERTIFICATION | N = 6 = 9% |
| BACCALAUREATE | N = 9 = 14% |
| MASTERS | N = 0 = 0% |
| PROFESSIONAL DESIGNATION: | | 
| RN | N = 39 = 59% |
| RPN | N = 6 = 9% |
| LGN | N = 21 = 32% |
| ETHNIC BACKGROUND: | | 
| CAUCASIAN | N = 31 = 47% |
| ORIENTAL | N = 31 = 47% |
| NATIVE INDIAN | N = 0 = 0% |
| EAST INDIAN | N = 2 = 3% |
| OTHER | N = 2 = 3% |
| NURSES’ JOB SATISFACTION: | | 
| POOR | N = 0 = 0% |
| GOOD | N = 49 = 74% |
| EXCELLENT | N = 17 = 26% |

(*) The percentages are rounded off, so they do not add up to 100%.
Table 3  Response Rates of the Staff Nurses Across the Three Professional Designations

<table>
<thead>
<tr>
<th>REGISTERED NURSES</th>
<th>REGISTERED PSYCHIATRIC NURSES</th>
<th>LICENSED GRADUATE NURSES</th>
<th>TOTALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>NUMBER OF STAFF NURSES INVITED TO PARTICIPATE IN THE SURVEY</td>
<td>73</td>
<td>6</td>
<td>31</td>
</tr>
<tr>
<td>NUMBER OF STAFF NURSES RESPONDING TO THE SURVEY</td>
<td>40</td>
<td>6</td>
<td>22</td>
</tr>
<tr>
<td>RESPONSE RATES</td>
<td>55%</td>
<td>100%</td>
<td>71%</td>
</tr>
</tbody>
</table>

Note: One registered nurse and one licensed graduate nurse did respond, but their questionnaires were incomplete.

actually has about the other one, different ranges of values are used following Fleiss (1981) guidelines. Values below 40% are taken to represent very little misperception, values greater than 75% are taken to represent a high degree of misperception, while values between 40% and 75% are taken to represent a fair amount of misperception. In order to present a range with groupings, the terms “very little” and “little misperception” are both used.

Issue No. 1 - Professional Competency

Part A - Are Nurses in Long-Term Care Facilities Competent?

93% physicians said that nurses are competent.

7% physicians said that nurses are not competent.

100% physicians perceived that nurses would think of themselves as competent.
0%  physicians perceived that nurses would not think of themselves as competent.

95%  nurses said that they are competent.

5%  nurses said that they are not competent.

83%  nurses perceived that physicians would say that nurses are competent.

17%  nurses perceived that physicians would say that nurses are not competent.

All physicians perceived that nurses would think of themselves as competent. In fact, 95% of the nurses thought of themselves as competent. It appears, therefore, that there is very little misperception (100% - 95% = 5%) on the part of the physicians about the nurses’ view on their own competency.

A majority (83%) of the nurses perceived that physicians would say that nurses are competent. In fact, 93% of the physicians said that the nurses are competent. It appears, therefore, that there is very little misperception on the part of the nurses (93% - 83% = 10%) about the physicians’ view on nurses’ competency.

Part B - Are Physicians in Long-Term Care Facilities Competent?

96%  physicians said that they are competent.

4%  physicians said that they are not competent.

93%  physicians perceived that nurses would say that physicians are competent.

7%  physicians perceived that nurses would say that physicians are not competent.

86%  nurses said that physicians are competent.

14%  nurses said that physicians are not competent.

100%  nurses perceived that physicians would think of themselves as competent.

0%  nurses perceived that physicians would not think of themselves as competent.

A majority (93%) of the physicians perceived that nurses would say that physicians are competent. In fact, 86% of the nurses said that physicians are competent. It appears, therefore,
that the physicians have very little misperception (93% - 86% = 7%) about the nurses’ view of physicians’ competency.

All nurses perceived that physicians would think of themselves as competent. In fact, 96% of the physicians said that they are competent. It appears, therefore, that there is very little misperception on the part of the nurses (100% - 96% = 4%) of the physicians’ view of themselves as competent.

**Issue No. 2 - Professional Autonomy**

**Part A - Do Nurses in Long-Term Care Facilities Have Very Little Autonomy?**

- 36% physicians said nurses do have very little autonomy.
- 64% physicians said nurses do not have very little autonomy.
- 61% physicians perceived that nurses would say that nurses do have very little autonomy.
- 39% physicians perceived that nurses would say that nurses do not have very little autonomy.
- 39% nurses said that they do have very little autonomy.
- 61% nurses said that they do not have very little autonomy.
- 45% nurses perceived that physicians would say that nurses do have very little autonomy.
- 55% nurses perceived that physicians would say that nurses do not have very little autonomy.

A majority (61%) of the physicians perceived that nurses would say that nurses do have very little autonomy. In fact, 39% of the nurses said that they do have very little autonomy. It appears, therefore, that there is little misperception (61% - 39% = 22%) on the part of the physicians about the nurses’ view of themselves as having very little autonomy.

A majority (55%) of the nurses perceived that physicians would say that nurses do not have very little autonomy. In fact, 64% of the physicians said that nurses do not have very little
autonomy. It appears, therefore, that there is very little misperception \((64\% - 55\% = 9\%)\) on the part of the nurses about the physicians’ view that nurses do not have very little autonomy.

### Part B - Do Physicians in Long-Term Care Facilities Have Very Little Autonomy?

- **25\%** physicians said that they do have very little autonomy.
- **75\%** physicians said that they do not have very little autonomy.
- **18\%** physicians perceived that nurses would say that physicians do have very little autonomy.
- **82\%** physicians perceived that nurses would say that physicians do not have very little autonomy.
- **17\%** nurses said physicians do have very little autonomy.
- **83\%** nurses said physicians do not have very little autonomy.
- **33\%** nurses perceived that physicians would say that physicians do have very little autonomy.
- **67\%** nurses perceived that physicians would say that physicians do not have very little autonomy.

A majority (82\%) of the physicians perceived that nurses would say that physicians do not have very little autonomy. In fact, 83\% of the nurses said physicians do not have very little autonomy. It appears, therefore, that there is very little misperception \((83\% - 82\% = 1\%)\) on the part of the physicians about the nurses’ view that physicians do not have very little autonomy.

A majority (67\%) of the nurses perceived that physicians would say that physicians do not have very little autonomy. In fact, 75\% of the physicians said that they do not have very little autonomy. It appears, therefore, that there is very little misperception \((75\% - 67\% = 8\%)\) on the part of the nurses about the physicians’ view that physicians do not have very little autonomy.
Part A - Do Nurses Understand the Capabilities of Physicians in Long-Term Care Facilities?

82% physicians said nurses do understand the capabilities of physicians.

18% physicians said nurses do not understand the capabilities of physicians.

96% physicians perceived that nurses would say that nurses do understand the capabilities of physicians.

4% physicians perceived that nurses would say that nurses do not understand the capabilities of physicians.

97% nurses said that they do understand the capabilities of physicians.

3% nurses said that they do not understand the capabilities of physicians.

85% nurses perceived that physicians would say that nurses do understand the capabilities of physicians.

15% nurses perceived that physicians would say that nurses do not understand the capabilities of physicians.

A majority (96%) of the physicians perceived that nurses would say that nurses do understand the capabilities of physicians. In fact, 97% of the nurses said that they do understand the capabilities of physicians. It appears, therefore, that there is very little misperception on the part of the physicians (97% - 96% = 1%) about the nurses’ view that they do understand the capabilities of physicians.

A majority (85%) of the nurses perceived that physicians would say that nurses do understand the capabilities of physicians. In fact, 82% of the physicians said that nurses do understand the capabilities of physicians. It appears, therefore, that there is very little misperception on the part of the nurses (85% - 82% = 3%) about the physicians’ view that nurses do understand the capabilities of physicians.
Part B - Do Physicians Understand the Capabilities of Nurses in Long-Term Care Facilities?

89% physicians said they do understand the capabilities of nurses.

11% physicians said they do not understand the capabilities of nurses.

43% physicians perceived that nurses would say that physicians do understand the capabilities of nurses.

57% physicians perceived that nurses would say that physicians do not understand the capabilities of nurses.

64% nurses said physicians do understand the capabilities of nurses.

36% nurses said physicians do not understand the capabilities of nurses.

89% nurses perceived that physicians would say that physicians do understand the capabilities of nurses.

11% nurses perceived that physicians would say that physicians do not understand the capabilities of nurses.

A majority (57%) of the physicians perceived that nurses would say that physicians do not understand the capabilities of nurses. In fact, 36% of the nurses said that physicians do not understand the capabilities of nurses. It appears, therefore, that there is little misperception on the part of the physicians (57% - 36% = 21%) about the nurses' view that physicians do not understand the capabilities of nurses.

A majority (89%) of the nurses perceived that physicians would say that physicians do understand the capabilities of nurses. In fact, 89% of the physicians, indeed, said that they do understand the capabilities of nurses. It appears, therefore, that there is no misperception on the part of the nurses (89% - 89% = 0%) about the physicians' view that physicians do understand the capabilities of nurses.
Issue No. 4 - Professional Concern with Patient Welfare

Part A - Are Nurses in Long-Term Care Facilities Highly Concerned with the Welfare of the Patient?

96% physicians said nurses are highly concerned with the welfare of the patient.

4% physicians said nurses are not highly concerned with the welfare of the patient.

100% physicians perceived that nurses would say that nurses are highly concerned with the welfare of the patient.

0% physicians perceived that nurses would say that nurses are not highly concerned with the welfare of the patient.

95% nurses said that they are highly concerned with the welfare of the patient.

5% nurses said that they are not highly concerned with the welfare of the patient.

98% nurses perceived that physicians would say that nurses are highly concerned with the welfare of the patient.

2% nurses perceived that physicians would say that nurses are not highly concerned with the welfare of the patient.

All physicians (100%) perceived that nurses would say that nurses are highly concerned with the welfare of the patient. In fact, 95% of the nurses said that they are highly concerned with the welfare of the patient. It appears, therefore, that there is very little misperception on the part of the physicians (100% - 95% = 5%) about the nurses’ view that nurses are highly concerned with the welfare of the patient.

A majority (98%) of the nurses perceived that physicians would say that nurses are highly concerned with the welfare of the patient. In fact, 96% of the physicians said that nurses are highly concerned with the welfare of the patient. It appears, therefore, that there is very little misperception on the part of the nurses (98% - 96% = 2%) about the physicians’ view that nurses are highly concerned with the welfare of the patient.
Part B - Are Physicians in Long-Term Care Facilities Highly Concerned with the Welfare of the Patient?

100% physicians said they are highly concerned with the welfare of the patient.

0% physicians said they are not highly concerned with the welfare of the patient.

82% physicians perceived that nurses would say that physicians are highly concerned with the welfare of the patient.

18% physicians perceived that nurses would say that physicians are not highly concerned with the welfare of the patient.

70% nurses said physicians are highly concerned with the welfare of the patient.

30% nurses said physicians are not highly concerned with the welfare of the patient.

97% nurses perceived that physicians would say that physicians are highly concerned with the welfare of the patient.

3% nurses perceived that physicians would say that physicians are not highly concerned with the welfare of the patient.

A majority (82%) of the physicians perceived that nurses would say that physicians are highly concerned with the welfare of the patient. In fact, 70% of the nurses said that physicians are highly concerned with the welfare of the patient. It appears, therefore, that there is very little misperception (82% - 70% = 12%) on the part of the physicians about the nurses’ view that physicians are highly concerned with the welfare of the patient.

A majority (97%) of the nurses perceived that physicians would say that physicians are not highly concerned with the welfare of the patient. In fact, 100% of the physicians said that they are highly concerned with the welfare of the patient. It appears, therefore, that there is very little misperception on the part of the nurses (100% - 97% = 3%) about the physicians’ view that they are highly concerned with the welfare of the patient.
Issue No. 5 - Professional Territoriality

Part A - Do Nurses Sometimes Encroach on Physicians’ Professional Territory in Long-Term Care Facilities?

39% physicians said nurses do sometimes encroach on physicians’ professional territory.

61% physicians said nurses do not encroach on physicians’ professional territory.

25% physicians perceived that nurses would say that nurses do sometimes encroach on physicians’ professional territory.

75% physicians perceived that nurses would say that nurses do not encroach on physicians’ professional territory.

30% nurses said that they do sometimes encroach on physicians’ professional territory.

70% nurses said that they do not encroach on physicians’ professional territory.

53% nurses perceived that physicians would say that nurses do sometimes encroach on physicians’ professional territory.

47% nurses perceived that physicians would say that nurses do not encroach on physicians’ professional territory.

A majority (75%) of the physicians perceived that nurses would say that nurses do not encroach on physicians’ professional territory. In fact, 70% of the nurses said that nurses do not encroach on physicians’ professional territory. It appears, therefore, that there is very little misperception (75% - 70% = 5%) on the part of the physicians about the nurses’ view that nurses do not encroach on physicians’ professional territory.

A majority (53%) of the nurses perceived that physicians would say that nurses do sometimes encroach on physicians’ professional territory. In fact, 39% of the physicians said that nurses do sometimes encroach on physicians’ professional territory. It appears, therefore, that there is little misperception (53% - 39% = 14%) on the part of the nurses about the physicians’ view that nurses do sometimes encroach on physicians’ professional territory.
Part B - Do Physicians Sometimes Encroach on Nurses’ Professional Territory in
Long-Term Care Facilities?

36% physicians said they do sometimes encroach on nurses’ professional territory
64% physicians said they do not encroach on nurses’ professional territory.
68% physicians perceived that nurses would say that physicians do sometimes encroach on
nurses’ professional territory.
32% physicians perceived that nurses would say that physicians do not encroach on nurses’
professional territory.
61% nurses said physicians do sometimes encroach on nurses’ professional territory.
39% nurses said physicians do not encroach on nurses’ professional territory.
27% nurses perceived that physicians would say that physicians do sometimes encroach on
nurses’ professional territory.
73% nurses perceived that physicians would say that physicians do not encroach on nurses’
professional territory.

A majority (68%) of the physicians perceived that nurses would say that physicians do
sometimes encroach on nurses’ professional territory. In fact, 61% of the nurses said that
physicians do sometimes encroach on nurses’ professional territory. It appears, therefore, that
there is very little misperception (68% - 61% = 7%) on the part of the physicians about the
nurses’ view that physicians do sometimes encroach on nurses’ professional territory.

A majority (73%) of the nurses perceived that physicians would say that physicians do not
encroach on nurses’ professional territory. In fact, 64% of the physicians said that they do not
encroach on nurses’ professional territory. It appears, therefore, that there is very little
misperception on the part of the nurses (73% - 64% = 9%) about the physicians’ view that
physicians do not encroach on nurses’ professional territory.

Issue No. 6 - Professional Ethics

Part A - Are Nurses in Long-Term Care Facilities Highly Ethical?

93% physicians said nurses are highly ethical.
7% physicians said nurses are not highly ethical.
100% physicians perceived that nurses would say that nurses are highly ethical.
0% physicians perceived that nurses would say that nurses are not highly ethical.
89% nurses said that they are highly ethical.
11% nurses said that they are not highly ethical.
85% nurses perceived that physicians would say that nurses are highly ethical.
15% nurses perceived that physicians would say that nurses are not highly ethical.

All the physicians (100%) perceived that nurses would say that nurses are highly ethical. In fact, 89% of the nurses said that nurses are highly ethical. It appears, therefore, that there is little misperception on the part of the physicians (100% - 89% = 11%) about the nurses’ view that nurses are highly ethical.

A majority (85%) of the nurses perceived that physicians would say that nurses are highly ethical. In fact, 93% of the physicians said that nurses are highly ethical. It appears, therefore, that there is very little misperception on the part of the nurses (93% - 85% = 8%) about the physicians’ view that nurses are highly ethical.

Part B - Are Physicians in Long-Term Care Facilities Highly Ethical?
93% physicians said they are highly ethical.
7% physicians said they are not highly ethical.
93% physicians perceived that nurses would say that physicians are highly ethical.
7% physicians perceived that nurses would say that physicians are not highly ethical.
71% nurses said physicians are highly ethical.
29% nurses said physicians are not highly ethical.
95% nurses perceived that physicians would say that physicians are highly ethical.
5% nurses perceived that physicians would say that physicians are not highly ethical.
A majority (93%) of the physicians perceived that nurses would say that physicians are highly ethical. In fact, 71% of the nurses said that physicians are highly ethical. It appears, therefore, that there is little misperception on the part of the physicians (93% - 71% = 22%) about the nurses’ view that physicians are highly ethical.

A majority (95%) of the nurses perceived that physicians would say that physicians are highly ethical. In fact, 93% of the physicians said that they are highly ethical. It appears, therefore, that there is very little misperception (95% - 93% = 2%) on the part of the nurses about the physicians’ view that physicians are highly ethical.

Issue No. 7 - Interprofessional Role Expectations

Part A - Do Nurses Expect Too Much of Physicians in Long-Term Care Facilities?

- 25% physicians said nurses do expect too much of physicians.
- 75% physicians said nurses do not expect too much of physicians.
- 4% physicians perceived that nurses would say that nurses do expect too much of physicians.
- 96% physicians perceived that nurses would say that nurses do not expect too much of physicians.
- 24% nurses said that they do expect too much of physicians.
- 76% nurses said that they do not expect too much of physicians.
- 61% nurses perceived that physicians would say that nurses do expect too much of physicians.
- 39% nurses perceived that physicians would say that nurses do not expect too much of physicians.

A majority (96%) of the physicians perceived that nurses would say that nurses do not expect too much of physicians. In fact, 76% of the nurses said that they do not expect too much of physicians. It appears, therefore, that there is little misperception (96% - 76% - 20%) on the part of physicians about the nurses’ view that nurses do not expect too much of physicians.
A majority (61%) of the nurses perceived that physicians would say that nurses do expect too much of physicians. In fact, 25% of the physicians said that nurses do expect too much of physicians. It appears, therefore, that there is little misperception (61% - 25% = 36%) on the part of the nurses about the physicians' view that nurses do expect too much of physicians are highly ethical.

Part B - Do Physicians Expect Too Much of Nurses in Long-Term Care Facilities?

21% physicians said they do expect too much of nurses.
79% physicians said they do not expect too much of nurses.
50% physicians perceived that nurses would say that physicians do expect too much of nurses.
50% physicians perceived that nurses would say that physicians do not expect too much of nurses.
44% nurses said physicians do expect too much of nurses.
56% nurses said physicians do not expect too much of nurses.
30% nurses perceived that physicians would say that physicians do expect too much of nurses.
70% nurses perceived that physicians would say that physicians do not expect too much of nurses.

Half of the physicians (50%) perceived that nurses would say that physicians do not expect too much of nurses. In fact, 56% of the nurses said that physicians do not expect too much of nurses. It appears, therefore, that there is very little misperception (56% - 50% = 6%) on the part of physicians about the nurses' view that physicians do not expect too much of nurses.

A majority (70%) of the nurses perceived that physicians would say that physicians do not expect too much of nurses. In fact, 79% of the physicians said that they do not expect too much of nurses. It appears, therefore, that there is very little misperception (79% - 70% = 9%) on the part of the nurses about the physicians' view that physicians do not expect too much of nurses.
Issue No. 8 - Professional Status

Part A - Do Nurses Have a Higher Status Than Physicians in Long-Term Care Facilities?

0% physicians said nurses do have a higher status than physicians.

100% physicians said nurses do not have a higher status than physicians.

0% physicians perceived that nurses would say that nurses do have a higher status than physicians.

100% physicians perceived that nurses would say that nurses do not have a higher status than physicians.

9% nurses said that they do have a higher status than physicians.

91% nurses said that they do not have a higher status than physicians.

17% nurses perceived that physicians would say that nurses do have a higher status than physicians.

83% nurses perceived that physicians would say that nurses do not have a higher status than physicians.

All the physicians (100%) perceived that nurses would say that nurses do not have a higher status than physicians. In fact, 91% of the nurses said that they do not have a higher status than physicians. It appears, therefore, that there is very little misperception (100% - 91% = 9%) on the part of the physicians about the nurses’ view that nurses do not have a higher status than physicians.

A majority (83%) of the nurses perceived that physicians would say that nurses do not have a higher status than physicians. In fact, 100% of the physicians said that nurses do not have a higher status than physicians. It appears, therefore, that there is little misperception on the part of the nurses (100% - 83% = 17%) about the physicians’ view that nurses do not have a higher status than physicians.
Part B - Do Physicians Have a Higher Status Than Nurses in Long-Term Care Facilities?

86\% physicians said they do have a higher status than nurses.

14\% physicians said they do not have a higher status than nurses.

82\% physicians perceived that nurses would say that physicians do have a higher status than nurses.

18\% physicians perceived that nurses would say that physicians do not have a higher status than nurses.

79\% nurses said physicians do have a higher status than nurses.

21\% nurses said physicians do not have a higher status than nurses.

86\% nurses perceived that physicians would say that physicians do have a higher status than nurses.

14\% nurses perceived that physicians would say that physicians do not have a higher status than nurses.

A majority (82\%) of the physicians perceived that nurses would say that physicians do have a higher status than nurses. In fact, 79\% of the nurses said that physicians do have a higher status than nurses. It appears, therefore, that there is very little (82\% - 79\% = 3\%) misperception on the part of the physicians about the nurses’ view that physicians do have a higher status than nurses.

A majority (86\%) of the nurses perceived that physicians would say that physicians do have a higher status than nurses. In fact, 86\% of the physicians, indeed, said that they do have a higher status than nurses. It appears, therefore, that there is no misperception on the part of the nurses (86\% - 86\% = 0\%) about the physicians’ view that they do have a higher status than nurses.
Issue No. 9 - Professional Ethnocentrism

Part A - Are Nurses in Long-Term Care Facilities Very Defensive about Their Professional Prerogatives?

43% physicians said nurses are very defensive about their professional prerogatives.

57% physicians said nurses are not very defensive about their professional prerogatives.

29% physicians perceived that nurses would say that nurses are very defensive about their professional prerogatives.

71% physicians perceived that nurses would say that nurses are not very defensive about their professional prerogatives.

53% nurses said that they are very defensive about their professional prerogatives.

47% nurses said that they are not very defensive about their professional prerogatives.

71% nurses perceived that physicians would say that nurses are very defensive about their professional prerogatives.

29% nurses perceived that physicians would say that nurses are not very defensive about their professional prerogatives.

A majority (71%) of the physicians perceived that nurses would say that nurses are not very defensive about their professional prerogatives. In fact, 47% of the nurses said that they are not very defensive about their professional prerogatives. It appears, therefore, that there is little misperception (71% - 47% = 24%) on the part of the physicians about the nurses’ view that nurses are not very defensive about their professional prerogatives.

A majority (71%) of the nurses perceived that physicians would say that nurses are very defensive about their professional prerogatives. In fact, 43% of the physicians said that nurses are very defensive about their professional prerogatives. It appears, therefore, that there is little misperception on the part of the nurses (71% - 43% = 28%) about the physicians’ view that nurses are very defensive about their professional prerogatives.
Part B - Are Physicians in Long-Term Care Facilities Very Defensive about Their Professional Prerogatives?

43% physicians said they are very defensive about their professional prerogatives.

57% physicians said they are not very defensive about their professional prerogatives.

68% physicians perceived that nurses would say that physicians are very defensive about their professional prerogatives.

32% physicians perceived that nurses would say that physicians are not very defensive about their professional prerogatives.

77% nurses said physicians are very defensive about their professional prerogatives.

23% nurses said physicians are not very defensive about their professional prerogatives.

48% nurses perceived that physicians would say that physicians are very defensive about their professional prerogatives.

52% nurses perceived that physicians would say that physicians are not very defensive about their professional prerogatives.

A majority (68%) of the physicians perceived that nurses would say that physicians are very defensive about their professional prerogatives. In fact, 77% of the nurses said that physicians are very defensive about their professional prerogatives. It appears, therefore, that there is very little misperception (77% - 68% = 9%) on the part of the physicians about the nurses’ view that physicians are very defensive about their professional prerogatives.

A majority (52%) of the nurses perceived that physicians would say that physicians are not very defensive about their professional prerogatives. In fact, 57% of the physicians said that they are not very defensive about their professional prerogatives. It appears, therefore, that there is very little misperception (57% - 52% = 5%) on the part of the nurses about the physicians’ view that physicians are not very defensive about their professional prerogatives.
Issue No. 10 - Interprofessional Trust

Part A - Do Nurses Trust Physicians' Professional Judgment in Long-Term Care Facilities?

89% physicians said nurses do trust physicians' professional judgment.

11% physicians said nurses do not trust physicians' professional judgment.

89% physicians perceived that nurses would say that nurses do trust physicians' professional judgment.

11% physicians perceived that nurses would say that nurses do not trust physicians' professional judgment.

73% nurses said that they do trust physicians' professional judgment.

27% nurses said that they do not trust physicians' professional judgment.

80% nurses perceived that physicians would say that nurses do trust physicians' professional judgment.

20% nurses perceived that physicians would say that nurses do not trust physicians' professional judgment.

A majority (89%) of the physicians perceived that nurses would say that nurses do trust physicians’ professional judgment. In fact, 73% of the nurses said that they do trust physicians’ professional judgment. It appears, therefore, that there is little misperception on the part of the physicians (89% - 73% = 16%) about the nurses’ view that nurses do trust physicians’ professional judgment.

A majority (80%) of the nurses perceived that physicians would say that nurses do trust physicians’ professional judgment. In fact, 89% of the physicians said that nurses do trust physicians’ professional judgment. It appears, therefore, that there is very little misperception on the part of the nurses (89% - 80% = 9%) about the physicians’ view that nurses do trust physicians’ professional judgment.
Part B - Do Physicians Trust Nurses' Professional Judgment in Long-Term Care Facilities?

86% physicians said they do trust nurses' professional judgment.

14% physicians said they do not trust nurses' professional judgment.

71% physicians perceived that nurses would say that physicians do trust nurses' professional judgment.

29% physicians perceived that nurses would say that physicians do not trust nurses' professional judgment.

86% nurses said physicians do trust nurses' professional judgment.

14% nurses said physicians do not trust nurses' professional judgment.

91% nurses perceived that physicians would say that physicians do trust nurses' professional judgment.

9% nurses perceived that physicians would say that physicians do not trust nurses' professional judgment.

A majority (71%) of the physicians perceived that nurses would say that physicians do trust nurses' professional judgment. In fact, 86% of the nurses said that physicians do trust nurses' professional judgment. It appears, therefore, that there is little misperception on the part of the physicians (86% - 71% = 15%) about the nurses' view that physicians do trust nurses' professional judgment.

A majority (91%) of the nurses perceived that physicians would say that physicians do trust nurses' professional judgment. In fact, 86% of the physicians said that they do trust nurses' professional judgment. It appears, therefore, that there is very little misperception on the part of the nurses (91% - 86% = 5%) about the physicians' view that physicians do trust nurses' professional judgment.
Issue No. 11 - Interprofessional Advice

Part A - Do Nurses Seldomly Ask Physicians for Professional Advice in Long-Term Care Facilities?

25% physicians said nurses do seldomly ask physicians for professional advice.

75% physicians said nurses do ask physicians for professional advice.

32% physicians perceived that nurses would say that nurses do seldomly ask physicians for professional advice.

68% physicians perceived that nurses would say that nurses do ask physicians for professional advice.

5% nurses said that they do seldomly ask physicians for professional advice.

95% nurses said that they do ask physicians for professional advice.

20% nurses perceived that physicians would say that nurses do seldomly ask physicians for professional advice.

80% nurses perceived that physicians would say that nurses do ask physicians for professional advice.

A majority (68%) of the physicians perceived that nurses would say that nurses do ask physicians for professional advice. In fact, 95% of the nurses said that they do ask physicians for professional advice. It appears, therefore, that there is little misperception (95% - 68% = 27%) on the part of the physicians about the nurses' view that the nurses do ask physicians for professional advice.

A majority (80%) of the nurses perceived that physicians would say that nurses do ask physicians for professional advice. In fact, 75% of the physicians said that nurses do ask physicians for professional advice. It appears, therefore, that there is very little misperception on the part of the nurses (80% - 75% = 5%) about the physicians' view that nurses do ask physicians for professional advice.
Part B - Do Physicians Seldomly Ask Nurses for Professional Advice in Long-Term Care Facilities?

29% physicians said they do seldomly ask nurses for professional advice.

71% physicians said they do ask nurses for professional advice.

61% physicians perceived that nurses would say that physicians do seldomly ask nurses for professional advice.

39% physicians perceived that nurses would say that physicians do ask nurses for professional advice.

65% nurses said physicians do seldomly ask nurses for professional advice.

35% nurses said physicians do ask nurses for professional advice.

48% nurses perceived that physicians would say that physicians do seldomly ask nurses for professional advice.

52% nurses perceived that physicians would say that physicians do ask nurses for professional advice.

A majority (61%) of the physicians perceived that nurses would say that physicians do seldomly ask nurses for professional advice. In fact, 65% of the nurses said that physicians do seldomly ask nurses for professional advice. It appears, therefore, that there is very little misperception (65% - 61% = 4%) on the part of the physicians about the nurses’ view that the physicians do seldomly ask nurses for professional advice.

A majority (52%) of the nurses perceived that physicians would say that physicians do ask nurses for professional advice. In fact, 71% of the physicians said that physicians do ask nurses for professional advice. It appears, therefore, that there is little misperception on the part of the nurses (71% - 52% = 19%) about the physicians’ view that physicians do ask nurses for professional advice.
Issue No. 12 - Interprofessional Utilization of Capabilities

Part A - Do Nurses Fully Utilize the Capabilities of Physicians in Long-Term Care Facilities?

64% physicians said nurses do fully utilize the capabilities of physicians.

36% physicians said nurses do not fully utilize the capabilities of physicians.

68% physicians perceived that nurses would say that nurses do fully utilize the capabilities of physicians.

32% physicians perceived that nurses would say that nurses do not fully utilize the capabilities of physicians.

85% nurses said that they do fully utilize the capabilities of physicians.

15% nurses said that they do not fully utilize the capabilities of physicians.

80% nurses perceived that physicians would say that nurses do fully utilize the capabilities of physicians.

20% nurses perceived that physicians would say that nurses do not fully utilize the capabilities of physicians.

A majority (68%) of the physicians perceived that nurses would say that nurses do fully utilize the capabilities of physicians. In fact, 85% of the nurses said that they do fully utilize the capabilities of physicians. It appears, therefore, that there is little misperception on the part of the physicians (85% - 68% = 17%) about the nurses’ view that nurses do fully utilize the capabilities of physicians.

A majority (80%) of the nurses perceived that physicians would say that nurses do fully utilize the capabilities of physicians. In fact, 64% of the physicians said that nurses do fully utilize the capabilities of physicians. It appears, therefore, that there is little misperception on the part of the nurses (80% - 64% = 16%) about the physicians’ view that nurses do fully utilize the capabilities of physicians.
Part B - Do Physicians Fully Utilize the Capabilities of Nurses in Long-Term Care Facilities?

50% physicians said they do fully utilize the capabilities of nurses.

50% physicians said they do not fully utilize the capabilities of nurses.

36% physicians perceived that nurses would say that physicians do fully utilize the capabilities of nurses.

64% physicians perceived that nurses would say that physicians do not fully utilize the capabilities of nurses.

55% nurses said physicians do fully utilize the capabilities of nurses.

45% nurses said physicians do not fully utilize the capabilities of nurses.

80% nurses perceived that physicians would say that physicians do fully utilize the capabilities of nurses.

20% nurses perceived that physicians would say that physicians do not fully utilize the capabilities of nurses.

A majority (64%) of the physicians perceived that nurses would say that physicians do not fully utilize the capabilities of nurses. In fact, 45% of the nurses said that physicians do not fully utilize the capabilities of nurses. It appears, therefore, that there is little misperception on the part of the physicians (64% - 45% = 19%) about the nurses’ view that physicians do not fully utilize the capabilities of nurses.

A majority (80%) of the nurses perceived that physicians would say that physicians do fully utilize the capabilities of nurses. In fact, 50% of the physicians said that they do fully utilize the capabilities of nurses. It appears, therefore, that there is little misperception on the part of the nurses (80% - 50% = 30%) about the physicians’ view that physicians do fully utilize the capabilities of nurses.

Issue No. 13 - Interprofessional Cooperation

Part A - Do Nurses Not Cooperate Well with Physicians in Long-Term Care facilities?

14% physicians said nurses do not cooperate well with physicians.
86% physicians said nurses do cooperate well with physicians.

11% physicians perceived that nurses would say that nurses do not cooperate well with physicians.

89% physicians perceived that nurses would say that nurses do cooperate well with physicians.

5% nurses said that they do not cooperate well with physicians.

95% nurses said that they do cooperate well with physicians.

20% nurses perceived that physicians would say that nurses do not cooperate well with physicians.

80% nurses perceived that physicians would say that nurses do cooperate well with physicians.

A majority (89%) of the physicians perceived that nurses would say that nurses do cooperate well with physicians. In fact, 95% of the nurses said that they do cooperate well with physicians. It appears, therefore, that there is very little misperception on the part of the physicians (95% - 89% = 6%) about the nurses’ view that nurses do cooperate well with physicians.

A majority (80%) of the nurses perceived that physicians would say that nurses do cooperate well with physicians. In fact, 86% of the physicians said that nurses do cooperate well with physicians. It appears, therefore, that there is very little misperception on the part of the nurses (86% - 80% = 6%) about the physicians’ view that nurses do cooperate well with physicians.

Part B - Do Physicians Not Cooperate Well with Nurses in Long-Term Care Facilities?

14% physicians said they do not cooperate well with nurses.

86% physicians said they do cooperate well with nurses.

29% physicians perceived that nurses would say that physicians do not cooperate well with nurses.
71% physicians perceived that nurses would say that physicians do cooperate well with nurses.

35% nurses said physicians do not cooperate well with nurses.

65% nurses said physicians do cooperate well with nurses.

12% nurses perceived that physicians would say that physicians do not cooperate well with nurses.

88% nurses perceived that physicians would say that physicians do cooperate well with nurses.

A majority (71%) of the physicians perceived that nurses would say that physicians do cooperate well with nurses. In fact, 65% of the nurses said that physicians do cooperate well with nurses. It appears, therefore, that there is very little misperception on the part of the physicians (71% - 65% = 6%) about the nurses’ view that physicians do cooperate well with nurses.

A majority (88%) of the nurses perceived that physicians would say that physicians do cooperate well with nurses. In fact, 86% of the physicians said that they do cooperate well with nurses. It appears, therefore, that there is very little misperception (88% - 86% = 2%) on the part of the nurses about the physicians’ view that physicians do cooperate well with nurses.

Issue No. 14 - Professional Training

Part A - Are Nurses in Long-Term Care Facilities Well Trained?

75% physicians said nurses are well trained.

25% physicians said nurses are not well trained.

96% physicians perceived that nurses would say that nurses are well trained.

4% physicians perceived that nurses would say that nurses are not well trained.

94% nurses said that they are well trained.

6% nurses said that they are not well trained.

77% nurses perceived that physicians would say that nurses are well trained.
nurses perceived that physicians would say that nurses are not well trained.

A majority (96%) of the physicians perceived that nurses would say that nurses are well trained. In fact, 94% of the nurses said that they are well trained. It appears, therefore, that there is very little misperception on the part of the physicians (96% - 94% = 2%) about the nurses’ view that nurses are well trained.

A majority (77%) of the nurses perceived that physicians would say that nurses are well trained. In fact, 75% of the physicians said that nurses are well trained. It appears, therefore, that there is very little misperception on the part of the nurses (77% - 75% = 2%) about the physicians’ view that nurses are well trained.

**Part B - Are Physicians in Long-Term Care Facilities Well Trained?**

96% physicians said they are well trained.

4% physicians said they are not well trained.

89% physicians perceived that nurses would say that physicians are well trained.

11% physicians perceived that nurses would say that physicians are not well trained.

80% nurses said physicians are well trained.

20% nurses said physicians are not well trained.

98% nurses perceived that physicians would say that physicians are well trained.

2% nurses perceived that physicians would say that physicians are not well trained.

A majority (89%) of the physicians perceived that nurses would say that physicians are well trained. In fact, 80% of the nurses said that physicians are well trained. It appears, therefore, that there is very little misperception (89% - 80% = 9%) on the part of the physicians about the nurses’ view that physicians are well trained.

A majority (98%) of the nurses perceived that physicians would say that physicians are well trained. In fact, 96% of the physicians said that they are well trained. It appears, therefore,
that there is very little misperception on the part of the nurses (98% - 96% = 2%) about the physicians' view that physicians are well trained.

**Issue No. 15 - Interprofessional Relationships**

**Part A - Do Nurses Have Good Relations with Physicians in Long-Term Care Facilities?**

- **89%** physicians said nurses do have good relations with physicians.
- **11%** physicians said nurses do not have good relations with physicians.
- **86%** physicians perceived that nurses would say that nurses do have good relations with physicians.
- **14%** physicians perceived that nurses would say that nurses do not have good relations with physicians.
- **89%** nurses said that they do have good relations with physicians.
- **11%** nurses said that they do not have good relations with physicians.
- **92%** nurses perceived that physicians would say that nurses do have good relations with physicians.
- **8%** nurses perceived that physicians would say that nurses do not have good relations with physicians.

A majority (86%) of the physicians perceived that nurses would say that nurses do have good relations with physicians. In fact, 89% of the nurses said that they do have good relations with physicians. It appears, therefore, that there is very little misperception on the part of the physicians (98% - 96% = 2%) about the nurses' view that nurses do have good relations with physicians.

A majority (92%) of the nurses perceived that physicians would say that nurses do have good relations with physicians. In fact, 89% of the physicians said that nurses do have good relations with physicians. It appears, therefore, that there is very little misperception on the part of the nurses (98% - 96% = 2%) about the physicians' view that nurses do have good relations with physicians.
Part B - Do Physicians Have Good Relations with Nurses in Long-Term Care Facilities?

96% physicians said they do have good relations with nurses.

4% physicians said they do not have good relations with nurses.

82% physicians perceived that nurses would say that physicians do have good relations with nurses.

18% physicians perceived that nurses would say that physicians do not have good relations with nurses.

82% nurses said physicians do have good relations with nurses.

18% nurses said physicians do not have good relations with nurses.

95% nurses perceived that physicians would say that physicians do have good relations with nurses.

5% nurses perceived that physicians would say that physicians do not have good relations with nurses.

A majority (82%) of the physicians perceived that nurses would say that physicians do have good relations with nurses. In fact, 82% of the nurses, indeed, said that physicians do have good relations with nurses. It appears, therefore, that there is no misperception (82% - 82% = 0%) on the part of the physicians about the nurses’ view that physicians do have good relations with nurses.

A majority (95%) of the nurses perceived that physicians would say that physicians do have good relations with nurses. In fact, 96% of the physicians said that they do have good relations with nurses. It appears, therefore, that there is almost no misperception (96% - 95% = 1%) on the part of the nurses about the physicians’ view that physicians do have good relations with nurses.
Summary of the Degrees of Misperceptions Found among the Physicians and the Nurses in Long-Term Care Facilities

In table 4 the degrees of misperceptions as represented by percentages among physicians and nurses have been summarized. They are misperceptions held by the members of one profession on how the members of the other profession view the 15 professional issues that have been included in the survey.

The misperceptions have been ranked in order of percentage, from the highest percentage of misperception to the least percentage. In other words, the misperceptions of one profession at the bottom of the list are not far from the actual opinions expressed by the members of the other profession.

Table 4   List of the Degrees of Misperceptions Represented by Percentages Found Among the Physicians and the Nurses in Long-Term Care Facilities

<table>
<thead>
<tr>
<th>DEGREE OF MISPERCEPTION</th>
<th>ISSUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>36%</td>
<td>nurses’ misperception of physicians’ views on whether nurses expect too much of physicians.</td>
</tr>
<tr>
<td>30%</td>
<td>nurses’ misperception of physicians’ views on whether physicians fully utilize the capabilities of nurses.</td>
</tr>
<tr>
<td>28%</td>
<td>nurses’ misperception of physicians’ views on whether nurses are very defensive about their professional prerogatives.</td>
</tr>
<tr>
<td>27%</td>
<td>physicians’ misperception of nurses’ views on whether nurses ask physicians for professional advice.</td>
</tr>
<tr>
<td>24%</td>
<td>physicians’ misperception of nurses’ views on whether nurses are very defensive about their professional prerogatives.</td>
</tr>
<tr>
<td>22%</td>
<td>physicians’ misperception of nurses’ views on whether nurses have very little autonomy.</td>
</tr>
<tr>
<td>22%</td>
<td>physicians’ misperception of nurses’ views on whether physicians are highly ethical.</td>
</tr>
<tr>
<td>Percentage</td>
<td>Misperception</td>
</tr>
<tr>
<td>------------</td>
<td>---------------</td>
</tr>
<tr>
<td>21%</td>
<td>Physicians' misperception of nurses' views on whether physicians understand the capabilities of nurses.</td>
</tr>
<tr>
<td>20%</td>
<td>Physicians' misperception of nurses' views on whether nurses expect too much of physicians.</td>
</tr>
<tr>
<td>19%</td>
<td>Nurses' misperception of physicians' views on whether physicians ask nurses for professional advice.</td>
</tr>
<tr>
<td>19%</td>
<td>Physicians' misperception of nurses' views on whether physicians fully utilize the capabilities of nurses.</td>
</tr>
<tr>
<td>17%</td>
<td>Nurses' misperception of physicians' views on whether nurses have a higher status than physicians.</td>
</tr>
<tr>
<td>17%</td>
<td>Physicians' misperception of nurses' views on whether nurses fully utilize the capabilities of physicians.</td>
</tr>
<tr>
<td>16%</td>
<td>Physicians' misperception of nurses' views on whether nurses trust physicians' professional judgment.</td>
</tr>
<tr>
<td>16%</td>
<td>Nurses' misperception of physicians' views on whether nurses utilize the capabilities of physicians.</td>
</tr>
<tr>
<td>15%</td>
<td>Physicians' misperception of nurses' views on whether physicians trust nurses' professional judgment.</td>
</tr>
<tr>
<td>14%</td>
<td>Nurses' misperception of physicians' views on whether nurses sometimes encroach on physicians' professional territory.</td>
</tr>
<tr>
<td>12%</td>
<td>Physicians' misperception of nurses' views on whether physicians are highly concerned with the welfare of the patient.</td>
</tr>
<tr>
<td>11%</td>
<td>Physicians' misperception of nurses' views on whether nurses are highly ethical.</td>
</tr>
<tr>
<td>10%</td>
<td>Nurses' misperception of physicians' views on whether nurses are competent.</td>
</tr>
<tr>
<td>9%</td>
<td>Nurses' misperception of physicians' views on whether nurses have very little autonomy.</td>
</tr>
<tr>
<td>9%</td>
<td>Nurses' misperception of physicians' views on whether physicians encroach on nurses' professional territory.</td>
</tr>
<tr>
<td>9%</td>
<td>Nurses' misperception of physicians' views on whether physicians expect too much of nurses.</td>
</tr>
<tr>
<td>9%</td>
<td>Physicians' misperception of nurses' views on whether nurses have a higher status than physicians.</td>
</tr>
</tbody>
</table>
9% physicians' misperception of nurses' views on whether physicians are very defensive about their professional prerogatives.

9% nurses' misperception of physicians' views on whether nurses trust physicians' professional judgment.

9% physicians' misperception of nurses' views on whether physicians are well trained.

8% nurses' misperception of physicians' views on whether physicians have very little autonomy.

8% nurses' misperception of physicians' views on whether nurses are highly ethical.

7% physicians' misperception of nurses' views on whether physicians are competent.

7% physicians' misperception of nurses' views on whether physicians sometimes encroach on nurses' professional territory.

6% physicians' misperception of nurses' views on whether physicians expect too much of nurses.

6% physicians' misperception of nurses' views on whether nurses cooperate well with physicians.

6% nurses' misperception of physicians' views on whether nurses cooperate well with physicians.

6% physicians' misperception of nurses' views on whether physicians cooperate well with nurses.

5% physicians' misperception of nurses' views on whether nurses are competent.

5% physicians' misperception of nurses' views on whether nurses are highly concerned with the welfare of the patient.

5% physicians' misperception of nurses' views on whether nurses encroach on physicians' professional territory.

5% nurses' misperception of physicians' views on whether physicians are very defensive about their professional prerogatives.

5% nurses' misperception of physicians' views on whether physicians trust nurses' professional judgment.

5% nurses' misperception of physicians' views on whether nurses ask physicians for professional advice.
4% nurses’ misperception of physicians’ views on whether physicians are competent.

4% physicians’ misperception of nurses’ views on whether physicians seldom ask nurses for professional advice.

3% nurses’ misperception of physicians’ views on whether nurses understand the capabilities of physicians.

3% nurses’ misperception of physicians’ views on whether physicians are highly concerned with the welfare of the patient.

3% physicians’ misperception of nurses’ views on whether physicians have a higher status than nurses.

3% physicians’ misperception of nurses’ views on whether nurses have good relations with physicians.

3% nurses’ misperception of physicians’ views on whether nurses have good relations with physicians.

2% nurses’ misperception of physicians’ views on whether nurses are highly concerned with the welfare of the patient.

2% nurses’ misperception of physicians’ views on whether physicians are highly ethical.

2% nurses’ misperception of physicians’ views on whether physicians cooperate well with nurses.

2% physicians’ misperception of nurses’ views on whether nurses are well trained.

2% nurses’ misperception of physicians’ views on whether nurses are well trained.

2% nurses’ misperception of physicians’ views on whether physicians are well trained.

1% physicians’ misperception of nurses’ views on whether physicians have very little autonomy.

1% physicians’ misperception of nurses’ views on whether nurses understand the capabilities of physicians.

1% nurses’ misperception of physicians’ views on whether physicians have good relations with nurses.
In table 5 a list is provided indicating the issues around which either the physicians or the nurses appear not to have a misperception of the views held by the members of the other profession.

<table>
<thead>
<tr>
<th>DEGREE OF Misperception</th>
<th>ISSUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>nurses' misperception of physicians' views on whether physicians understand the capabilities of nurses.</td>
</tr>
<tr>
<td>0%</td>
<td>nurses' misperception of physicians' views on whether physicians have a higher status than nurses.</td>
</tr>
<tr>
<td>0%</td>
<td>physicians' misperception of nurses' views on whether physicians have good relations with nurses.</td>
</tr>
</tbody>
</table>
CHAPTER 5

Discussion of the Findings

Introduction

The survey among the physicians and the nurses of 13 long-term care facilities in Vancouver, British Columbia, has measured the misperceptions among these professionals on 15 professional issues. A total of thirty-one physicians responded to the voluntary survey. Three responses of the physicians were incomplete and could not be included in the study, leaving a sample of twenty-eight physicians (n = 28). Sixty-eight nurses responded, of which 2 nurses provided incomplete responses, leaving a sample of sixty-six (n = 66) nurses. All the information obtained through the survey has been tabulated in the previous chapter and is further discussed in this chapter.

The chapter has been divided into three sections. The first section provides a general overview of the misperceptions found among the physicians and the nurses. Finer details of the misperceptions are discussed in the second section of the chapter. In this section the subjects' direct perceptions as well as related misperceptions each are discussed under the headings of the 15 separate professional issues, which have been measured by the Interprofessional Perception Scale (Ducanis and Golin, 1979). The third section of the chapter provides a summary of the findings.

Misperceptions Among the Physicians and the Nurses

Based upon the predetermined range of values from Fleiss (1981), where values below 40% are taken to represent very little misperception, it appears that there are very little misperceptions among the physicians and the nurses in long-term care facilities. In fact, on a
number of responses the majority of the physicians and the nurses appear to have no
misperceptions of the other profession at all.

On the issue of how well physicians relate with nurses, the majority of the physicians
perceived that nurses will agree that physicians have good relations with nurses. An equal
majority of nurses indeed confirmed that they find the physicians to relate well with nurses.

Similarly, there appears to be no misperception on the part of a majority of the nurses on
two additional issues. A majority of nurses perceives that physicians will say that physicians do
have a higher status than nurses, which is confirmed by an equal majority of physicians. A
majority of nurses also perceive that physicians will say that physicians do understand the
capabilities of nurses. Indeed, a similar percentage of physicians shares this notion.

Even though equal majorities of physicians and nurses seem to confirm each others’
perceptions on these certain issues, the two professions still appear to be apart on these other
issues based on the expressed direct views by the members of each of the professions. The
specific details on these direct perceptions are discussed in the next section. The fact remains,
however, that the majority of the one profession sees eye to eye with the exact same majority of
the other profession on these three important professional issues in collaborative team work.

The one issue around which there appears to be the highest degree of misperception
concerns the nurses’ expectations of physicians. A majority of 61% nurses perceives that
physicians will say that nurses do expect too much of physicians. However, a much smaller
percentage of physicians expresses a similar view. In fact, only 25% of the physicians do say
that nurses expect too much of the physicians. The nurses, therefore, have a 36% degree of
misperception of the physicians on the issue, which, according to Fleiss (1981), is considered to
be still a very little degree of misperception.

Despite the fact that all the degrees of misperceptions among the subjects in the survey
have been found to be very little or even non-existent, it should be pointed out that such findings
do not automatically mean that all is smooth between the physicians and the nurses. There are several illustrations of this point described in the next section of this chapter.

The participant responses are discussed further under the headings of the 15 separate professional issues underlying the Interprofessional Perception Scale in the next section. Areas of concern are identified and discussed in conjunction with both misperceptions and the related direct perceptions expressed by the members of each of the professions.

Discussions of the Findings for Each of the 15 Professional Issues

Issue No. 1 - Professional Competency

Large majorities of physicians (93%) and nurses (95%) say that nurses in long-term care facilities are competent. The physicians appear to have only a very small misperception (5%) about the nurses' own views of their competency. Of interest, however, is the perception held by 17% of the nurses who perceive that physicians will say that nurses are not competent. This (17% - 7% = 10%) misperception on the part of the nurses is a small misperception held by a minority of nurses, but still is noteworthy. It will benefit these nurses to know that 93% of the physicians with whom they work in long-term care facilities think that nurses are competent. In other words, the actual number of physicians, who believe that nurses are competent is higher than is expected by the group of nurses. Perhaps this misperception reflects a degree of low self-esteem or a lack of self-confidence or a feeling of not being respected and valued. A large majority of physicians (96%) think that physicians are competent. This opinion, however, is shared by only 86% of the nurses. Interestingly, all nurses (100%) do perceive that physicians will think of themselves as competent. This perception turns out to be only a small misperception (100% - 96% = 4%).

It will be of interest to the physicians to know that all nurses in long-term care facilities believe that physicians think of themselves as competent, but that not every nurse actually agrees
with this perception. Nor does 4% of the physicians’ own membership believe that physicians are competent in long-term care facilities.

The administration of the long-term care facilities should take note that also 5% of the nurses has described themselves as not competent. These findings of self-confessed incompetency among the physicians and the nurses may reflect their high sense of self-criticism, or may indicate their need for educational opportunities to enhance their professional skills and knowledge.

**Issue No. 2 - Professional Autonomy**

Approximately one third of the physicians (36%) and the nurses (39%) appear to believe that nurses in long-term care facilities have very little autonomy. The fact that approximately one third of both groups have close agreement on this issue is, of itself, a concern. Their respective misperceptions on the issue are further apart. The physicians have a 22% misperception of the nurses’ views on the issue of nurses’ professional autonomy, and the nurses have a 9% misperception of the physicians’ views on this issue.

These figures compare to much lower percentages expressed on the autonomy issue for physicians. A fourth or 25% of the physicians and 17% of the nurses say that physicians in long-term care facilities have very little autonomy. The physicians have a very small misperception (1%) of the nurses’ views, and the nurses have an 8% degree of misperception of physicians’ views on the issue of physician’s professional autonomy.

It seems that physicians are perceived to enjoy higher levels of professional autonomy in long-term care facilities than nurses. Judging further from the direct views on the issue, the perception seems to be acknowledged almost equally by both professions.

Despite the fact that physicians appear to have higher levels of autonomy, still 25% of the physicians say that they have very little autonomy. It appears, therefore, that considerable
numbers of members in both professions believe that they have very little professional autonomy in long-term care facilities. It has been stressed in the literature that professionals have a need to be autonomous (Nason, 1983; Stein, et al., 1990). The findings of this survey show that significant numbers of physicians and nurses do not see their needs for professional autonomy met.

**Issue No. 3 - Professional Capabilities**

The majority of physicians (82%) and nurses (97%) believe that nurses understand the capabilities of physicians in long-term care facilities. The physicians only have a 1% misperception of nurses on this issue, and the nurses only have a 3% misperception.

Of concern is the belief of 18% of the physicians who say that nurses do not understand the capabilities of physicians. Even though only 3% of the nurses admits to this lack of understanding, the fact remains that 18% of the physicians still believes that nurses, with whom they work in the facility, do not understand their capabilities.

A majority of 89% of the physicians say that they do understand the capabilities of nurses in long-term care facilities, whereas only 64% of the nurses believe this understanding to be true. The two professions appear to be considerably more apart on this issue (89% - 64% = 25%) as compared to the issue of the nurses' (97% - 82% = 15%) understanding of the physicians' capabilities. The perception appears to exist that in long-term care facilities nurses understand physicians better than physicians understand nurses with respect to each others' professional capabilities. The review of the literature on professional capabilities has illustrated the physicians' lack of understanding the capabilities of nurses in other clinical areas such as obstetrics (Hutchison, 1993). Whether the physicians truly have a lack of understanding the nurses' capabilities also in long-term care facilities needs to be further explored. The administration of the long-term care facilities should take note that 36% of the nurses and 18% of the physicians
feel that their respective capabilities are not understood by the members of the other profession. A feeling of not being understood is frustrating and will not enhance the collaborative effort between the two professions.

There is also a considerable difference in the degrees of misperception on the part of both professions. The physicians have a 21% degree of misperception of nurses on the issue of the physicians’ understanding of nurses’ capabilities. The nurses drastically differ, in this respect, with a 0% degree of misperception. The nurses appear to match their perceptions about physicians’ views on the issue of the physicians understanding of nurses’ capabilities.

This finding illustrates very well that nurses are still facing a problem in their collaborative efforts with physicians, despite the fact that the nurses do not have a misperception of the physicians’ views. A large group of nurses (36%) still believes that physicians do not understand the nurses’ capabilities.

**Issue No. 4 - Professional Concern With Patient Welfare**

A majority of the nurses (95%) say that they are highly concerned with the welfare of the patient. Most physicians (96%) believe that this conviction of the nurses in long-term care facilities is true. As for the physicians, all of them (100%) say that they are highly concerned with the welfare of the patient. Almost one third of the nurses (30%), however, believe that physicians in long-term care facilities are not highly concerned with the welfare of the patient. In addition, the majority of nurses (97%) perceive that physicians will say that they are highly concerned with the welfare of the patient.

The misperceptions on the issue of the physicians’ concern for the welfare of the patient are 12% on the part of the physicians and 3% on the part of the nurses. Once again, low degrees of misperceptions do not automatically mean that all is smooth between the physicians and the nurses. There appears to be a definite problem around the nurses’ perceived lack of physicians’
concern for the welfare of the patient. The administration of long-term care facilities should take note of this critical view of the physicians among nurses, and try to resolve the issue through open discussions with the two professional groups.

**Issue No. 5 - Professional Territoriality**

The issue of professional territoriality appears to be a concern of both professions. A rather large minority of physicians (39%) feels that nurses sometimes encroach on physicians' professional territory. At the same time a small majority of nurses (61%) also feels that physicians do encroach on the nurses' professional territory. In addition, 36% of the physicians say that they encroach on nurses' territory, and 30% of the nurses say they encroach on physicians' territory. It appears also that a fair number of physicians (39%) and a majority of nurses (61%) feel that their professional territory is violated by the members of the other profession. It also appears that significant numbers of physicians (36%) and nurses (70%) admit to their encroachment on the territory of the other profession.

On the issue of nurses encroaching on the physicians' territory, the physicians have a 5% misperception of the nurses' point of view and the nurses have a 14% misperception of the physicians' view. The viewpoints of the members of the other profession on the issue of physicians encroaching on the nurses' territory is misperceived by 7% of the physicians and 9% of the nurses. The misperceptions are not high on the issue of professional territoriality, but judging from the percentages of direct perspectives, there appears to be a potential problem between the physicians and the nurses in long term care on the issue. Based on the literature review, this finding is not surprising. The literature indicates that the physicians and the nurses are known to encroach on each other's professional territory (Fagin and Diers, 1983). This encroachment is a highly sensitive area and a major barrier to collaborative practice (Fagin, 1992).
Issue No. 6 - Professional Ethics

The majority of nurses (89%) in long-term care facilities think of themselves as highly ethical, and most physicians (93%) share this view. Many nurses (85%) actually expect that physicians, indeed, will say that nurses are highly ethical. In fact, nurses have only an 8% misperception of the physicians’ view on the nurses’ level of ethics.

The situation is slightly different for the physicians. A large majority of physicians (93%) say that they are highly ethical, but only 71% of the nurses share this view. This difference will come as a surprise to the physicians, because a majority of 93% of them perceive that nurses will say that physicians are highly ethical. In fact, the physicians have a 22% misperception of the nurses’ view on this issue.

The profile of the 29% nurses who say that physicians are not highly ethical consists of Oriental registered nurses, who mostly are in their 40s and are diploma trained (see table 6). Of note is the high representation of Oriental nurses in this group. Perhaps there is a difference in outlook on what constitutes ethical behavior based on one’s ethnic background.

Also of interest are the findings that 7% of physicians and 11% of nurses say that they (physicians and nurses respectively) are not ethical. It appears ethics is an area of concern both interdisciplinarily and intradisciplinarily, which requires further exploration. Perhaps the changes in technology in long term care have created new ethical dilemmas that need collaborative problem solving both inter- and intradisciplinary.
Table 6  Demographic Data of the 29% Nurses who Say that Physicians in Long-Term Care Facilities are Not Highly Ethical.

<table>
<thead>
<tr>
<th>Category</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>N = 19 = 100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>GENDER:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>19</td>
<td>100%</td>
</tr>
<tr>
<td>Male</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td><strong>AGE (*):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-30</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>31-40</td>
<td>5</td>
<td>26%</td>
</tr>
<tr>
<td>41-50</td>
<td>8</td>
<td>42%</td>
</tr>
<tr>
<td>Over 50</td>
<td>5</td>
<td>26%</td>
</tr>
<tr>
<td><strong>NUMBER OF YEARS THE NURSES HAVE CARED—for patients in Long-Term Care Facilities (*):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-5 YEARS</td>
<td>6</td>
<td>32%</td>
</tr>
<tr>
<td>6-10 YEARS</td>
<td>2</td>
<td>11%</td>
</tr>
<tr>
<td>11-15 YEARS</td>
<td>6</td>
<td>32%</td>
</tr>
<tr>
<td>OVER 15 YEARS</td>
<td>5</td>
<td>26%</td>
</tr>
<tr>
<td><strong>EDUCATIONAL PREPARATION (*):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diploma</td>
<td>14</td>
<td>74%</td>
</tr>
<tr>
<td>Specialty Certification</td>
<td>2</td>
<td>11%</td>
</tr>
<tr>
<td>Baccalaureate</td>
<td>3</td>
<td>16%</td>
</tr>
<tr>
<td>Masters</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td><strong>PROFESSIONAL DESIGNATION (*):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RN</td>
<td>10</td>
<td>53%</td>
</tr>
<tr>
<td>RPN</td>
<td>3</td>
<td>16%</td>
</tr>
<tr>
<td>LGN</td>
<td>6</td>
<td>32%</td>
</tr>
<tr>
<td><strong>ETHNIC BACKGROUND:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>7</td>
<td>37%</td>
</tr>
<tr>
<td>Oriental</td>
<td>11</td>
<td>58%</td>
</tr>
<tr>
<td>Native Indian</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>East Indian</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td><strong>NURSES’ JOB SATISFACTION:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Good</td>
<td>16</td>
<td>84%</td>
</tr>
<tr>
<td>Excellent</td>
<td>3</td>
<td>16%</td>
</tr>
</tbody>
</table>

(*): The percentages are rounded off, so they do not always add up to 100%
Issue No. 7 - Interprofessional Role Expectations

A majority of physicians (75%) feel that nurses do not expect too much of the physicians in long-term care facilities. An almost equal majority of nurses (76%) share this view. Yet, a large number of nurses (61%) perceive that physicians will say that nurses do expect too much of physicians. This perception turns out to be a 36% misperception on the part of the nurses, and is the highest degree of misperception found in this survey among the nurses and the physicians in long-term care facilities. It seems that some nurses believe that they are not expecting too much of physicians, but they get the impression that physicians think differently. It will benefit these nurses to know that 25% of the physicians feel that nurses expect too much of physicians. This percentage is high enough to validate the nurses’ perception that physicians will say that nurses do expect too much of physicians, but it may be important to show the nurses that it is only one quarter of the physicians.

The nurses appear to be almost equally split on the issue of physicians’ expectations of nurses. A small majority (56%) think that physicians do not expect too much of them, but 44% of the nurses say that physicians do expect too much. The profile of the 44% nurses consists mostly of Oriental licensed graduate nurses, who are in their 40s and are diploma trained. Most of these nurses have worked between 6 to 10 years in long-term care facilities (see table 7). Of note is the high representation of licensed graduate nurses in this group. Although a majority of physicians (79%) believe that they do not expect too much of the nurses in long-term care facilities, 21% say physicians do expect too much. The profile of the 21% of physicians does not significantly differ from the total group.

The misperceptions of the other profession’s view on the issue are small, the physicians have a 6% misperception and the nurses have a 9% misperception. Both professions seem to be fairly much in tune with what views are held by the other profession on the issue of the physicians expectations of nurses. The problem seems to rest with the direct perceptions,
Table 7  Demographic Data of the 44% Nurses who Say that Physicians Do Expect Too Much of Nurses in Long-Term Care Facilities.

| GENDER: FEMALE | N = 28 | 97% |
| GENDER: MALE | N = 1 | 3% |
| AGE (*): 20-30 | N = 0 | 0% |
| 31-40 | N = 8 | 28% |
| 41-50 | N = 17 | 59% |
| Over 50 | N = 4 | 14% |
| NUMBER OF YEARS THE NURSES HAVE CARED FOR PATIENTS IN LONG-TERM CARE FACILITIES: | |
| 1-5 YEARS | N = 4 | 14% |
| 6-10 YEARS | N = 10 | 34% |
| 11-15 YEARS | N = 7 | 24% |
| OVER 15 YEARS | N = 8 | 28% |
| EDUCATIONAL PREPARATION: | |
| DIPLOMA | N = 20 | 69% |
| SPECIALTY CERTIFICATION | N = 4 | 14% |
| BACCALAUREATE | N = 5 | 17% |
| MASTERS | N = 0 | 0% |
| PROFESSIONAL DESIGNATION: | |
| RN | N = 13 | 45% |
| RPN | N = 2 | 7% |
| LGN | N = 14 | 48% |
| ETHNIC BACKGROUND: | |
| CAUCASIAN | N = 8 | 28% |
| ORIENTAL | N = 18 | 62% |
| NATIVE INDIAN | N = 0 | 0% |
| EAST INDIAN | N = 2 | 7% |
| OTHER | N = 1 | 3% |
| NURSES’ JOB SATISFACTION: | |
| POOR | N = 0 | 0% |
| GOOD | N = 24 | 83% |
| EXCELLENT | N = 5 | 17% |

(*) The percentage are rounded off, so they do not always add up to 100%
especially the ones expressed by the nurses, who are not together on whether physicians expect too much from the nurses. Based on these findings, the nurses appear to be confused on the issue of role expectations, which confirms earlier views expressed by Fagin (1992). The author points out that medicine and nursing overlap in many areas of their service to patients, which has contributed greatly to the confusion around role expectations. This area needs further exploration to determine how problematic this issue is as a barrier to collaboration.

**Issue No. 8 - Professional Status**

None of the physicians feel that nurses have a higher status than physicians in long-term care facilities. Furthermore, none of the physicians even expect nurses to think that nurses have a higher status than physicians. These direct perspectives are in keeping with the traditional view of the status of physicians and nurses (Ducanis and Golin, 1979; Ornstein, 1990). Of interest, however, is the small minority (9%) of nurses who feels that they do have a higher status than physicians. Accordingly, the physicians have a 9% misperception of the nurses’ views on the issue. The profile of these 9% nurses consists mostly of Caucasian registered nurses, who are older than 50 and are diploma trained (see table 8). Of note is the high representation of older nurses in this group.

A majority of 79% of the nurses feel that physicians do have a higher status than nurses in long-term care facilities. Most nurses (86%) also expect that physicians will say that they have a higher status than nurses. An equal number of physicians, indeed, say that they have a higher status. Accordingly, the nurses have no misperception of physicians’ views on this issue. Of interest is the 14% of physicians, who say they do not have higher status than nurses. This perception goes against the traditional view. Their profile does not significantly differ from the total group of physicians in the survey.
**Table 8**  Demographic Data of the 9% Nurses who Say that Nurses Do Have a Higher Status than Physicians in Long-Term Care Facilities

<table>
<thead>
<tr>
<th></th>
<th>N = 6 = 100%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GENDER:</strong></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>N = 6 = 100%</td>
</tr>
<tr>
<td>Male</td>
<td>N = 0 = 0%</td>
</tr>
<tr>
<td><strong>AGE:</strong></td>
<td></td>
</tr>
<tr>
<td>20-30</td>
<td>N = 0 = 0%</td>
</tr>
<tr>
<td>31-40</td>
<td>N = 2 = 33%</td>
</tr>
<tr>
<td>41-50</td>
<td>N = 1 = 17%</td>
</tr>
<tr>
<td>Over 50</td>
<td>N = 3 = 50%</td>
</tr>
<tr>
<td><strong>NUMBER OF YEARS THE NURSES HAVE CARED FOR PATIENTS IN LONG-TERM CARE FACILITIES (*):</strong></td>
<td></td>
</tr>
<tr>
<td>1-5 YEARS</td>
<td>N = 0 = 0%</td>
</tr>
<tr>
<td>6-10 YEARS</td>
<td>N = 2 = 33%</td>
</tr>
<tr>
<td>11-15 YEARS</td>
<td>N = 2 = 33%</td>
</tr>
<tr>
<td>OVER 15 YEARS</td>
<td>N = 2 = 33%</td>
</tr>
<tr>
<td><strong>EDUCATIONAL PREPARATION:</strong></td>
<td></td>
</tr>
<tr>
<td>Diploma</td>
<td>N = 5 = 83%</td>
</tr>
<tr>
<td>Specialty Certification</td>
<td>N = 0 = 0%</td>
</tr>
<tr>
<td>Baccalaureate</td>
<td>N = 1 = 17%</td>
</tr>
<tr>
<td>Masters</td>
<td>N = 0 = 0%</td>
</tr>
<tr>
<td><strong>PROFESSIONAL DESIGNATION:</strong></td>
<td></td>
</tr>
<tr>
<td>RN</td>
<td>N = 5 = 83%</td>
</tr>
<tr>
<td>RPN</td>
<td>N = 1 = 17%</td>
</tr>
<tr>
<td>LGN</td>
<td>N = 0 = 0%</td>
</tr>
<tr>
<td><strong>ETHNIC BACKGROUND:</strong></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>N = 4 = 67%</td>
</tr>
<tr>
<td>Oriental</td>
<td>N = 2 = 33%</td>
</tr>
<tr>
<td>Native Indian</td>
<td>N = 0 = 0%</td>
</tr>
<tr>
<td>East Indian</td>
<td>N = 0 = 0%</td>
</tr>
<tr>
<td>Other</td>
<td>N = 0 = 0%</td>
</tr>
<tr>
<td><strong>NURSES’ JOB SATISFACTION:</strong></td>
<td></td>
</tr>
<tr>
<td>Poor</td>
<td>N = 0 = 0%</td>
</tr>
<tr>
<td>Good</td>
<td>N = 5 = 83%</td>
</tr>
<tr>
<td>Excellent</td>
<td>N = 1 = 17%</td>
</tr>
</tbody>
</table>

\(\ast\) The percentages are rounded off, so they do not always add up to 100\%
Issue No. 9 - Professional Ethnocentrism

The subjects have been asked to comment on their defensiveness about their professional prerogatives. Professionals may feel that they have certain prerogatives or privileges simply because they are "the physician" or "the nurse", and will go to great lengths to protect these professional privileges. A sense of defensiveness of one’s professional prerogatives partially reflects one’s feelings of professional ethnocentrism.

A large minority of physicians (43%) feel that nurses in long-term care facilities are very defensive about their professional prerogatives. An almost equal number of nurses (53%), indeed, say that they are defensive. The majority of nurses (71%), in fact, expect physicians to come to this same conclusion. This perception on the part of the nurses is a 28% misperception of the physicians on the issue. It seems that almost half of the nurses see themselves definitely as defending their prerogatives, and they also believe that they are not hiding this fact from the physicians.

A fairly large group of physicians (43%) feel that they also are very defensive of their professional prerogatives. A much larger group of nurses (77%) appear to have come to the same conclusion. The physicians seem to be aware of these feelings among nurses, because they have only a 9% misperception of the nurses’ view on the issue.

Both professions appear to be fairly defensive groups of their respective prerogatives, and this sense of professional ethnocentrism also appears to be mutually acknowledged by the physicians and the nurses. Ducanis and Golin (1979) have cited professional ethnocentrism as a primary barrier to collaborative team work. It is fundamental to the survival of the collaborative team that one acknowledges that all its members are equally important. Based on this view, the findings of this survey on professional ethnocentrism among the physicians and the nurses in long-term care facilities become a primary area of concern. It may be useful to explore territoriality issues together with ethnocentrism.
**Issue No. 10 - Interprofessional Trust**

The majority of nurses (73%) say that they do trust physicians' professional judgment. Most of the physicians (89%) perceive that nurses indeed will say that they do trust them. However, the physicians appear to have a 16% degree of misperception of nurses' views on this issue. Eleven percent of physicians say nurses do not trust them.

It should be noted, also, that a fairly large number of nurses (27%) say that they do not trust the physicians' judgment. In addition, 14% of physicians say they do not trust nurses.

The majority of physicians (86%) say that they do trust nurses' professional judgment. An exact same majority of nurses (86%) indeed feel that physicians do trust them. The majority of the nurses (91%), in fact, expects that physicians will say that they trust the nurses. There appears to be a 5% misperception on the part of the nurses of the physicians' view on this issue.

For the most part, it appears that both professions do trust each other's professional judgment. The majorities of both professions also believe that they can count on the other professional's trust. However, the 27% of nurses who do not trust physicians and the 14% of physicians that say they do not trust nurses is still noteworthy. Trust is a very central element in any collaborative relationship (Ornstein, 1990).

**Issue No. 11 - Interprofessional Advice**

A rather large majority of nurses (95%) say that they do ask physicians for professional advice. Equally, a majority of physicians (75%) feel that nurses indeed do ask them for advice. In the reverse situation, it is noted that the majority of physicians (71%) say that they also ask the nurses for professional advice. However, the majority of the nurses do not seem to share this notion. In fact, 65% of the nurses say that they feel that physicians seldomly ask nurses for advice.
In the eyes of this majority of nurses the physicians are not asking the nurses for professional advice, yet the majority of physicians say that they do ask the nurses for their advice. Interestingly enough, a small majority of nurses (52%) perceive that physicians indeed will say that they do ask nurses for professional advice. This perception turns out to be a 19% misperception on the part of the nurses of the physicians' views on the issue. Perhaps nurses acknowledge that physicians ask them many questions, but in the eyes of the nurses these questions do not necessarily get at the arsenal of the nurses' professional advice.

These findings bring out a rather interesting difference between the majorities of physicians and nurses in the way both professionals assess this issue. There might be a difference of opinion between the two professions on what constitutes "professional advice".

**Issue No. 12 - Interprofessional Utilization of Capabilities**

A small majority of physicians (64%) believe that nurses do fully utilize the capabilities of the physicians in long-term care facilities. This notion is shared by a majority of 85% of the nurses. In the reverse situation, a very small majority of nurses (55%) feel that physicians do fully utilize the capabilities of nurses. The group of physicians are split in half on the issue. Exactly 50% of the physicians say that they do fully utilize the capabilities of nurses. It appears that significant numbers of physicians (36%) and nurses (45%) believe that their capabilities are not fully utilized by the members of the other profession. What is of interest is that half of the physicians in the survey admit that they do not fully utilize the capabilities of nurses, and that 15% of the nurses admit not to utilize the physicians fully either.

On the issue of the utilization of the physicians, the physicians misperceive the views of the nurses by 17%, and the nurses misperceive the views of the physicians by 16%. On the issue of the utilization of the nurses, the physicians misperceive the views of the nurses by 19%, and the nurses misperceive the views of the physicians by 30%. Even though all these misperceptions are
considered to be small, it appears that both groups of professionals on this issue have developed misperceptions of each other, which differ in one important aspect from all the misperceptions the professionals have of each other on any of the other issues. In this survey groups of 4 misperceptions are computed per issue, two for each profession. As a group of 4, the misperceptions relating to the issue of interprofessional utilization of capabilities ranks as the highest in comparison with all the other groups of misperceptions (see table 4, p. 107).

In summary, it appears, therefore, that significant numbers in both professionals are not using each others’ capabilities as much as each profession wants to be used, and they also are not in tune with the views of the other professionals on the issue. This underscores the findings in the literature that physicians and nurses do not have opportunities in their educational process to learn about one another’s capabilities (Fagin, 1992). Most interestingly, however, is that some physicians and nurses admit not to use the other professions’ capabilities. It appears that there is room for improvement on the part of both professions. Both can gain a better perception of the other profession’s views on the issue, and both professions can increase their utilization of the capabilities of the members of the other profession.

**Issue No. 13 - Interprofessional Cooperation**

In terms of interprofessional cooperation, it appears that the physicians do not score as well as the nurses are doing in long-term care facilities. A higher percentage among nurses (35%) believe that physicians do not cooperate well, compared to only 14% of the physicians, who believe that the nurses do not cooperate well.

In their self-evaluation as cooperative team members, a large majority of nurses (95%) do believe that they cooperate well with physicians, and also a large majority of physicians (86%), in turn, think of themselves as cooperating well with nurses. In great parts, these notions are shared by the members of the other profession. The majority of physicians (86%), indeed, say
that nurses do cooperate well with them, and 65% of the nurses say that physicians do cooperate well with the nurses.

In their genuine efforts to become cooperative team members, it appears that physicians could stand to gain the most from these findings. The fairly large majority of physicians (86%), who believe that they are good cooperative team members must realize that only 65% of the nurses share this view with them. It is encouraging to note that the physicians do appear to be aware of their reputation as cooperative team members. Among the physicians only 71% perceives that the nurses, indeed, will say that physicians cooperate well with nurses. This perception is only a 6% misperception on the part of the physicians, but seen in the context of the other findings the physicians are wise to take a careful look at how well they are perceived by the nurses as cooperative team members. At the same time, 14% of physicians say that nurses do not cooperate well with physicians. It might be conjectured, that other issues such as territoriality and ethnocentrism or defensiveness may influence the degree of interprofessional cooperation. Strong sense of territoriality and ethnocentrism might correlate negatively with interprofessional cooperation. This conjecture needs further exploration. In addition, there may be differences in how cooperation is defined. This also needs further exploration.

Issue No. 14 - Professional Training

Generally, both the physicians and the nurses are thought off as well trained. High percentages of physicians (96%) and nurses (80%) say that physicians in long-term care facilities definitely are well trained. The percentages for the nurses are assessed at somewhat lower levels by the physicians. A majority of 75% physicians say that nurses are well trained and this notion is shared by 94% of the nurses. Of interest is the 25% physicians, who feel that the nurses in long-term care facilities are not well trained.
The large majority of nurses (94%), who think of themselves as well trained must realize that only 75% of the physicians have a similar view on the issue. With a degree of misperception of only 2%, it appears that the nurses are well aware what physicians will say about the training levels of nurses in long-term care facilities. With a quarter of the physicians thinking that nurses are not well trained, both professions will have to work hard to remedy the issue and avoid having it stand in the way of their collaborative team work. The question arises as to whether it is additional training that is needed for the nurses or an improved ability to articulate their unique areas of knowledge without becoming defensive. Ornstein (1990) suggests that nurses actually have no choice in this instance. She feels that nurses should obtain additional training as well as improve on their skills in articulation.

A final point of interest is the 11% of physicians who perceive that nurses will say physicians are not well trained, and the 20% of nurses who, indeed, say that physicians are not well trained. This reflects a 9% misperception on the part of the physicians of the nurses’ view on how well the physicians are trained. This finding among one fifth of the nurses needs further exploration to determine what "well trained" means to these nurses. It may well be that physicians are in need of additional education specifically related to long term care.

**Issue No. 15 - Interprofessional Relationships**

Based on all the previously discussed findings, the specific findings for this last issue are not a surprise. For the most part, both professions indicate that they have good relations with each other, which is in keeping with what has been described in the literature (Fagin, 1992). Equally high percentages of physicians and nurses (both at 89%) express the view that nurses have good relations with physicians in long-term care facilities. The two professions are somewhat apart in their assessments of how well physicians relate to nurses, but still give the
physicians high marks. A large majority of the physicians (96%) feel that they do have good relations with nurses. This view was shared by the nurses, but at a lower percentage of 82%.

The physicians appear to have no misperceptions at all of what nurses are saying about the physicians’ ways of relating with nurses in long-term care facilities. With a misperception of 1%, the nurses are not far behind on this issue. On the nurses’ ways of relating with the physicians, the misperceptions are very low as well. Both the physicians and the nurses have a 3% misperception of each other on the issue. Both professions appear to be very well aware of the views held by the members of the other profession on the issue of interprofessional relationships.

However, as a final comment, physicians would benefit to know that 18% of the nurses think physicians do not relate well with nurses. Almost one out of every five nurses appears to have a negative feeling about the physicians’ ways of relating with nurses. Of note is the finding that most of these 18% nurses have worked less than 5 years in long-term care facilities (see table 9). Perhaps these nurses have recent work experiences in areas other than long term care, such as acute care. If this conjecture is valid, these nurses may be in a position to compare their current professional relationships with physicians to the relationships they have had in their previous work settings. Such comparisons could shed some light on possible differences in collaborative practice as seen in long term care and other segments of the health care system. Of interest also would be to find out whether these nurses will agree with Fagin’s observation (1992), that the relationship with the physicians is still a hierarchical one, where the nurse is subordinate to the physician. This would be suggested by the responses to many other related issues, including status, capabilities and role expectations.
Table 9  Demographic Data of the 18% Nurses who Say that Physicians Do Not Have Good Relations with Nurses in Long-Term Care Facilities

<table>
<thead>
<tr>
<th>Category</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>11</td>
<td>92%</td>
</tr>
<tr>
<td>Male</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>Age:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-30</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>31-40</td>
<td>2</td>
<td>17%</td>
</tr>
<tr>
<td>41-50</td>
<td>7</td>
<td>58%</td>
</tr>
<tr>
<td>Over 50</td>
<td>2</td>
<td>17%</td>
</tr>
<tr>
<td>Number of years the nurses have cared for patients in long-term care facilities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-5 years</td>
<td>5</td>
<td>42%</td>
</tr>
<tr>
<td>6-10 years</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>11-15 years</td>
<td>3</td>
<td>25%</td>
</tr>
<tr>
<td>Over 15 years</td>
<td>3</td>
<td>25%</td>
</tr>
<tr>
<td>Educational preparation:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diploma</td>
<td>11</td>
<td>92%</td>
</tr>
<tr>
<td>Specialty Certification</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>Baccalaureate</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Masters</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Professional designation:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RN</td>
<td>5</td>
<td>42%</td>
</tr>
<tr>
<td>RPN</td>
<td>3</td>
<td>25%</td>
</tr>
<tr>
<td>LGN</td>
<td>4</td>
<td>33%</td>
</tr>
<tr>
<td>Ethnic background (*):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>6</td>
<td>50%</td>
</tr>
<tr>
<td>Oriental</td>
<td>4</td>
<td>33%</td>
</tr>
<tr>
<td>Native Indian</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>East Indian</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>Nurses' job satisfaction:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Good</td>
<td>8</td>
<td>67%</td>
</tr>
<tr>
<td>Excellent</td>
<td>4</td>
<td>33%</td>
</tr>
</tbody>
</table>

(*) The percentages are rounded off, so they do not always add up to 100%
Summary of the Findings

Two summaries are provided in this section. First, the findings are summarized on the 15 professional issues included in the survey among the physicians and the nurses in long-term care facilities. The second summary deals with the subjects’ demographic correlates of interprofessional misperceptions and team work.

Summary of the Findings on the 15 Professional Issues

The physicians and the nurses in long-term care facilities do not seem to have major misperceptions of each other’s views on the 15 important professional issues. The degrees of misperceptions range from 0% to 36%, and are all considered to be very small. A majority of the misperceptions, in fact, are at 7% or lower.

However, when considered in conjunction with the related direct views that have been expressed by the subjects in the survey, some of these issues do gain in significance. That is, they agree on many items on which one or both professional groups are dissatisfied. The misperception may be small, but the issue that surrounds the misperception still may create problems for the professionals involved. This point is true, for instance, for the misperceptions relating to the issue of professional territoriality. The misperceptions are between 5% and 14%. In other words, both professions have a fairly good idea of what the members of the other profession think on the issue of mutually encroaching onto each other’s professional territory. Despite the fact that the one profession fairly well knows where the other one stands on the issue, both professions still are faced with a definite problem. Amongst the group of physicians, 39% feels that nurses encroach on the physicians’ professional territory. An even larger percentage of nurses (61%) feel that physicians encroach on their territory.

These relatively large numbers of physicians and nurses, who feel that the other profession is encroaching on their territory, partially indicate that both professions have strong feelings of
professional ethnocentrism. The findings in the survey on the subjects’ defensiveness of their professional prerogatives seem to confirm that significant numbers among the professionals indeed have these strong feelings of professional ethnocentrism.

Despite these strong and somewhat negative feelings, majorities in both professions generally also express very positive feelings about the other profession. Most of them feel that the members of the other profession cooperate well with them. In fact, large numbers of physicians and nurses indicate that they have good relations with each other. It is good to note that both professions generally have expressed these positive feelings of each other, but a more detailed look at their responses to some of the other issues in the survey still brings out some concerns.

As noted in the previous section, the majorities of physicians and nurses believe that the members of the other profession are competent and well trained. In fairly large numbers both professions also express their trust in the professional judgment of the members of the other profession. With all this expressed trust and belief in each other’s competency, it is concerning to note that significant numbers in both professions feel that their capabilities are not fully used by the members of the other profession. This apparent discrepancy is surprising, especially when it is noted that both professions actually claim to understand the capabilities of the members of the other profession. They understand the capabilities, but they do not use them.

Despite all the trust in the nurses’ competency by the majority of physicians, it is noteworthy to find that most nurses feel that physicians seldom ask the nurses for their professional advice. It is not surprising, therefore, to find that a small majority of nurses feel that physicians do not expect too much of the nurses.

An additional point, which likely will be of more concern to the physicians than the nurses, relates to the views of both professions on the issues of professional ethics and patient welfare. The physicians do not fare as well as the nurses on both these issues. Higher percentages of
nurses are seen to be ethical and highly concerned with the welfare of the patient in comparison with the correlating percentages among the group of physicians in long-term care facilities.

A final point of interest to be included in this summary of the findings, concerns the issues of professional status and professional autonomy. Large numbers in both professions believe that physicians have a higher professional status than nurses. Despite the acknowledged higher status of the physicians, one fourth of the physicians feels that they have very little autonomy in long-term care facilities.

Summary of the Demographic Correlates of Interprofessional Misperceptions and Team Work

To complete the summary section of this chapter general profiles are included of the physicians and the nurses, who participated in the survey. The profile of the 28 participating physicians consists mostly of Caucasian male family practitioners, who are in their 40s, and some are over 50 years old. Most of these physicians have worked for more than 15 years in long-term care facilities (see table 1, p. 76). Most of the 66 nurses in the survey are Caucasian or Oriental female registered nurses, who are diploma trained and are in their 40s. The nurses have worked anywhere from a few months to more than 15 years in long-term care facilities (see table 2, p. 78). The physicians and the nurses appear to be fairly close in their age distribution. The nurses, however, have a wider range in years of work experience in long-term care facilities as compared to the physicians. Of note is the difference in ethnic background between the two professions. The fairly high representation of Oriental nurses compares significantly to the low percentage of Oriental physicians. Given that the majority of the nurses are diploma trained, it is obvious that the two groups of professionals are far apart in terms of their educational preparation. Finally, the two groups definitely differ with respect to their gender.
A total of 138 physicians had been invited to participate in the survey. Only 31 physicians have responded, leaving the physicians with a response rate of 22%. In addition, of the 31 questionnaires, 3 have been filled out incomplete. The rather low response rate seems to partially confirm the notion that physicians have a limited interest in the administrative functioning of a team (Hanlon and Gladstein, 1984).

The response rate for the nurses is considerably higher at 62%. The questionnaire has been distributed to 110 nurses, and 68 nurses have returned their copy. A comparison across the three different professional designations shows that the registered nurses have a considerably lower response rate than the licensed graduate nurses and the psychiatric nurses in the survey (see table 3, p. 79). In all, two participants had returned an incomplete questionnaire, leaving a sample of 66 nurses.

From table 2 it is noted that all the nurses say that their job satisfaction is either good or excellent. None of the nurses describe their job satisfaction as poor. The important aspect of job satisfaction, as noted in Chapter Two, is the argument that job satisfaction is increased as the professionals are exposed more to true collaborative team work. Based on the current findings it could be concluded that the level of job satisfaction is not related to whether the nurses have negative feelings about their collaborative experiences with the physicians. At the same time, however, one could also draw the conclusion that the relative low degrees of misperception partially might have contributed to the positive feelings surrounding the nurses’ job satisfaction.

In this chapter all the findings have been discussed of the survey conducted among the physicians and the nurses in 13 long-term care facilities in Vancouver, British Columbia. All the misperceptions and direct perceptions among the subjects have been reviewed under the headings of the 15 separate professional issues found in the Interprofessional Perception Scale. These findings have been summarized at the end of the chapter together with a summary of the subjects’ demographic correlates of interprofessional misperceptions and team work.
The next chapter is devoted to summarize the entire study and make some concluding remarks about the findings. The limitations of the study are outlined as well in this final chapter and also strategies are indicated that may be implemented to enhance team collaboration in long-term care facilities. In addition, several suggestions are made to further explore the concerns and the questions that have surfaced in the course of this study.
CHAPTER 6

Conclusion

Introduction

In this final chapter of the report some concluding remarks are made about the findings of the survey on the interprofessional misperceptions among physicians and nurses in long-term care facilities.

The chapter has been divided into five sections. A summary of the study is provided in the first section. In the second section limitations of the study are discussed. The third section in this chapter indicates possible strategies that could be implemented to enhance team collaboration in long-term care facilities. In the fourth section suggestions are made for further study. In the final section some concluding remarks are made to this study.

Summary of the Study

Much attention has been devoted to the beneficial consequences of collaborative team work in health care (Baggs and Schmitt, 1988). Appropriate collaboration among physicians and nurses will benefit the patients, the physicians and the nurses, as well as the health care organizations. Some benefits are well documented by research in the literature. Improved patient outcome and increased levels of job satisfaction, as well as a decrease in overall health care costs have been indicated as some of the benefits of using the collaborative team concept (Ritter, 1989; Ornstein, 1990; Fagin, 1992).

Despite the research evidence in support of interprofessional collaboration, historically, physicians and nurses are reported to seldom function collaboratively (Nason, 1983). This lack of interprofessional collaboration can be related to a number of major barriers that prevent
physicians and nurses from entering a collaborative work relationship. Interprofessional misperceptions on major professional issues has been indicated as one barrier (Banta and Fox, 1972; Jacobson, 1974; Ducanis and Golin, 1979).

Fagin (1992) and Samuelson (1992) report minimal research that has been done to assess the effects of interprofessional collaboration in long-term care facilities. A review of the literature for this study did not reveal any research available on the level of interprofessional misperceptions among the physicians and the nurses in long-term care institutions. The purpose of this exploratory study has been to examine the interprofessional misperceptions among the physicians and the nurses in long-term care facilities in the city of Vancouver, British Columbia.

The findings of the study indicate that there is very little misperception among the two professions. In fact, the highest degree of misperception is only 36%, and is found among the nurses. They have a 36% misperception of physicians’ views on whether or not nurses expect too much of the physicians. The rating scale used for the determination of degrees of misperception rates any percentage under 40% as very little misperception.

When the findings of this survey on misperceptions are taken together with the claim made by Banta and Fox (1972), Jacobson (1974), and Ducanis and Golin (1979) that misperceptions form a major barrier in the way of collaboration, it can be concluded that collaborative efforts between the physicians and the nurses in the long-term care facilities in Vancouver, British Columbia, are not obstructed by the barrier of interprofessional misperceptions. It should be noted that the above cited authors’ claim that misperceptions (where they exist) would be a barrier to collaborative practice can be neither supported nor disputed by the findings of this survey. Their argument is that interprofessional misperceptions lead to a lack of collaborative practice. The findings of this survey show that there are very few misperceptions, yet based on the direct views expressed by the subjects, there appear to be other obstructions to collaborative practice between physicians and nurses in the long-term care facilities of Vancouver.
In her review of the collaborative practices between physicians and nurses, Fagin (1992) states that there are major cognitive and perceptual obstructions between the two professions. Based on the direct perceptions expressed by the physicians and the nurses in this survey, it appears that both professions are challenged by a number of cognitive and perceptual obstructions. Both feel the other profession to be encroaching on their own professional territory. There also appears to be a rather strong sense of professional ethnocentrism among the physicians and the nurses. On another issue, both professions feel that their capabilities are not fully used by the members of the other profession. Thus, their agreement is high (low misperception), but their satisfaction is low. Both professions also have an additional concern about their professional autonomy. Significant numbers of physicians and nurses feel that they have very little autonomy in long-term care facilities. The final problem only seems to be experienced by the nurses and concerns their professional advice. A majority of the nurses feel that the physicians seldom ask them for professional advice.

Ornstein (1990) notes that the professional relationship between the physicians and the nurses has remained physician dominated. This study does confirm the physicians' dominance on the teams in long-term care facilities. Large majorities of both professions indicate that physicians have a higher status than nurses. The perception of dominance definitely is reinforced by this belief on the part of both professions that physicians have a higher status. In addition, most of the nurses in the survey also feel that physicians seldom ask them for professional advice. It seems that physicians are making the pertinent patient-care decisions on their own. The nurses are not included in the decision process.

Ornstein (1990) also notes that physicians generally have resisted collaborative efforts with nurses. Based on the findings in this survey, it is not quite clear where the physicians in long-term care facilities stand with respect to their willingness to collaborate with the nurses. On the one hand, the physicians in the survey describe their relationships with nurses to be good.
The physicians also feel that there is a good degree of cooperation between the two professions. On the other hand, however, as just noted, the findings show that nurses feel that physicians seldom ask the nurses for professional advice and do not fully use their capabilities. Yet, asking the other professional for his or her professional advice and using each other's professional capabilities fully are very fundamental to the collaborative team concept.

Although the focus of this study is on the physicians and the nurses, the important role of the administration of the long-term care facilities must not be overlooked. It can not be stressed enough that the role of the administrators is extremely crucial to the success of the collaborative team concept. Their management expertise is needed to guide the physicians and the nurses in their collaborative efforts. It is highly important, in this respect, that the administrators are perceived as credible internal management consultants by the physicians and the nurses (Fried et al., 1988). They must be knowledgeable about the make-and-break issues in interdisciplinary collaboration.

It is crucial for the administrators to have the ability to cultivate the physician-nurse relationship, because a well functioning team of physicians and nurses is linked to the success of the individual long-term care facility (Eubanks, 1991). The administrators must be aware that unless the physicians and the nurses are given support in their collaborative efforts, these professionals may become instruments of frustration and even resort to sabotage of the collaborative team concept (Samuelson, 1992).

The findings of this study confirm that not all is well between the physicians and the nurses in long-term care facilities. There is a need for improvement in the work relationships between the two professions. For the good of the patients, the professionals, and the long-term care facilities, appropriate team collaboration has become a necessity for the physicians and the nurses.
Limitations of the study

There are some obvious limitations to this study and survey, which must be carefully considered when drawing conclusions from the findings. Even more caution is necessary for the interpretation of the findings prior to attempting any form of remedy for some of the indicated problems.

The limitations are centered around the sample size, the non-response bias, the external validity, the instrument, and the demographic correlates of interprofessional misperceptions and teamwork.

Sample Size

Relatively small numbers of physicians and nurses volunteered to participate in the survey. The numbers may, in fact, be too small to be truly representative of the populations of physicians and nurses who work in long-term care facilities. If generalizable at all, the findings may only be generalizable to the long-term care facilities in the city of Vancouver, British Columbia.

The survey has been conducted during the summer months and many of the potential subjects may have been on vacation during the period of data collection, which may have contributed to the low numbers of subjects in the survey.

Non-Response Bias

A potential bias may have emerged in the representation of certain subgroups in the populations of physicians and nurses in long-term care facilities. Those professionals, who have shown an interest to participate in the survey, already may have a very positive outlook on interprofessional issues. It is possible that those physicians and nurses, who refused to participate, did exactly so, because of their lack of interest in anything that relates to collaborative team work, including this survey. The bias could be in the direction of the more
cooperative and satisfied physicians and nurses who have been willing to fill out the questionnaire, or the bias could be in the direction of the less satisfied physicians and nurses who have filled out the questionnaire as an outlet for their frustrations. Either bias could affect the internal validity of the study.

**External Validity**

Given that each long-term care facility is unique, it is also possible that a bias emerged in the representation of certain subgroups of long-term care facilities. The external validity, however, has been increased by randomly selecting the 13 long-term care facilities from a universe of 22.

**Instrument**

The subjects may have experienced some difficulties with the wording of the Interprofessional Perception Scale, which was used as the instrument for data collection. Take for instance the question, "Do physicians sometimes encroach on the nurses' professional territory?". The subjects, who have responded with "false", may have done so because they believe that physicians always encroach on nurses' territory. Other subjects, who have responded with "false", may have done so, because they believe that physicians never encroach on nurses' territory. The word "sometimes" is difficult to interpret when perceptions are being measured. The use of double negatives also may have caused some confusion among the subjects. Take, for instance, the statement, "nurses expect too much of physicians". The subject, who feels that this statement is false, has to re-word the statement to say, "no, nurses do not expect too much of physicians in long-term care facilities".

An additional problem may have been caused by the different definitions that subjects may have given to some of the professional issues. It is possible, for instance, as pointed out
previously, that not every subject will have defined the issue of professional advice in the same way or will give the same meaning to the statement, "physicians are well trained". A true/false response to an issue depends much on how one defines that issue.

The subjects, however, have been encouraged to provide their first impression and not to spend too much time on any one statement. The content validity of the instrument is established by the direct nature of the questions posed.

Demographic Correlates of Interprofessional Misperceptions and Team Work

The numbers of subjects in the survey are not large enough to draw any conclusions about the specific demographic correlates of professional misperceptions and team work. The pool of demographic data on the subjects is too small to confirm any real potential they might have for influencing the physicians and the nurses in their development of different perceptions and attitudes about the 15 professional issues.

Similarly, the pool of data concerning the job satisfaction of the nurses is not large enough to confirm the findings in the related literature on job satisfaction and collaborative team work. A considerable number of subjects is required to detect any consistent correlation between low levels of job satisfaction and the interprofessional misperceptions surrounding the 15 issues. In any event, it should be further noted that one's level of job satisfaction is likely to be the end result of a number of different contributing factors. The membership of a well functioning collaborative team is only one of those factors.

Strategies Toward Improved Team Collaboration

Ornstein (1990) points out that economic, political, technical, and social changes in the health care system have not spontaneously stimulated collaborative efforts between the physicians
and the nurses. It appears that there is a need for a more structured and deliberate plan of action to move the two professions closer together in their work relations.

There are a number of effective methods available to the physicians and nurses, as well as the management of long-term care facilities to improve the work relationships among the physicians and the nurses. The strategies are presented in this section as suggestions either specifically meant for the physicians alone, or aimed at the nurses as a group by themselves, or specifically meant just for the administration of long-term care facilities. A number of strategies also are suggested, which might be helpful for all three groups to engage in collectively.

**Strategies for the Physicians**

1. — The findings of the survey show that physicians are perceived to be dominant in the pertinent decisions in the development of patient care plans. Consider, for instance, the 65% nurses, who feel that physicians seldom ask nurses for professional advice, or the 45% nurses, who believe that their capabilities are not fully used by the physicians. Based on these findings, it seems important for the physicians to realize that nurses do not feel that physicians treat the nurses as true team members. The physicians must have a careful look at how they make their decisions in long-term care facilities. It is time for the physicians to review their old ways of collaborating with nurses.

   Fagin (1992) urges that physicians should reevaluate their traditional way of viewing the broad, complex health care field. She adds that the physicians should begin to realize that their single-discipline centered approach to health care is a chief barrier to a more collaborative behavior of the health care team.

2. — Again, the findings of the survey show that many physicians appear not to include the nurses in the decision-making process around patient care issues. Baggs and Schmitt (1988) have commented that collaborative practice requires physicians and nurses to participate in many joint
meetings, which are time consuming. It seems that the physicians in long-term care facilities are not in a position to take the time and discuss the care options with the nurses. As a rule, physicians are not compensated for meeting time (Ornstein, 1990). It is suggested, therefore, that physicians should lobby for appropriate compensation on a fee-for-service basis for committee work. With such compensation, physicians might be in a better position to participate in the collaborative team concept.

Strategies for the Nurses

1. In order for the nurses to become full partners with the physicians on the collaborative teams, the nurses have to look at a comprehensive redesign of their role. (Eubanks, 1991; Fagin, 1992). In the collaborative team context the nurses will take on a consultative role to the physicians, which will require increased levels of responsibility and accountability. The nurses must prepare themselves well for these increased levels.

Marriner (1984) makes suggestions on how to be prepared to take on increased levels of responsibility. To begin with, the nurses must ensure that they fully understand the additional consultative activities for which they will be made responsible. Responsibility denotes obligation, the nurses, therefore, must decide to accept the obligation created by the increased levels of responsibility. Before they accept the obligation, however, the nurses should participate in developing clearly written directions with their superiors, which will clarify for the nurses what is really expected of them in their consultative role to the physicians. These directions, in turn, need to be discussed with the physicians.

Marriner (1984) also has made suggestions for the nurses on how to be accountable for their actions. Accountability refers to liability. In other words, the nurses are liable to satisfactorily complete their work. The nurses must feel comfortable to take on this liability. The nurses should feel confident and not fear failure and criticism. They should develop guidelines
and standards enabling them to take on the increased levels of accountability as full members of a collaborative team.

In general, nurses will have to assert themselves in their new consultative role to the physicians. They should ask for increased levels of control over their own activities. They should not accept increased levels of responsibility and accountability without increased levels of control. Through these increases in control, responsibility and accountability the nurses will come to realize that the opportunities for them to use the full scope of their knowledge and skills have increased as well. Based on the finding in the survey that 45% of the nurses feel that their capabilities are not fully utilized by the physicians, it appears that the nurses in long-term care facilities are eager to contribute more to the overall care delivery. The nurses must realize that the opportunities are there for them to increase their contributions, but that they will have to be prepared to take on the accompanying responsibilities and accountabilities. The nurses must articulate clearly their contributions to physicians.

2. — From table 2 (p. 78), it is apparent that 77% of the nurses in the survey are diploma prepared nurses. Ornstein (1990) questions whether nurses at the diploma levels are adequately prepared to handle the responsibilities and authority necessary in collaborative team work. Fagin (1992) makes it clear that upgrading the basic nursing education to a respected level (e.g., at least the baccalaureate degree) will help nurse-physician relationships become more reciprocal. She argues that the current difference between the educational preparation of physicians and nurses perpetuates many of their interprofessional communication problems. It is suggested that the nurses in long-term care facilities make a commitment to upgrade themselves to the baccalaureate degree.

3. — The survey shows that 39% of the physicians feel that nurses in long-term care facilities are encroaching on the physicians' professional territory. Nurses will have to be prepared to work with physicians, who feel that their territory is threatened. As part of their
preparedness, the nurses should be aware that professional territoriality is a sensitive issue. The nurses should learn how to skillfully approach the physicians with the message that physicians and nurses are in a position to complement each other's roles. It requires much skill to jointly decide on who is going to do what for the patient.

Ornstein (1990) suggests that nurses must develop skills in leadership, bargaining and also negotiating. With these improved skills the nurses will appear less threatening in their relations with the physicians and eventually earn their collegiality. It is suggested that the nurses find ways to develop these helpful skills by signing up for workshops that specifically are designed to focus on these skills. Of course, these workshops could be made available to members of both professions. Physicians would stand to gain just as much as nurses would from an increase in leadership and other skills.

4. — Keddy et al. (1986) suggest that nurses should endeavor to educate the public about the true value and role of nurses. The authors argue that until society recognizes the true value of nurses and begins to equate their worth with that of the physicians, much of the conflict and frustration between the two professions will remain. The nurses should speak up when they see themselves portrayed in the media as temperature takers with small brains and big hearts or handmaidens to physicians (Keddy et al., 1986; Nurse-Physician, 1989). The nurses should recognize the consumers of health care services as allies. The nurses can teach the patients and their families how the profession of nursing contributes to their care.

**Strategies for the Administration of the Long-Term Care Facilities**

1. — Vance (1992) points out that new staff should be prevented from being absorbed by bad politics in the work-place. The author explains that new employees will need to learn the organization's proper norms and practices. The administration of the long-term care facility, therefore, should spent a considerable portion of their time setting the standards and the
expectations for collaborative team work. The administration should create an organizational culture that supports collaboration. This culture needs to be permeated by the patient centered focus spoken of by Joyce Clifford (Bocchino, 1991). This culture should be conveyed to new employees early in their employment. All elements of collaborative team work already in place in the facility should be pointed out carefully to the new physicians and nurses.

2. — Eubanks (1991) and Fagin (1992) encourage the establishment of a corporate culture which supports physician-nurse collaboration. Ornstein (1990) suggests that the administration defines new roles and relationships in support of the collaborative team concept. The management of the facility should have clearly spelled out job descriptions and functions, with which they can reinforce the new professional boundaries among the physicians and nurses. The facilities’ policies and procedures on collaborative team work should be made binding to both professions. The physicians and the nurses who want to practice their profession at a facility can be asked first to sign an agreement to observe all the policies and the procedures of the facility prior to becoming a member of the facility’s team.

3. — Davidhizar and Bowen (1992) stress that camaraderie in the work-place offers a valuable avenue for coping with stress and maximizing the pleasure experienced at work. The work stress in long-term care facilities is well documented (Samuelson, 1992). The management team of a long-term care facility, therefore, should develop appropriate levels of camaraderie among the physicians and nurses by organizing opportunities for the professionals to socialize and learn details about each other that go beyond their professional image of the physician or the nurse on the team. It has become quite apparent from the survey that there is a distinct professional distance between the physicians and the nurses in long-term care facilities. The physicians, for instance, are considered to have a higher status than nurses. A majority of 79% of the nurses acknowledge this difference, and 86% physicians have stated that they, indeed, have a higher status than nurses. The notion of a professional distance between the two
professions in the survey is reinforced further by the finding of a strong sense of professional territoriality among the subjects. The findings show that 39% of the physicians and 61% of the nurses in the survey feel that their professional territory has been threatened by the members of the other profession. It seems that significant numbers of physicians and nurses are very territorial in their approach to the delivery of care. With this professional distance between physicians and nurses well established, the administration should try to get the two groups of professionals as close together as possible in every aspect of their work relationship. The development of a sense of camaraderie between the physicians and the nurses will enhance the attempt to bring the two professions closer together. Baldwin (1993) indicates that socialization strategies have the potential to move the professionals toward more equality, which in turn will enhance the collaborative team concept.

4. — Russell-Babin (1992) points out that the development of an effective collaborative team is a deliberate process in which the leader assumes a major role. This leadership role should not be automatically assigned to physicians. The administration, therefore, should be very cognizant of who the leader needs to be on the different teams, and provide that person with all the available support and directions. Baldwin (1993) suggests, for instance, that the leader must be encouraged to wield strong enough authority to create a participatory culture among the team members.

5. — Nurses in long-term care facilities have very high patient workloads and find it difficult, therefore, to participate in a collaborative practice (Ornstein, 1990). A rather effective and practical strategy for the administration of long-term care facilities, therefore, should be to develop a more reasonable distribution of patient workloads. The administration is much restricted in this redistribution by the funding they receive from the government. Collectively the administration must stress with the government the urgency of reducing the high patient workloads in the long-term care facilities. The current staff-patient ratios in the facilities are
extremely stretched and allow the staff only to attend to the basic needs of their patients. It follows that not much time is available for team building in long term care (Samuelson, 1992). In their approach to the government, the administrators should link the relevant issues. They should explain that the current funding for the staff-patient ratio does not enable physicians and nurses to work collaboratively. This lack of interprofessional collaboration, in turn, should be linked to the inability for the patients, the professionals, and the health care system to enjoy the benefits of collaborative team work as documented in Chapter Two of this study.

6. — Nason (1983) makes the point that many collaborative teams remain only an illusion, because few institutions are willing to commit time and resources needed for the training of the physicians and the nurses to work more collaboratively. It is suggested that the administration supports the professionals in their collaborative effort by providing them with the necessary resources and tools needed for their training. The administration should lobby the government for budget allocations towards seminars and workshops, which all promote the interprofessional team concept.

7. — The administrators should assure themselves that they are fully aware of the issues explored in this study and particularly are familiar with the make-and-break potential of these issues in collaborative team work.

Strategies For All Three Professional Groups

1. — Interprofessional education opportunities at the medical and nursing schools should be explored and supported in an attempt to facilitate a better understanding among the physicians and the nurses of each others’ roles (Mechanic and Aiken, 1982; Keddy et al., 1986; Ornstein, 1990; Fagin, 1992; Horder, 1992). All three professions should strive for the systematic development of an interdisciplinary educational program (Fagin, 1992). Horder (1992) points out that increasingly more interest is shown in the idea of interprofessional education. The three
groups should use this window of opportunity to increase the offerings where different health
disciplines can work and study together.

2. — Ongoing education at the facility is a key to improvements in physician-nurse
relationships (Anvaripour et al., 1991; Butterill et al, 1992). Administrators should encourage the
development of workshops, where physicians and nurses discuss together the issue of
physician-nurse collegiality. At these workshops open discussions should be encouraged about
any contentious issues. Baldwin (1993) suggests that these discussion groups, for instance, could
address gender awareness and attitudes toward dominator and partnership models of team work.
Fagin (1992) suggests that the real-life experiences with collaborative team work definitely
should be discussed at these workshops. Take, for instance, the 18% physicians and the 36%
nurses in the survey who feel that their capabilities are not understood by the members of the
other profession. These frustrating feelings need to be discussed. In particular the positive
experiences should be brought out in the open at these discussions and used as illustrations of
how well the collaborative team concept, indeed, can work in the facility. Since educational
experiences for collaborative skill building are a rarity in long-term care facility, this strategy
warrants special attention (Samuelson, 1992).

3. — The dynamics of the teams should be periodically reviewed by its members. A team
can benefit from self- examination (Butterill et al., 1992). The review should be encouraged by
the administration of the facility and also be guided with pertinent management thought and
practice.

4. — The idea of joint practice committees should be implemented in each long-term care
facility (Eubanks, 1991; Fagin, 1992). The deliberate use of interprofessional committees for
cross-disciplinary projects will encourage better working relationships between the physicians and
the nurses. Epton et al. (1984) warn, however, that this strategy calls for considerable
management ability in guiding the physicians and the nurses in their collaborative efforts.
As a general cautionary remark, it should be noted that not all these suggested strategies may be suitable for all physicians and nurses in each long-term care facility. Their suitability needs to be discussed by all parties prior to implementing any of these suggestions. It is important to have an open dialogue about these strategies and their consequences. Fagin (1992) also stresses the importance for the professional organizations of physicians and nurses to endorse the appropriate strategies for improving interprofessional collaborations.

A final comment should be made about the expected resistance to change that will be caused by any of the above suggested strategies. Anderson and Finn (1983) suggest that such resistance may be overcome through gradual introduction of the strategy, joint participation by those professionals effected by the strategy, and continuous support to the professionals throughout the implementation of the strategy.

In addition to the strategies indicated above, the collaborative team concept for the physicians and the nurses in long-term care facilities also is enhanced by further research. This study has given rise to a number of concerns and questions, which definitely are worth of further exploration.

Suggestions For Further Study

1. — As indicated before, the respective samples of physicians and nurses in this study are rather small. The survey bears repeating among a much larger number of physicians and nurses in long-term care facilities. Of interest is to see whether the results of this small survey are going to be confirmed by larger samples of physicians and nurses.

2. — There are differences between long-term care facilities and acute care facilities, which make each of these health care organizations unique. It would be of interest to assess the effect of the difference between long term care and acute care on the degree of interprofessional
misperception found among physicians and nurses in each of these respective facilities. It is possible that a focus group approach to the interprofessional issues in nursing homes would yield a unique set of issues not captured in the Ducanis and Golin (1979) instrument.

3. — Whether one professional thinks he or she is competent, or perceives the other professional to think he or she is competent, or actually is perceived as competent, still does not confirm either way that the professional, indeed, is competent. Actual existing competency levels among the physicians and nurses in long-term care facilities should be further explored.

4. — The study indicates that considerable numbers of professionals in both groups believe they have very little professional autonomy. This finding raises a concern that needs to be further explored. How do the physicians and the nurses in long-term care facilities define their professional autonomy? On what basis do they feel they have very little autonomy? How can they increase their professional autonomy? These are some of the questions that could be made the focus of a rather valuable study.

5. — The study indicates that significant numbers in both professions feel that their capabilities are not fully used by the members of the other profession. It also shows that 15% of the nurses and 50% of the physicians admit that they do not fully utilize the capabilities of the other profession. An exploratory study could be conducted to find out exactly what type of professional capabilities are perceived not to be used by the members of the other profession. A further observational study could also have these perceptions confirmed. These additional studies could try to clarify the reasons behind the interprofessional under-utilization of professional capabilities.
6. — Almost one third of the nurses in the survey believe that physicians in long-term care facilities are not highly concerned with the welfare of the patient. Of interest would be to find out what concrete evidence the nurses have to come to this rather serious conclusion about the physicians. The study also shows that a majority of nurses (97%) perceive that physicians will say that they are highly concerned with the welfare of the patient. A further study on this issue could explore whether the nurses believe that physicians only pretend to be concerned about the welfare of their patients.

7. — Of particular interest for further exploration is the issue of professional territoriality. This study has shown that both professions feel that members of the other profession are encroaching on their territory. Whether both professions are actually encroaching on the other profession's territory, and more importantly, in what manner, would be of great interest to all members on the team to have further explored.

8. — The findings of the survey concerning the issue of professional ethics are very interesting and definitely need to be explored further. Almost one third of the nurses say that physicians are not highly ethical. What evidence are these nurses using as a basis for their critical view of the physicians' sense of ethics? It seems that many Oriental nurses feel that physicians are not highly ethical. Is there a significant cultural component to the issue of professional ethics? Of great concern is the 7% physicians and 11% nurses, who admit that they are not highly ethical. These percentages are small, but in the context of professional ethics and health care these findings are alarming and definitely need to be further explored.

9. — The nurses in the survey appear to be almost equally split on the issue of physicians' expectations of nurses. It seems that the nurses are not sure of what the physicians could expect
from nurses. This area may need further exploration to determine how problematic the issue of role expectations is in long-term care facilities.

10. — Both professional groups in the survey appear to be fairly defensive of their respective prerogatives, and this sense of professional ethnocentrism or chauvinism also appears to be mutually acknowledged by the physicians and the nurses. These findings illustrate the presence of a barrier between the two professions, which stands in the way of their collaborative practice. This area of concern should be further explored. For instance, what prerogatives actually exist among the physicians and the nurses? Why do they see these items as prerogatives? What does it take for the respective professionals to give up these prerogatives for the sake of collaborative team work? Answers to these questions would increase the chances for the two professions to get closer to the ideal concept of collaborative team work.

11. — In Chapter Two the question was posed as to what develops first, interprofessional trust or collaborative practice between physicians and nurses? The literature seems to support either argument. This may be no more than another proverbial paradox of what came first, the chicken or the egg. Nonetheless, it would be interesting to find out more about the intricacies between interprofessional trust and collaborative practice.

12. — The findings of the study indicate that nurses feel physicians seldom ask the nurses for professional advice. At the same time, however, a majority of the physicians say that they do ask the nurses for professional advice. Additional studies could explore this discrepancy. How does each profession define the issue of professional advice? What type of professional advice do nurses think they could give physicians, if only they would ask the nurses? Do nurses give
professional advice, whether the physicians ask for it or not? These questions could be addressed through further study of the details surrounding professional advice.

13. — The barrier to collaborative team work created by clinical uncertainty in health care has been discussed in Chapter Two. It seems that quite opposite views are supported in the literature. On the one hand clinical uncertainty is indicated as a barrier (Horder, 1992), on the other hand uncertainty in patient care is felt to be the driving force for health professionals to work collaboratively (Fried et al., 1988). Further exploration of this discrepancy would contribute significantly to the enhancement of the collaborative team concept.

14. — The study has stressed the importance of administrative support for the collaborative team concept. The existing long-term care facilities’ policies and procedures on collaborative team work should be further explored. Are these policies actually written and used? Is the issue of team collaboration dealt with during the orientation programs of new staff? In what other ways is there evidence of the administrative support for the collaborative work relationships between physicians and nurses? Are there any workshops or discussion groups organized on the topic?

15. — Not much is known about the leadership function on collaborative teams in long-term care facilities. Who are the leaders? Do they consistently come from one professional discipline? To what extent are they actually instrumental in the development of the collaborative team concept in the individual facility? These question are just some of the interesting details on the leadership function that could be explored through further study.

16. — The benefits of self-examination for a team have been indicated. How many teams in long-term care facilities actually do take time out for some self-examination? Of real interest
would be a before-after study, to determine whether an improvement is noted in team functioning following a series of self-examinations.

17. — The high patient workload makes it difficult for nurses in long-term care facilities to commit fully to the collaborative team concept. What are the specific details of these patient workloads that seem to form a barrier for the nurses to collaborate well with the physicians? Further study could explore these details.

Conclusion

This exploratory study among 28 physicians and 66 nurses in long-term care facilities in the city of Vancouver, British Columbia, has found some evidence of cognitive and perceptual obstructions in the way of the collaborative practice between the two professions. The two professions do seem to have direct perceptions of each other on some important professional issues. The findings, however, do not indicate that these perceptual obstructions are necessarily formidable barriers. In fact, the misperceptions are all considered to be very little to non-existent. More than half of the misperceptions among 57 tested were less than 7%. It should be noted further that some misperceptions are even in a positive direction. For instance, the actual number of physicians, who believe that nurses are competent, is much higher than expected by some of the nurses. Nonetheless, some misperceptions are there, and they should not be ignored. Ideally, both professions should know exactly where the members of the other profession stand on each of the professional issues. In addition, data from direct perceptions provided valuable information on barriers or obstructions that exist. Openly discussing these barriers and deliberate activities to change them are necessary for collaborative team work to occur.
In closing, it bears repeating that there appears to be no longer an option for physicians and nurses in long-term care facilities to collaborate. Fagin (1992) argues that physicians and nurses, together with the guidance of administrators, must participate collaboratively in the delivery of health care in the coming decades. Although there are barriers to overcome, the physicians and the nurses must realize that there is a common link between them that can serve as a uniting force (Ornstein, 1990). The author points out a desire on the part of both professions to provide the patient with the highest possible level of care. It is clear that this desire can only be fulfilled when the physicians and the nurses in long-term care facilities fully commit to the proper use of the collaborative team concept and to the diminishing of perceptual obstructions between them that prevent the realization of the concept.
REFERENCES


Maine aims antitrust blow at MDs and saves the day for CRNAs. (1985). *The American Journal of Nursing*, May, 600-601 and 612.


APPENDIX A

INTERPROFESSIONAL PERCEPTION SCALE

FOR THE

PHYSICIANS
INTERPROFESSIONAL PERCEPTION SCALE

Code Number __

All answers are confidential. Do not sign this form.

This is a study of interprofessional perceptions. It is intended to get at some of the ways various professions view each other and how they think others view them.

Respondent data: Profession __Physician__
Gender: Female______ Male______
Age: 20-30____ 31-40____ 41-50____ Over 50____
Number of years you have cared for patients in long term care facilities: __________________________

Area of practice: Family Practice____
Other (please specify)_____________________

Ethnic background: Caucasian________________________
Oriental________________________
Native Indian________________________
East Indian________________________
Other________________________

Please fill in the information on this page, but do not sign your name.

Note. Adapted from The Interdisciplinary Health Care Team (pp. 38-40) by A. J. Ducanis and A. K. Golin, 1979, Germantown, Maryland: Aspen Systems Corporation. Copyright 1979 by Aspen Systems Corporation.
In answering the following items, do not spend too much time on any one statement. Your first impression is what we want. Please answer with as much candor as possible. Answer the two parts of each question as you proceed. The questionnaire should take only about 15 minutes. Please answer each item.

The focus of this study is on physicians, who have patients at long term care facilities, and on staff nurses, who work in these same long term care facilities.

As you look at the following page, you will see that in Column I you should indicate whether you think the statement is true or false; and in Column II you should indicate how you think the other professional would answer. Please place an X to indicate your answers.

You may begin now.
Answer the following items in relation to NURSES IN LONG TERM CARE FACILITIES

<table>
<thead>
<tr>
<th>How Would You Answer?</th>
<th>How Would Nurses Answer?</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRUE</td>
<td>FALSE</td>
</tr>
<tr>
<td>TRUE</td>
<td>TRUE</td>
</tr>
</tbody>
</table>

NURSES

1. Are competent

2. Have very little autonomy

3. Understand the capabilities of physicians

4. Are highly concerned with the welfare of the patient

5. Sometimes encroach on physicians' professional territory

6. Are highly ethical

7. Expect too much of physicians

8. Have a higher status than physicians
Continue to answer the following items in relation to NURSES IN LONG TERM CARE FACILITIES

<table>
<thead>
<tr>
<th>How Would You Answer?</th>
<th>How Would Nurses Answer?</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRUE</td>
<td>TRUE</td>
</tr>
<tr>
<td>FALSE</td>
<td>FALSE</td>
</tr>
</tbody>
</table>

NURSES

9. Are very defensive about their professional prerogatives

10. Trust physicians' professional judgment

11. Seldom ask physicians professional advice

12. Fully utilize the capabilities of physicians

13. Do not cooperate well with physicians

14. Are well trained

15. Have good relations with physicians
Answer the following items in relation to Your Own Profession

<table>
<thead>
<tr>
<th>PHYSICIANS</th>
<th>How Would You Answer?</th>
<th>How Would Nurses Answer?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are competent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Have very little autonomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Understand the capabilities of nurses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Are highly concerned with the welfare of the patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Sometimes encroach on nurses' professional territory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Are highly ethical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Expect too much of nurses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Have a higher status than nurses</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Continue to answer the following items in relation to Your Own Profession

<table>
<thead>
<tr>
<th></th>
<th>How Would You Answer?</th>
<th>How Would Nurses Answer?</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHYSICIANS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Are very defensive about their professional prerogatives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Trust nurses’ professional judgments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Seldom ask nurses professional advice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Fully utilize the capabilities of nurses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Do not cooperate well with nurses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Are well trained</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Have good relations with nurses</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX B

INTERPROFESSIONAL PERCEPTION SCALE

FOR THE

NURSES
INTERPROFESSIONAL PERCEPTION SCALE

Code Number ___

All answers are confidential. Do not sign this form.

This is a study of interprofessional perceptions. It is intended to get at some of the ways various professions view each other and how they think others view them.

Respondent data: Profession __Staff Nurse__

Gender: Female___ Male___

Age: 20-30___ 31-40___ 41-50___ Over 50___

Number of years you have cared for patients in long term care facilities: ________________________________

Educational preparation: Diploma____
Baccalaureate____
Masters____
Specialty Certification________

________________________________________

Professional designation: RN___ RPN___ LGN___

Ethnic background: Caucasian___________________________
Oriental___________________________
Native Indian___________________________
East Indian___________________________
Other______________________________

How would you rate your job satisfaction: poor___________
good___________
excellent___________

Please fill in the information on this page, but do not sign your name.

Note. Adapted from The Interdisciplinary Health Care Team (pp. 38-40) by A. J. Ducanis and A. K. Golin, 1979, Germantown, Maryland: Aspen Systems Corporation. Copyright 1979 by Aspen Systems Corporation.
In answering the following items, do not spend too much time on any one statement. Your first impression is what we want. Please answer with as much candor as possible. Answer the two parts of each question as you proceed. The questionnaire should take only about 15 minutes. Please answer each item.

The focus of this study is on physicians, who have patients at long term care facilities, and on staff nurses, who work in these same long term care facilities.

As you look at the following page, you will see that in Column I you should indicate whether you think the statement is true or false; and in Column II you should indicate how you think the other professional would answer. Please place an X to indicate your answers.

You may begin now.
Answer the following items in relation to PHYSICIANS

<table>
<thead>
<tr>
<th>How Would You Answer?</th>
<th>How Would Physicians Answer?</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRUE</td>
<td>FALSE</td>
</tr>
<tr>
<td>TRUE</td>
<td>FALSE</td>
</tr>
</tbody>
</table>

PHYSICIANS

1. Are competent
2. Have very little autonomy
3. Understand the capabilities of nurses
4. Are highly concerned with the welfare of the patient
5. Sometimes encroach on nurses' professional territory
6. Are highly ethical
7. Expect too much of nurses
8. Have a higher status than nurses
Continue to answer the following items in relation to PHYSICIANS

<table>
<thead>
<tr>
<th>How Would You Answer?</th>
<th>How Would Physicians Answer?</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRUE</td>
<td>FALSE</td>
</tr>
</tbody>
</table>

PHYSICIANS

9. Are very defensive about their professional prerogatives

10. Trust nurses' professional judgment

11. Seldom ask nurses' professional advice

12. Fully utilize the capabilities of nurses

13. Do not cooperate well with nurses

14. Are well trained

15. Have good relations with nurses
Answer the following items in relation to NURSES IN LONG TERM CARE FACILITIES

<table>
<thead>
<tr>
<th>How Would You Answer?</th>
<th>How Would Physicians Answer?</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRUE</td>
<td>TRUE</td>
</tr>
<tr>
<td>FALSE</td>
<td>FALSE</td>
</tr>
</tbody>
</table>

**NURSES**

1. Are competent
2. Have very little autonomy
3. Understand the capabilities of physicians
4. Are highly concerned with the welfare of the patient
5. Sometimes encroach on physicians' territories
6. Are highly ethical
7. Expect too much of physicians
8. Have a higher status than physicians
Continue to answer the following items in relation to NURSES IN LONG TERM CARE FACILITIES

<table>
<thead>
<tr>
<th>How Would You Answer?</th>
<th>How Would Physicians Answer?</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRUE</td>
<td>FALSE</td>
</tr>
</tbody>
</table>

NURSES

9. Are very defensive about their professional prerogatives

10. Trust physicians' professional judgments

11. Seldom ask physicians' advice

12. Fully utilize the capabilities of physicians

13. Do not cooperate well with physicians

14. Are well trained

15. Have good relations with physicians
AGENCY CONSENT

Approval has been given to Albertus Roskam to distribute a questionnaire to our regular full-time and part-time staff nurses.

In granting him approval, it is understood that:

- the title of his project is Interprofessional Misperceptions among Physicians and Nurses in Long Term Care Facilities.

- his research is for a graduate thesis in the program of Health Services Planning and Administration of the Department of Health Care and Epidemiology at the University of British Columbia.

- his faculty advisor is Dr. Larry Green, who can be contacted at 822-2258.

- Albertus Roskam can be reached to answer any inquiries by dialing 669-5042 at his home, or at his work 872-0044.

- the study tries to determine the degrees of misperception physicians and nurses in long term care have of each other on collaborative professionalism.

- the data will be collected by using a questionnaire, which has been previously validated, and is entitled "Interprofessional Perception Scale".

- the identity of the subjects will be kept confidential, because they are being instructed not to sign the questionnaire with their name.

- the subjects are encouraged to fill out the questionnaire at their own convenience and volition.

- the return of the questionnaire by the subjects implies their consent.

- a list is needed identifying the number of nurses eligible to participate in the survey.

- the questionnaire, together with an explanatory letter, will be distributed to all eligible nurses.

- an advertisement will be posted in the facility to encourage the nurses to complete the questionnaire.
- the questionnaire should take only about 15 minutes to complete.

- the subjects will be asked to return their completed questionnaires by placing them in an envelope located in the staff room.

- a follow up letter will be sent to all nurses as a thank-you for those who have responded and a reminder for those who have not completed the questionnaire.

- a list is needed with the names and the addresses of all physicians who admit residents to the facility.

Agency

_____________________________ ______________________
Name Phone

Agency Official

_____________________________ ______________________
Signature Position Date
APPENDIX D

INTRODUCTORY LETTER

TO THE

PHYSICIANS
Dear Physician:

I am writing to invite you to participate in a survey, the purpose of which is to learn more about the ways physicians and nurses in long term care view each other. I am a graduate student in the program of Health Services Planning and Administration in the Department of Health Care and Epidemiology of the Faculty of Medicine at the University of British Columbia. The title of my graduate thesis is Interprofessional Misperceptions among Physicians and Nurses in Long Term Care Facilities, and the enclosed survey is a major part of my thesis.

There is a growing evidence in the literature that positive patient care outcomes and job satisfaction are enhanced by appropriate collaboration between health professionals. My ultimate goal is to have the results of my study used as a point of departure in educating physicians and nurses in long term care on how they tend to view each other and to explore the reasons for any misperceptions the one profession may have of the other. Such exploration hopefully will further guide the relationship between physicians and nurses toward a good collaborative work experience.

The enclosed questionnaire should take no more than 15 minutes of your time to answer. Please note that the completion of the questionnaire implies your consent. You may refuse to participate or withdraw from the study at any time. The questionnaire has been given a code number to assure that the information you give me will remain strictly confidential and you will not personally be identified in the research report. The questionnaires will be destroyed at the completion of my study. There is no monetary compensation. The results will be presented at a seminar in the Department of Health Care and Epidemiology, and may be used for other future presentations and publications.
I hope you will take a few moments now to complete the questionnaire and return it to me in the enclosed self-addressed stamped envelope. If you have any concerns about the survey, please feel free to contact me at work, 872-0044 or at home, 669-5042. You may also contact my Faculty Advisor, Dr. L. Green at 822-2258. Thank you in advance for your willingness to participate.

Yours sincerely,

Albertus Roskam
APPENDIX E

INTRODUCTORY LETTER

TO THE

NURSES
Dear Nurse:

I am writing to invite you to participate in a survey, the purpose of which is to learn more about the ways physicians and nurses in long term care view each other. I am a graduate student in the program of Health Services Planning and Administration in the Department of Health Care and Epidemiology of the Faculty of Medicine at the University of British Columbia. The title of my graduate thesis is Interprofessional Misperceptions among Physicians and Nurses in Long Term Care Facilities, and the enclosed survey is a major part of my thesis.

There is a growing evidence in the literature that positive patient care outcomes and job satisfaction are enhanced by appropriate collaboration between health professionals. My ultimate goal is to have the results of my study used as a point of departure in educating physicians and nurses in long term care on how they tend to view each other and to explore the reasons for any misperceptions the one profession may have of the other. Such exploration hopefully will further guide the relationship between physicians and nurses toward a good collaborative work experience.

The enclosed questionnaire should take no more than 15 minutes of your time to answer. Please note that the completion of the questionnaire implies your consent. You may refuse to participate or withdraw from the study at any time. The questionnaire has been given a code number to assure that the information you give me will remain strictly confidential and you will not personally be identified in the research report. The questionnaires will be destroyed at the completion of my study. There is no monetary compensation. The results will be presented at a seminar in the Department of Health Care and Epidemiology, and may be used for other future presentations and publications.
I hope you will take a few moments now to complete the questionnaire and return it to an envelope located in your staff room. The envelope is labelled "Survey-Physicians and Nurses in Long Term Care". If you have any concerns about the survey, please feel free to contact me at work, 872-0044 or at home, 669-5042. You may also contact my Faculty Advisor, Dr. L. Green at 822-2258. Thank you in advance for your willingness to participate.

Yours sincerely,

Albertus Roskam
DEAR NURSES:

CURRENTLY A SURVEY IS CONDUCTED AND I AM INVITING YOU TO PARTICIPATE.

THE PURPOSE OF THE SURVEY IS TO LEARN MORE ABOUT THE WAYS PHYSICIANS AND NURSES IN LONG TERM CARE VIEW EACH OTHER.

EACH OF YOU WILL RECEIVE A QUESTIONNAIRE WHICH I HOPE YOU WILL BE WILLING TO COMPLETE.

THE INFORMATION YOU GIVE ME WILL REMAIN COMPLETELY CONFIDENTIAL.

THE QUESTIONNAIRE SHOULD TAKE NO MORE THAN 15 MINUTES OF YOUR TIME TO ANSWER.

PLEASE TAKE A FEW MOMENTS TO COMPLETE THE QUESTIONNAIRE AND RETURN IT TO THE ENVELOPE LOCATED IN YOUR STAFF ROOM. THE ENVELOPE IS LABELLED "SURVEY - PHYSICIANS AND NURSES IN LONG TERM CARE".

ANY CONCERNS ABOUT THE SURVEY CAN BE DIRECTED TO ME BY CONTACTING ME AT ANY OF MY TELEPHONE NUMBERS BELOW.

YOURS SINCERELY,

ALBERTUS ROSKAM, RN
TELEPHONE (HOSPITAL): 872-0044
TELEPHONE (HOME): 669-5042
APPENDIX G

FOLLOW-UP LETTER

TO THE

PHYSICIANS
Dear Physician:

About two weeks ago, I wrote to invite you to participate in a survey, the purpose of which was to learn more about the ways physicians and nurses in long term care view each other. I am a graduate student in the program of Health Services Planning and Administration in the Department of Health Care and Epidemiology of the Faculty of Medicine at the University of British Columbia. The title of my graduate thesis is Interprofessional Misperceptions among Physicians and Nurses in Long Term Care Facilities, and the enclosed survey is a major part of my thesis.

If you have not yet returned your questionnaire, would you please take a few moments now to complete it (I have enclosed another copy) and return it to me in the enclosed self-addressed stamped envelope. Your participation is needed in order to have as complete a picture as possible of the physicians’ views. It will allow me to contribute toward a better understanding among physicians and nurses in long term care of each other’s roles. Such heightened understanding can assist to promote collaboration between the two professions, and ultimately enhances positive patient care outcomes.

As stated in my earlier letter, the questionnaire should take no more than 15 minutes to complete. The completion of the questionnaire implies your consent. You may refuse to participate or withdraw from the study at any time. Please be assured that the information you give me will remain completely confidential and you will not personally be identified in the research report. The questionnaires will be destroyed at the completion of my study. There is no monetary compensation. The results will be presented at a seminar in the Department of Health Care and Epidemiology, and may be used for other presentations and publications in the future.
If you have already returned your questionnaire, or if you have decided not to participate, please disregard this reminder and accept my thanks. If you have any concerns about the survey, please feel free to contact me at work, 872-0044 or at home, 669-5042. You may also contact my Faculty Advisor, Dr. L. Green at 822-2258.

Yours sincerely,

__________________________

Albertus Roskam
APPENDIX H

FOLLOW-UP LETTER

TO THE

NURSES
Dear Nurse:

About two weeks ago, I wrote to invite you to participate in a survey, the purpose of which was to learn more about the ways physicians and nurses in long term care view each other. I am a graduate student in the program of Health Services Planning and Administration in the Department of Health Care and Epidemiology of the Faculty of Medicine at the University of British Columbia. The title of my graduate thesis is Interprofessional Misperceptions among Physicians and Nurses in Long Term Care Facilities, and the enclosed survey is a major part of my thesis.

If you have not yet returned your questionnaire, would you please take a few moments now to complete it (I have enclosed another copy) and return it to an envelope located in your staff room. The envelope is labelled "Survey-Physicians and Nurses in Long Term Care". Your participation is needed in order to have as complete a picture as possible of the nurses' views. It will allow me to contribute toward a better understanding among physicians and nurses in long term care of each other's roles. Such heightened understanding can assist to promote good collaboration between the two professions, and ultimately enhances positive patient care outcomes.

As stated in my earlier letter, the questionnaire should take no more than 15 minutes to complete. The completion of the questionnaire implies your consent. You may refuse to participate or withdraw from the study at any time. Please be assured that the information you give me will remain completely confidential and you will not personally be identified in the research report. The questionnaires will be destroyed at the completion of my study. There is no monetary compensation. The results will be presented at a seminar in the Department of Health Care and Epidemiology, and may be used for other presentations and publications in the future.
If you have already returned your questionnaire, or if you have decided not to participate, please disregard this reminder and accept my thanks. If you have any concerns about the survey, please feel free to contact me at work, 872-0044 or at home, 669-5042. You may also contact my Faculty Advisor, Dr. L. Green at 822-2258.

Yours sincerely,

Albertus Roskam