Understanding Collaboration Between Nurses and Physicians as Knowledge at Work

By Jane Stein-Parbury, RN, PhD, and Joan Liaschenko, RN, PhD

Background Collaboration between nurses and physicians is linked to positive outcomes for patients, especially in the intensive care unit. However, effective collaboration poses challenges because of traditional barriers such as sex and class differences, hierarchical organizational structures in healthcare, and physicians’ belief that they are the final arbiter of clinical decisions.

Objective To further analyze the results of an investigation on how intensive care unit culture, expressed through everyday practices, affected the care of patients who became confused.

Methods A model of the types of knowledge (case, patient, and person) used in clinical work was used to analyze the breakdown in collaboration detected in the original study.

Results Breakdown of collaboration occurred because of the types of knowledge used by physicians and nurses. Certain types of knowledge were privileged even when not applicable to the clinical problem, whereas other types were dismissed even when applicable.

Conclusion Viewing collaboration through the conceptual lens of knowledge use reveals new insights. Collaboration broke down in the specific context of caring for patients with confusion because the use of case knowledge, rather than patient knowledge, was prominent in the intensive care unit culture. (American Journal of Critical Care. 2007;16:470-478)
Collaboration between nurses and physicians is a complex interactional process between different professional groups. As long as a patient’s progress proceeds as expected, understandings are shared between the disciplines, and hard and fast boundaries between the groups are not often drawn, collaboration proceeds fluidly. Because the disciplines of medicine and nursing have different histories, political agendas, and forms of education that forge professional identities, values, and skills, these differences can be highlighted under conditions of stress. At these times, boundaries tend to be drawn regarding who owns what kinds of knowledge and who is responsible for specific kinds of work. Breakdown in collaboration reveals whose knowledge is privileged and the ways in which professional identities are brought to the fore and reinforced.

In this article, we extend the current understanding of nurse-physician collaboration by examining the breakdown of collaboration in relation to the specific clinical problem of patients with confusion in the intensive care unit (ICU). Our central thesis is that breakdown occurs when neither physicians nor nurses know what to do for a patient’s clinical problem. It is precisely at this time that collaboration is most needed. We present a model of knowledge and suggest that how nurses and physicians use this knowledge offers an analytic tool for enhancing the understanding of collaboration between these 2 groups.

Literature Review

The ICU is an appropriate setting for an analysis of collaboration between nurses and physicians because it is the context considered the prototype of interdependent “teamwork” in healthcare.1 The historical account of ICUs by Fairman and colleagues2,3 indicated that critical care units equalized the professional status of nurses and physicians by fostering a mutually beneficial trade-off. The medical staff benefited by allowing physicians to treat increasingly ill patients. The physicians’ success depended on having nurses as astute observers and monitors of ICU patients. ICU nurses benefited by gaining social status in relation to both physicians and other nurses.4

The complex needs of critically ill patients has increased the need for nurse-physician collaboration.1,4 Because ICU care is characterized by instability, uncertainty, and variability,6 physicians remain close at hand and that situation facilitates ongoing communication and collaboration.7,8 The fact that collaboration positively affects patients’ outcomes, particularly in the clinical context of intensive care, is well documented.1,9-13 Traditionally, collaboration between nurses and physicians has meant interpersonal interaction.6,14-16 Collaboration “implies collective action toward a common goal in the spirit of trust and harmony.”17(p116) In the context of healthcare, collaboration is understood as the way in which physicians and nurses interact with each other in relation to clinical decision making.18 Collaboration involves direct and open communication, respect for different perspectives, and mutual responsibility for problem solving.18,19

In a recent review of the literature, San Martin-Rodriguez et al8 concluded that the interactional determinants of collaboration, which include interpersonal trust, respect, and open communication, have received the most attention. These authors asserted that interactional factors alone are not sufficient for a thorough understanding of collaboration. They claimed that other determinants, such as organizational structures and philosophy, including leadership and administrative support, and systemic factors such as professional power, culture, and socialization, have received less attention but also are necessary for successful collaboration. In the ICU, organizational structure is recognized as a factor that influences collaboration.19 Other factors addressed in the nursing literature focus on gender and social class as the basis of medical dominance.20,21

Collaboration breaks down when neither doctors nor nurses know what to do for a clinical problem.

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Differences in disciplinary perspectives affect the understandings of clinical situations. Nurses more often use interactional and relational understandings of patients, whereas physicians primarily rely on measurable and “factual” understandings. Both ways of understanding are privileged and reproduced by hierarchical structures that grant social and cognitive authority to medicine. Studies have indicated that physicians both dismiss and devalue nurses’ knowledge. In addition, physicians perceive themselves as the primary decision makers in healthcare, and they feel free to change treatment plans without consultation. It is not surprising that compared with physicians, nurses perceive lower levels of collaboration and are less satisfied with the collaboration.

Although the basis for collaboration is the need to bring different perspectives to clinical decision making, the evidence suggests that when differences are reconciled, physicians are more likely than nurses to maintain authority and dominance. This evidence implies that not much has changed since Stein first mentioned the “doctor-nurse game.” Recently, Hawryluck et al and Lingard et al explored how the “rules of the game” are actually negotiated in day-to-day work. The results indicated that power was negotiated by trading commodities that included equipment, resources, respect, goodwill, and knowledge.

Although mentioned as a factor that affects negotiation, knowledge is not explained in any detail in the literature. In this article, we use a model of various types of clinical knowledge to examine the results of a previous ethnographic study in which a breakdown in collaboration occurred between physicians and nurses. The original study focused on nursing care of patients who became confused while in the ICU (the term confusion rather than delirium was used because confusion is the term used by nurses, and delirium is one of many possible reasons for patients’ confusion in the ICU).

We use the schema developed by Liaschenko and Fisher, which describes the types of knowledge nurses use in the conduct of their work, to explain why collaboration broke down when patients in the ICU became confused. Although the schema was not used at the outset of the ethnographic study, it has been applied post hoc as an explanatory framework.

The Schema: Case, Patient, and Person Knowledge

Liaschenko and Fisher theorized that the types of knowledge used in nursing work could be classified as case, patient, and person. This model resulted from the authors’ efforts to understand the interaction between knowledge and work and the importance of “knowing the patient.” Liaschenko and Fisher reported that the meaning of the phrase knowing the patient is understood in various ways, reflecting the kind of knowledge needed to do the work of nursing. The labels—case, patient, and person—represent different types of knowledge and do not refer to the actual recipient of care, usually called the patient. Although only nurses were studied, Liaschenko and Fisher maintain that both nurses and physicians use all 3 types of knowledge and that the knowledge used by either group at any given time varies according to circumstances.

Case Knowledge

Case knowledge is biomedical, the scientifically established knowledge of anatomy, physiology, pathophysiology, genetics, disease processes, therapeutics, and so forth. Scientific knowledge is generalizable to groups and is independent of any particular patient. Evidence for case knowledge is most commonly demonstrated by “objective” measures that are compared with normative values. Clinical thinking is organized largely through medical diagnoses, which are the primary means of structuring case knowledge. Case knowledge is largely the province of physicians because the diagnosis and treatment of disease fall within the jurisdiction of medicine. Diagnoses are used as explanatory frameworks to predict the likelihood of therapeutic interventions. Much of the work of nurses as the eyes and ears of physicians is to observe the responses to disease and treatment in terms of case knowledge.

Patient Knowledge

In contrast to case knowledge, patient knowledge involves understanding a particular human being’s experience of disease and response to treatment. Nursing work emphasizes patient knowledge, whereas medical work emphasizes case knowledge. Patient knowledge is unique to the recipient of care and is not accessible or meaningful outside an embodied experience. Access to patient knowledge requires sensitivity to the complexity and idiosyncrasies of the recipients of care in the recipients’ particular context. Patient knowledge requires and provides proximity to recipients of care over time, allowing nurses to make comparisons and thus interpret responses. Interpretations are based on comparing the recipient of care...
with case knowledge, with the recipient himself or herself over time, with other patients, and with occurrences rarely seen. With these comparisons, nurses can often make sense of atypical responses that would be considered outliers in relation to case knowledge.

**Person Knowledge**

Person knowledge is knowledge of an individual as a self with a personal biography. To know a recipient of care as a person is to know something about what it means for the person to have a specific history, live a particular life, and engage with the world in the way that he or she does. To know a patient as a person is to know what the recipient of care knows, what matters to the recipient and why, and that the recipient acts on individual desires and intentions for reasons that make sense to him or her. Person knowledge is not always possible, necessary, or desirable. It tends to be more relevant in situations in which an illness has markedly disrupted a patient’s life and in which questions or conflict exist about end-of-life decisions.

**The Original Investigation**

The original investigation was an ethnographic fieldwork study in a 12-bed, mixed medical-surgical, adult ICU located in a metropolitan tertiary teaching hospital in Australia. Human research ethics committees of both the hospital and the university approved the study. The purpose of the study was to reveal everyday practices, rituals, and norms of the unit (ie, an ethnographic insight into the culture) in order to investigate how the culture affected the nursing care of patients with confusion. Confusion was selected because it is a long-recognized clinical problem in the ICU.

Patients in the ICU often experience acute confusion, a cognitive disruption characterized by an inability to make sense of incoming perceptual stimuli, faulty information processing, altered level of consciousness, and distorted attention and concentration. These cognitive changes could indicate delirium but also may be related to other factors, such as awakening from a comatose state. Although the confusion is internal in the sense that it is experienced subjectively, it is manifested outwardly through behavior.

**Data Collection**

Data collection had 2 phases. The first phase consisted of participant observation of personnel in the ICU during a 6-month period and included interactions with all registered nurses, physicians, and other clinical staff who were present during the observation periods. These staff included all levels of personnel (eg, medical students were observed) with various levels of skill. Because the study was ethnographic, all those present in the ICU during the fieldwork were observed. Observations were made of activity during all shifts and included interactions between nurses and physicians as these healthcare providers discussed patients’ care. At the bedside, nurses were interviewed in order to understand their rationale for nursing care actions. Observations, interpretations, and discussions were recorded in field notes. Fieldwork was stopped after 320 hours because no new insights were available; that is, data saturation occurred.

The next phase of data collection involved interviews with 12 nurses selected for their ability to articulate and describe their nursing care. The interviews, which lasted from 30 minutes to 2 hours, were semistructured on the basis of interpretive themes derived from field notes. The interviews were recorded on audiotape and were transcribed before final analysis.

After analysis of field notes and interviews, a written ethnographic account of cultural norms and practices was constructed and was offered to physicians and nurses in the ICU for comment. The ethnographic account included an account of both a lack of and a breakdown in collaboration, especially in the case of patients with confusion. Those ICU personnel who commented were disturbed, angered, and shocked by this interpretation because they viewed collaboration as satisfactory. During discussion of their responses with the researcher (J. S.-P.), the ICU staff, particularly the nurses, did not question the validity of the interpretation but rather resented it being “out in the open.” Their feedback became an important data source because collaboration is often assumed to be inherent in ICU culture.

**Analysis**

All data were analyzed through interpretation and triangulation of data sets. Throughout the fieldwork, ongoing interpretations of the nursing care were shared with research participants (ICU personnel) and key informants (those who were interviewed at length) to refine further analysis. Interpretations that ICU personnel who participated in the study considered inaccurate were corrected and revised as the researcher sought to understand the practices involved understanding a particular patient’s experience of disease and response to treatment.
and norms of the ICU. Throughout the study, comparisons were made between nurses and doctors in the ICU and other key informants and between fieldwork and interview data. Such comparisons were especially important when discrepancies occurred in the data. Initial interpretations were accepted when they were validated by all data sources; that is, data were triangulated for convergence. In the final analysis, these interpretations were then compared with findings in the literature.

Results

ICU nurses suspected that a patient might be confused when they observed certain behaviors, most commonly motor restlessness to the point of “not being able to be still, pulling at lines, reaching and plucking at objects unseen to others, darting eye movements, and alert and wide-eyed facial expressions.” In short, patients who were thought to be possibly confused appeared agitated and anxious. An ICU patient may manifest agitation in response to several possible stimuli: severe physical pain, discomfort from equipment, position in bed, being too hot or too cold, intolerance of an endotracheal tube, anxiety and fear, or not wanting to be treated in an ICU setting.12,23

Nurses’ Assessment of Patients’ Confusion. Nurses took action when a patient was suspected of being confused because such a patient posed risks of injury, made his or her physiological status more unstable, and expended energy needed for recovery. An initial response was to take measures to protect the patient, such as applying physical restraints to prevent the patient from pulling at equipment, especially tubes and catheters. Simultaneously, the nurses searched for possible causes, which varied from the discomfort of lying in a wet bed to severe pain to obvious delirium.

The particular clinical circumstances of a patient were essential to nurses in sorting through possible reasons for the patient’s behavior. In their clinical assessments, nurses relied on their ongoing observations as patients interacted with them and the environment. For example, when a patient was recovering from being sedated, nurses oriented the patient to the surroundings and situation by providing a comforting presence and reassuring factual information; the nurses helped the patient regain entry to the external world in much the same way as recovery room nurses do when caring for patients coming out of an anesthetic state. Nurses reached through the patient’s clouded sensorium, expressed as a way “through the fog.”26 In this way, ICU nurses were able to establish contact with the patient through verbal attempts to interact and reassure; they used that contact to link the particulars of the patient’s responses to the immediate clinical circumstances.

Patients were not considered confused when the nurses could communicate with them and reassure them through information and orientation. The nurses in this study16 discussed and confirmed the importance of using interactive data: “their response to you,” “It depends whether you can talk to them and find out what is going on,” and “I know patients are not confused when I can make contact with them.” In this sense, ICU nurses relied on relational cues; that is, how a patient was interacting with them. They used interpersonal interaction and the development of the relationship to assess the meaning of the patient’s behavior.

When nurses were not successful in relating to a patient and did not have a definable explanation for agitation, such as decreased oxygen saturation, they suspected confusion. Typically, at this point, nurses sought assistance from their medical colleagues. When nurses thought that medication changes were indicated to manage a patient, they needed medical collaboration. In other words, the nurses wanted the help of their medical colleagues in both assessing and managing the patient, and so they summoned a physician to the bedside. Collaboration was essential.

Doctors’ Assessment of Patients’ Confusion. At the bedside, physicians reviewed treatment and medication orders and assessed the patient, typically by using standardized clinical tests such as the Glasgow Coma Scale and routine blood analysis. (We recognize that the Glasgow Coma Scale is not a valid clinical instrument for determining delirium; nevertheless, it was used by physicians in this study.) In addition, the study was conducted before the development of an assessment method to determine delirium in ICU patients.) Sometimes results revealed an underlying physiological cause, such as abnormal electrolyte or blood gas levels. In gathering assessment data, physicians often dismissed nurses’ reports as “vague and imprecise” and requested “facts, not opinions.”

When the results of the physicians’ assessments were inconclusive or ambiguous and they could not see any outward reason for a patient’s behavior, they tried to reassure the nurses that there was nothing obvious about which to worry. Physicians sometimes remarked that nurses requested medication orders because “they [the nurses] wanted to have a quiet shift.” They
instructed nurses to “handle the patient as best you can” or “just hold their hand and give them a kiss,” implying that the situation was a matter for the nursing staff to manage. Then the physicians left the bedside.

When physicians left the bedside, nurses often expressed dismay, frustration, and anger. Nurses thought physicians were unable to understand the patient’s behavior because the physicians were not at the bedside continuously and did not consider the patient “in context.” Comments by the nurses included statements and phrases such as the following:

- Doctors have other priorities
- Difficulty getting doctors to order adequate sedation
- I can’t get through to them
- They don’t understand
- They put you off
- They only stand by the bedside for 15 minutes
- They focus on what they know, hypothetical scenarios

Discussion

ICU nurses engaged in 2 types of work when they cared for a patient who the nurses suspected might have confusion: management work and diagnostic work. Management work involved attempting to control the situation and calm the patient, especially when patients were in danger of dislodging catheters. Diagnostic work involved attempts to find an explanation for the patient’s behavior. Both types of work required collaboration.

Collaboration broke down when physicians dismissed nurses’ clinical assessment and concerns about a patient because the nurses’ contributions did not fit into a schema of case knowledge. Nurses’ assessment and concerns were based on relational aspects of patient knowledge; that is, how the patient was or was not attending to nurses’ overtures to establish interpersonal connections. A patient’s inability to make such connections is directly relevant to the medical diagnosis of delirium because the cognitive function of attention is a key in the diagnosis. Attention involves connecting to the external environment and registering meaningful sensory input.

Case knowledge also is required for the diagnosis, because the causes of delirium are physiological. Collaboration worked best when case knowledge was the basis of information exchange between nurses and physicians. When nurses’ interactional cues and relational patient knowledge were confirmed by evidence of a physiological disruption such as hypoxemia (ie, based on case knowledge), collaboration went smoothly. In situations in which patient knowledge could not be verified by case knowledge, physicians dismissed patient knowledge and collaboration became more distant.

Although this analysis is consistent with the notions that physicians and nurses access different information for decision making and that physicians dismiss and devalue nurses’ knowledge, this interpretation illustrates why such dismissals occur. The interpretation provides a conceptual schema for understanding the significance of knowledge in collaboration. The breakdown of nurse-physician collaboration in the situation of ICU patients with confusion relates to how work and knowledge intersect.

Both nurses and physicians are concerned with patient knowledge, especially in relation to response to treatment. The work of physicians is to evaluate patients’ responses on the basis of expected statistical patterns of therapeutic efficacy; that is, through the use of case knowledge. For a physician, a patient’s response is understood and checked against scientific facts, including statistical analyses and physiological parameters. Although vitally important, what is known statistically may include only a range of responses that are standard or expected for most patients.

Nurses’ work is also concerned with this standardized range of responses, but a patient is continuously responding to much more than medical diagnoses and interventions alone. Patients are responding to the conditions of the environment, their own physical states, their own history, their own meaning, and their own psychological well-being and sense of self. Nurses’ work involves attending to all of these conditions. Making sense of patients’ responses is a significant part of nurses’ work. However, nurses’ work is often poorly understood and less relevant to physicians, whose primary work concerns the disease itself and its treatment.

Our findings indicate that management of ICU patients who were confused remained a problem to be solved by nurses, because confusion is behaviorally manifested and behavioral management is a responsibility of nurses, even though medical input is required. Managing a disease is fundamentally different from managing a patient. Patient knowledge is central to the management because, by definition, effective behavioral management is relative to understanding the circumstances of a particular patient. When case knowledge did not offer a diagnostic explanation, the physicians “did not know” and they did not collaborate further in the management of
the patient. At times, the physicians would devalue patient knowledge and nurses’ labor.

Limitations

The results of the original study\(^4\) and the nature of ethnographic inquiry are context specific; therefore, what was observed might have been idiosyncratic to the particular ICU selected as the study site and that particular time and place. Because collaboration has been documented as a common cultural practice in the ICU;\(^2\) the breakdown of collaboration in the care of patients with confusion became a matter of interest that transcended geographic locale and temporal space.

Qualitative inquiry can be judged on its ability to provide theoretical insights into a phenomenon. Using a model of the types of knowledge used in clinical care to analyze the data from the original study\(^4\) revealed an interesting theoretical understanding that may be applicable not only in other ICUs but also in other clinical settings; the final judgment of qualitative inquiry may be the transferability of the theory to other settings.

Conclusion

Collaboration requires recognition that knowledge and work are intimately related. A smooth, effortless flow of work gives the impression that knowledge bases are shared between nurses and physicians and that the work is mutually understood and supported. The clinical situation of ICU patients with confusion is a good illustration of how knowledge and work are not exchanged or mutually understood. The model of case, patient, and person knowledge illuminates how physicians and nurses operate by using different types of knowledge, partly because the 2 groups are engaged in different kinds of work. When knowledge bases are not understood, are dismissed, or cannot be communicated, professional boundaries are reinforced and management of a patient is relegated solely to nurses.

A problem that initially appeared as a problem in patients that called for interdisciplinary collaboration became solely the nurses’ problem. In the absence of a way to communicate knowledge other than case knowledge, the nurses and physicians’ mutually shared ground from which to work disintegrated. When the physicians exhausted their case knowledge about how to solve the problem, they felt they had nothing else to offer and left the management to the nurses. Sadly, the walking away was often accompanied by a devaluation of nurses’ work. Relational work is often confused with sentimentality and attributed to nurses’ meeting their own needs rather than the needs of a patient.

Collaboration between nurses and physicians involves the seamless flow of work when the collaboration is based on case knowledge or when patient knowledge is not contested. Case knowledge provides a false sense of certainty or, at least, minimal ambiguity. We have proposed a way of conceptualizing collaboration that includes the kinds of knowledge used in the care of patients and the factors that influence the kind of knowledge brought to bear. Circumstance shapes the use of knowledge and location binds knowledge in particular ways, thus delegating some knowledge to the foreground and some to the background, while other knowledge is rendered invisible.

In the circumstances of ICU patients with confusion, collaboration became problematic because case knowledge was not sufficient in doing the work of diagnosing the condition and managing the patients. When nurses explicitly sought help from their medical colleagues in these less-than-ideal circumstances, the nurses often felt abandoned, rejected, or ignored. Employing a model of the different types of knowledge used in different kinds of work provides a valuable schema for extending the view of nurse-physician collaboration. The lack of valuing patient knowledge, and an unwillingness to understand this type of knowledge, is historically rooted in hierarchies of knowledge, gendered work, and protocols of behavior between nurses and physicians that remain relevant today. Collaboration remains a problematic and serious issue because the stakes are high not only for patients’ outcomes but also for professional identity. Collaboration is a matter of knowledge and a matter of morality.\(^5\)

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None reported.

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1. Which of the following best describes the thesis of this article?
   a. Nurses have a greater capacity for collaboration in the intensive care unit (ICU) compared with physician providers.
   b. Breakdown in collaboration occurs when neither physicians nor nurses know what to do for a patient’s clinical problems.
   c. The physician’s success depends on having nurses as astute observers.
   d. Collaboration positively affects patients’ outcomes.

2. Using the context of healthcare, which of the following statements most clearly defines collaboration for the purpose of this article?
   a. Personal interaction between ICU staff and physicians
   b. Interpersonal trust, respect, and open communication
   c. Collective action toward a common goal in the spirit of trust and harmony
   d. The manner in which physicians and nurses interact with each other in relation to clinical decision making

3. Which of the following statements is not true regarding differences in disciplinary perspectives?
   a. Physicians rely primarily on objective and factual understanding.
   b. Evidence shows that physicians rarely change treatment plans without consulting the healthcare team.
   c. Nurses use relational and interactional understandings of patients in decision making.
   d. Evidence shows that physicians dismiss and devalue nurses’ knowledge.

4. Which of the following populations of ICU patients best describes those who were the focus of nursing and medical care in this study?
   a. Those who experienced delirium while in the ICU
   b. Those who were involved in major trauma while in the ICU
   c. Those who sustained a pneumothorax during central line insertion in the ICU
   d. Those who experienced confusion while in the ICU

5. Which of the following is not one of the types of clinical knowledge described in this article?
   a. Patient knowledge
   b. Objective knowledge
   c. Person knowledge
   d. Case knowledge

6. Which of the following statements is true regarding case knowledge?
   a. It is the understanding of a particular human being’s experience of disease.
   b. It is more relevant in situations in which illness has disrupted a patient’s life.
   c. It uses diagnoses as an explanatory framework to predict the likelihood of therapeutic interventions.

7. Which type of knowledge is most commonly used as a basis for nursing interventions?
   a. Patient knowledge
   b. Case knowledge
   c. Interpersonal knowledge
   d. Person knowledge

8. Which of the following best describes patient knowledge?
   a. Biomedical, scientifically based knowledge
   b. Understanding a particular human’s experience of disease and response to treatment
   c. A kind of knowledge that is useful in end-of-life decisions
   d. Knowledge of an individual as a unique self

9. Which of the following best describes the type of knowledge expected in the work of nurses in observing responses to disease and treatment?
   a. Person knowledge
   b. Interpersonal knowledge
   c. Case knowledge
   d. Patient knowledge

10. In what 2 types of work did nurses engage as they cared for a patient whom they suspected might be confused?
    a. Diagnostic work and management work
    b. Management work and interpersonal work
    c. Diagnostic work and case knowledge work
    d. Work to maintain patient safety and diagnostic work

11. Which of the following best describes one of the conclusions of this study?
    a. Sex and social class factors lead to the basis of medical dominance.
    b. Stress in the climate of caring for a patient in the critical care unit enhances collaboration.
    c. Physicians and nurses operate using different types of knowledge.
    d. Physicians believed that nurses administered inadequate amounts of sedation despite orders.

12. With which of the following is the relational work of nurses often confused by physicians?
    a. Collaboration
    b. Sentimentality
    c. Case knowledge
    d. Lack of empathy
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