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THE EXPERIENCE OF DECISION-MAKING
AMONG TELEPHONE ADVICE/TRIAGE NURSES

by

Ann Mayo, RN, MSN

A dissertation presented to the
FACULTY OF THE PHILIP Y. HAHN SCHOOL OF NURSING
UNIVERSITY OF SAN DIEGO

In partial fulfillment of the
requirements for the degree
DOCTOR OF NURSING SCIENCE

May 1998

Dissertation Committee

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ABSTRACT

The Experience of Decision-making Among Telephone Advice Triage/Nurses

The role of the telephone advice/triage nurse is both complex and demanding. All decisions are made while assessing patients without seeing or touching patients. In addition, the role is often developed to decrease health care costs which can be perceived by nurses as being in conflict with their nursing beliefs. The ambiguous nature of the role makes these nurses' daily experiences with decision-making a challenge.

Using a phenomenological method, the lived experience of decision-making among telephone advice/triage nurses was explored by conducting multiple interviews with ten nurses. The internal structure of the lived experience was identified through the philosophical perspective of Merleau-Ponty's phenomenology of perception and the process of Van Manen's researching lived experience. Eight essential themes emerged to explain the lived experience.

Connecting relationships between nurses and patients were critical to the process of decision-making as well as to what it meant for the nurses to be decision-makers. Nurses involved patients in decision-making, utilized decision-making support protocols, considered deviating from protocols, and sought validation for certain decisions. The nurses' perceptions of what it was like to assume responsibility for decision-making reflected feelings of self-accountability to job responsibility. All nurses realized that they needed to know clinical information about their patients, but some shared that they needed to maintain an awareness of their personal knowing to support their decision-making.

Different ways of coming to decisions included making justifiable decisions based upon what was best for the patient, validating the right call based upon nurse comfort, and striking a balance based upon maintaining system equilibrium between patient satisfaction and the health care organization's resources. All nurses spoke of themselves as decision-makers and sensed feelings of confidence, certainty, and uncertainty in being decision-makers. All study themes were conjoined, occurring simultaneously among the descriptions of the decision-making experience.

The study's findings support theoretical work in decision-making as well as cognitive development. Focusing upon the experience and meaning of decision-making, bringing to light the everyday experience of nurse decision-making has important implications for the science of nursing and clinical practice.

DEDICATION

To a far away, but very significant voice, Beth Hook: thank you for always being proud of what I have done over the years. And, for always telling me so!

To my children, Kevin and Kelly: thanks for being my cheerleaders, keeping me young, challenging my ideas, and helping me to understand that learning is a life long adventure!

To my husband, Ron: thanks for being my partner in life-long learning. And, most especially for believing in me! No, we didn't make that left-hand turn, but this has been fun too. And there's always tomorrow... .

ACKNOWLEDGMENTS

Many thanks to all those who have supported this journey of discovery!

To all the nurses who participated in this study: I thank you so very much for sharing your thoughts and feelings.

To Christa Hitt, who transcribed hours of audio tapes: your attention to detail, listening and replaying tapes to capture each and every uttered word, demonstrated the respect you have for the nurses who participated in this study.

To my committee members, Dr. Jane Georges and Dr. Mary Ann Thurkettle: thank you for your guidance and sharing your perspectives.

To my committee chairperson, Dr. Patricia Roth: you have always supported me in so many ways over the years. Your standards are high, you always challenge me, and yet you manage to remain flexible and open to all kinds of ideas. How do I capture that with mere words? Your ways of knowing have made an impact upon me and this study.

To my friends and colleagues, Carol Huff, Marlene Ruiz, Liza Webb, and Sylvia Everroad: you have patiently supported me during the course of this study. Thank you for caring.

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CHAPTER I

FOCUS OF THE INQUIRY

In health care today the nursing profession's unique relationship with patients requires that all nurses practice compassionate and caring behaviors, deal with large amounts of patient data, think critically and flexibly, and make independent decisions (Singleton, 1994; Valiga, 1983). Telephone advice/triage nurses are no exception. In fact, these nurses are expected to make decisions with each and every patient encounter. At the same time, their inability to see or touch their patients can create difficult, complicated, and ambiguous patient encounters. As supports, telephone advice/triage nurses utilize telecommunication and computer technologies to establish and maintain their relationships with patients. Their roles, while new and still emerging, are regarded as necessary for cost cutting efforts in health care today.

The decisions telephone advice/triage nurses make have the potential to save the costs of emergency room visits, physician visits, and hospital admissions. Cognitive development is important to nurse decision-making. As a gradual unfolding of the process of knowing, cognitive development includes both awareness and judgment (Webster, 1993). And as Valiga (1983) explains, components of cognitive development such as being able to structure and organize experience and knowledge, handle diverse pieces of information, and interpret data lead to the ability to make decisions. Successive qualitative

changes in or the unfolding of these components represents the dynamic aspect of cognitive development (Valiga, 1993; Webster, 1993). Because the process of decision-making utilizes components of cognitive development, it represents one window from which to understand cognitive development among nurses.

Decision-making has long been studied within an information processing context (Reed, 1992), but decision-making that is independent of efforts to manipulate the process has received little attention. Specifically, efforts to study decision-making have focused upon identifying predetermined choices for the purpose of understanding how people choose between options. While the current call is for creative and flexible thinking to drive new health care decisions, our knowledge regarding decision-making has been limited to research which has involved participants choosing between predetermined, constrained and restricted options.

The experience of decision-making and cognitive development among nurses need direct attention. An in-depth understanding of decision-making is a necessary beginning step to build additional nursing knowledge regarding not only various types of thinking and conditions of decision-making, but also cognitive development among nurses. Focusing upon the experience and meaning of decision-making, bringing to light the everyday experience of nurse decision-making is important to the science of nursing and clinical practice.

Purpose of the Study

The purpose of this study was to uncover the experience of telephone advice/triage nurse decision-making. Nurse perceptions regarding decision-making experiences assisted in revealing the meaning of being decision-makers.

Lines of Inquiry

The purpose of this qualitative study was to describe the experience of telephone advice/triage nurse decision-making. There were two lines of inquiry for this study. First, the study aimed to illuminate the meaning of telephone advice/triage nurse decision-making as perceived by the participants. And second, the study explored the everyday experience of telephone advice/triage nurse decision-making with a view to gaining an understanding of how that everyday experience revealed aspects of cognitive development among nurses.

In pursuing these aims, it was determined that the lines of inquiry for the study would be best served by phenomenological research. “Phenomenological research always asks about the nature or meaning of the human experience--- what is it like?” (Powers & Knapp, 1995, p. 123). So, “phenomenology asks, what is this or that kind of experience like?” (Van Manen, 1990, p. 9). “In concrete terms, the question will ask the “whatness” of being in the experience: “What is it like to . . . ?”” (Munhall, 1994, 50). Therefore, this study sought to answer the following question: What is it like for telephone triage/advice nurses to make decisions?

Philosophical Underpinnings

The philosophical foundation for this study was derived from Merleau-Ponty’s phenomenology of perception. Merleau-Ponty posited perceptions and the meaning of lived experiences as the basis for furthering knowledge development. Similar to Husserl, Merleau-Ponty preferred viewing the world as a lived experience. Like Heidegger though, Merleau-Ponty believed that phenomenology and modern science were in opposition in furthering knowledge development (Omery & Mack, 1995). Perception, Merleau-Ponty’s primary

phenomenological tenet, is defined as an indeterminate, existential act making human relationships with the world ambiguous (Carey, 1997; Omery & Mack, 1995). Merleau-Ponty rejected methods of analytical thought which propose that those things which are unclear are false. Therefore, unclear perceptions are not untrue perceptions (Carey, 1997); they reveal themselves as ambiguities. Envelopment of "...the close, the far-off, the horizon in their indescribable contrast form a system, and it is their relationship within the total field that is the perceptual truth" (Merleau-Ponty, 1967, p. 22).

Merleau-Ponty, like Heidegger, advocated a new approach to relating to Being. Cartesian dualism relative to body and mind was not acknowledged by either philosopher. In fact, both describe the body as intelligent. Merleau-Ponty offers the hand as a classic example: the hand not only pushes, pulls, grasps, and catches, it also welcomes, extends itself, and receives its own welcome (Carey, 1997).

Actually, Merleau-Ponty's approach to phenomenology builds upon Heidegger's work. While Heidegger connected body experience to understanding being in the world, Merleau-Ponty developed the idea much farther by defining and connecting the concept of pre-reflection to the body. "The body is the vehicle of being in the world. ... I am my body...." (Merleau-Ponty, 1967, p. 198). Merleau-Ponty utilized the example of non-calculated bodily movements (which prevent us from injury) to illustrate that "meaning" exists prior to conscious reflection. In this way, the mind is not separate from the body. The importance of perception for Merleau-Ponty is the reflective world. Being in the world is an impulse and perception, offers the clearest view of the

human relationship to being in the world (Carey, 1997). Merleau-Ponty (1967) calls this immediate impulse and perception, “sensibility”.

Because the purpose of this study was to uncover the experience of telephone advice/triage nurse decision-making as it is humanly lived, and nurses described their lived experience, it was important to acknowledge nurse perceptions. Merleau-Ponty acknowledges that the meaning of lived experiences is understood by being present in and attending to the context and dimensions of those lived experiences (Merleau-Ponty, 1967). The self uses perception to gain access to world experiences prior to any analysis (Boyd, 1993). Dillion (1991, p. xxvii) explains Merleau-Ponty’s position as follows,

In this understanding of presence, the relation of the present moment to past and future becomes comprehensible: it is the unfolding of phenomenon, the appearance of movement and change (with its privative moment of stasis), the style of worldly disclosure.

Nurses in this study verbalized their decision-making experiences with the investigator at one moment in time (“moment of stasis”). It was through the researcher’s attending to and understanding the “presence” of each nurse in the experience that the “appearance of movement and change”, relative to perceptual decision-making experiences, was revealed and nurse cognitive development was understood (the style of worldly disclosure).

Merleau-Ponty’s central theme of envelopment helped to explain why the attendance to perceptions with all their background was so critical to understanding phenomena. Three modalities assist the phenomenologist toward the goal of understanding: simultaneous presence (co-existence), mutual implication (a folding into), and contraction (an economy of depth). Envelopment

acts to conjoin the modalities (Dillion, 1991). Envelopment is important within the profession of nursing. The act of nursing, whether one is describing caring, critical thinking, or decision-making, does not take place in an a-contextual world.

Nursing acts co-exist and fold into each other, creating an economy of depth. In other words, acts are interrelated but finite in order to accomplish a pre-established goal.

Merleau-Ponty's philosophy of phenomenology supported this study in two ways. First, it allowed the investigator to examine the lived experience of decision-making as an envelopment process, acknowledging a variety of coexisting acts which nurses perceived and discussed as they dialoged about the meaning of their decision-making. Second, it allowed the investigator to consider cognitive development as an unfolding process which represented itself during the appearance of movement and change within the meanings of decision-making.

Methodology

Phenomenology, a qualitative research method, was appropriate for this study because it guided the study of lived experience. An in-depth study of the decision-making experience allowed this investigator the opportunity to study the meaning of that experience from each individual participant's perspective.

Grasping an essence of a lived experience is the desired outcome of phenomenological research. The method begins by inviting the participants to discuss personal instances regarding the study phenomenon and to share the meaning of their lived experiences as those meanings relate to the phenomenon. Through the sharing of meanings, internal structure(s) of instances related to the phenomenon can be investigated. An investigator then studies those internal

structure(s) in search of grasping the essence of the lived experience. Essence description is accomplished through a synthesized process of analysis and writing, utilizing the internal structure(s) to frame meanings. Finally, readers come to connect with and know the phenomenon in a personal way (grasp the essence) as an investigator uses representative shared meanings to illustrate internal structures of decision-making (Boyd, 1993; Van Manen, 1990).

While some formal knowledge exists regarding the process of decision-making among nurses, there is no information available which elucidates the meaning of the decision-making experience among nurses. Most nursing studies have focused upon individual aspects of decision-making such as cue recognition or critical thinking. This narrowed focus may exist because caring practices of nurses, which includes decision-making, are generally difficult for nurses to articulate due to the complexity, context, and meaning of those practices (Benner, 1984). However, by examining decision-making through phenomenology, the complexity of the phenomenon, within the ongoing context of the everyday experience, can be elucidated.

In addition to examining the full experience of decision-making, utilizing the method of phenomenology can allow an investigator the opportunity to examine decision-making's relationship to cognitive development. Dialog about lived experiences reveals meanings. As verbalized, everyday experiences have the potential to reveal emotions, feelings, modes, and sensations (Van Manen, 1990). "Meaning is multi-dimensional and multi-layered. Reflecting on lived experience then becomes reflectively analyzing the structural or thematic aspects of that experience" (Van Manen, 1990, p. 78). Specific to the relationship between decision-making and development, Gilligan (1993) explains that the

contextual relativism of decisions “elucidate the pattern observed in the description of the development ...” (p. 22). Therefore, the meaning of decision-making, as told by participants, can be a window into their pattern of development.

Specific to this study, grasping the essence of nurse decision-making was accomplished through a systematic and explicit process. Phenomenology, as a method by which to examine the experience of decision-making, demonstrated the potential to reveal meanings. Those meanings because of their multidimensionality, upon reflection, revealed developmental understandings within the experiences of telephone advice/triage nurse decision-making. Decision-making is known to be a contextual and multidimensional process and therefore has the potential to advance our understanding of cognitive development. As telephone advice/triage nurses shared the meaning of their decision-making experiences, internal structures of those instances revealed patterns of development.

Reduction

Reduction is the phenomenological device which allows a researcher to discover the spontaneity of lived experiences (Van Manen, 1990). During this study, reduction allowed this researcher to overcome subjective feelings which would have prevented the understanding of decision-making as it was lived by the participants. Reduction allowed this researcher to eventually see decision-making in a non-abstracting way.

Van Manen (1990) describes two levels of reduction which had applicability to this study. The key is to balance the levels. With the first level of reduction, a researcher needs to overcome “private feelings, preferences,

inclinations, and expectations” as well as “theories and scientific conceptions” in order to understand the phenomenon as it is lived by the participant. This experiential level is accomplished as a researcher brackets (identifies) various beliefs and preconceptions while studying the phenomena (Boyd, 1993; Lauterbach, 1993).

The investigator is not a telephone advice/triage nurse. However, as an experienced acute care nurse, educator, and nursing administrative consultant, the investigator had certain beliefs and preconceptions (feelings, theories, and inclinations) which were brought to this study. In those roles, the investigator had observed practicing nurses, nursing students, and nurse administrators making decisions. Therefore, the following biases were disclosed (bracketed) to increase investigator sensitivity to beliefs and preconceptions.

While considering the first level of reduction, six investigator beliefs and preconceptions were identified. First, perceived decision-making experiences vary among nurses. Those perceived experiences are influenced by a variety of professional and personal experiences. Second, regardless of perceived decision-making ability, external forces such as supervisor management style or standardized protocols can impact the process by which nurses make decisions. Third, regardless of external forces, nurses share common, universal meanings regarding decision-making. Forth, nurses integrate many human experiences into the meaning of their decision-making. For example, nurse experience with loss may effect the meaning of some of their decisions and will influence nurse decision-making. Fifth, cognitive development is more than a staged thinking process. It is personal “knowing”. It is a dynamic unfolding process which involves becoming aware of multiple dimensions of human experience and

integrating that awareness into day-to-day living such as decision-making. Finally, cognitive development is multidimensional and varies among nurses. Their developmental unfolding is influenced by their lived human experiences, their awareness of those experiences, and their experiences with integrating those experiences into their decision-making processes.

In the second level of reduction, relative to the individual participant interviews, a researcher “needs to see past or through the particularity of lived experience toward universal essence” and move beyond “the concreteness of lived meaning” (Van Manen, 1990, p. 185). This level of reduction can be seen as abstracting the essence from the lived experiences. Conducting a number interviews with telephone advice/triage nurses and analyzing multiple decision-making instances ensured that a more universal essence would emerge from the data. In summary, both levels of reduction ensured that the essence(s) of the phenomena were derived from accounts of experience (not the researcher’s), but, at the same time, were not so tightly linked to individual specific participant accounts so as to generate rigid, specific, or narrow interpretations.

Significance of the Study

Current strong interest exists among health care organizations and schools of nursing regarding all aspects of the expanded role of telephone advice/triage nursing, especially decision-making. Decision-making is an important aspect of any nursing practice today, but it is integral to the efficiency and survival of expanded roles such as telephone advice/triage nursing (Edwards, 1994). At the same time, decision-making can pose risks to organizations and contribute to a nurse’s professional vulnerability if decisions result in negative patient outcomes (Edwards, 1994).

Little is known about decision-making experiences among telephone advice/triage nurses. Decision-making themes related relationships between the telephone advice/triage nurse, the patient, and the organization are lacking. For example, there is very little in nursing literature regarding telephone advice/triage nurses' experiences with assessing patients over the phone or using organizational decision-making algorithm protocols (Edwards, 1994; Mayo, 1997). In addition, personal and professional meaning relative to the individual nurse's decision-making experiences is unknown.

In order to promote positive patient outcomes, nurse administrators and nurse educators are encouraged to consider the meaning of nurse decision-making as nurses have lived decision-making. In this way, "the category of lived experience [can be understood] in all its modalities and aspects" (Van Manen, 1990, p. 32). The meaning of decision-making can shed light upon awareness, organization of experience and knowledge, diversity in thinking, and interpretation of data. Because these are all components of cognitive development and lead to the ability to make decisions (Valiga, 1983; Webster, 1993) these nurses are encouraged to consider cognitive development among nurses as well as the meaning of nurse decision-making.

As we approach the next millennium, nurses will require a greater understanding of how the multiple dimensions, contexts, and ambiguities of health care impact the making of important patient care decisions. Understanding real life nurse decision-making will assist in the design of appropriate educational and support mechanisms for nurses to manage their nursing practice. For example, do expensive computerized advice protocols have meaning for nurses as they

make decisions? Or, would discussing decisions with a fellow nurse be more meaningful?

Likewise, the greater our understanding of cognitive development among nurses, the more successful nurse educators may be in promoting critical thinking, managing change, and caring behaviors among nurses. For example, when are nurses cognitively situated to be taught critical thinking skills? When in their development are they able to incorporate this type of thinking into their practice? Without this information, the nursing education is at risk for teaching knowledge and skills for which the nurse may be incapable of learning or integrating into practice. Similar in nature to attempting to teach seven year olds abstract math concepts when their development is concrete in nature, teaching nurses critical thinking when their developmental perspective is all subjectively situated may be inappropriate.

While understanding cognitive development among nurses may hold the key to developing critical thinking, managing change, and caring among nurses, to date a basic lack of understanding regarding both decision-making and cognitive development among nurses exists. This lack of knowledge has limited and diminished our ability to develop or support both decision-making and cognitive development among nurses.

Finally, taking a broader view, up-to-date contributions to both adult cognitive developmental research as well as developmental theory are needed. Few studies exist which examine adult cognitive development today. Of those available, research methods have not been clearly defined by the researchers. Additional qualitative studies with well explicated qualitative methods are needed to assess adult cognitive development.

CHAPTER II

CONTEXT OF THE INQUIRY

This chapter will review literature relevant to an investigation of understanding cognitive development among nurses through the lived experience decision-making. First, the review of literature will begin with an overview of relevant cognitive developmental schemas including discussions about cognitive development among nurses. Second, the role of decision-making in cognitive development research will be discussed. Third, decision-making theories will be presented followed by a review of pertinent aspects and empirical evidence regarding nurse decision-making. Finally, the specific role of the telephone advice/triage nurse will be discussed and research regarding telephone advice/triage nurse decision-making will be presented.

Cognitive Development

Cognitive development can be defined as personal development, reflective of various types of thinking. Historically, cognition, or “thinking”, has been explicated through problem solving and decision-making and presented in the form of frameworks, linear models, or schema. In addition, cognitive development has also addressed perception and responses to experience, integrating both social and intellectual development resulting in multidimensional models (Mayer, 1981).

Cognitive developmental frameworks can differ from one another based upon populations observed (i.e., children versus adult) (Piaget, Brown, Kaegi, 1981; Erikson, 1987; Turner & Helms, 1995). For example, Piaget focused upon child cognitive development (Piaget, Brown, Kaegi, 1981) and Perry (1970) upon college student development. Developmental frameworks can also differ from one another based upon types of problem solving and decision-making (i.e., concrete/abstract problem solving versus moral dilemma problem solving) (Piaget, Brown, Kaegi, 1981; Kohlberg, 1981; Turner & Helms, 1995). For example, Piaget gave children in the concrete operations stage concrete objects and observed the children group objects in an attempt to better understand the objects (Turner & Helms, 1995). Kohlberg followed Piaget's cognitive developmental approach but set up social conflict as the problem of concern (Winland-Brown, 1983).

A number of developmental psychologists, such as Piaget and Erikson, identify sequential, discrete stages as the framework for their theories. The individual stages of development within a framework differ from one another in that they are hierarchical and become more complex at higher levels (Mayer, 1981; Turner & Helms, 1995). For example, Kohlberg and Piaget's cognitive developmental frameworks identify a hierarchy of increasingly complex problem-solving abilities as criteria for stage advancement (Winland-Brown, 1983).

Two developmental studies which have relevance to this investigation will be examined. According to Turner and Helms' (1995) definition of human development models, both studies qualify as human developmental models because they identify patterns of human development which become more complex at each position or perspective. Both studies resulted in frameworks or schema of development. As part of each study's descriptive qualitative design,

both studies examined decision-making among participants as an approach to generate data for analysis. Finally, each study examined the meaning of experience as an interpretive device to specifically analyze data. First, Perry's (1970) study of college men will be presented. Then, Belenky, Clinchy, Goldberger, and Tarule's (1997) study of women will be examined.

Perry's Scheme for Adult Cognitive Development

As part of a longitudinal study, Perry (1970) conducted voluntary interviews with college men during their four years at a liberal arts college. A total of 464 interviews were conducted with 84 of the participants completing four consecutive annual interviews. Prior to conducting the study, Perry and colleagues had initially been intrigued with the variety of ways students integrated themselves into their learning experiences. Pre-study observations of students' choices included fragmentation, integration, alienation, or involvement with their education process. The planned outcome for the study was to generate "portraits of students" regarding the experience of making choices (decisions) about their education.

However, as students discussed their experiences and Perry (1970) "spelled out the development in first-person phenomenological terms" (p. 8), he and the research team noted that they "could detect behind the individuality of the reports a common sequence of challenges to which each student addressed himself in his own particular way" (p.8). The result of Perry's analysis was a scheme of development which has "an imaginary modal student moving along the center line of a generalized sequence of challenges and resolutions which [the research team] thought [they] saw behind all the variegated reports of individual volunteers" (p. 8).

While Perry (1970) never explicitly states that the study's qualitative design utilizes a phenomenological method to collect and analyze data, the study's descriptive procedures and data analysis (i. e., general philosophical forms or outlines were initially "derived from concrete details of the student's talk" during "free interviews with students" (p. 10)) coupled with the researcher's initial intent to generate "portraits" rather than a generalizable model, lead one to believe that at the very least a phenomenological approach was taken with this study. Others agree that Perry was committed to a "phenomenological approach" (Belenky, et al, 1997, p. 10).

Turning to the scheme itself, like Piaget's developmental theory (Piaget, Brown & Kaegi, 1981), Perry's (1970) scheme represents movement from an egocentric level to a more objective level. Unique to this scheme however, Perry addresses the drive to move from one stage to the next. In contrast to Piaget (movement driven by biological age and some external forces [i.e., attending school at age six]), Perry speaks explicitly about the movement from one position to another as being driven by internal motivation, rather than external or environmental stimulants.

Perry's (1970) model has nine positions which move through a hierarchical growth process represented by four major phases. These four major phases include: (1) simple dualism (right versus wrong), (2) complex dualism (self belief in right versus wrong remains, but now acknowledges that others see relativism), (3) relativism (self confusion with existent relativism), and finally, (4) commitment to relativism (accepts value of self experience, senses identity, balances dichotomous feelings such as freedom versus constraint). According to Perry, students move from position to position when they are presented with dilemmas which do not

match their current cognitive problem solving skills. The goal of development within Perry's scheme is to attain the ability to make and stay with a commitment within the continuity of one's own identity. The strength of Perry's scheme is that it gives credence to some perceived contextual elements (i. e., power) as external driving influences of cognitive development. However, Perry's scheme does follow in the footsteps of other traditional theories; that being a positivistic approach which assigns individuation and objectivity as the goal of advanced cognitive development.

The purpose of Perry's (1970) scheme was to provide educators a framework to understand development in the post adolescent years. Two studies which staged nurses according to Perry's developmental model found nurses limited to positions two through four (out of nine possible positions). While practicing nurses understood that multiple truths or relativism existed, they had not internalized relativism and so followed the dictates of authority regarding understanding, choices, and clinical decision-making (Carper, 1975; Murphy, 1976). In addition, Zorn, Ponick, and Peck (1995) used the Perry-based Measurement of Epistemological Reflection (MER) instrument to measure student nurse development regarding participation in an abroad exchange program. None of the 28 students (experimental/control or pre/post) scored past position five. Both studies had limitations which are based upon the reliability of utilizing Perry's scheme with nurses. It could be argued that Perry's scheme holds little relevance for examining cognitive development among nurses. While Perry's study utilized a large sample, the participants were primarily men and all were college students.

Many contemporary theorists, researchers and educators have criticized traditional theories for their reliance upon individuation as the goal for development, as noted in Perry's scheme above (Belenky, et al, 1997; Chickering, 1969; Gilligan, 1993; Rybash, Hoyer & Roodin, 1986). When criticized, many theories are also exposed for their a-contextual nature, rigid stages, (Turner & Helms, 1995), over emphasis of problem solving versus problem finding, and exclusion of the emotional aspects of cognition (Moran, 1990). Contemporary theories, however, follow a constructivist approach, emphasizing relationship building, contextual understanding and assimilation (situatedness), and constructive reality as their goals.

Belenky, et al's Perspectives of Women's Ways of Knowing

Belenky, et al's (1997) study is an example of a qualitative descriptive investigation which advances cognitive developmental understandings along the lines of a contemporary model. The research team acknowledges that Perry's scheme informed their study in that it stimulated their interests in "modes of knowing" and provided them with their "first images of the paths women might take" (p.10).

In addition to Perry's scheme, Gilligan's developmental work with women also contributed to the Women's Ways of Knowing study. Specifically, Gilligan's moral development work with women examined identity and moral development in the context of responsibility and caring. For example, women described their identity and moral decision-making in connection with their roles (future mother, present wife, past lover, etc.) (Gilligan, 1993). It was in the context of these relationships with others that women performed their problem solving. Gilligan determined that women "frame" moral judgments in terms of connected

responsibilities and therefore “stages” vary according to those connected relationships. Gilligan provided the lens of responsibility and caring which moved Belenky, et al’s (1997) understanding of human development beyond Perry’s individualistic perspective.

Similarly, Belenky, et al’s (1997) study informs this investigator’s study because it demonstrates a more contemporary approach to studying cognitive development and provides information about women’s development, which Perry does not. Specifically, Belenky, et al’s study utilizes subjective, constructed knowledge as the basis for addressing: (1) differentiation and integration of cognitive development, (2) movement within the scheme (which is context-awareness dependent), and (3) gender differences in cognitive development.

Belenky, et al’s (1997) perspectives of development address the female experience of cognitive development. Six stages of development (termed perspectives by the researchers), not mutually exclusive, emerged from the qualitative study involving 135 women. Unlike Perry, Belenky, et al distinctly state that their study methods were committed to a phenomenological approach. Interviews were lengthy (two to five hours) and the purpose was to explore the experience of women related to problems as both learners and knowers. A variety of broad questions were asked of the women, including questions about “real-life decision-making and moral dilemmas” (p. 11).

Overall, the study brought together women from diverse backgrounds. Belenky, et al (1997) believed that “perspectives”, rather than stages, emerged from the data because of the non-homogeneous backgrounds of participants and the varying contextual life circumstances they brought to the study. As a result, the team believes that further work is needed to bring these “perspectives” to

the point where discrete qualities would qualify them as stages. At this point however, the researchers believe that the perspectives qualify as “epistemological categories” (p. 15).

The first perspective, Silence, is seen as a restrictive perspective since these women are generally dependent on others for knowledge and decision-making. The second perspective, Received Knowing, has women learning through listening. It is distinguished from the first perspective in that these women have confidence in their learning abilities. The third perspective, Subjective Knowing, is where women communicate with their inner self, trust their own knowledge, and become more independent. Separate and Connected Procedural Knowing, the fourth and fifth perspectives, are when women integrate systematic approaches to analysis and knowledge acquisition. Separate Procedural Knowing occurs when the woman objectifies herself to gain and share knowledge; a very positivistic approach to knowing. Connected Procedural Knowers continue to objectify themselves, but are willing to integrate others’ viewpoints. Constructed Knowing, the final stage, is seen as a dynamic stage where women incorporate the previous levels of knowing simultaneously and appropriately to identify problems and to problem solve. Issues of concern to women at all stages are relationships with others and the context in which their problem solving takes place.

While both Belenky et al’s and Perry’s works are widely read by educators, few follow-up studies have been conducted. As a result, the education discipline is limited with regards to development theoretical perspectives. Specific to nurse educators, already limited in access to adult cognitive developmental knowledge in general, even fewer studies are available which have examined

cognitive development among nurses. One of the few studies which offered a more contemporary view of cognitive development was conducted by Westmoreland, Grisby, Brosnoki, and Solberg (1995). This study of hospital staff nurses found that nurse knowing matched five of Belenky, et al.'s (1987) perspectives (received knowing through constructed knowing). However, these researchers described "many" nurses as subject knowers because nurses verbalized egocentric behaviors in caring for patients. As a beginning step for adding to the work of other developmentalists, this study has significance for nursing because the researchers interviewed nurse precipitants about their ways of knowing, relationships, clinical judgment, and decision-making; all concepts related to contemporary developmental theory and all issues of concern to nursing today.

Decision-making: A Window into Cognitive Development

The development of the capacity for decision-making has its foundation in cognitive development (Belenky, et al, 1997; Hickman, 1993; Perry, 1970). Numerous schema have been generated to explain intellectual and cognitive development as well as decision-making behavior. In fact, researchers interested in cognitive and intellectual development have utilized the decision-making process as the vehicle with which to generate their developmental schema (Belenky, et al, 1997; Gilligan, 1993; Perry, 1970). The reason for this is that the proficiency level of decision-making seems to mirror changes in cognitive development (Hickman, 1993). For example, Perry's (1970), Belenky, et al's (1997), and Gilligan's (1993) initial perspectives reflect deference to authority and silence, a novice form of decision-making. At this level or perspective, the

decision-making behavior of the person is limited, inflexible, and rule-governed (Belenky, 1997; Gilligan, 1993; Hickman, 1993; Perry, 1970).

As developmentalists, Belenky, et al, Gilligan, and even Perry understood that situations, contexts and dimensions were important considerations in studying cognitive development. All three took phenomenological and constructivist approaches to studying development. It was through interviews, following the language and the logic of participants' thoughts, and posing follow-up questions regarding the context and meaning of decision-making responses that developmental schema and perspectives were revealed. In essence, discovering the meaning of decision-making via a phenomenological and constructivist approach provided those investigators a window for exploring cognitive development.

Decision-making

A number of decision-making theories and models have been developed to describe the complex process of decision-making. An overview of relevant theories and models will be presented as a foundation for exploring nurse decision-making.

Decision-making Theories and Models

Compensatory models of decision-making emphasize attribute selection as the basis of decision-making. These models consider how people choose between attractive and unattractive attributes as they weight options during decision-making. For example, many times decisions are made by considering the pros and cons which have minimum cut off points for decisions. With these types of models, all possible attributes are scored and added for each and every option under consideration. While compensatory models represent systematic ways for

decision-making, the models are not practical because they are time consuming (Reed, 1992).

Noncompensatory models demonstrate a more practical and less calculating approach to decision-making. With these elimination-type models, decisions are made by eliminating less attractive options quickly (Tversky, 1972). When one attribute of an option does not meet a minimum cut-off standard, that entire option is quickly eliminated. Overall, this elimination model (unlike the compensatory models) is considered a simpler model because it requires that no calculations or attention be given to accumulating attributes or options (Reed, 1992).

Decision-making can also include the process of hypothesizing the probability of certain outcomes occurring (Kahneman & Tversky, 1973). The evaluation of probabilities in decision-making is effected by the availability of the related cases a person can recall from memory. In addition, the degree of representativeness of recalled cases to the actual situation will drive one to make similar decision-making choices (Reed, 1992).

Utility theory brings attention to the decision maker's subjective values. The utility of an outcome (or perceived value of consequences) (i.e., would choice A save money over choice B?) assists the decision maker in making choices. Essentially, this theory has the ability to explain why choices are made when outcome "probabilities" are unknown (Gilboa & Schmeidler, 1995; Reed, 1992). This theory requires that one know all possible decision-making outcomes, but not the probabilities of each occurring. For example, this theory explains why one would purchase flood insurance if their home was in a flood plain. There are two possible outcomes: 1) losing the home and paying for rebuilding or 2) not

losing the home and not having to incur rebuild costs. The decision maker is aware of the possible outcomes, but unaware of the probabilities of either occurring. In this case, the decision maker might subjectively fear paying for rebuilding costs and select to pay for insurance. Even though the decision maker will be paying for insurance, the utility of this decision is that it may save the decision maker thousands of dollars. The strength of this theory lies in its subjective perspective.

Some decision-making research has revealed combinations of models are used to arrive at a final decision. For example, Payne's (1976) research revealed how various dimensions enter into choosing at the end of the decision-making process. In Payne's classic 1976 study, students utilized the easier non-compensatory models to quickly eliminate most options. Then the students switched to compensatory models. According to Payne (1976), the point at which people switch between strategies (i.e., they no longer eliminate an option because it did not meet the minimum cut-off point), happens when incorporate multiple dimensional thinking into their decision-making. This research is significant in that it offers an explanation as to how contextual, situational, or organizational dimensions enter into decision-making.

A Heuristics Scheme

Up to this point, decision-making has appeared fairly linear and process oriented. However, none of the models presented thus far have addressed the "relative importance" of certain decisions made by people everyday. Mitchell and Beach's (1990) heuristic scheme will be presented as representative of more contemporary and comprehensive approaches to understanding decision-making.

Mitchell and Beach's (1990) intuitive and automatic scheme expands Payne's work by explicating how dimensions such as beliefs, values, plans, goals and evaluations influence decision-making. Simply stated, Beach and Mitchell propose that these dimensions are represented as sets of images, namely, value images, trajectory images, and strategic images. Together, these sets of images represent the scheme which "guides" decision-making. Value images are the decision maker's principles (i.e., beliefs, values, ethics). Trajectory images (goals) consist of the decision maker's future aspirations. And finally, strategic images are the decision maker's plans (tactics and forecasts) which are used to attain goals. In action, the scheme influences two types of decisions (adopt the decision or evaluate the progress of the decision).

Mitchell and Beach (1990) share that their work is influenced by others' work (i.e., Heidegger, Gadamer, and Habermas) in the areas of social construction, temporality, and hermeneutics. According to these two researchers, decision-making is experienced in the now and in the possible future. When decision-making becomes difficult, the decision maker becomes more attentive to the environment and possible constraints. Attentiveness results in the production of "holistic" images (beliefs, values, plans, goals and evaluations). These "holistic" images are located within the value, trajectory, and strategic images of Mitchell and Beach's scheme. Mitchell and Beach's (1990) scheme clearly represents an improvement over utility theory and the other linear-type models.

In summary, a number of decision-making theories have been presented, concluding with a heuristic scheme which offers a more contemporary approach to understanding decision-making. For purposes here, two categories of decision-making have been presented. First, simple models, such as compensatory and non-

compensatory models which utilize attribute selection were presented. Within these simple models, decisions are made regarding attributes based upon pro and con, minimum cut-off point, or probability processes. Second, the relative importance of decisions approach to decision-making, which was not addressed by the simpler models, was presented utilizing Mitchell and Beach's (1990) comprehensive heuristic scheme. Mitchell and Beach (1990) developed a four dimensional model to explain how beliefs, values, plans, goals and evaluations effect decision-making. While this models appears more complex due to its multidimensionality, it does offers a comprehensive approach to studying decision-making.

Nurse Decision-making

The study of nurse decision-making was well underway by the late 1970's. Borrowing various decision-making theories such as utility theory, probability theory and systems theory, nurse researchers began applying these models to nurse decision-making (Ruybal, 1978).

By the mid 1980's, student nurses as well as practicing nurses were studied with regard to their decision-making patterns. Cue recognition was a prime focus for trying to understand nurse decision-making (del Bueno, 1983; Thiele, Baldwin, Hyde, Sloan, & Strandquist, 1986). In addition, during the 1980's Benner (1984) offered nursing a skill acquisition model to examine nurse decision-making. Benner's continuum-based concept of novice-to-expert with regards to skill acquisition has been applied to decision-making numerous times (Benner, 1984; Carnevali, Mitchell, Woods & Tanner, 1984; Henry, LeBreck, Holzemer, 1989; Pardue, 1987).

Cue recognition. Thiele, et al (1986) were concerned with teaching students to make decisions by improving cue recognition. These researchers believed that to assess patients, nurses must detect, group, and assign meanings to cues which are obtained from patients. The researchers tested the students' abilities to recognize relevant cues from irrelevant cues, link cues to develop clinical inferences (utility theory), and finally to make decisions regarding appropriate nursing care. The research team was able to demonstrate improved cue sorting and decision-making after students used Computer-assisted Simulation (CAS) to practice cue sorting. Since researchers did not evaluate other teaching or coaching methods, it is unclear if cue sorting practiced in another setting (i. e., classroom, bedside) would have achieved similar or different results.

Also focused upon cue recognition, del Bueno (1983) utilized video vignettes to present overt and covert physiological patient problems. del Bueno discovered an important implication for nursing in the 1984 study: overall, most nurses were able to identify the patient clinical conditions (symptom cue recognition), but were unable to identify correct interventions for those clinical conditions. Among the possible explanations for the findings were that nurses were unable to synthesize cues into a clinical judgment and that they failed to recognize the context in which the cues were given.

Novice-to-expert and decision-making. Benner's (1984) qualitative novice to expert study described five levels of clinical competence with much of the leveling emerging from clinical decision-making verbalized by nurses. The levels, novice, advanced beginner, competent, proficient, and expert, reflect various levels of skill acquisition and practice in acute care settings. Because the study was based upon the Dreyfus Model of Skill Acquisition, it was limited in its ability

to move beyond the classification of skills to examine the meanings of nursing practice. For example, the following dialog was labeled by Benner as “expert” nursing practice:

...We took off a blood [sample] from the arterial line and sent it down for a type and cross match. Meanwhile, I started Plasmanate and lactated Ringers,... (Benner, 1984, p. 18).

To contrast the above, Benner labeled the following as only “advanced beginner” practice:

This man is a very pleasant fellow, very bright, very alert and awake, and was unfortunately requiring tracheal suctioning approximately every hour to two hours for moderate amounts of tracheal secretions which were relatively tenacious in character.... He unfortunately did not tolerate the suctioning extremely well (Benner, 1984, p. 19).

On the basis of task skill acquisition and its impact upon rapid clinical decision-making, a single context from which to view these dialogs, the first example is clearly reflective of an expert. However, if the second dialog is examined carefully, the “advanced beginner” is very aware of the multiple dimensions regarding the patient’s situation and has tuned into the “unfortunate” nature of the situation. Rather than just an “advanced beginner” in task skill acquisition, this second nurse demonstrates quite an advanced cognitive ability in connecting with the patient. Benner, while stating to be contextual in the approach with text analysis, was actually a-contextual as the above example indicates. Benner’s study is therefore limited in its ability to clarify the contextual nature of nursing and patient care.

Unfortunately, much of the research during the 1980's regarding nurse decision-making was a-contextual and ignored the multiple dimensions in which nurses made decisions. Since 1990, researchers have taken two different approaches to examining decision-making: subsets of the decision-making process (i.e., critical thinking, heuristics, divergent thinking) and the entire process as a whole.

Critical thinking. Bacon and Thayer-Bacon (1993) describe a critical thinker as someone capable of assessing reason from more than one point of view, having the ability to make judgments upon that reasoned assessment, and, most importantly, having the critical spirit or desire to provide an impartial judgment even when their own beliefs and actions are challenged. In nursing, critical thinking has been deemed by many as the cornerstone to reasoned clinical practice (Meleis, 1991; Bacon & Thayer-Bacon, 1993).

Critical thinking has received a tremendous amount of attention within health care organizations and from the National League of Nursing due to its perceived connection to patient outcomes; however, the construct for critical thinking is not yet clear (Kataoka-Yahiro & Saylor, 1994). While Facione, Facione, and Sanchez's (1994) work in developing a critical thinking instrument derived a "robust definition of the construct of critical thinking, encompassing both cognitive skills and person attributes" (p. 349), these researchers admit that the resulting construct contains "overlaps" of problem solving, reasoning, and clinical judgment. Jones and Brown's (1991) study involving a survey of deans and directors of baccalaureate schools of nursing illustrated that even leaders in nursing academia lack conceptual and operational clarity regarding the concept

of critical thinking. Much work is needed to begin exploring the construct of critical thinking in nursing.

Heuristics in diagnostic and clinical reasoning. Diagnostic reasoning involves the generation of a hypothesis and the search for information needed to reject or accept that hypothesis (Cholowski & Chan, 1992). Diagnostic reasoning among second-year nursing students was studied by Cholowski and Chan (1992). Findings indicated that when approaches to information processing were superficial, poor quality nursing diagnosis were the result. However, through pathway analysis it was discovered that content knowledge alone was not enough to produce accurate and high quality nursing diagnoses; logical reasoning mediated varying amounts of nurse knowledge.

Utilizing a different approach to understand nurse reasoning, Fisher and Fonteyn (1995) implemented a “think aloud” method to explore neurosurgical nurses’ thoughts as they reasoned and made clinical decisions about patient care. In a pilot study, nurses were tape recorded as they provided patient care. Real patient situations allowed the researchers to identify the following nurse heuristics: pattern recognition, anchoring, attending, focused questioning, and listing. The strength of this pilot study was that the data was collected in a natural setting and therefore offered a beginning to our understanding of nurse reasoning in natural settings.

Divergent thinking. Koerner (1996) and Lunney (1992) examined divergent thinking among nurses. According to Lunney, divergent thinking is important when data for a problem can be given a number of different explanations, an accurate explanation (nursing diagnosis) is required, and perception abilities affect the choice of explanations. Fluency (ability to consider

many different units of information), flexibility (ability to change from one category to another), and elaboration (ability to consider many different, uncommon details within the information) were the measured variables while nurses made nursing diagnoses. It is important to note that these variables support differentiation in thinking, not just assimilation. Lunney found that when nurses were presented with complex and unfamiliar patient situations, inaccurately diagnosed patients were correlated with low scores in all three variables.

While most of the research concerning decision-making examined subsets of the process during the early 1990's, a few studies attempted to examine decision-making as an entire process. The next portion of this paper will address recent research regarding the process of nurse decision-making.

Decision-making as a process. Most recently, nurse researchers have made attempts to understand the nurse decision-making process through a variety of contexts and multiple dimensions of nursing practice. Empirically, levels of experience, education, and knowledge remain areas of interest with regard to nurse decision-making.

Henry's (1991) computer clinical simulation study examined levels of experience and decision-making. Specifically, the study measured the effect of nurse experience with varying patient acuity levels upon nurse clinical decision-making. Interestingly, there was no decision-making difference between experienced and inexperienced nurses. However, it should be noted that the study design took place in an unnatural setting (a-contextual) and utilized computer simulation, neither of which may support accurate nurse decision-making.

Unlike Henry (1991) above, Lauri and Salanterä (1995) found that for Finnish nurses, experience was an important variable in decision-making. The researchers' validated instrument (based up Benner's work and the Dreyfus Model of Skill Acquisition) was designed to measure holistic-interpretive decision-making, systematic-analytical and rule-based decision-making, including data collection, data processing, planning, and finally implementing, monitoring and evaluating. The study demonstrated that 43% of nurse decision-making findings could be explained by differences in experience (factors linked to the constructs of novice versus expert nurses). The value of this study is that the investigators have developed a tool which examines a number of constructs related to decision-making.

Qualitative, descriptive studies have also contributed to our understanding of nurse decision-making during the 1990's. Jenks' (1993) and Grisby and Westmoreland (1993) offer examples of qualitative, descriptive studies.

Jenks' (1993) interviewed acute care staff nurses with varying educational backgrounds in a qualitative, descriptive field study. Nurses shared that outcome success in clinical decision-making was more dependent upon their interpersonal relationships with patients, physicians, and other nursing staff than upon their educational level.

Grisby and Westmoreland (1993) conducted a descriptive study which identified the various epistemological perspectives of staff nurses working in acute care hospitals. Interpretive methods consistent with a constructivist paradigm concluded that nurse personal knowledge matched Belenky et al's (1997) perspectives of knowing (received knowing, subjective knowing, etc.). The value of this particular study is that it offers nurses a new and different

approach from which to interpret decision-making as well as further insight into how decision-making relates to a cognitive development scheme. The weakness of this study is that it viewed nurse knowing through the lens of Belenky et al's scheme leaving us wondering what nurse knowing might look like if examined from a nurse perspective.

In summary, a variety of approaches have been taken by nurse researchers interested in nurse decision-making. The 1980s advanced our understanding regarding cue recognition and provided one of the first models for looking at nurse clinical practice and decision-making. Researchers in the 1990s explored nurse decision-making from two diverse perspectives: by examining subsets of decision-making as well as the larger process of decision-making. Overall, results remain unclear as to the contribution that experience, education, and nurse knowing have upon decision-making. In addition, no investigation has specifically examined the meaning of nurse decision-making or utilized nurse decision-making to advance our understanding of cognitive development among nurses. The next section will discuss the role of the telephone advice/triage nurse and the research available regarding telephone advice/triage nurse decision-making.

Telephone Advice/Triage Nursing

The Role

Telephone advice/triage nurses will participate in the proposed study. Telephone advice/triage nursing is a relatively new form of practice for nurses. Therefore, to provide additional background information for the study the following section of this paper will provide information about this unique nursing role.

“Telephone care is a goal-directed health care information service” (Guy, 1995, p. 27) provided by nurses working in a variety of health care settings. The two forms of telephone care include telephone advice and telephone triage. Telephone advice may include counseling, consultation, or health teaching. Telephone triage typically refers to making a referral to a specific level of care (i.e., the emergency room) after performing a client telephone assessment. Nurses perform both of these duties within telephone advice/triage positions. In addition, nurse advice/triage positions offer the opportunity for nurses to become more involved in patient education and patient advocacy (Genusa, 1995).

Decision-making

Telephone advice/triage nurse do not have direct, face-to-face contact with their patients as they conduct assessments for decision-making. According to Brennan (1992), nurses have come to rely on type-written or computerized advice protocols to organize and expedite client symptom assessments and to make decisions (Brennan, 1992; Narayan, Tennant, Benedict, Morrison, & Peyton, 1997). Unfortunately, protocols do not support comprehensive, contextual assessments. Contextual assessments address the psychosocial meaning of the symptoms as perceived by patients and caregivers (Narayan, et al, 1997). Therefore, the primary decision-making dilemma which remains for these nurses involves attempting to make accurate clinical and comprehensive client assessments while not having direct contact with those clients or control over the decision-making process (McMahon, 1986).

Two studies in recent years have contributed to the understanding of the telephone advice/triage nurse role and decision-making. Both studies utilized an ethnographic approach to examine telephone advice/triage nursing.

In the first study, Edwards (1994) specifically set out to investigate decision-making among telephone triage nurses. Five nurses were asked to triage two simulated calls. Tapes of the simulated calls and triaging process were replayed for the nurses who were then asked to discuss what they had been thinking about during their decision-making process. Edwards discovered that the nurses did utilize a systematic and identifiable framework for decision-making. Specifically, nurses considered the most likely cause of the patient problem, the impact of the problem upon the patient, accessibility to health care, and the nurse's professional vulnerability in providing advice. In the end, Edwards stated that nurses "balance" the most probable outcome to the worst possible outcomes and then decide upon an option (i.e., go to emergency room).

Like Edwards' (1994) study, nurses in Mayo's (1997) study described a number of situations where "deciding" was a "balancing act". Again, it was discovered that the nurses had developed purposeful and systematic processes to support their "deciding". In fact, nurses described one such process as "connecting" with patients over the phone and stated that when this occurred they perceived their assessments to be more comprehensive and appropriate. Examples of telephone advice/triage "deciding" included making decisions about (1) when to use available computerized protocol systems, (2) where to make patient dispositions, and (3) "what to tell patients". Both studies contributed to a foundation for understanding telephone advice/triage nurse decision-making demonstrating linkages to decision-making theories (i. e., compensatory models, probability theory). However, further study is needed which examines the impact of protocols, organizational situations, as well as what patient and family connections mean relative to nurse decision-making.

Cognitive Development

Because these nurses attempt to make comprehensive client assessments while not having direct contact with their patients, their everyday practice involves decision-making dilemmas. (McMahon, 1986). As discussed earlier, researchers in the field of cognitive development present their participants with dilemma-type situations and subsequently study decision-making as way to understand aspects of cognitive development. No studies which have examined decision-making among this population of nurses have utilized findings to examine aspects of cognitive development. Therefore, studies are needed which begin to explore the topic of cognitive development among nurses.

Analysis and Critique

While studies concerning decision-making and cognitive development have been presented, knowledge gaps as well as biases still exist. Applying findings from these studies is difficult with regard to promoting nurse decision-making and cognitive development.

Much of the decision-making research has ignored multiple, contextual and situational variables which impact the making of decisions. Simple models such as the compensatory and non-compensatory models (Reed, 1992) ignore the fact that humans have the ability to accumulate multiple complex options during their decision-making process. Complex decision-making is the reality in health care today. Many variables must be attended to simultaneously in order to meet the needs of patients, families, and organizations. These simple types of models do not contribute to our understanding of nurse decision-making today.

Nurse decision-making has significant relevance for nursing today. However, to date, nurse decision-making studies have only examined subsets of

decision-making, and like decision-making research in general, have virtually ignored the contextual nature of decision-making as was discovered to exist in both Perry and Belenky et al's developmental work in the 1970's and 1980's. For example, Thiele et al's (1986) and del Bueno's (1983) work with regard to cue recognition did not examine if and how nurses synthesized cues with other variables to make decisions regarding clinical interventions. Once again, such limited, narrowly focused research does not contribute enough knowledge to assist nurse educators or administrators to promote nurse decision-making in health care today.

Cognitive development within nursing has remained virtually untouched by nurse researchers. Only a few studies could be offered to demonstrate the current state of cognitive developmental knowledge among nurses. For example, Zorn, Ponc, and Peck (1995), utilizing Perry's scheme, and Westmoreland, et al (1995), utilizing Belenky, et al's scheme, were able to demonstrate that nurse development matches lower developmental levels and perspectives. These researchers utilized schemes which were generated by either samples of men or women, none of whom were known to be nurses. Therefore, it remains to be seen if the findings offer an accurate picture of cognitive development among nurses. Of primary concern is the idea that the schema utilized to measure or describe cognitive development among nurses, are known to have represented men or women's thoughts exclusively and definitely have excluded the nurse perspective during their construction.

A phenomenological investigation, which will examine what decision-making among telephone advice triage nurses is like, is proposed as a step to address the lack of knowledge regarding nurse decision-making and to offer a

window into cognitive development among nurses. Portraits of nurse decision makers, which shed light upon the meaning of their decision-making, will be derived from lengthy interviews and systematic phenomenological analysis.

CHAPTER III

METHODOLOGY

Phenomenological research is the study of essences. By definition, an essence is a universal that is grasped intuitively through the study of the internal structure of instances of the phenomenon under study (Boyd, 1993, p. 126).

As a human scientific process, the phenomenological research process contains all the characteristics of scientific ways of knowing (Van Manen, 1990). Phenomenology involves both systematic and explicit processes. Procedurally, an investigator orients to the phenomenon, formulates a phenomenological question, discusses assumptions, explores the phenomenon through data gathering techniques, conducts thematic analyses, writes to mediate reflection, and disseminates findings (Boyd, 1993).

Method

Phenomenology was the qualitative methodological approach chosen for this study. The philosophical underpinnings for this study were derived from Merleau-Ponty's (1967) phenomenology of perception, a phenomenological philosophy. Merleau-Ponty acknowledges that perceptions are formed from the inner self as well as background layers of experiences. Merleau-Ponty's philosophy supported this study in two ways. First, through the acknowledgment of layers of experiences, it was possible to gain an in-depth understanding of how

various nurse experiences, personal, system and organizational processes possibly relate to nurse decision-making (i. e., computerized triage protocols). Second, the philosophy assisted the investigator to see that experiences with decision-making could be viewed as unfolding layers of cognitive development. Various expressions of awareness regarding personal and professional knowledge and experience constituted layers. Therefore, Merleau-Ponty's philosophical perspective regarding layers of experiences allowed the investigator to apprehend nurse decision-making as meaningful "layers" in the form of a very basic, beginning understanding of cognitive development among telephone advice/triage nurses.

The operational framework for this study was structured according to one research method: the Van Manen (1990) Researching Lived Experience Method. The Van Manen method allowed the investigator to interview, analyze, and write in a commingled way. Van Manen supports a hermeneutic phenomenological approach which allows investigators to learn from participants and incorporate those learnings into future interviews. In addition, the practice of writing is recommended to be ongoing because "interpretive phenomenological research and theorizing cannot be separated from the textual practice of writing" (p. ix). Within this study, as a part of investigating internal structure(s), continuously co-constituting patterns of decision-making relative to cognitive development actually unfolded during the writing processes. It was important that interviewing and analysis processes continued to inform the writing process and that all three processes occurred simultaneously throughout the duration of the study.

Research Design

This study was designed to gather data which would illuminate the meaning of decision-making. To accomplish this goal, qualitative research approaches were used to select participants and gather data.

Participants

For the qualitative researcher, sampling methods are concerned with understanding the conditions under which the phenomena of interest exists (Huberman & Miles, 1994). In addition, sampling methods are directly related to the goals of the research and therefore vary among specific qualitative methodologies. Specific to phenomenology, explicating “universal” essential themes and grasping the essence of phenomena are the goals of phenomenological research, therefore, maximum variety or extreme or deviant case sampling would not be required for the phenomenological method. Morse indicates that since the goal is not to develop mid-range theory, participants simply need to have experienced the phenomena.

For the purpose of this study, research participants were selected from the Southern California community of telephone advice/triage nurses living the experience of decision-making. Gaining entree to the research participants occurred through individual nurse contacts in the community. The participant selection process did not focus upon organizations relative to inclusion or exclusion criteria. Rather, this study included telephone advice/triage nurses employed a number of organizations. Essential themes, which are universal, would not be influenced by specific organizational systems. “The scope of phenomenology goes beyond the study of particulars to include investigating

general essences” (Boyd, 1993, p. 111). Therefore, individual nurses were asked to participate in this study.

Initially, the investigator contacted the five nurses who participated in the investigator’s 1997 telephone advice/triage nurse role pilot study. A nominated sampling method was then utilized to obtain the balance of the qualitative participants. Following their interview process, the initial participant(s) were asked to give a one page flyer to another telephone advice triage nurse in the community. This flyer provided a brief overview of the study and the telephone number of the investigator. Each subsequent participant was be asked to nominate another. The strength of this sampling method was that the selection of potential “insider” informants (1) was guided by those nurses who were knowledgeable about the experience of decision-making as telephone advice/triage nurses and (2) had the potential to result in “the best interview[s]”(Morse, 1991, p. 130).

Initial participants were contacted by the investigator via phone. Each 1997 pilot study nurse was be provided an overview of the current study and asked to participate in this study. If the nurses agreed to participate, the investigator obtained informed verbal consent and arranged for a future date to obtain informed written consent (see appendix A) and to the conduct actual interviews. Subsequent nurse-nominated participants, who had been given a research flyer by a 1997 pilot study nurse, initiated phone contact with the investigator during which time informed verbal consent was obtained and arrangements made to obtain informed written consent (see appendix A) and to conduct the actual interviews.

Inclusion criteria. All participants were Registered Nurses (RNs), currently employed part time or full time, in the primary nursing role of telephone advice/triage nursing, and spoke English. All ages, genders, ethnic/racial backgrounds, and nursing and educational backgrounds qualified for inclusion.

Many telephone advice/triage nurses provide advice for a number of patient populations (pediatric, adult, geriatric) and cover a number of functional areas of nursing (medical, surgical, gynecology) simultaneously (Guy, 1995; Mayo, 1997). During surface meaning analysis, some trends emerged showing discrete patient populations and functional areas of nursing regarding individual nurses' roles. These trends will be reported within the following chapters.

Establishment of reoccurring experiential themes which were common to various descriptions of the lived experience of decision-making was an indicator that the study is nearing an end. Following Van Manen's (1990) analytical approach, establishment of an essential theme or themes for decision-making was the primary determinant for ending the study. "Apprehending essential themes" using free imaginative variation (Van Manen, 1990, p. 107) was utilized to determine the essential theme(s) for this study. The process of free imaginative variation involved asking two questions: "Is this phenomenon still the same if we imaginatively change or delete this theme from the phenomenon? And, "Does the phenomenon without this theme lose its fundamental meaning?" (Van Manen, 1990, p. 107).

Essential themes were apprehended by the time interviews with ten nurses totaling approximately 25 hours of interview time had transpired. Because interviewing, analysis, and writing was an integrated and ongoing process, the investigator was aware of the theme emerging status of the study at all times,

including when additional meanings ceased to emerge (the point of saturation). Nurse interviews were arranged according to the status of the study. Two additional nurses called the investigator towards the end of interview schedule. At that time, the investigator could not determine if additional interviews would be needed to complete the study, so, names and phone numbers were recorded. These nurses were subsequently called and informed that additional interviews were not be needed.

Data Gathering

This study asked nurses to reflect on and describe decision-making situations, circumstances, and meanings. Descriptions involved nurses remembering their decision-making experiences and sharing the meaning of those experiences. Interview data was gathered via semi-structured interviews. An interview guide was utilized by the investigator (see appendix B). In addition, the investigator took opportunities to elicit clarifying examples and to clarify issues as they arose during conversation. For descriptive purposes demographic data was collected at the completion interviews. Consistency with interviews over time were handled by the investigator using systematic preparation for each interview. Preparation for each included reviewing the interview guide, reviewing previous interview notes and transcripts, and making notes regarding which questions would be asked.

Interviews. After obtaining informed written consent, individual participants were asked to verbalize their descriptions for tape recording and subsequent analysis. To allow additional time to clarify interview content and to follow up with additional probing questions as analysis proceeds, each individual nurse was interviewed twice.

All taped interviews were conducted at a time convenient for both the participant and the investigator. A private setting was chosen by the participant. All tapes were transcribed onto a diskette by a transcriptionist, the diskette and tape were given to the investigator.

Initial interviews were approximately one hour in length. The purposes of the first interview were to establish rapport and to stimulate the nurse's memory regarding decision-making experiences. Nurses were asked to describe experiences and the personal meaning of those experiences. Initial interviews began with broad questioning regarding decision-making experiences and become more focused as the nurses discussed specific experiences and interpreted meanings (see appendix B).

The purpose of the second interview was to allow participants additional time to elaborate and clarify their decision-making experiences. The second interview also allowed the investigator to confirm that the descriptive data from each participant was complete, a process important to the method of phenomenology (May, 1991). Therefore, each nurse was asked to participate in a second one hour interview approximately one to two weeks later. By that time, the investigator had had time to initially contemplate the data and was then prepared to ask each participant to further elaborate on their descriptions (see appendix B). For example, if a nurse had initially described "connecting" with a patient as important in decision-making, the investigator would ask the participant to elaborate on "connecting" and decision-making. Two interviews with each nurse allowed inquiry, discovery, clarification and initial interpretation to coexist (May, 1991; Parse, Cody & Smith, 1985).

Ethical Considerations

Approval for this study was obtained from the University of San Diego Committee on the Protection of Human Subjects (see appendix C). Committee members, University of San Diego faculty members, were kept advised of the investigator's progress as an ongoing process throughout the study.

Participants were invited to participate in the study. Consent to participate was obtained from each participant prior to the initial interview (see appendix A). The research question and purpose of this study was discussed with participants. The interview process, along with the time commitment, was explained. Each participant was informed that they could withdraw from the study at any time. Participant personal confidentiality was maintained. Interview tapes with diskette transcriptions and participant names were stored in two separate, locked locations.

No risks were anticipated for participants. Risk management was focused upon keeping the participants informed about the study and asking participants to not discuss any identifying patient information during interviews. Lack of knowledge regarding the study could have been perceived negatively by the participants so every effort was made to keep participants informed before, during, and after the study. In addition, participants were asked to not divulge patient names or sensitive medical or other information which might have had the potential to identify a patient (i. e., a rare or unusual medical diagnosis). Had a participant shared information which could have potentially identified a patient, the interview would have stopped, that portion of the tape erased, and the interview would have been resumed. Finally, participants were informed that

should any descriptions from the study be published, no names would included in the publications.

While there are no direct benefits from participating in this study, potential benefits may have included the time and attention given to the participant nurses by a fellow nurse (the investigator) who was interested in the participant's perception of the phenomenon of decision-making. With the opportunity to withdraw from the study at any time and efforts taken to keep the participants informed regarding the study, the potential benefit of dialogue with the investigator outweighed any risks. A summary of research findings were offered to all participants.

Data Management

Recording and Storage of Data

Investigator interview notes, interview tapes, computer data diskettes, and hard copy transcripts were all considered research data. Investigator notes taken during interviews were written onto three-ring notebook paper. Once transcribed, numeric and letter coded interview tapes, along with the corresponding diskettes, were stored in a locked metal cabinet in the investigator's home. The code book was kept in a separate locked file cabinet in the investigator's office. Hard copy transcripts were placed in three ring notebooks along with the investigator notes. These three ring notebooks were stored in a locked file cabinet in a third location. All research data will be destroyed within five years of the completion of this study.

Data Analysis

Data was analyzed utilizing Van Manen's (1990) techniques of phenomenological reflection and writing. Both techniques were conducted

concurrently because they contributed to analysis by supporting each other. In other words, reflection enabled writing and writing provided a medium for reflection.

Phenomenological reflection involved two steps, conducting thematic analyses and determining essential themes. Themes emerged as the descriptions of the structures of the lived experience. According to Van Manen (1990),

themes are more like knots in the webs of our experiences, around which certain lived experiences are spun and thus experienced as meaningful wholes (p. 20).

Uncovering themes was accomplished by reviewing data carefully and repeatedly.

Conducting thematic analyses. Initially, reading and rereading of participant descriptions was done for the purpose of establishing surfacing meanings of decision-making and grasping the uniqueness of the phenomenon. Surface meaning codes were typed into the right hand margins of the transcripts as they are identified. This process was always be completed prior to the second interview with each participant.

Determining essential themes. Next, further analysis was conducted to establish characteristics of decision-making and to establish any relations decision-making may have to other phenomena for the purpose of determining essential themes. Van Manen (1990) describes four fundamental existentials which were helpful to consider at this point during analysis: spaciality, corporeality, temporality, and relationality. First, understanding the nature of the participant's spaciality, or lived space, contributed to understanding the quality of meanings. For example, the feelings of comfort and intimacy are usually related

to close lived space. However, geographic closeness does not always necessitate a feeling of closeness. Any meanings shared relative to spaciality were analyzed. Second, corporeality, or lived body describes the phenomenological concept that every human occupies a living body and this body is visible. As applied to this study, Van Manen's concept was analyzed relative to the nurses lack of patient visualization. Third, temporality, or lived time, relates to subjective time. Lived time may speed up or slow down depending on a person's feelings. Applied to this study, the perception of time related to making decisions assisted in revealing feelings and meanings. Finally, relationality, or lived other, relates to both the interpersonal space humans share as well as experiences with others, searching for a sense of purpose in life, spirituality, and a meaningfulness in being human. Relating the different aspects of relationality to the data during the analysis phase assisted in a fuller understanding of meanings as expressed by the participants. Procedurally, the investigator considered initial surface meanings (which were discovered from the initial interview), as well as additional surface meanings discovered from the second interviews, in relation to each of the four existentials. As surface meanings emerged as possible essential themes, the corresponding descriptions were identified with an additional code.

Once essential themes were identified, "apprehending essential themes", a process discussed earlier was utilized by the investigator. Systematically, two questions were asked during data analysis to apprehend and finally determine essential themes. These questions were: "Is this phenomenon still the same if we imaginatively change or delete this theme from the phenomenon? And, "Does the phenomenon without this theme lose its fundamental meaning?" (Van Manen, 1990, p. 107).

Writing. Writing and rewriting were ongoing as surface meanings as well as essential themes were identified. While the four existentials identified by Van Manen (1990) above were assistive in identifying themes, and were of help for writing, Van Manen's warning that writing up one's findings by "weaving one's phenomenological description against the existentials" (p. 172) may produce an animated structural definition of the experience was heeded by the investigator. During data analysis, writing was a major reflective strategy utilized by this investigator; however, reading and rereading participant descriptions, comparing transcripts with audio tapes, as well as, consulting and dialoging with research committee members comprised additional data analysis strategies utilized by this investigator to balance the data analysis process. According to Van Manen (1990):

a good description that constitutes the essence of something is construed so that the structure of a lived experience is revealed to us in such a fashion that we are now able to grasp the nature and significance of this experience in a hitherto unseen way (p. 39).

Rigor

By design, qualitative research processes involving interpretive description such phenomenology require attention to rigor. According to Thorne, Kirkham, and MacDonald-Emes (1997), because interpretive description is utilized, bias within qualitative research is impossible to eliminate. Therefore, an audit trail must be maintained for a number of reasons: 1) to assist with subsequent replications of the original study and 2) to assist with decision-making regarding application of the study's findings.

In addition, the goal of this investigator was to use systematically applied rigor strategies to help to further support analytic findings rather than leave findings open to negative interpretations such as researcher bias. Three strategies were utilized to reduce bias. First, to establish a written document to address confirmability of data and interpretations, investigator interview notes which recorded the context and situations of data gathering were kept. Guba and Lincoln (1989) recommend that both data and interpretations be traceable to their sources. In this study, the purpose of this first strategy was to provide a reference document to assist the investigator in tracing analytical findings back to specific non-tape recorded situations which may have occurred during interviews (Thorne, Kirkham, and MacDonald-Emes, 1997). For example, the researcher may have noted that each time a participant discussed supervisor participation in decision-making, body posture stiffened. This written documentation established an audit trail which demonstrated that a finding such as “influence of supervisor” could be traced to non-verbal body language.

Dependability, stability of data over time (Guba and Lincoln, 1989), was addressed by a second strategy. The investigator reviewed the interview guide prior to each interview. To maintain dependability and stability of data over time, the subject matter for first interviews with each nurse did not vary. After the second interview with each participant, transcripts were reviewed, the interview guide revisited, and additional questions were formulated and typed onto the interview guide. In this way, any methodological changes and shifts in constructs due to second interview questions were addressed and recorded and could be tracked for future use.

Third, while analysis was ongoing, insights were sought from committee members as to why data did, and even more importantly, did not seem to fit emerging themes and focal meanings. The purpose of this third strategy was to challenge emerging themes during the data analysis process. Data analysis needed to move beyond the concrete of singular experiences yet at the same time not be influenced by the investigator's prejudgements. Guba and Lincoln (1989) recommend the process of peer debriefing to address this issue of credibility. Committee members were asked to consider the investigator's analysis because they were in the unique position to be able to move between a narrowed and a broadened view of the investigator's work. They were familiar with both the study's background and the investigator's biases. Committee members were provided with copies of some transcripts as well as reflective writing papers. Discussions of findings also occurred during the study. As themes emerge, committee members could objectively confirm or challenge the investigator's theme analysis. Challenging the investigator's analysis promised to be the greatest contributor to credibility of the findings. During challenging, the investigator was called upon to explicate the rationale for decisions, synthesize all data which supported internal structures and move beyond any concreteness and into a well understood essence. Written notes were kept of this strategy.

These rigor strategies, interview note taking, recording changes to the interview guide, and eliciting committee input, allowed the investigator greater confidence that conceptualizations of internal structures were grounded in the participants data and were not the result of investigator bias. In addition, attention to rigor and process documentation established an audit trail which was

of assistance to not only this investigator but could assist other investigators in the future.

The final section of this chapter has reviewed the research method and specific strategies which were chosen to examine the lived experience of decision-making within telephone advice/triage nursing. To summarize, phenomenology was chosen because of the method's ability to explicate the meaning of lived experiences. Specifically, the Van Manen method of researching the lived experience supported this study by allowing the investigator to elicit the structures of the experience reflective of the meaning of nurse decision-making and to communicate, through writing, the essence of that meaning.

CHAPTER IV

FINDINGS OF THE INQUIRY

The aim of this study, based upon a phenomenological perspective, was to illuminate the meaning of telephone advice/triage nurse decision-making. The participants discussed many aspects of decision-making throughout the study. Reflecting on their experiences, professional and personal meanings were revealed making the experience of decision-making complex.

The uniqueness of decision-making among telephone advice/triage nurses was confirmed by all nurses in the study. As compared to decision-making experienced in prior roles, these nurses described telephone advice/triage nurse decision-making as working without all of their senses which resulted in less information about patients and required them to rely upon the patient's word for what was really going on. All nurses, not surprisingly, related that the nurse-patient relationship was therefore critical.

This chapter will begin with a description of participants and of the environmental context within which these nurses work. Utilizing Van Manen's analytically-oriented writing approach, representative decision-making anecdotes along with analysis will be used to present both essential and related incidental themes. The multidimensional, contextual, and simultaneous experience of decision-making for the nurses will be evident among, as well as, between the themes.

Description of Participants

Nurses who participated in this study were telephone advice/triage nurses working in Southern California. Of the ten nurses interviewed, nine were female and one was male. All were Registered Nurses (RNs) ranging in age from 30 years of age through their mid-50's. Seven of the nurses ethnic backgrounds were Caucasian and three were African American.

The nurses came from diverse educational and practice backgrounds. One nurse had graduated from an associate nursing degree program just over a year ago. Eight others possessed baccalaureate degrees in nursing and one nurse had a masters degree in nursing. Years of RN experience among the group ranged from one year to over 35 years.

Prior to working as telephone advice/triage nurses, the participants also had varied nursing experiences. While all of them had worked in hospitals, four of them also had experience working in ambulatory settings (clinics and emergency rooms). Four nurses had medical/surgical hospital experience, three had obstetrical and gynecological (OB/Gyn) hospital experience, and one nurse had pediatric hospital experience. As far as clinic experiences, those included OB/Gyn, organ transplant, and pediatrics. Additionally, three of the nurses had been nurse managers at some point in their careers. Two of the nurses also had previous experience working as nurses aides, medics, or LVNs (licensed vocational nurses).

All nurses transitioned into telephone advice/triage nursing from other nursing roles. Most nurses had left hospital positions, explaining that they had become "burnt out with the fast work pace which left little time to be with patients". One nurse came from a clinic setting, explaining that a nine-to-five working schedule did not accommodate her new school schedule.

None of the ten nurses had been formally educated or trained to assume the role of a telephone advice/triage nurse. Informal approaches were used to orient nurses to their new roles. The primary strategy was to place the nurses with other experienced telephone advice/triage nurses. As new nurses, they were encouraged to read department policies and procedures and telephone advice “how to” manuals at the start of their orientation. Ultimately, they were expected to have read through all the available protocols, guidelines, and other literature by the end of their orientation. Time with their preceptor varied from a few days to two weeks.

At the time of study, the group of nurses had spent between six months to over five years in their roles as telephone advice/triage nurses. All shared that initially there was much to learn. Two primary learnings involved knowing available resources outside of the hospital setting and performing patient assessments without seeing or touching patients.

Learning to do patient assessments without the use of their sense of sight or touch did not represent an overwhelming challenge for these nurses. While all nurses shared that they quickly realized how they had depended upon all of their senses in their previous nursing experiences, they explained that they were able to transition themselves into doing without their senses of sight and touch by sharpening their sense of hearing.

Nurse characteristics will continue to be presented through out the findings of this study. As participants are anonymously introduced (through the use of pseudonyms) in pages to follow, more specific demographic and experiential information will be shared. Next, the environmental context within

which nurses came to make to their decisions will offer more information about their experiences.

Environmental Context of Decision-making

Nurses in this study were employed by a variety of organizations which included government hospital/clinic organizations, private hospital/clinic organizations, Health Maintenance Organizations (HMOs), and private medical management firms. Practice settings for nurses included offices, clinics, and their homes. Office settings were located in or around hospitals or clinic buildings, with the immediate work area being located in an office-type setting, not easily accessible to patients. Clinic settings consisted of office space or office-type cubicles located in a clinic, close to patient flow areas. Finally, the home setting consisted of space dedicated for work with equipment such as desks, phones, fax machines, paper and office supplies.

Nurses shared that once they began practicing telephone advice/triage nursing, they were surprised with the pace of the work; it was faster than they had expected. For example, many of these nurses stated that they arrived to work on Monday mornings to find 30 patient messages called in over the weekend and then continued to receive 30 to 60 more patient calls over the course of the next eight hours.

Nurses processed between 30 and 100 calls per eight hour shift. Each phone call usually required more than one decision on the nurse's part, sometimes reaching as many as one decision every two to three minutes. Time spent on the phone with patients ranged from between two to fifteen minutes, with one nurse reporting a phone call lasting 50 minutes. Some nurses were aware of time spent with patients on the phone because their organization's computerized telephone

system monitored length of calls. However, most nurses did not have access to this quantified information and so estimated their time ranges for this study.

Most nurses worked weekday shifts during day time hours. Only two nurses worked evenings, nights, and on weekends. All nurses, except one, worked eight hour shifts on a full time basis. The remaining nurse worked a combination of six hour and eight hour shifts three days per week.

All nurses in this study triaged patients and provided advice to patients. Nurses triaged patients for the purpose of 1) determining the urgency of patient situations and, 2) if care was needed, determining what type of setting should provide that care (patient disposition). Possible patient dispositions ranged from emergency rooms, urgent care settings, clinics, to patients' homes. As part of their role, some nurses would call ahead to care settings, communicate their assessment to the providers, and formally authorize the care setting to initiate care. Additionally, all nurses provided advice to patients. Advice ranged from providing medical information (i.e., more information about a diagnosis) to patient teaching (i.e., tepid bath for high fevers).

To determine patient dispositions and what advice to provide patients, nurses assessed patients. Nurses performed independent nursing assessments and utilized structured assessment-decision tools called protocols or guidelines. All nurses utilized, at one time or another, some form of protocol or guideline which had been sanctioned by their organization. Protocols were standardized procedures which had been formulated or purchased by their employing organizations. Nurses explained that all protocols had been reviewed by or written by physicians associated with their organizations, thereby meeting their understanding of state regulations. Protocols were designed to guide the nurses

through assessments of patients. These protocols were algorithm-based, decision tree framed, which linked questions to patient responses eventually leading to patient disposition suggestions. When the disposition was for the patient to remain at home, the protocol instructed the nurse to provide some specified home care advice or might even instruct the nurse to call a pharmacy with a prescription for medication. Some protocols were computerized, others were in manual form. On the other hand, all guidelines were in manuals. Guidelines were less rigidly structured than protocols and typically only listed questions for the nurse to ask the patient in order to determine urgency of problems. Some also led to a patient disposition such as emergency room or urgent care, but most did not, usually leaving the decision for a care setting up to the nurse.

As part of their triaging role, nurses referred patients to specialty clinics or community resources. A number of nurses shared that they learned about the “big picture” of patient referrals “the hard way”. Supervisors or physicians would review their decisions and point out that they should have referred the patient elsewhere. Other nurses had nurse colleagues immediately available in their work space areas and so would ask these nurses about resources while the patient was still on the line.

Nurses documented their work in a variety of ways. Some nurses utilized pre-printed intake paper forms. These forms provided specific areas where nurses hand wrote their assessment information, patient dispositions, advice, and so on. Other nurses utilized forms and hand wrote what ever they deemed appropriate to record about their patients. Finally, some nurses charted patient information into computers, either in concert with algorithm-based protocols, into structured intake forms, or into blank progress-type notes.

All nurses believed that telephone advice/triage nursing benefited both their organizations as well as patients. All nurses preferred their current position over their previous positions saying, “this is the last role where a nurse can spend time talking with patients”.

The Experience of Decision-making

There were eight essential themes which characterized the experience of decision-making among telephone advice/triage nurses. All ten nurses mentioned each of these themes as they described their decision-making experiences. Themes emerged to illustrate the “whatness” of the lived experience of decision-making among the ten nurses (see table 1).

Incidental themes emerged within the descriptions of essential themes illustrating the nurses’ varying perspectives around each essential theme. Incidental themes were representative of more individual ways the nurses felt or thought about their decision-making experiences. Similar to incidental music (descriptive music presented during a play to project a mood), incidental themes are presented so that readers can might gain additional insight into some of the individual perspectives nurses shared while describing their experiences.

Connecting emerged as an essential theme as nurses discussed the importance of their relationships with patients for decision-making. Nurse perceptions varied regarding how connecting effected their decision-making, but emphasized it was critical to not only the process, but who they were as decision-makers. Connecting relationships between nurses and patients were apparent throughout all of the essential themes.

Involving patients in decision-making, a second essential theme, depicted how patients became involved in the decision-making process. The nurses

described when and how patients were involved in decision-making. Incidental themes varied regarding nurse perceptions about when and if it was appropriate that patients be involved in the decision-making.

A third essential theme, deviating from protocol, emerged as nurses spoke about using protocols to support their decision-making. All nurses recognized patient conditions or situations did not perfectly match their protocol frameworks. Nurses varied in their willingness to deviate from protocols which was reflected among incidental themes.

Validating the right call, the fourth essential theme, represented the way nurses became confident or certain regarding their decisions. All nurses wanted to make the “right” call for each and every patient so prior to implementing their decisions would validate their decisions. Some nurses described “self” as they spoke about what this was like, while others used peers, other providers, or system mechanisms to validate their decisions.

The fifth essential theme, living with responsibility, illustrated that all nurses were aware of the importance of their decisions. Their perceptions of what it was like to assume responsibility varied reflecting feelings of self-accountability to viewing responsibility as part of their role or job.

All nurses believed that they could know something about their patients, so this sixth essential theme, knowing what’s really going on, represented a more philosophical belief regarding knowing. In addition, knowing reflected what nurses determined they needed to make the best decisions. All nurses realized that they needed to know clinical information about their patients, but others shared that they also needed to know themselves and maintain an awareness of their professional and personal knowing.

The seventh essential theme, coming to a decision, illustrated how nurses came to their decisions as well as what their decisions were based upon. Three ways nurses came to a decision emerged during the study. Making a justifiable decision was based upon what was best for the patients. Validating the right call was based upon nurse comfort. And striking a balance was based upon the nurse trying to maintain system or organizational equilibrium between patient satisfaction and the system's resources.

Finally, all nurses spoke of themselves as being a decision-maker. This essential theme reflected the nurses sensing themselves in the experience of decision-making. Their varying perceptions attended to feeling certain and confident as being decision-makers.

It is important to note that while essential themes are presented separately here, the themes did not exist as separate entities of the lived experience for the nurses. The essential themes were conjoined, occurring simultaneously in their descriptions of the decision-making experience.

Connecting

All nurses described feeling connected to patients during their decision-making experiences. Most nurses spontaneously utilized the terms connecting or connection in describing characteristics of their relationships with patients. Integral to all of their decision-making experiences, nurses in this study explained that connecting with patients helped them to obtain the information they needed in order to make decisions.

Nurses also discussed how the process of connecting occurred for them. Many nurses explained that connecting begins when they answer the phone. All nurses in this study discussed their connecting relationships with patients, how

connecting effected their decision-making while offering varying perceptions about what it was like to be connected with or to patients.

Being in tune. Some nurses in this study talked about connecting with patients in terms of what it was like to be in tune with their patients. Being in tune with patients involved a feeling of being part of them and a flowing interchange of energy, feelings, information, and personal knowing. Connecting for these nurses meant that both patient and nurse were involved in connecting. Nurses alone did not set the course. From the nurses' perspectives, being in tune was a mutual experience. They believed that being in tune with their patients put them in touch with what patients felt and enabled them to help and nurture their patients.

Peggy uses what she terms her "sixth sense" to get in tune with her patients. Peggy is a telephone advice/triage nurse working in an adult specialty clinic. She came to telephone advice/triage nursing about eight months ago with over 10 years of intensive care nursing experience. Peggy's sixth sense, a nurse-centered sense, developed during some of her early educational and professional decision-making experiences,

In nursing you develop that sixth sense. I think when nurses come into triage, they bring that sixth sense with them. They bring that experience with them in dealing with patients. You have to be very in tune to what the person is saying.

When asked what she thought this sixth sense was, without hesitation, Peggy responded, "When people care about human beings, [they] learn how to become part of them." Peggy struggled to explain that she had learned what

patients feel and was now sensitive to it. Over the years, learning to be in tune with patients began with her student experiences,

There's certain things, when you go to college and [when] you do your student nursing, that you take a little bit [of with you] and it never leaves you. Why did you come into nursing? The first thing that comes out of your mind, is [that] you came to help. You want to help people. You want to nurture. And now you start nurturing, and you find as a student nurse, you'll find a patient who says, "oh thank you dear, oh you make me feel so much better".

Peggy believes she incorporated being in tune with her patients into her nursing role, building upon those connecting experiences over the years,

Now, you store that, okay? You store that in your head and you always leave it there. Now you start building on it and the experiences you have from day to day from [your] nursing you build on, and now you say [to yourself], "you know, when I touched her need and it made her feel so much better, I think I'll touch another need". And eventually you find all these different ways to comfort people. So when you come to the telephone, you bring all that experience with you. You get a feel for that, and that's what helps you to make decisions in triage.

Being in tune with patients was an aspect of Peggy's decision-making which she believed helps her decision-making.

Valerie, having over 25 years of hospital and clinic experience caring for all types of patient populations, has been a telephone advice/triage nurse for over five years. She continues to work with a general patient population. She works in close proximity to an Emergency Room, but is technically considered part of the

clinic setting in her organization. Valerie also believes that connecting is important to her decision-making. Like Peggy, Valerie experiences connecting in terms of tuning in or focusing in to get clarity. Once tuned in, energy flows.

Valerie feels the energy of connecting, "...when you are connected you are working together, you are getting information that you need... ." Connection for Valerie was described as,

Energy, a place of clarity, a place of knowing. ... You know you are doing the right thing and you are going in the right place and you are focusing in the right area, and its knowing what types of questions to ask to elicit things."

In describing more about what connection felt like, Valerie placed it in the context of question-asking and explained that she does not have to think about what to ask, it just flows. She can feel being in that place. If she is not connected, "if I can't get there", then the conversation between herself and the patient is "disjointed".

Valerie values connection because "it allows a lot of information to come in". She shared that connection goes both ways and that she can control access on her end. While following a decision-making algorithm or even her own decision-making experience she "might get some very good information". But, if she and her patient are not connected and the patient has some information to share, she believes that she will not get that information unless she gives the patient "that access" on her end. She was also aware that caring (something she sends to her patients while feeling connected) "may not necessarily come through" to them if patients are not open. Overall, however, connecting with patients allows Valerie to "know [I am] doing the right thing".

As an example, connection between Valerie and a patient (an ex-prisoner of war calling about gastrointestinal symptoms) allowed them to tune in “to the heart of the problem”. She believed that her own personal experience with being in the military opened the door and allowed access to information. This situation stood out most in her mind as she reflected upon what it was like to make decisions as a telephone advice triage nurse. She and the patient did not connect immediately, she was not even sure what happened to connect the two of them. But once connection was made, things were different,

And, you know, I really don't know how we got there, but I think I asked him something about his sleep, because something he had said had just kind of jarred that. And then we got off on a whole different thing. And once we got on that, it was like we rolled. I mean the difference was incredible and I found that what he was experiencing, at least in part, was probably impacted by, or a symptom of, I don't know, ..., but the fact that he had been a prisoner of war and he had been having nightmares for the last couple of months about his experiences And lo and behold, the symptoms had started soon after the onset of these nightmares. And I felt that they were intimately connected in some way. And he cried. I mean it was a very long conversation. It was a very emotional conversation. I think on both sides because it is hard to hear somebody in that much pain. And, but, I was, you know, I think I did a better job of helping him out in terms of being able to refer him... . But I think overall that stands out as one of the times where you really connect and you really somehow find the way to get where you need to be.

Valerie believed that connection should happen for both patient and nurse. When both are in tune, connection is a positive experience for both people. Outcomes of this dual process include empowerment, satisfaction, and good feelings. And, good feelings on her part indicate to her that “we’ve been able to do something that the patient wanted or had negotiated”.

Overall, connecting allowed Valerie to feel the energy of the experience in order to get the information she needed to help her patient. In addition, connecting “is energy, a place of clarity, a place of knowing” and involved an outcome which was more than just getting information from patients. For Valerie, it allowed her to know that she was doing the right thing, she was in the right place, she was focusing in the right area of concern, in other words, tuned in with her patient.

Connie believes that her relationships with patients are more than “just getting information from patients”. Connie considers herself an experienced telephone triage nurse. She has been in her current position for over three years. Connie also has a varied nursing background which includes 15 years of working on medical-surgical units and in emergency rooms. Today, Connie works for a health care organization in the telephone advice department. With about same length of telephone advice/triage experience as Valerie, she also values connecting relationships where she can tune in with patients.

Relationships between Connie and her patients begin when she picks up the phone. Connections with patients are dynamic, an expanding back and forth process, making the topic difficult for her to articulate,

The patient relationship begins as the phone rings, you introduce yourself, they introduce themselves, they may say what their problem is, you start

talking more and more, and there is a relationship that builds that's difficult to articulate, even to the end point, you can't say, "this is what the relationship is". . . . I can develop relationships with people even on the telephone, even in a very brief period of time, and get to where I need to go. But how do I do that? I don't know.

Connie explained that she works to establish her relationships with patients. Ultimately, these relationships allow for better communication which helps her decision-making,

[but] what I need to do is work on establishing a relationship with the patient, and I think that does affect my ultimate decision, because if we are communicating well and I feel like there's a relationship that I've established, then I feel much more comfortable with whatever the plan is.

Connie explained that connecting with her patients is important because she cannot physically be with her patients as she performs her assessment. Connie must rely upon what patients tell her and in order to trust what her patients are telling her, she must establish a relationship with her patients,

One of the things that I think of automatically is that we have less information than we are accustomed to dealing with when we make decisions, you know, like in a hospital or clinic setting. We rely on less senses. The relationship is critical because that's all we have, is their word for it, for what's going on.

Tacking to stay on course. For other nurses in this study, connecting involved tacking to stay on course. Unlike being in tune with patients, this aspect of connecting meant that the nurses, usually by deciding to use a protocol,

determined the course and nurses adjusted their methods of eliciting the information they felt they needed from patients.

For Kathy, connection seemed to involve patients being on her course as she attempted to obtain information from them in order to “make the right call”. Kathy, a nurse with over 35 years of nursing experience and four years in her current position, works in a specialty clinic triaging and providing advice to patients. For Kathy, “tacking” means being “very flexible in adjusting your methods of drawing information out [of patients]”. According to her, “you develop different techniques to get information [from patients] depending on how they are responding to your question. You can pick up pretty quickly which tack you have to take to get what you need.” Questioning patients obtains for Kathy what she needs, in other words, helps her to maintain her course in staying connected with her patients.

As she pays attention to how patients respond to her questioning, Kathy tacks to stay on course. She explained that this is not a feeling emanating from a patient, but is a self-generated feeling based upon how patients respond to her questions. For example, she shared,

Fairly soon in a conversation I can feel how they are going to answer. Are they going to answer in a way that makes sense? Or, are they going to answer [me] in a way that’s very round-about and [I’ve] got to draw every piece of information out of them that [I] need?

Finally, in cases where tacking does not obtain her the information she needs, she will decide to bring the patient into the clinic “to be hands-on evaluated and to see what’s going on”.

On the other hand, Eva understands that some patients will occasionally determine the course. Eva is a nurse with over 23 years of patient care and nursing management experience. Like Kathy, Eva has no back and forth interchange of energy, feelings, or exchange of information with patients and so does not experience connecting in terms of tuning in with patients. Connecting is about “getting a patient to tell [me] what’s going on”. Once Eva determines that she is talking to a patient who is determined to set the course for the conversation, she spends time trying to understand what the call is about and will allow these patients to verbalize more at the beginning of their conversation. In this way she learns more about their problems, can determine their course. She does her best to tack into where they are going in order to help them. When she gets on course with them and finds out what the patients really has called for, she gets very excited. Once “I get them to tell me what’s going on, I can help them”.

Overall, tacking seemed to be a process these nurses practice in order to stay on course in terms of simply obtaining information from patients. It was an activity which is performed based upon feelings about where the nurses, their protocols, or on rare occasions, where patients want to go with the telephone conversation.

Doing business. For nurses who took a business view of the process of connecting with patients, the “business” of accessing care for their patients provided the nurse-patient relationship and the ultimate connection between them. These nurses perceived that they were the connector between the patient and care services.

Hank’s perception of connecting with patients incorporates this business view. He feels that his connection with patients involves helping them to

navigate the health care system, “I am still a patient advocate even though we try to contain costs, I’m still a patient advocate. I always look for the patient’s best interest at heart”. Hank receives calls from patients as well as various health care, emergency, and hospital settings. He provides advice to patients and authorizes (or denies) contracted settings to provide patient services dependent upon his assessment of patient conditions. Hank has had experience as an LVN in a variety of settings, has been an RN for about one year, and now works as a telephone advice/triage nurse.

For Hank, connecting with patients was based upon the system designs which determine when and how to provide care to patients. Hank is the connector in the process, which sometimes means that connecting is not always about what patients want,

I will go against what a patient wants, you know. [For example] the patient shows up in the ER [Emergency Room] and wants to be seen because something has been going on for a week, two weeks, “sorry, you know, it’s not an emergency”. I had a lady that did this back in October, she came in [to an ER] a week after she had burned herself, I guess she had had hot water poured on her a week ago, and she came in at 10:00 at night and wanted to be seen in ER. I said, “I’m sorry, I can’t authorize this. It happened a week ago, this is not an emergency”. “Well, my skin is falling off”. “Well, I’m sorry that you had a blister and popped it, you can trim the edges off, put some Neosporin on it, and call the doctor in the morning”.

Dolores also took a business-like view of connecting with her patients.

Dolores has been a telephone advice/triage nurse for the past two years and

shared that she brings all of her over 15 years of varied nursing experience, including her nursing management experience, to her current role. For Dolores, connecting is always rewarding when patients agree with the system designed dispositions she uses routinely to frame her decisions,

That's what's satisfying is when you feel like you're both on the same page -- they're comfortable with the plan and you're comfortable with the plan. Hopefully you asked the right questions so that there aren't any little surprises for them to pop [in] at the last minute. ... Things that would bump everything up.

Even though maintaining system equilibrium primarily involves balancing what the patient wants with the organization's needs, Dolores still senses gratification from patients when her patients are content,

So, when everybody agrees and everybody feels happy, those are the most satisfying calls. And then they'll thank you and it's a sincere, you know, not just an "oh that's what I'm supposed to say at the end of a conversation". That they really do appreciate it. And that's the most gratifying one --- that you know they really are glad that you're there, and they're content and they're happy and they're going to go to bed and sleep good that night.

Connecting with patients was an essential theme of the lived experience of decision-making among telephone advice triage nurses. While individual perceptions about connecting varied among the nurses in this study, connecting with patients was very important to all them. Being connected with patients was integral to their decision-making considerations and their process of coming to a

decision and therefore remained evident among each of the remaining six essential themes of the experience.

Involving Patients During Decision-making

Involving patients in decision-making was seen from differing perspectives but always involved the nurse in relation to the patient. Different aspects of involving patients in decisions included nurses varying patient involvement, making decisions for patients, and telling patients what to do.

Varying patient involvement. Connie explained that she varies patient involvement in decision-making based upon the urgency of the patient's needs. And so, there are some occasions when Connie does not involve her patients in decision-making; especially in emergency situations, "But you know, there's of course, the time when you have to say, 'this is life threatening, etc.'."

Connie shared that she usually involves patients in decision-making. Relationships with her patients effect patient involvement in decision-making. Connie is aware that she works to establish relationships with patients in order to feel comfortable with involving patients in decision-making,

In terms of knowing the patient personally or being in the office where I would have an actual chart, then, since I don't have access to those things, what I need to do is work on establishing a relationship with the patient and I think that does affect my ultimate decision as well, because if we are communicating well and I feel like there's a relationship I've established, then I feel much more comfortable with whatever the plan is than if it's just [that] I'm providing a service [to] anyone at the end of the phone. ... I don't think it's okay to be paternalistic about care, the patient has to be involved with it as well.

Because Connie usually does not know the person calling her, she believes she must develop a relationship with a patient to avoid being paternalistic in her decision-making,

In clinic settings, hospital settings, we are, any health provider is very paternalistic and there is a little bit less of that [here], I think, that goes on with the telephone because you are pretty much equal. ...I don't have as much input and ... you have to trust them and believe what they are saying. But I'm not positive that everyone [each nurse] gets there. There are certainly some triage nurses who say, "well I'm telling you to do this, so you do this". So, I can't say for sure it's less paternalistic, but I think that it has the potential for being less paternalistic. Because you're necessarily involving the patient in their care. So, I think that's a difference.

Making decisions for patients. Most nurses in this study made decisions for patients. They believed that patients telephone them for that primary purpose. They believed that their nursing experience and especially their skill in assessing patients enabled them to make the right decisions for patients. Patient involvement existed in their practice, but did so in terms of patients providing information and clues to the nurses. Listening on the part of the nurse engaged the patient in decision-making, " We make a lot of decisions for them. ... You listen to what they're really saying about their child, or you might catch something that they've said that clues you that you need to ask some more questions". For Susan, listening to patients is an important part of being able to make "the right decisions" for patients.

Susan worked in the field of pediatric nursing for about 25 years before becoming a telephone advice/triage nurse. Currently she provides advice to and triages patients from all types of patient populations. While Susan shared that she makes decisions for patients, she explained that she carefully listens to patients prior to making her decisions. Susan shared her perspective about what it feels like to listen versus just hear her patients,

We listen to what the patient is saying. ... You have to hear the tone of their voice, a panicked mother is different than just a mother calling to find out what she can do for this child with a cold.

Susan explained that the words telling, saying, hearing and listening have different meanings. And, it is important to Susan that she understand the meaning of what patients tell her, in other words, what they are really saying. What a patient is saying, not telling, and what Susan listens for, not hears,

...puts a whole different look on [patients]. So, you have to listen to what they're saying. ... So, you know, one of the first questions is, "okay, what kind of symptoms are you having? You say you have the flu." What does the mean? ...You might catch something that they've said that clues you that you need to ask some more questions in another area.

Important for her assessments, understanding meaning many times means understanding "worry",

You really have to listen to their tone of voice, and know when they're more worried than they should be for the things they are talking about. For example, I heard a woman yesterday call with "I think my child had chicken pox before. Could [she] get another case?" And I said, "well, what are you talking about?" Well, [the child] had broken out in a rash on

the front and back of [his] body... . So, you clue in. So you have to listen-- they're saying chicken pox, but

Listening carefully can change what Susan thinks is going on with the child,

After listening you've totally changed the outlook from what the mother thought she was calling about. And it's because you have to listen to what they're saying."

While Susan primarily makes decisions for patients, she does not tell them what to do. Sometimes patients do not agree with an initial stay-at-home disposition decision Susan makes and tell her so. She approaches this situation by expanding her assessment. So, Susan shared that she will try to ask, "are you comfortable with this?", and the patient will tell her, "well, no." Susan explained that the patient tells her no, she hears no, but the patient is really saying something more which she can pick up "if I really listen". Therefore, initial decisions made for her patients can change based upon her careful listening for additional information and clues patients provide.

Whether she makes decisions for patients or not, connecting with her patients through careful listening is rewarding for Susan,

And when you get to a decision about a patient that you can take through the system, get what they need, you know what kind of care they need, and you get them to that care... . Its like getting them to the Emergency Room and finding out they had a heart attack after they got there and there was somebody there to take care of them. It's just a feeling of, I'm so glad that I was able to help that person. And I think that's what we go into nursing for, is to be able to help patients get the right kind of care.

Most of nurses in this study made decisions for patients. However, to do this they engaged the patient in the decision-making process by listening carefully to the clues and information provided as well as understanding the meaning of what patients were telling them.

Telling patients what to do. A few nurses explained one aspect of their experience with decision-making as telling patients what to do. These nurses believed that patients call for the primary purpose of being told what to do. As a result, the patient's involvement in decision-making was minimal. Dolores shared her perspective,

When the patient calls, what's really on their mind is either, "do I need to come in or what should I do for this, or what do I have?" So there's, you can feel that pressure from the other end of the phone, "tell me what's wrong with me".

The nurse-to-patient relationship is an important aspect of Dolores' current role. For Dolores to be able to tell her patients what to do, she explained that she and the patient need to be "on the same wavelength", "You're like in tune with each other, that you're both having the same conversation, you're not having one by yourself."

Dolores is able to tell her patients what to do because she uses telephone advice/triage protocols as well as guideline books. These documents help her to do three things which support her decision-making. First, they allow her to obtain only relevant information based upon her patient's complaint or problem,

If you've gone through all the Emergent criteria and the patient doesn't have any of those symptoms, you've gone through all the Care Needed Today criteria, and the patient doesn't have any of those symptoms, ... and

the last category is Home Care Only, that they don't ever need to come in, you're just going to give them home care advice.

Second, these documents provide her with information about what to tell patients. As she determines which criteria her patients meet for what dispositions, she narrows in on what to tell the patient to do, "So that's how they [the guidelines] break it down, if they [the patients] meet the criteria, then that's what you tell them to do."

Third, by using these documents, Dolores is assured that she is meeting her patients', the organization's, and her own needs. She believes the protocols and guidelines help to make her practice safe and that, in turn, helps her to feel secure in her decision-making,

You can sleep fine that night [because] you didn't miss somebody that really should have come in. . . . That's a hell of a lot safer than just thinking to yourself did I ask about this, did I ask about that... . That's why I really think we should be using the guidelines much more religiously because then you have a greater sense of security that you haven't missed something key.

Sometimes Dolores feels "frustrated" as she tells patients what to do. She is usually aware that she is not on the same wavelength with the patient. One type of situation involves difficulties using the protocols and guidelines. The difficulty arises primarily because that information the patient is giving does not fit in with the protocol or guideline questions. When this happens, Dolores sometimes brings patients in to be seen by providers,

You are trying to give them a lot of information and they just are not capable of receiving and acting on it. And those are the most frustrating

ones and you sometimes, for any of those reasons, have to bring somebody in because you can't feel confident that you have the full picture because you are not on the same wavelength ... you can't get lined up ... and they are not giving you the information that you are asking for.

Dolores explains that most of her frustrating experiences occur because of the rushed nature of her work. Once again she is not "on the same wavelength" with her patient, but this time it is due to the fact that she is aware there are too many other calls waiting on hold and becomes distracted. In these cases she decides to use the protocols anyway, finding the quickest and best fit for the patient's problem.

And especially if it's busy and you're rushing, okay, "do this, this, and this, got it? Okay, bye". You hope that it's not like that but the reality is sometimes it is and it's almost like, "keep up patient, you're going to miss the boat".

Since telling patients what to do involves following her organizationally approved protocols and guidelines, Dolores also fulfills some of the system's objectives. Dolores explains it this way,

[It feels good] because you know that you made a difference for them, for their household, for the child, for the parent, and also because you are fulfilling some of the organizational goals at the same time. That that person isn't coming in, clogging up the doctor's schedules, making it difficult for him to add in people who really do need to be seen that day, that want to see their own doctor ... and it is making the system work.

Like Dolores, Hank also saw his role as a telephone advice/triage nurse in terms of telling patients what to do. In addition, Hank's interview also revealed that he sees others in health care as telling patients what to do,

And she called me back about two hours later [after she had been seen by the provider], and said, "they put me on this medication, can I nurse?" I just said, "well, what did they tell you do at the office?"

The nurses who tell patients what to do envisioned themselves as a link between their organization and the patients. In this role, they believed their duty was to tell patients what to do.

A variety of perspectives emerged during this study regarding involving patients in their decision-making. All nurses expressed that patient relationships were important to their experience with involving patients in decision-making, whether that be supporting patient decisions or telling patients what to do. Connecting with patients will continue to be important to these nurses as they now discuss deviating from protocols.

Deviating From Protocol

All nurses described using some type of decision-making support protocols which were endorsed and made available by their employing organizations. Protocols provided the nurses with questions to ask patients. Nurses chose a certain protocol based upon the patients initial complaint. While nurses discussed experiences with following these protocols, interestingly, they also shared what it was like to not follow them. Nurses who decided not to follow protocols did so because patients would say something that did not fit a protocol-expected response. Typically that would occur when either the patient volunteered or the

nurse elicited additional information beyond a yes/no type format. In those instances, nurses spoke of the protocol not “fitting” the patient’s condition.

Willing to deviate from protocol. While all nurses had at least one protocol available for decision-making support, not all of them routinely used protocols. And so, being willing to deviate from protocols was part of the decision-making experience for some nurses in this study. Overall, these nurses deviated from protocols in the best interest of their patients. Nurses who were willing to deviate from protocol spoke in terms of needing to communicate well with their patients, considering many variables while assessing patients, and being aware of why they would make a decision to deviate from a protocol.

As explained earlier, Connie works on establishing a relationship with her patients. The purpose for this is so that she can feel comfortable with her final decision, knowing that it is in the best interest of her patient,

I think it does affect my ultimate decision as well, because if we are communicating well and I feel like there’s a relationship I’ve established, then I feel much more comfortable with whatever the plan is. . . .

In assessing her patients, Connie is aware that her patients can have many problems. She believes that protocols are not always the best decision-making support when her patients have multiple problems,

...there’s always variables. ...There’s not just dealing with patient’s medical problems. Certainly, the more information I can gather, the more certain I feel of what decision I will ultimately make. So sometimes, particularly [with] people who have a lot of health problems, it is difficult [to use protocols].

Protocols can actually restrict Connie's assessment in certain situations. So, at times she feels more certain in her decision-making by not following protocol,

[For example,] if someone has AIDS, its so big that they forget to say, 'oh, yeah, and by the way, I was exposed to TB'. [So,] you know something, [if] it's [the protocol is] all prioritized, they [other nurses] may not remember or think it's important [to ask]-- all the things I would.

Background experiential knowledge with making her own decisions also has a place in Connie's willingness to not follow protocols. Connie is aware of her past experiences and how some of those were uncomfortable for her,

I started working in a hospital and I very quickly said, "can't do that", and for a really clear reason, you know. And nobody who I talked with had any idea what I was talking about. Nobody within the profession was where I was. But it just wasn't comfortable for me, so. But it's gotten clearer, and, I mean that was just like [when] I knew some things 'yes/no', but I think I've gotten a little more since then. . . .

Over time, Connie came to believe that her wider base of nursing knowledge, not her experiences with specialty nursing knowledge, contributed to her being able to see a bigger picture. She shared that she now realizes that decisions made without that wider scope can cause harm to patients; even if the decision is written in a protocol,

I think I've gotten a bigger, broader base of knowledge and so I have more of an idea of what, I mean, you know, the Hippocratic Oath, first do no harm. I mean, you know, like basic, these are the rules and that's, those are all good rules to have and to live by. But I think that, as time has gone

on and I've been in different situations. . . . So some of it is just the scope has broadened.

It is not that Connie never uses protocols. But Connie sees them as a back-up to her decision-making when she encounters unfamiliar patient conditions. As she explained, "Certainly the algorithms [protocols] are, they're a definite safety net. I don't have to think, 'oh my God, I've never encountered this.'"

In those unfamiliar situations, Connie feels unprepared to decide upon her own and so will use the protocols, "I have someone else who has done the research for me, and I see what's the right thing to do."

Overall, however, Connie feels her sense of right does not include compromising the safety of patients by rigidly following protocols,

But in the end, yeah, I do feel safer having a sense of what I think is right in health care [because] ... I feel like I'm placing that person in an unsafe position by following the exact rules.

For Connie, being willing to deviate from protocols is a benefit to her patients. She believes there are possible inherent dangers in rigidly assessing by and following protocols.

Kathy, like Connie, is willing to deviate from protocol. To avoid being rigid, Kathy recommends that nurses,

be flexible and keep an open mind with all the information you have, for your self--see what your impressions are, what your 'feelings' are, if you want to use that word, of what's going on with the patient. ...Its just something that probably started as a young nurse and its continued to be the way I work, is the way I think most successful nurses work that are

successful at all in nursing. You've got to be able to, um, be flexible and open.

Kathy goes on to share what being flexible and open feels like, "...it flows, it's comfortable, um, and it helps me to feel at the end of the decision-making process that I made the best decision I can..."

Hoping for a good protocol to fit. Most nurses in this study were not willing to deviate from protocol. Instead they routinely used their protocols. They felt that their organizational sanctioned protocols were helpful in supporting their decision-making. These nurses began their patient conversations hoping that their protocol-generated patient assessment data would make a good "fit" to the protocol.

Irina, an experienced hospital obstetrical and gynecological nurse now working as a telephone advice triage nurse for the past six months in an adult specialty clinic, uses protocols to support her decision-making much of the time. For Irina, a decision is "a slam dunk" when her patients "fit the criteria" of a protocol. For example,

[I] have a protocol for a urinary tract infection that [I] go through and it's an easy kind of thing if [the patients] fit the criteria, [I] can call a prescription and that's done with . . . There's a set-standard of things that [I] do. When a patient needs to be seen and when they don't need to be seen.

Overall, Irina shared that if she can determine that the protocol fits her patients' conditions, they are helpful to her in her decision-making.

However, there are times when her patients' conditions or situations do not fit the protocols, "We have screening guidelines that we use and it's a nice

thick booklet and its broken down to OB, birth control, pregnancy, Gyn problems. [But] not all the problems are in there.”

Irina’s goal is to make the right decision with each and every call. But she is unwilling to make a protocol fit the patient’s condition. When faced with not finding a fit and usually not being able to make the “right” decision on her own, she has two options. Her first option, when she obtains clear information from patients, is to use other professionals in her clinic to help with her decision-making,

...just from my own personal experience, I’ve got people who have been doing this [advice/triage] for a long time. They are good resource people, and you could always put them [patients] on hold and go and talk to [the resource people]. . . . That makes it a lot easier, so I use a lot of those people and I feel like that’s better to do that than to get into trouble and have a bad outcome because I don’t want to do that!

Irina’s second option is to bring patients into the clinic. She utilizes this option when the patients provide vague information,

If they’re [the patients are] iffy in what [about] their symptoms or [the patient is] not too sure, “I think I did this, but I’m not too sure my doctor told me the last time but I’ve had this problem and it’s not going away”, I mean if they just go on and on and it’s all vague and its like, “Mmm, we’re not going to answer this on the phone”, it’s just easier to book them, have them seen, have them talk to a physician, and the patients seem to do better with that also.

Valerie also uses protocols to support her decision-making. While she also prefers not to deviate from protocols, she de-emphasizes Irina’s “patient fit”

perspective. Rather, Valerie emphasizes “self”. She explains she feels lost, rather than saying that the patient condition does not fit the protocol, “The protocols are certainly helpful. [But] I have a number of [other] resources [that I use], where at times it still comes up, where you haven’t a clue where you are, much less where to go.

Valerie also uses professional staff in her decision-making, but she once again emphasizes where her feelings and thoughts are in this process,

Being comfortable to take a few minutes to say okay, I really need to go and sit and think about this for a minute, just draw back and figure out where you are and where you need to go. Our medical director is always available. . . . I’ve got wonderful colleagues that we, who have real different experiential backgrounds and that’s wonderful to be able to bounce it off someone.

And finally, Valerie brings back into focus the relationship she maintains with her patient even while using other colleagues to support her decision-making,

And I guess part of it is feeling comfortable saying to the patient look, “excuse me for a minute, I need to talk to my colleagues about this”. [I’m] not sure that it’s unprofessional, you know, but that is part of your role to integrate this and figure out what is going on. And if I’m at a total loss, it’s really comfortable to say to the patient, you know I really want to help you but I just don’t think I’m understanding what’s going on.”

Hoping for a good fit did not mean that these nurses always followed protocols. In addition, they did not always consult others to support their decision-making. In these instances it was because they had years of some

specialty experience. They shared that they felt very comfortable in their decision-making with specific patient problems which “fit” their depth of specialty knowledge. As an example, Kathy was helped by her 15 years of work in a clinical specialty, “There was no question in my mind what he needed to do. ...because of my background in ..., I usually feel more comfortable with [these] patients because I know what to tell them.

Irina is sometimes helped by her own personal experience. She explained that her own personal experience with surgery gives her a shared understanding of what the experience is like for her patients, “If someone calls in and says their incision is looking funny. I had that surgery, so [I] had a little bit more of an understanding toward that, and it’s an experience shared”.

However, Irina was quick to point out, that she shares in the experience of her patient, but her patient does not share in her experience,

I don’t get into personal stuff with myself and a patient. But [I] know exactly what they’re talking about when they say something and if I’ve gone through it... . That has helped. It just adds to your own information, you know, past experience that you recall.

Overall, most of the nurses in this study used their organizations protocols to support their decision-making. However, they were unwilling to “fit” a patient condition into a protocol when it did not belong. In those cases they usually sought the decision-making support of colleagues or asked the patient to come into the clinic for further assessment.

Making the protocol fit. A few nurses stated that they would never deviate from protocols. These nurses’ perceptions regarding their decision-making experiences were substantially different from other nurses’ experiences.

As previously presented, a few nurses had utilized protocols or guidelines as a last resort in supporting their decision-making while other nurses began with patient information which would then be evaluated as fitting or not fitting a protocol.

Nurses who were never willing to deviate from protocols structured their decision-making around protocols. Initially, however, they had to decide upon which protocol to follow. Patient complaints were thought of as problem lists. Deciding which protocol to use was based upon how many patient problems fell under each protocol. When not all patient problems could be addressed by a certain protocol, nurses focused in on only certain patient problems and therefore were able to “fit” the protocol to those problems.

One such nurse, Eva, stated that she always begins her assessments with patient problem lists. She begins a sorting and weighting process before selecting a protocol or guideline,

The hard decisions are when you have a multitude of things and you try to figure out what’s the most important ... especially if they have a large array of symptoms or things that are going on with them. I try very hard not to allow the patient to give me everything at once. And I’ve been known to say, “okay, why don’t we, um, put this in a category? Or why don’t we number your problems? What do you feel problem number one is”?

Eva does not want any surprises later in the conversation so she makes sure the patient has exhausted each problem,

And then I let them tell me about problem number one and I let them exhaust that, so we don’t have to come back to it. . . . So I try to help them help me by putting, telling me about things one at a time. And when I write

my notes, that's how I write it: you know, problem number one, whatever it is.

Once Eva has decided what each of the patient's problems are, she tells them what would be best to do,

And then I tell them what I'm doing. "Okay, for this problem I think it will be best if we do dah, dah, dah, dah". Uh, if there is patient teaching involved with that particular problem, that's when we talk about teaching also.

She keeps patient problems separate and distinct even as she provides advice,

I don't mix them together. I try to handle one problem at a time and you know, let them know that the problem with your feet, the problem with your back, or the problem with your eyes, you know, how we can handle this.

Attentive to some possible patient dissatisfaction with the plans or advice, Eva will change what she tells the patient to do, but only if there is room within the protocol. Remembering that the protocols are selected from weighting patient problems, Eva is certain that she has decided upon the best protocol and therefore switching or abandoning protocols is not an option,

If they are really, really unhappy with the way something is being approached, if it [the protocol] has room to change and if it's possible to do whatever makes them happy, then I do, I will do that. But if that's not possible, then I explain to them, that I appreciate what they are saying and I do understand, but these are my limits.

Hank also discussed his use of protocols and the fact that he was never willing to deviate from his organizationally sanctioned protocols. During interviews, the primary focus for Hank was the triage component of his role. While his official role was to provide both advice and triage, Hank's meaningful experiences involved triaging patients and authorizing various patient care settings to provide care and services to his patients.

Hank explained that he was never willing to deviate from protocols because protocols had contributed to his professional growth within in his role, When I first started, I was giving almost blanket authorization for everybody. And I have since tightened things up. ... I think it [following authorization formats] makes me sharper because I can be a lot more discerning [about] what needs to be done, what doesn't need to be done.

Hank also works from an envisioned patient problem list. Like Eva, he decides upon specific protocols based upon how many patient problems match each one, choosing the one which best addresses most of the patient's problems. When Hank makes his decision and notices that a patient problem is not addressed by his chosen protocol he will still choose a protocol, making it fit based upon the majority of his patient's complaints. Here is an example of how that situation is handled, "...if the fever comes up, you call us back, otherwise that [advice] should take care of it. And if it doesn't you give us a call back."

On the rare occasion when Hank does not follow a protocol, he will contact another provider. However, accessing other providers for decision-making is perceived by Hank to be outside of the system framework and so is approached in the following way, "I always say, 'sorry to bother you, but I have

a patient here', give them the information and let them make the decision from there."

While Hank usually follows his protocols, the reality is that occasionally there are patients who do not want to do what he tells them to do, "There are people that [are] just adamant about going to an emergency room and I'm like, 'okay, you can go but you may get stuck with bill.'"

Hank is persistent in his explanation of how the system works and perceives these explanations as a very important part of his role as an employee of his organization, "And they're like, 'well, I have an HMO'. 'Yes, but your HMO is contracted with us and you don't fit the parameters to go to the emergency room'."

Even when patients complain, Hank continues to value his role in authorizing services, because he is told that he makes the right decisions,

And they complain [to my boss] and [the response by my boss to] the complaint comes back [to me], "you were right, they were wrong, and don't worry about it". It makes me feel good to make the right decision.

Most nurses in this study used protocols as long as the information which patients supplied fit in well with the protocol. All nurses were aware that protocols were not perfect matches. Nurses took a variety of routes in their decision-making when they realized this situation. An important aspect to consider next will be the nurses' experiences with validating their decisions, the next essential theme.

Validating Decisions

Validating decisions primarily involved those decisions made by nurses which were not supported by protocols or guidelines. Prior to confirming

finalized plans with patients, nurses shared that they engaged in a variety of processes to validate their decisions. Some nurses justified their decisions to themselves, others sought validation for their decision-making from others, and a few nurses relied on organizational system checks and balances to ensure their decision-making.

Justifying decisions to self. Realizing that telephone advice/triage nursing involves many variables, even beyond what a protocol or guideline would ever generate, Connie believes her job is very complex, “There’s always variables ..., and that again is a good example of what triage nursing is, because you don’t get a clean, easy problem.”

Because of her dynamic connections with patients Connie is able to elicit much information about her patients and believes she is the keeper and processor of that information. Therefore, Connie explains that she justifies her decisions to herself,

I don’t make a decision without being able to justify it in my head. You know, I always think, if someone came to me and said, “why the hell did you send this person to the emergency room”?, I could say, “oh, you’re right, it looks funny on paper, but let me explain”. . . . I know within myself why I arrive at a certain decision. . . . So that’s how I get there, and I’ve really never been challenged on it.

For Connie, being able to justify her decisions to herself also involves an awareness of her values and ethics. This awareness effects her decision-making experiences, “...see my decisions are from my value base. I need to live with myself and my sense of ethics. . . . I need to approach my decisions and my work from my value base.”

Irina also justifies decisions to herself, but does so regarding only one type of decision she makes: booking patients to be seen by providers whose schedules are already full. Irina was able to offer the following example illustrating what it feels like when she intervenes in such a situation, “I’m so glad that I intervene at [those] times rather than say, ‘okay, stay home’”.

Not all nurses feel as Irina does about bringing patients in when providers’ schedules are already full, “Some [telephone advice/triage nurses] have the feeling that they don’t want to waste appointments, you know, ‘we’re too busy as it is, we don’t want to double book.’”

Irina, concerned with possible negative patient outcomes, can justify to herself that bringing patients in is the right decision,

[Sometimes] I just don’t feel quite right or [the patient situation] doesn’t feel quite right ... and those are two reasons I think to myself, “it’s okay to double book, or it’s OK to bring them in because [patient situations] have the potential to be bad situations where someone would either be sent home or staying at home would really lead to trouble”.

Seeking validation for decisions. On the other hand, Irina also seeks validation for her decisions. In situations when she does not utilize a protocol or guideline, Irina validates her decisions with others because she is concerned about being criticized regarding her decision-making. She couples that concern with the worry that she will not make the right decision and so will seek validation from other health care providers for her decisions, “...its good to know you made the right decision and it’s reassuring that what you think you should do is validated, that it was the right thing.”

Irina, like most nurses in this study, talked about not being able to see her patients. This contributed to her worries regarding potential negative patient outcomes,

I wouldn't want to think that there was a bad outcome because of a decision. That's, you know, you're always on the, sort of, on the edge with everything, with every phone call because you can't see them, can't feel them, can't look up and say, "um, yes, you're right". Its almost like doing it blind.

Like most nurses, Irina was also concerned that she might miss something obvious about a patient and make a poor decision which another professional would not have made easily,

It would make me feel bad professionally if I missed something that maybe tipped a physician as a slam dunk. "Of course, he [the patient] should have come in". "Of course he should come in" versus I think he should come in ..., it's hard for me to decide.

Irina differentiates between "should come in" and "I think should come in". "I think he should come in" alerts her that she is not certain with her decision, and she will validate her decision with others,

And when I get, "I think he should come in", I'll take it to someone else. . . . Take it to the physician, "this man has such and such or whatever and, you know, tell me, do you think he should be seen"? And she'll [the physician will] say, "of course, of course", and then he'll [the patient will] come in.

Susan shared a slightly different experience with obtaining validation for her decisions. Rather than seeking immediate validation, Susan has received

unsolicited validation after her decision-making regarding a patient, “We don’t hear a lot of reactions [about our decisions]. [However,] we had one physician that used to call and question us Two physicians would call and go ‘what was your thinking on this patient’?”

Physicians questioning decisions validated Susan and her colleagues’ decision-making,

But they were the doctors, they were the two that, they’re the ones that stick up for us the most, that wrote letters saying they liked our service, and have said to us, “this is the hardest job, I could never do this job. And we have nothing but admiration for what you do”.

As a result, Susan wished that “[more physicians] would say, ‘well, why did you want to send this patient in? Or why did you keep this one home?’, and you [would] have explain what your thinking was.” Susan explains what she likes about this in this way, “it tells [me] that [I’m] thinking properly, that [my] concerns [about the patient] are valid” ... and that [I’m] making the right call”.

Most nurses in this study felt that validation by others for their decision-making helped them to know that they were making correct decisions for their patients. Validation especially became important when they could not use their protocols and guidelines as supports for decision-making.

A non-issue: checks and balances. Justifying or seeking validation for decisions was a non-issue for a few nurses in this study. These nurses believed that their organizations provided “checks and balances” for decisions. Hank explained it this way, “There’s checks and balances that we can go through. . . . We have paperwork that we can refer to as far as, if A happens, do B, if B doesn’t work, then do C.”

Hank is confident that his organizational protocols and guideline books will address almost any patient situation,

Depending on the situation, I have triage books that I can refer to as far as protocols; that I refer to primarily for pediatrics, [but] mainly [for] med-surg adult nursing. . . . I do have protocols that I have to follow as far as [if] a child swallows a quarter, yeah, they have to be seen. If they swallow a dime, they don't have to. So it's just the diameter of the foreign body swallowed and, you know, it goes from there.

Hank believes that his decision-making, while using protocols and guidelines is so comprehensive that no follow-up to his decisions is necessary. Unlike most nurses in this study, he is not concerned with what other providers may think about his decisions. Follow-up is about the business of triaging patients,

The only follow-up I do is if I give authorization to a facility [to provide care]. Before the end of my shift I try to follow-up and make sure that the patient has shown up, they've been discharged, what the diagnosis is, so that I can review for coordination. So they [the office] can document on their files, but otherwise I don't call back and say, "hi, how are they [you] doing"?

However, occasionally Hank does speak to a patient a second time. Sometimes he will recognize a patient's name and at other times patients recognize him because he is a male. In either case, as he speaks to the patient, he feels no need to validate that his previous decision was correct,

Now there are times when I will get kind of what I call repeat business.

Where I recognize names on different days, and I'll say [to myself] what's

going on with them now, and its like, “hi, how are you doing? What did he get into now”? And I’m the only male nurse in the system so I’ve kind of [got] a corner on the market and everybody knows when I call, they go “hi, you’re the guy I talked to before”. I’m like, “yeah, I guess so, I’m the only guy in the system”.

Dolores, with an eye to system quality assurance, also felt that there was no need to justify or validate decisions. Her feelings were based upon her belief in the purpose of protocols and guidelines. Dolores shared that what the nurse asks the patient is as important as what the nurse tells the patient at the end of the call. Dolores’ example illustrates the balancing input/output function of her protocols, negating her need to validate her decisions,

[The purpose of a protocol is] so that it is consistent information that the person calls with no matter which nurse they are talking to, and [that] they [the patients] are going to get roughly the same kind of information [from any nurse].

While validating decisions emerged as an essential theme in this study, nurses once again varied in their perceptions regarding their experiences. Similarly, nurses also varied in their perceptions regarding living with the responsibility of their decision-making.

Living with Responsibility

Living with the responsibility of decision-making took on different meaning to different nurses. Nurses in this study shared their thoughts about feeling self accountability, taking responsibility, feeling unwanted responsibility, and facilitating others’ in assuming their responsibility. In most cases, nurses discussed having or taking responsibility for acts. Accountability, versus

responsibility, took on an overall importance with self for the few nurses who discussed the term accountability.

Feeling self accountability. Very few nurses in this study discussed the idea of feeling self accountable for their decisions. Accountability was important to Connie as evidenced by her thoughts here and her discussions about accountability with her manager,

I feel accountable for my actions. I mean that's something that's important to me. ... We both [Connie and her manager] have a very strong code of ethics and she said she thinks all nurses do. And they probably do.

Another important point Connie wanted to share was that "having" accountability was different from "knowing" what someone's accountability was, "...but we [Connie and her manager] not only have it, we know what it is."

Connie shared more thoughts about feeling accountable and how she came to the point where she is now,

... probably in the very beginning of nursing, I was sort of like floating along and getting to figure out all the ins and outs of it [nursing], and, you know, there's all of the physical aspects, the technical aspects, the intellectual aspects, I mean all of that stuff. But I'd say within three years I knew what I thought was right, what was good health care, and I know what I thought wasn't.

Taking responsibility. Taking responsibility was different from feeling accountable. Here, Dolores points out that taking responsibility means "fixing" something. Being in tune with patients for the purpose of getting information for patient assessments was important to Dolores, and she had this to share about taking responsibility for that tuning-in process,

[When] you're like in tune with each other, you're both having the same conversation, you're not having one by yourself. . . . I think most of the time the nurse would be the one to sense it and I think certainly it is the nurse's responsibility to sense it and to try to fix it if it's fixable.

Peggy explains that responsibility is an evolutionary process. For her, it began when she entered nursing,

When I first came into nursing, nurses didn't make decisions. You know, and as time has progressed and nurses have become so much more knowledgeable and have been given so much more responsibility you have to live with that responsibility, because you do make a lot of decisions.

Living with the responsibility one is given, means that Peggy is a real nurse. Being a real nurse means one is worthy of the trust others place in the person. Knowing that nurses' decisions effect patients, others trust Peggy to make the right decisions,

It makes you become a real nurse. You are somebody. Do you see what I mean? And I like that. I like making a decision. I like being worthy. . . .

Because whatever you do today, you are responsible for, and you want to make a better tomorrow.

Feeling unwanted responsibility. Previously, Peggy indicated that responsibility was given to her. Here, Eva takes that idea a step farther by pointing out that she sometimes must take responsibility for her decisions to carry out plans which are made by others. Eva shares her feelings about such administrative decisions and her responsibility in deciding to carry out those plans with patients,

...the nurses are always down on the firing line. And this is another situation that has put the nurses on the firing line, and it upsets me. Because I hate that situation where they're up there making these decisions, but they are not dealing with people everyday. And they're saying, "okay, I've made this decision, now you carry it out". And they shoot bullets, then you put up shields, but that's your responsibility. It doesn't make me feel very good.

Facilitating others in assuming their responsibility. Hank, on the other hand had quite different views regarding decision-making responsibility. He discussed two types of responsibilities, patient responsibility and system responsibility. As Hank discussed these responsibilities, his role as a telephone advice/triage nurse emerged as one which was to facilitate the two parties in coming together.

First, Hank feels that patients should know how "the system works" and assume their responsibility in making it work for them,

It's frustrating sometimes when people call [me] after hours constantly and want to go to Urgent Care, they want to go to the Emergency Room and it's like why don't you go to the doctor's during regular hours. And unfortunately this isn't the time, it's 12:30, doctor's office has been closed for half an hour, and the majority of them know the doctor's offices are open [until 12:30] on the weekends --- pediatrician's offices.

When patients do not assume their responsibilities for accessing care Hank feels frustrated. He talked about how he cannot understand why patients or parents of patients would not do as he would do since they must know how the system works,

And I say, “why didn’t you take them [in before] now? Why are you waiting a half hour after they closed to call [me] and say they have a fever? Why didn’t you do this first thing in the morning?” If it was my kid, I’d be waiting, you know, doctor’s office opens at 8:00, I’m calling at 8:01, you know, to say, “my kid’s sick, what should I do”? ... I mean you’ve got to know how the system works.

As Hank tries to explain how the system works to his patients, he is aware that he does not want to appear superior to them,

I try not to be condescending with this, because I don’t want to talk down to them, I’m just trying to enlighten them as to what all is going on, how the system works, and how the ‘game’ is played.

According to Hank, not only do patients have responsibilities, but his organization also has responsibilities. Those responsibilities include providing the framework and system to support his decision-making. Hank’s role is intimately tied up in the system and representing the system to his patients,

I always look out for the patient’s best interest at heart. And, um, you know, there’s always, you know fallback. We have referrals, we have paperwork that we can refer to as far as if A happens, do B, if B doesn’t work, then do C. So there is, you know, there’s checks and balances that we can go through.

While the organization’s responsibilities to patients for accessing care are delineated through protocols and guidelines, Hank’s perception of his role in implementing those guidelines remains a caring one,

Everybody wants, you know, the magic bullet, and it doesn’t work that way. Authorization means that they’ve met the criteria, we will authorize

them to be seen through their HMO, so they can be [seen] and everybody's happy. ... Almost every call that I get I tell the person, if it's them, if it's the significant other, parent, or whatever, that I have called in something or if I've suggested something, that I always hope that they feel better. That's kind of like my, you know, [way] to reach out to them. You know, [I] say, I care and I hope they feel better.

Dolores also believes her job is to facilitate others, namely patients and the system, in assuming their responsibilities. She also views herself as the connector between the patient and the system. Here, Dolores discusses the conflict she feels in sometimes having to decide to side with the system in allocating telling the patients that they are responsible for their own care and do not meet the parameters for a visit,

...if you set up your triage system to be a gatekeeper, patients are going to clue into that very quickly and then resent it, and not see it as a value added service, but see it as an obstacle to get through. "I have to convince that nurse that I am really sick enough to be seen." ...That isn't even ethically what your role should be, but at the same time, you don't want to unnecessarily have people to go to the ER and wracking up expenses, because you want the institution to survive. . . ."

Kathy believes that most patients do not understand how the system works and that is why they do not assume their responsibility within the health care system, And they mistakenly think that that action is to bring their child to the doctor, when that really isn't going to do much for the child. ... They're not calling saying, "I don't know what to do." They're calling saying, "I know exactly what to do and you just don't get in my way, I'm bringing

my kid in. ... Sometimes they'll say, "Oh, I already tried all those things." And its like, okay that's the failed home care category, so, "you bought yourself an appointment!"

Living with responsibility meant different things to different nurses in this study. Knowing what is really going, the next essential theme, also meant different things to different nurses.

Knowing What's Really Going On

All nurses in this study shared that they would like to know "what's really going on". To know what's really going on meant having information to make the best decisions they could make. For most nurses, knowing what's really going on was discussed in terms of knowing about their patients. For a few nurses, it also meant being aware of their own knowing.

Most nurses believed that they could come to know "something" about why patients call and could therefore obtain enough assessment data for making correct decisions. A few nurses, however, believed that they could never really know what was going in terms of their patients.

Knowing patient and self. For some nurses, knowing what's really going on involved the patient and the nurse. It was about the nurse knowing the patient as well as the nurse knowing himself or herself.

Connie shared that really knowing what a patient's call is all about goes far beyond the information she receives from patients in order to just triage or provide advice to them. The "beyond" involves patients not wanting to be alone and hoping they will be listened to and will get care. Primarily, it's about patients being fearful of a changing world,

I'll tell you what I think a lot of it is about is that people are very afraid in the world, and the thought that there is somebody on the other end of the telephone who will make sure that they won't be alone, that they will have access to health care if they need it, that they will be listened to; I really think that's what it is about. I really do. Sometimes it's about lifesaving things like they are having an MI, but I think it's about how frightening the world is. . . .

Knowing what's really going on also involved Connie processing knowledge and being aware of her knowledge. This is an experience which happened over time for Connie. Connie explained that while she possesses knowledge, she is now aware of what she knows,

I think that when I look back on my nursing career, in the beginning I don't think that I made wrong decisions, but they were more instinctive and I would search out answers if I didn't know them. Now I have, obviously from my experience and education, I recognize that I have a much broader knowledge base. ... I guess it makes me feel much more comfortable in my decisions because I know where it [my knowledge] comes from. I'm aware that I have it in the first place, so I know where it comes from.

The outcome of having knowledge and being aware of it are that Connie's decisions are congruent with her "self",

So because number one I have it, number two I'm aware of it, I know that my decisions are congruent. I know where they [my decisions] come from. They aren't a surprise to me. ... The more mindful one is of where, or of

their knowledge base, then probably the better the decisions, or at least the more congruent one would be with their decisions.

Going by what they tell you. For most nurses, knowing what's really going on focused upon knowing the patient. And in most instances, nurses shared that they never really knew all that was going on with their patients. For these nurses this meant that they did not always feel that they knew everything about their patients. This being the case, nurses were somehow aware that there was more to know.

Eva expressed that there are calls which seem to represent more than is initially presented by the patient. Eva believes that a nurse can "know what a call is about, can find out what they really called for, ...but, you don't always know what's really happening". To understand what a call is about, Eva routinely just allows patients to verbalize. And, once in a while, when she finds out what patients really call for, she gets very excited. Demonstrating this feeling during an interview, she rose to her feet and shouted, "Yes!!! Yes!!! [Once] I get them to tell me what's going on, I can help them".

These nurses believed there was more they could know about their patients, but in some instances their patients did not want them to know everything. For example, Peggy sometimes wonders if patients are always truthful as they provide information over the phone,

I wonder sometimes if they're [patients are] telling me the truth and the reason that I wonder that is because sometimes the [patients'] calls are so often. See, so now we're dealing in a different ball game. When you're getting a lot of calls from the same people, now you're wondering if what they're feeling is real.

But Peggy takes a philosophical approach with this subject demonstrating her sensitivity with patients and their personal perspectives, "...You have to take it for what it's really worth. Nobody will ever know for sure though, because we only tell people what we want other people to know. So you will know as much as can be known."

Not knowing everything that is going on with patients can be dependent upon time and how patients change over time. In relation to her own decision-making and what other providers might later assess is really going on with patients, Dolores shares the following,

...all you can go by is what they tell you on the phone. You know, that's the only data that you have to work with so that's another reason why I think it's really important to send our assessment notes out [on to other providers] so that they understand that this is what it looked like from where we were sitting, with what we had at that time frame and then the patient's symptoms can change in the interim, but you know [things can change between] when you talk to them and when they're seen and you can't predict that. You can only go by what you know at the time that you make the assessment. And I feel pretty comfortable that at that time it's the right decision.

According to Dolores, knowing all that can be known is also dependent upon the patient's perceptions. While she attempts to do an objective assessment with her patients, Dolores is aware of how subjective that assessment really is. Dolores discussed her feelings about patient assessments and what role her patients' own perceptions play in her decision-making,

You can do things to try to make it [the assessment] more objective. But when they are telling you their story, it's their story. It's about as subjective as it can get. ... You can try to pin them down to make it more objective. [But] it's rare that it's ever presented to you that way.

Everything that they're saying is colored by their perception of it.

She continued to explain that no matter how objectively she approaches her assessment, her patient's perceptions still enter into her data,

Even if you ask them, you know, [if] you're checking for pitting edema, "I want you to press your finger in on your ankle. Does it leave an indentation"? That sounds like an objective sign but it still is being filtered through the patient's visual acuity, through their perceptions, through their leg which is a barrier, so it's, it sounds impossible now that I'm describing it that way that you could ever come up with any useful data!

Dolores concluded her discussion about "knowing all that can be known" this way,

No. No, I don't think you can. I don't even know that you can do that when they're [the patients' are] there [in front of you]. And that's maybe kind of a philosophical thing. But like most decisions in life, you're making your decision with less than full information.

Never really knowing what is going on. A few nurses talked about feeling that they never knew what was really going on with their patients. In answer to why they felt this way, these nurses shared that too many times they learned completely different things about their patients after care had been rendered.

Even though Hank assesses his patients over the phone, he shared that he frequently does not know what is really going with his patients until after they

have been seen by a provider and he is called to authorize services, “No. Never. There’s a lot of times when I have no idea what’s going on. And I don’t find out until after the fact.”

However, while believing that he never really knows what is going on with patients, Hank does sense things about patients, “I can sense usually if they’re afraid, if I have a patient with chest pain, if I have somebody in definite pain, I can tell, usually they’re crying or they just have a real pained, pained voice”.

From Irina’s perspective, she, not her patient is the reason she never knows what is really going on with her patients. Irina included her perception of her own knowledge as part of never knowing what is really going on. Irina feels that while she had broad nursing knowledge, she will never possess enough specific knowledge and this keeps her from truly knowing what is going on with her patients, “as a nurse you have that broad foundation, that base, but you don’t have a lot of spikes in, for instance, the [biochemistry aspect] of things.”

Opinions about knowing what’s really going on with their patients varied among the nurses in this study. While most nurses addressed the issue relative to the lack of patient information, one nurse thought about this in terms of her own knowledge as a decision-maker.

Coming to a Decision

All nurses in the study spoke about coming to decisions. However, different ways of coming to a decision were evident among nurse decision-making. Some nurses made justifiable decisions in the best interest of the patients. These nurses were clear about their own personal and professional knowledge, ethics and values, and what they knew about their patients. They believed that

because of their “mindfulness”, sense of ethics and values, and knowing their patients, they were obligated to first justify all decisions to themselves. Most nurses in this study did not justify their decisions to themselves, instead, they validated that they were making the right call based upon what felt comfortable to them. These nurses worried about coming to a decision and possible bad outcomes and so to increase their comfort level with coming to a decision they validated their decisions with protocols, guidelines or other providers. Finally, still another group of nurses came to decisions by striking a balance in an effort to maintain system equilibrium. These nurses did their best to remain aware of both the cost of health care and patient satisfaction.

Making justifiable decisions. In coming to a decision, a few nurses communicated that they first justified their decisions to themselves. These nurses were aware that not all of their decisions would be correct in terms of organizational expectations. However, they were very clear in stating that their decisions were made in the best interest of the patients and that was how they justified their decisions to themselves. The types of relationships these nurses had with patients helped them to obtain a wide range of information about their patients. In addition, what these nurses believed they knew about themselves contributed to their ability to justify their decisions to themselves.

In making justifiable decisions, nurses explained that connecting relationships among themselves and patients were dynamic and allowed for much information to be exchanged between both nurse and patient. The relationship usually began at the beginning of the conversation.

While Connie had difficulty articulating the theme of connecting, it was real for her and she used what she learned about patients in making justifiable decisions,

I did establish a relationship with this person and talked to him several times in the next like 48 hours. Which I think was important because I think one of his, um one of his issues, was fear, which makes sense, totally makes sense given the circumstances.

In making justifiable decisions nurses involved patients in decision-making. They welcomed all sorts of information about the patient's condition, situation, and anything else the patient felt was important for the nurse to know. The nature of their connecting allowed them to trust their patients and know that what the patient said represented the "truth" about what was really going on. As an example, Susan obtains information beyond clinical findings,

She [the patient] didn't think anything of it and I'm picking it up saying, "this is something that I'm more concerned about than the symptoms you are talking about right now". ... So I guess it's just that, just hearing more than what they're actually, what they're actually saying to you.

While these nurses had protocols and guidelines available to support their decision-making, they were willing to deviate from the protocol if they felt it was not in the best interest of the patient. They were "mindful" of a multitude of patient variables, their own knowledge, and their own experience which made it possible to deviate from protocols.

For example, Susan justified her decisions to herself. She perceived that she had reliable information about what was really going on with patients. Susan was also aware of her personal value base and sense of ethics. All in all, Susan felt

certain about the decisions she ultimately made. She made justifiable decisions based upon the best interest of the patient and therefore was secure in her decision-making,

And I walked up stairs, and we had met with a lot of resistance from the departments trying to get patients in and they re-triage what we do, the medical assistant or the secretary, "Oh no, we don't need to see that." So I walked up with this message, and I said, "this patient has chicken pox and I'm concerned about his eye". And the nurse turned around and goes, "well, we never see chicken pox." And I said, "I know that, I am concerned about this child's vision." And she jumped back, and within five minutes a doctor called back, we had that taken care of.

Finally, in coming to a decision, justifying one's decision to one's self was integral to these nurses. As explained by Connie, that justification was grounded in self values and ethics,

I don't make a decision before being able to justify it in my head. ... See my decisions are from my value base. I need to live with myself and my sense of ethics. ... I need to approach my decisions and my work from my value base.

Validating the right call. In coming to a decision most of the nurses in this study explained that they validated their decisions. These nurses worried about their decision-making. They had feelings of uncertainty and sought validation for their decision-making. Feeling comfortable that they were making the right decision with each and every call was their goal for coming to a decision. And, having their decisions validated helped them to feel more comfortable.

Connecting with patients was about patients providing information for good nurse assessments leading to the right decisions. Patient-to-nurse relationships were important to these nurses from the perspective of trying to obtain the clearest and most accurate information so that they could make the right decisions for their patients.

Validating the right call involved nurses taking their assessment data and looking for a fit between patient problems and their protocols or guidelines. When a fit happened they felt that they could make the right decision. Susan discussed her feelings associated with validating the right decision in this way,

I guess it starts when the call comes [in], when [I] realize there's a serious problem that needs to be addressed right away. ... It's just [that] [I'm] feeling confident that [I] know that [I'm] making this call correctly ... its an adrenaline rush. ... It was the right call ... I'm glad ...It's a happy kind of feeling, and it's a feeling, I mean those are the kinds of times when [I] know that's why [I'm] in this job. That's a good feeling to know that [I] got somebody the care they needed.

Sometimes nurses could not determine a fit between the patient's problem and their protocols and guidelines. One reason Irina gave for this was patient vagueness,

She's giving you all of these vague kind of things, you can tell that she's getting anxious about it. It just seems better to bring them in and have them checked.

These nurses hoped that their patient assessment would make for a good fit to their protocols, explaining that they sometimes only knew what was going on with their patients. They worried about their decision-making and possible

bad patient outcomes. However, they felt that they should be able to always “make the right call” because they were RNs and valued those kinds of decisions.

but for our own nursing integrity kind of thing, you know, you always want to do the right thing and you hold a great value to that because you’re an RN and you should be able to make that kind of decision.

These nurses never-the-less frequently sought validation for their decisions. All nurses concerned with making the right decision worried about bad patient outcomes and so when a fit did not occur, they would usually ask the patient to come in to be seen by a provider, “It’s better to bring them, my feeling is, it’s better to bring them in and have it be nothing that have them stay home and have a problem”.

A few nurses talked about using their own personal experience to validate that they were coming to a “right” decision. Personal experience with having children was a common connection. As Susan explains,

...and as a human being, and having just lived so many years and gone through some of these things. ... I know what parents are going through because I’ve also had children. ... I can empathize with them when they have sick children. ... So it’s, that helps.

Sometimes nurses relied upon their own professional experience in coming to a “right” decision. As an example, one nurse knew what to tell patients because of her 15 years of work in that specialty, “There was no question in my mind what he needed to do. ...because of my background in ..., I usually feel more comfortable with [these] patients because I know what to tell them”.

When nurses felt that they did not possess enough specific clinical knowledge to make decisions on their own, they also sought validation from others. Valerie shared her ideas about how she goes about obtaining more specific clinical knowledge,

...I talk with the other more [knowledgeable] nurses often and go over situations. ... That makes it a lot easier, so I use a lot of those people and I feel like that's better to do that than to get into trouble and have a bad outcome because I don't want to do that!

While these nurses expressed a desire to make the correct decision with every call, they realized that that did not always happen. But, as Peggy shared, "I can only go by what they tell me" and as long as the nurses did not feel that a wrong call would involve a potential bad patient outcome, there is little concern. For instance, Susan may decide a patient should be seen in the clinic, direct the patient to come in to be seen, and the health care provider in the clinic, after seeing the patient, may "find nothing",

So, [I] think, well, [I'm] only hoping to make the right call most of the time. ... I don't feel bad about that because I'm, I have to go by what [the patient is] telling me. ...And [I] just kind of hope, oh God, I don't want to be the one that makes the wrong call.

Coming to a decision for most of these nurses involved deciding based upon what felt comfortable. While these nurses expressed a desire to make the correct decision with every call, they knew that would not always occur. Nurses shared that they could only make decisions based upon what patients told them. They primarily felt uncertain in their decisions, seeking validation in coming to the

right decisions by using their protocols or guidelines and consulting with other providers.

Striking a balance. A few nurses in this study viewed coming to a decision in terms of system equilibrium. In other words, they were concerned with balancing their organization's resources with "customer" satisfaction. One nurse captured this balancing act in coming to a decision as: "everybody's happy". Feeling that they were making the correct organizational decision with each and every call was an important aspect in coming to a decision for these nurses. They felt that system mechanisms such as problem-oriented protocols and authorization and advice guidelines ensured that their decisions were correct.

As with other nurses in this study, relationships with patients were critical. But here, it was important that nurses helped patients to know how the health care system operated so that the nurse could apply the system framework to the patient problem in coming to a decision in order to tell the patient what to do. The nurse was the connector between the system and the patient.

In most cases nurses felt that their relationship involved helping the patient to navigate the health care system,

I am still a patient advocate even though we try to contain costs, I'm still a patient advocate. I always look for the patient's best interest at heart. ...

"well, I'm sorry if you've been sick for a week, that doesn't constitute an emergency and your HMO is not really going to be happy if I send you or if I approve that -- if I give authorization".

Overall, these nurses felt that they never really knew what was going on with the patients. However, they did not express frustration over not knowing as other nurses had done. These nurses believed that their role was to facilitate both

the responsibility of patients and the system by connecting the patients and the system, thereby ensuring that patients received “definitive care”. In other words, they were the connector and that was the part they played in connecting.

Use of protocols and guidelines were the mainstay to striking a balance in coming to a decision. Protocols and guidelines either matched and fit the caller’s situation or condition, or they did not. When protocols and guidelines appeared to match their patients’ situations or conditions, nurses felt that patients, their organizations and they, themselves were happy. But, as with other nurses, there were times when the protocols and guidelines did not fit the caller’s situation. These nurses approached this situation one of two ways. Either they applied the protocol closest to the patient’s condition or situation or they would apologetically approach other providers to make decisions.

When applying protocols or guidelines which do not have a perfect match to the patient condition or situation, these nurses worried and experienced anxiety but learned to deal with their feelings over time. Dolores offered an example,

But there are patients that you think about later and you think, well I wish I’d asked this one other thing [not in the protocol] or I hope they will feel free to call back if they’re not better in a day or two. . . . You don’t have time, I mean you just can’t have free floating anxiety about every call you’ve made that day. ...You have to move on and worry about the next patient.

Coming to a decision without some form of protocol or guideline support rarely occurred among these nurses, but the following illustrates this rare process when it occurred for Hank,

And there's times when the patient is talking to you and they're telling you their symptoms and it just doesn't hang together, it doesn't fit any pattern [protocol or guideline] and you just think, I have no idea. I don't know what's wrong with this patient! And obviously you have to bring those people in

From their perspective, following protocols and guidelines provided the assurance that these nurses needed in making decisions. They were confident that, in their roles, they were ensuring patients "get definitive care". For example, Hank explained that non-emergent patients sometimes go to Emergency Rooms without his pre-authorization. And when he receives a call from the ER, he will refer to his protocols and guidelines to make the most appropriate decision,

If they're in the ER, if they need to be seen, [but] can be seen at an Urgent Care or they can just be treated at home, [I tell them] just leave the ER.

I've had to do that a couple of times. It's not a real popular decision, but in the same sense they need to follow the procedure.

Dolores felt that there were "a lot of good reasons" to use protocols and guidelines,

Not only do I have to be sure that I've met the patient's needs and that I've made them safe and I haven't unduly abused the system, and racked up a lot of extra cost, but I also have to know that I've done it in such a way that I'm going to be comfortable about it when I think about that patient later on.

In striking a balance, following protocols and guidelines provided the assurance that these nurses needed to be decision-makers. They were certain that, in their roles, they were ensuring patients "got definitive care".

As nurses in this spoke about coming to a decision, three perspectives were evident. These three perspectives included making a justifiable decision based upon the patient's best interest, validating the right call based upon what feels most comfortable for the nurse, and striking a balance based upon maintaining system equilibrium.

Being a Decision-maker

Being a decision-maker emerged as an essential theme in this study as feelings were closely examined. Nurses talked about feelings throughout the interviews, especially when they were sharing decision-making experiences which represented for them what it meant to be a telephone advice/triage nurse. Sensing themselves in decision-making involved feelings of self-confidence, self-uncertainty, or self-certainty.

Feeling self-confidence. Being a decision-maker for a few nurses in this study, meant that they felt a sense of self-confidence during the experience. These nurses shared feelings about their decision-making which demonstrated this sense of feeling self-confidence. Evidence of that was found in the self-confidence with which Susan spoke of her decision-making experience, "It's just [that] [I'm] feeling confident that [I] know that [I'm] making this call correctly".

Connie, feeling confident in herself as a decision-maker also meant that she was aware of her feelings of uncertainty in making the right or absolute correct decision with each and every call. For Connie, being a confident decision-maker, included being aware of both certainties and uncertainties in her decision-making,

Certainly the more information I can gather, the more certain I feel of what [about] the decision I will ultimately make. So, sometimes, particularly

[with] people who have a lot of health problems, it is difficult. ... There's decisions, I think now, that are leaps that are almost inexpressible for me.

Overall, Connie's sense of being a decision-maker was one of confidence when it came to being a decision maker, "I don't make a decision without being able to justify it in my head. ... I know within myself why I arrive at a certain decision."

Feeling self-uncertainty. Being a decision-maker for most nurses in this study, meant that they felt a sense of self-uncertainty during the experience. They shared that they worried about making decisions. As they continually spoke about bad patient outcomes relative to decision-making, this focus related to past, present, and future experiences. Being a decision-maker for these nurses was commingled with worrying about bad patient outcomes. It was so integrated into being a decision-maker that they perceived patients could sense their uncertainty as decision-makers. These nurses spoke frequently about what it felt like to be uncertain in coming to a decision. Irina offers the following example,

I can tell you that there was a lady that called, who was pregnant, that had some vague kind of symptoms. She just didn't feel good, wasn't too sure -- she'd had some spotting, but it had gone away. Um, it was a call, "is it okay to let her stay at home and she's going to be fine, or does she need to come in"?

Feeling uncertain is not a pleasant feeling, as Irina shared, "When you're not certain, that's not a good feeling. You even, I think talk differently, and I think that patients can tell that you're at a little bit of a loss too."

These particular nurses were not wedded to either protocols or guidelines for all of their decision-making. They recognized when patient conditions and

situations did not “fit” their protocols or guidelines. Because they were unwilling to make protocol-determined decisions when patient conditions did not match approved protocol algorithms, they would frequently use other providers as validators for their decisions or relinquish decision-making all together to those providers,

...and, of course, when that happens you always have to be safe than sorry, be more conservative. . . . The more [I] take advantage of the resources and the people here in the clinic, the better I feel about it.

Feeling self-confidence, while rare, occurred for Irina when she was uncertain about her assessments. On these occasions she was confident in her decision-making in terms of doing no harm to patients by bringing them in,

[If] you were going to bring them in just anytime in the afternoon, but you're not certain what's going on and you decide to bump them up to coming in within the next hour or two, then you can feel confident that you haven't done any harm, you know that old saying, that at first, I don't know exactly how it goes, but at the most do no harm. If you can at least be confident that you haven't hurt the patient, there's still some confidence in there even when you're uncertain.

Overall, these nurses felt uncertain in their being decision-makers. The only instance when these nurses felt certain, was if they had had many years of working in a specialty field of nursing. For example, when a patient would call about a condition or situation within that nurse's area of “expertise” and the decision was perceived as a “very routine decision” by the nurse, the nurse was certain about the decision-making. Here, in this type of situation, over time, the nurse had integrated a sense of “expertness” into her being.

Feeling self-certainty. Being a decision-maker for some nurses in this study, meant that they felt a sense of self-certainty during their experiences. Feeling self-certainty, like feeling self-confidence, was a sense which occurred among only a few nurses. Integrating decision-making supports, either organizationally sanctioned protocols and guidelines or managers, was the major part of being decision-makers for these nurses. They were confident in the system's ability to ensure that each patient would be handled properly. As a result, they felt self-certain in being decision-makers while using the system supports. Dolores explains her feelings,

It's a real solid feeling that, like this is it, we're at the right place, we know what we're dealing with, and then often, once you know what you're dealing with, then it flows very obviously from that, what you're going to say next, what you're going to tell them to do. . . .

While these nurses were confident in the system of algorithms, sets of questions, and system of management which were in place to support their decision-making, they were not confident in themselves as decision-makers. These nurses relied almost exclusively upon protocols and guidelines for their feelings of self-certainty as decision-makers. For example, although a patient desires to go to an Emergency Room for care, a guideline may in fact lead Hank into deciding that an Urgent Care setting is most appropriate for the patient,

This way they are getting seen, they are seeing a doctor and their HMO's are happy because they [the HMO's] are not paying a couple of hundred dollars for an ER visit, they is paying for an Urgent Care visit. ... I want them, I don't want to deny care to anybody. I want them to be seen. I want them to get definitive care.

Making decisions without some form of system support rarely occurred for Hank, but was fraught with self-uncertainty when it did. The following provides an illustration,

I had one lady that was a [condition not in any protocol or guideline book]. ... “Okay, this isn’t going to be an easy mark”. So I’m talking to her, we’re shooting the bull and she’s telling me she had a bad situation at a doctor’s office and a couple of things. . . . It was weird because it was when the call came in, when I was talking to her, all the other nurses were in a meeting. . . . I figured I could handle this. . . . The next day I talked with my boss and I said, “did I do the right thing”? And she said, “you did everything perfectly”. It was very cool.

Being a decision-maker involved a number of different nurse perspectives. Feelings of self-confidence, self-uncertainty, and self-certainty represented what it felt like being decision-makers.

The lived experience of decision-making among telephone advice/triage nurses is complex. The findings of the study represent the multidimensional, contextual, and simultaneous nature of decision-making. While eight essential themes emerged to illustrate what the experience was like for these nurses, themes do not stand alone and are not separate. One theme did draw attention as it was woven throughout the experience. That theme was connecting. Over and over, nurses spoke in terms of what it was like to be connected to or with patients during decision-making. A discussion of these findings will be presented in the next chapter in order to consider theoretical implications.

CHAPTER V

DISCUSSION OF THE FINDINGS

The role of the telephone advice/triage nurse is both complex and demanding. Nurses come to this role with varying perceptions about the demands of telephone nursing. Minimal preparation and support is provided to help nurses adapt to the role. In addition, the ambiguous nature of the role makes their daily experiences a constant challenge. Nurses come to this role with the concept of caring as the foundation of their practice. However, the role is often presented within an efficiency model of health care services designed to decrease costs.

The challenges of decision-making are numerous. Telephone advice/triage nurses make decisions which effect patients, patients' families, health care organizations, and themselves. They work to develop strong working relationships with patients in very short periods of time. They assess patients without the use of all of their senses. They make multiple, important decisions with each and every call. The nurses in this study were very aware of the important role they played in the health and well being of their patients, as well as, the survival of their organizations. They took their decision-making very seriously.

Meaning of the Decision-making Experience

The "what is it like?" nature of the research question allowed for rich participant data which answered both epistemological as well as ontological

questions concerning the phenomenological experience of decision-making among telephone advice/triage nurses. The epistemological aspects of the experience of decision-making, in other words, types of decision-making knowing, are important to the overall meaning of the experience. It is also important to evolve an epistemological focus into an ontological focus for meaning to be examined through the nurses' reality of being decision-makers. Finally, considering how the meaning of decision-making reveals awareness and organization of professional and personal knowledge, diversity in handling pieces of information, and interpretation of data is important for understanding aspects of cognitive development among the nurses.

Epistemological Meaning of Decision-making

The findings from this study demonstrate that there are decision-making considerations (essential themes) which nurses "know" to be true and therefore contribute to the meaning of their experience. So, in answer to the epistemological question, "how do I come to know my decision-making?", both decision-making considerations and ways of coming to a decision are involved in answering that question for the group as a whole as well as each nurse.

Phenomenology of perception. The nurses' perceptions of the meaning of their decision-making experiences are integral to understanding the findings of this study. Envelopment and ambiguity, two concepts which contribute to the philosophical underpinning of this study, will be utilized to examine the findings.

Coming to an understanding of the meaning of the common lived experience of decision-making can be achieved by revisiting Merleau-Ponty's central theme of envelopment which is founded in a phenomenological view of perception. By considering envelopment, the multidimensionality (multiple

entities) and contextual nature (interrelated conditions) of decision-making can be discussed. As will be recalled, three modalities assist the phenomenologist toward the goal of understanding meaning and envelopment acts to conjoin the modalities. Modalities include 1) simultaneous presence (coexistence), 2) mutual implication (a folding into), and 3) contraction (an economy of depth). These are interrelated but finite in order to accomplish a pre-established goal (Dillion, 1991).

The experience of decision-making occurs while “being simultaneously present in each act” (Merleau-Ponty, 1967, p. 264). The acts in this study are the decision-making essential themes (i.e., involving patients in decision-making, validating decisions). These acts do co-exist for the nurses as they are connecting with patients. The acts fold into each other creating an economy of depth to the experience. Merleau-Ponty’s modalities are illustrated by the interrelationships among the essential themes as nurses shared what it was like to make decisions. For example, connecting was folded into coming to a decision as nurses discussed how feeling the energy helped them to obtain patient information in coming to decisions. And, involving patients in decisions helped nurses obtain the type of information they needed in order to justify their decisions to themselves. Economy of depth is achieved because these essential themes, or acts, are known to be interrelated and finite as nurses come to their pre-established goal, to make a decision. In other words, taken together, the essential themes make the experience of decision-making what it is.

By considering ambiguity, the complex nature of simultaneity in decision-making can be explored. An ambiguous nature to the essential themes was demonstrated within the incidental themes. For example, involving patients in decision-making and telling patients what to do are ambiguous notions within the

essential theme of involving patients during decision-making. However, according to Merleau-Ponty (1967), “ambiguity is the essence of human existence, [that] everything we live or think has always several meanings (p. 169). ...It is inherent in things (p. 172). ...Ambiguity is not some imperfection of consciousness or existence, but the definition of them” (p. 332). Merleau-Ponty’s “philosophy of ambiguity” is in fact his philosophy of perception. And, it is the perceptions of the nurses in this study which give rise to incidental themes. The ambiguity among the incidental themes account for the “several meanings” Merleau-Ponty describes and then go on to help to define the essential themes.

Theoretical perspectives. At this point, a consideration of the decision-making literature is helpful in furthering an understanding of incidental themes, essential themes and ways of coming to a decision. A number of decision-making models provide a theoretical perspective of the experience of decision-making.

While discrete models of decision-making (i.e., compensatory and non-compensatory models) can be found the literature, the nurses’ experiences in this study did not support any one discrete model. The findings did support the idea that combination models as well as heuristic models can help to explain decision-making.

Payne’s (1976) work during the 1970’s with a combination model discovered that switching between non-compensatory models and compensatory models was important in coming to a decision. Non-compensatory models by themselves represent practical and less calculating approaches to decision-making. Decisions are made by eliminating less attractive options quickly (Tversky, 1972). A more complicated model, the compensatory model, emphasizes attribute selection as the basis of decision-making. With this second approach to

decision-making, people consider attractive and unattractive attributes and weigh those options.

Switching decision-making approaches between a non-compensatory approach and a compensatory approach, as Payne had found with students, was also evident in this study. Specifically, those nurses in this study who utilized protocols up to the point where they determined that the patient's condition or situation no longer "fit" the protocol, support Payne's (1976) work with this form of a combination model. These nurses would begin working with their protocols using a non-compensatory approach while looking for a quick, practical "fit". However, when nurses determined there was not a "fit", they then switched to a compensatory model. They considered the attractive and unattractive attributes of the protocol, and chose to either continue using the protocol or abandon the protocol.

Nurses whose decision-making experiences involved maintaining system equilibrium support the work which has been done with the utility approach to decision-making. With this approach, the utility of outcomes (perceived value of consequences) are considered in coming to a decision (Gilboa & Schmeidler, 1995; Reed, 1992). In this study, system equilibrium-oriented decision-making among nurses consistently incorporated the value of saving system resources (i.e., ER utilization and cost versus Urgent Care utilization and cost).

The belief by a number of nurses in this study that practice helped them to feel more comfortable with their decision-making supports Benner's (1984) work with a skill acquisition model. The concept of novice-to-expert, mediated temporally, worked for these nurses in previous positions, was an expectation they held out for themselves when they were newer telephone advice/triage

nurses, and continued to operate as they shared how they believed they continued to learn as years passed on.

Fluency and flexibility, components of divergent thinking (Koerner, 1996; Lunney, 1992), were apparent in the decision-making considerations for nurses in this study. Fluency was demonstrated when nurses talked about how they considered and even welcomed many different pieces of information regarding patients and patients' situations. Flexibility, the ability to change from one category to another, was evident when nurses would decide to deviate from protocols.

An important connection was found between this study and Jenks' (1993) work with nurse decision-making and interpersonal relationships. Jenks' specifically reported that interpersonal relationships were deemed, by the nurses, more important to successful decision-making than their educational levels. While this study did not address the relative weighting of nurse-patient relationships to levels of nurse education and the perceived effects each had upon successful decision-making, the findings from this study clearly indicated that the nurse-patient relationship was critical to the meaning of the experience of decision-making for the nurse.

Overall, the nurses' decision-making experiences from this study provide support for a heuristic-oriented approach to decision-making similar to Mitchell and Beach's (1990) work. In their work, Mitchell and Beach (1990) identified value images, trajectory images, and strategic images as guides for heuristic decision-making. These images included decision-makers' principles such as values, belief and ethics as aides in making decisions. Their model represents a

integrated, simultaneous approach to understanding two types of decision-making, adopting the decision and evaluating the progress of the decision.

Coming to a decision, among nurses this study, resembles Mitchell and Beach's (1990) conceptualizations of both adopting the decision and evaluating the progress of the decision. As nurses discussed their decision-making experiences in terms of what those meant for them as being a telephone advice triage nurse, they spoke of their values, beliefs, ethics, and goals as contributing meaning. In this way, they discussed the "aides" which helped them to adopt and evaluate the progress of their of their decision-making. As an example, those nurses who felt accountable for their decisions, spoke of their value base and ethics, making decisions which, in the future would guarantee them that they would err on the side of the patient safety. As a second example, nurses who valued making the right decision saw the integrity of making the right decision and believed that RNs should be able to make those kind of decisions all the time. And finally, nurses who valued the goals of their organization, desired to maintain a balance between system resources and patient satisfaction worked to ensure that patients received the most appropriate care so that the organization did not spend an inappropriate amount of money providing that care.

Examining the epistemological meaning of the experience of decision-making among telephone advice/triage nurses has shed light upon how nurses come to know their decision-making. The meaning of their decision-making is complex because it involves of their values, beliefs, ethics, and goals. Merleau-Ponty's perceptual philosophy contributed to understanding the multidimensionality and contextual nature of the experience as well as the ambiguity individual nurse perspectives bring to understanding the experience.

Decision-making literature enhanced the understanding of the experience by providing a theoretical lens from which to view the findings of this study. While the epistemological meaning of experience is important in gaining an understanding of the lived experience of decision-making, a discussion of the findings would not be complete without examining the ontological meaning of the experience.

Ontological Meaning of Decision-making

The reality of being, in other words the ontological aspects of the study, will now be considered as the epistemological question evolves into an ontological question: “How do I find meaning in what I know?” (Silva, Sorrell, & Sorrell, 1995). “Ontological questions address issues of reality, meaning, and being” (Silva, Sorrell, & Sorrell, 1995, p. 4). The evolution from an epistemological focus (knowing decision-making) to ontological reflection on being in the experience requires reflection and interpretation on the part of the investigator as well as an incorporation of phenomenological philosophies described in earlier chapters.

Decision-making perceptual sensibilities. “The structures of my own most being, the structures of temporality constitutive of Being-in-the-world, necessarily elude my grasp in their intrinsic self-concealment” (Dillion, 1991, X). Here, Dillion succinctly translates Merleau-Ponty’s philosophy of perception as involving the elusiveness of being. Elusive as it may be for the person, Being-in-the-world, according to Merleau-Ponty (1967, 1968) is grasped through sensing one’s perceptions. While numerous possibilities exist for perceiving Being-in-the-world, the structures of one’s own being are constructed by self for the purpose of

sensing that the world is intelligible to that person. Therefore, perceptions give meaning and intelligibility to each person's existence and reality.

Possessing an ontological sense of being "in" an experience (as "in"volvement) establishes one's sense of existence and reality (Powers & Knapp, 1995). Sensing is an important aspect of being. Because being in the world is an impulse and perceptions offer the clearest view of the human relationship to being in the world, perceptions are important to the concept of being (Merleau-Ponty, 1962). And so, the role of sensing these perceptions can be characterized in terms of perceived sensibilities. An openness to perceptual sensibilities can give meaning to the reality of being (Silva, Sorrell, & Sorrell, 1995, p. 7).

According to Van Manen (1990), being-in-the-world experiences are sensed in terms of four existentials: lived body, lived space, lived time and lived relation. The four existentials cannot be separated as experiences are sensed. Like Merleau-Ponty, Van Manen views being-in-the-world as an impulse rarely reflected upon. Because experiencing existentials are "largely pre-verbal; we do not ordinarily reflect on [them]" (Van Manen, 1990, p. 102.). Yet, one knows what it feels like to find one self in an existential. For example, each person knows what it feels like to be in "slowed down" time: feeling bored, feeling anxious, etc. Therefore, when feelings are shared about experiences, perceived sensibilities can emerge.

Being-in-the-world for the nurses who participated in this study, which focused upon their lived experience of decision-making, involved exploring the perceptions of their sensing being decision-makers. Upon reflection, three decision-making perceptual sensibilities gave meaning to the findings from this

study. They included feeling self-confidence, feeling self-uncertainty, and feeling self-certainty. Together, these sensibilities emerged as the essential theme of being a decision-maker. They were examined in terms of Van Manen's (1990) four existentials and Merleau-Ponty's (1968) ontological notion of lived experience as "sensibility" while considering other essential themes along with corresponding incidental themes. For example, while considering the essential theme of validating the right call, from a temporal perspective, the investigator noted the nurses "worried" about being decision-makers in terms of future "bad" patient outcomes. These nurses shared that they felt uncertain in making decisions, seeking validation in coming to decisions from protocols, guidelines, or other providers.

Overall Meaning

According to Merleau-Ponty (1968), overall meaning is co-constituted. The dimensionality of meaning is achieved by co-mingling epistemological and ontological meanings while being present and attending to the context and dimensions of lived experiences. The self uses perception to gain access to world experiences. The nurses in this study sensed being decision-makers in three ways. Overall, nurses sensed self-confidence, self-uncertainty, or self-certainty.

A few nurses sensed self-confidence in being a decision-maker. Their perceptions definitely communicated a sureness in making decisions. They took in a tremendous amount of information about their patients and used that information in coming to decisions. An indicator of their confidence was that these nurses were willing to break from protocol and guidelines to make the best decision. In this way, their self-confidence enabled them to make justifiable decisions based upon knowing what was best for the patient.

The structure of being in decision-making for these nurses involved their sensing self-confidence. Their perceptions of self-confidence gave meaning and intelligibility to each nurse's existence in being a decision-maker. It was from this structure of being that connecting made sense as a feeling of being in tune, that involving patients in decision-making made sense, that deviating from protocols seemed the right thing to do, that justifying decisions to themselves was enough, that feeling self-accountability made sense, and that believing that they really knew what a call to a telephone advice/triage nurse was all about.

However, most nurses in this study sensed self-uncertainty in being a decision-maker. Their perceptions communicated feeling worried in terms of decision-making as well as feeling uncomfortable in terms of possible bad patient outcomes. They began their decision-making by following protocols and guidelines, but listened for information which did not "fit" the models. These nurses felt uncertain in being decision-makers whether or not they used protocols or guidelines. They always desired more specific self-knowledge, never being satisfied that they knew enough to make the right decision. One indicator of their uncertainty was that these nurses frequently sought the validation of others for their decisions. In this way, their self-uncertainty required them to validate that they were making the right decision so that they could feel comfortable in being a decision-maker.

The structure of being in decision-making for these nurses involved their sensing self-uncertainty. Their perceptions of self-uncertainty gave meaning and intelligibility to being a decision-maker. It was from this structure of being that connecting was all about getting patients to tell them what was going, that making decisions for patients made sense, that hoping for good protocol fits

seemed to be the right thing to do, that seeking validations for decisions seemed necessary, that feeling unwanted responsibility was part of the job, and that believing that only sometimes they really knew what their patients' calls were all about.

Only a few nurses in this study sensed self-certainty in being a decision-maker. These nurses' perceptions communicated certainty in making decisions as they discussed how their organization's system was designed to ensure the most appropriate care for the customers. They primarily took in information from their patients which was elicited by reading the protocol or guideline questions. They used that information in coming to a decision about the best "fit" of care. As an indicator of their self-certainty, these nurses were never willing to break from protocol and guidelines. In this way, their self-certainty allowed them to tell patients what to do, ensuring that the system resources would be allocated in terms of the patient receiving definitive care.

The structure of being in decision-making for these nurses involved their sensing self-certainty. It was their perceptions of self-certainty which gave meaning and intelligibility to their existence as being a decision-maker. It was from this structure of being that connecting made sense in doing the business of authorizing, advising and triaging, that telling patients what to do was their understanding of their role, that making protocols fit always seemed the right thing to do, that validating decisions was a non-issue since the system ensured balanced decisions, that facilitating others' responsibilities made sense, and that accepting, as employees, they never really never knew what was going on.

The ontological meaning of the experience of decision-making has given rise to three perceptual sensibilities which place each nurse "in" the experience.

Examining the perceptions of nurses in this study communicated their sense of being decision-makers.

Understanding both the epistemological and ontological meanings of decision-making have illuminated the meaning of telephone advice/triage nurse decision-making. However, additional understandings can be gleaned from the findings of the study. Understanding how the nurses' experience with decision-making might reveal aspects of cognitive development among telephone advice/triage nurses will now be explored.

Understanding the Experience in Terms of Cognitive Development

The second line of inquiry for this study was to gain an understanding of how the nurses' experiences with decision-making might reveal aspects of cognitive development among telephone advice/triage nurses. Researchers interested in cognitive and intellectual development have studied the decision-making process in order to generate developmental schema (Belenky, et al, 1997; Gilligan, 1993; Perry, 1970). Because the proficiency level of decision-making appears to mirror changes in cognitive development (Hickman, 1993), insights into cognitive development can be gained by studying decision-making.

After an extensive review of cognitive development models and schema was completed by the investigator, the decision-making experiences shared by the nurses did reveal aspects of cognitive development. Their experiences shed light upon aspects of cognitive development, support the idea of structuring development into patterns of schema.

Components of Cognitive Development

Valiga (1983) identified a number of components of cognitive development. These components consisted of structuring and organizing

experience and knowledge, handling diverse pieces of information, and interpreting data leading to the ability to make decisions. Nurses' experiences with decision-making support these components of cognitive development. These components were incorporated among the essential and incidental themes of this study. In addition, as essential themes were considered from an integrated point of view, the nurses demonstrated different ways of coming to decisions, in other words, making decisions.

Nurses' experiences around a number of essential themes in this study support Valiga's (1983) components of cognitive development. During decision-making nurses all nurses assessed their patients. In doing so, they spoke of patient data as well as their own knowledge and experiences. Nurses obtained the information they needed in order to make decisions through connecting with patients. Nurses structured and organized their experience and knowledge in a variety of ways which included involving patients in decision-making, looking for their patient assessments to fit protocols, validating decisions, and living with the responsibility of their decisions.

As an example, nurses' varied experiences with the essential theme of knowing what's really going on supported Valiga's (1983) component of cognitive development. The diversity of information handled by the nurses included patient clinical information as well as their own knowing. Through their awareness of the diversity of information, as well as, the way in which they structured and organized that information, the nurses formed their various beliefs (interpretations) about being able to truly know what was going on with their patients. Incidental themes, reflective of their beliefs, included knowing patient

and self, going by what they tell you, and never really knowing what is going on led to their decision-making.

More specifically, in being decision-makers, nurses evaluated their patient assessments for the purpose of determining patient dispositions. Some patients' conditions and situations were interpreted by the nurses as needing intervention which could be delivered in clinics, urgent care facilities, or hospitals emergency rooms. Other patients needed advice regarding how to manage their conditions at home. On some occasions, nurses felt uncomfortable and uncertain in being the sole decision-maker and would decide to consult with other or relinquish decision-making to another professional. Even these occasions demonstrated the nurses' ability to interpret data (here patient and self data) and were able to make decisions.

Developmental Schema

The findings from this study support aspects of cognitive development as well as the idea that schema can be used to frame cognitive development. The decision-making experiences among the nurses in this study support Turner and Helms' (1995) explanation of human developmental models and schema. Turner and Helms explained that patterns of cognitive development are typically framed around the idea that ones' development is based upon increasingly complex patterns. To become increasingly complex, patterns must first meet the prerequisite of variability. It is at this point that the findings of this study support the concept of schema for describing cognitive development. However, the nurses' experiences did not support the idea of linear hierarchical patterns of development, which the term "increasingly" seems to connote.

Variations within the essential themes, as illustrated by incidental themes, support the idea that cognitive development can be understood through schema. The variability in components of cognitive development among nurses in this study, has as its foundation, the variability of incidental themes which make up the essential themes. For example, varying complexities of handling information were spoken about when nurses discussed deviating from protocols. Some nurses spoke of considering and even welcoming many patient variables. Others spoke of getting patients to tell them what was going on by keeping patient problems separate and distinct, even to the point of providing the patient with a framework for verbalizing their problems in a separate and distinct manner for the nurses.

The findings from this study support the notion that cognitive development can be portrayed as qualitative changes in or an unfolding of a process of knowing, awareness, and judgment (Valiga, 1983; Webster, 1993). Unfolding cognitive development, in terms of knowing, awareness, and judgment, was the framework which emerged from the nurses' experiences in decision-making. In this way, the findings reinforce some, but not all, of the work generated two research teams, Perry (1970) and Belenky, et al (1997).

The work of each of these teams resulted in schema for understanding cognitive development which utilized aspects of decision-making to draw conclusions. Both Perry's scheme regarding forms of development and Belenky, et al's scheme for perspectives of knowing were derived from extensive interviews with participants using phenomenological approaches to data gathering and analysis.

Forms of development. Perry's scheme represented forms of development which were in part unfolding in nature. Linear and hierarchical in its primary

structure, Perry did note that the forms overlapped. Participants' development unfolded into the next form while still retaining some of the characteristics of the previous form for a period of time. In response to challenges over their four years in college, most students in Perry's study moved from an egocentric to a more objective form in resolving their challenges. In doing so, students displayed four major forms of development. Students moved from one form to the next as they encountered increasingly complex dilemmas requiring decisions and realized that their previous approaches to solving dilemmas were not adequate. The goal for development in Perry's scheme was the last form: commitment to relativism generated from an individualistic perspective. In other words, students would come to know that all knowledge was relative in terms of its contextual, yet independent, individualistic (stand on one's own two feet) view of life.

The findings from this study support a number of Perry's forms of development. Nurses experiences which revealed concern with validating the right call mirrored Perry's simple dualism. They believed there were only two types of decisions, right and wrong. Nurses who made protocols fit patient situations also supported the concept of rule governance within the form of simple dualism. Complex dualism, Perry's second form of development, is when absolutes still exist for self, but the person is beginning to see multiple conditions where another person might deviate from this absolute right versus wrong orientation. Those nurses whose experiences demonstrated an understanding that not all patient conditions "fit" protocols or guidelines supported Perry's complex dualism. Additionally when these nurses talked about relinquishing decision-making to another provider, they demonstrated that they were aware that other decisions existed. Relativism, Perry's third form of development was supported

by those nurses who realized that decisions, other than those framed by protocols and guidelines, had the potential to be made by themselves. These were nurses who consulted other providers regarding their own decisions when they did not find a “fit” between their patients’ conditions and the protocols or guidelines. Perry’s final form of development, commitment to relativism, was supported by the findings when just a few nurses shared their experiences with being willing to deviate from protocols and feeling that their primary responsibility in decision-making was to be able to justify those decisions to themselves. These nurses spoke about living with their own ethics and being mindful of their knowledge; in Perry’s words, these nurses had a “sense of being in one’s life”.

Perry’s forms of development appear to be supported by ways nurses came to make decisions in this study. However, there were two of Perry’s findings which were not supported by this study, the linear hierarchical pattern of the entire scheme and the individualistic perspective to the unfolding of cognitive development.

First, the nurses’ decision-making experiences as evidenced by essential themes, incidental themes, or ways of coming to a decision did not reveal a linear hierarchical schema as Perry had concluded from his findings. Temporally situated among students who progressed year after year in college, Perry’s study was longitudinal. Framed temporally, Perry could easily come to the conclusion that as groups of students changed their form of development, linear hierarchical forms of development emerged. This study was not a longitudinal study and therefore was not initially temporally framed. In addition, none of the nurse demographics (which could be interpreted as hierarchical) consistently gave rise to the ways nurses come to make decisions. Individual nurses did not discuss their decision-

making experiences in terms of their age or educational level. Some nurses did frame their decision-making in terms of experience. From a schematic point of view, an unfolding of an awareness self was identified by some of the nurses. For example, one nurse had discussed how of becoming mindful of her knowledge and experience contributed to her being able to justify decisions to herself, feel accountable for her decisions and sense self-confidence in being a decision-maker. Not exclusively temporally situated, but more spatiality situated, she explained that she knew early on (not later) in her career, due to a few experiences while working in a hospital, there were organizationally correct decisions she would just not make because she had come to understand for herself what good health care was all about.

Second, connecting with patients was integral in the nurses' experiences with decision-making. Therefore, the findings from this study do not support Perry's goal of individualism. Nurses in this study were committed to establishing relationships with patients. In fact, many nurses explained that because they could not see their patients while assessing them, they had to trust that what their patients told them was true. They worked to establish connected relationships with their patients believing that such relationships affect their ultimate decision-making. While some relationships appeared more dynamic and even intense (feeling energy) than others, all nurses shared that their relationships with patients were critical to their being decision-makers.

Perspectives of development. Belenky, et al's (1997) findings offer a non-hierarchical scheme for development which brings into focus varying perspectives of knowing. Each perspective differs in how groups of women incorporate self and others into their lived experiences. Inherent in the

perspective notion was that perspectives of situations change and therefore women can change their perspective of knowing, even blending perspectives. Belenky, et al chose to study women's development. This study included nine women participants and just one man. It should be noted that no discussion of the findings will occur in terms of gender differences. The reason for this is not due to the fact that just one man participated; it is because neither the male participant nor the female participants identified any significant meaning in their experiences (from their perspectives) related to their gender in terms of development. With this in mind, the findings from this study with telephone advice/triage nurses offer support to Belenky, et al's scheme, *Women's Ways of Knowing*, in two ways.

First, regarding connecting relationships, nurses in this study offered differing perspectives regarding how they were connected to patients. Belenky, et al's (1997) work also demonstrated that their participants offered different connecting perspectives. Similar to one-way connecting in this study, Belenky, et al discussed one-way talk, where conversations between family members were one-way and parents were not interested in understanding their daughters. Parents expected daughters to absorb ideas and to never think things through. In this study, some nurses used one-way connecting to elicit information from patients. Typically, the information obtained by nurses who used one-way connecting was limited. Additionally, one-way connecting never resulted in patients being involved in decisions.

Belenky et al's observation that "connectedness with others is one of the most complicated human achievements" (1986, p. 178) is substantially supported by this study. Specifically, those nurses who discussed more integrated forms of

connecting such as being in tune were the same nurses who expressed an awareness and inclusion of multiple, complex variables in their decision-making and felt that they really knew what their patients' calls were all about. On the other hand, nurses who felt that their connecting was one-way, were the same nurses who focused upon patient problem lists to narrow in on patient complaints and who felt that they did not always know what was really happening with their patients.

Second, a number of Belenky et al's perspectives of knowing were supported by the findings in this study. Remembering that Belenky et al's perspectives were not mutually exclusive was beneficial while making comparisons between the findings here and Belenky et al's findings. The experiences of a few nurses in this study support a combination of two perspectives, Silence and Received Knowing. Specifically, when nurses perceived that they never have enough knowledge for decision-making and were dependent upon others for decision-making demonstrate the characteristics of Silence and Received Knowing. Subjective Knowing was supported by experiences which illustrated how nurses incorporated many of their own experiences with nurturing patients. Experiences with connecting which involved doing business and being connectors between the system and the patient supported the perspective of Separate Procedural Knowing. Nurses who realized that not all protocols "fit" all of their patients' conditions and sought the advice of other providers to assist them in their decision-making supported the perspective Connected Procedural Knowing. And finally, the experiences of a few nurses in this study which included being mindful of their knowledge and

personal and professional experience supported the perspective of Constructed Knowing.

As investigators of human development, both Belenky, et al (1997) and Perry (1970) understood that situations, contexts and dimensions were important considerations in studying cognitive development. Both utilized phenomenological approaches to reveal the complexity of cognitive development. It was through extensive interviews with numerous participants that their developmental schema and perspectives were revealed. It is not surprising that many of the findings from this study support much of their work.

Illuminating meaning and gaining an understanding of the lived experience of decision-making among telephone advice/triage nurses has offered epistemological, ontological, and developmental perspectives as ways to explore the experience. As nurses' mindfulness of their lived experiences and sense of self unfolded, they seemed to become more aware of the dynamic, multidimensional, and contextual nature of their decision-making.

The concept of unfolding cognitive development was put into perspective for the investigator of this study when one nurse spoke of being mindful and Merleau-Ponty's (1967) notions of presence and appearance of movement and change were considered. The nurse spoke about of having developed a sense of self-knowing as well as continuing to develop an ongoing sense of self-knowing, based upon an ever expanding awareness of her knowledge and professional and personal experiences. It will be recalled from chapter one, that an understanding of presence can reveal how the present moment is related to the past and the future. Understanding presence results in an unfolding of phenomena. Here, the

nurse articulated how her development unfolded as the investigator attended to presence with the nurse in terms of her self-knowing.

While one nurse's conversation helped to disclose that increasing awareness of professional and personal experiences (knowing) contributed to an understanding of unfolding development for the investigator, other nurses reinforced this notion. By returning to interviews, it could be learned that others' awareness varied in terms of types of knowing and amount of knowing present in sense of self. It was also learned that through sense of self, nurses varied incorporating their knowing in being decision-makers.

Some nurses spoke of justifying their own decisions within themselves. They explained that they realized that telephone advice/triage nursing involved many variables, even beyond what a protocol or guideline would ever generate. In realizing this, they believed their job was very complex: from their perspective "you don't get a clean, easy problem." These nurses expressed an understanding of not only having knowledge and professional and personal experiences, but also of being aware of their knowledge and experiences and articulated that they incorporated their sense of self-knowing into their decision-making.

Now, in contrasting those nurses' experience with other nurses' experience of validating the right call as a way of coming to a decision, differences were noticeable. Validating the right call did not reflect the depth of incorporating personal knowing as making a justifiable decision had done. Nurses had realizations, but here, those realizations were in terms of "patient" conditions being variable and not fitting protocols. Validating the right call involved being responsible for their decisions so that bad patient outcomes would not occur. These nurses were mindful of knowledge and experience but did not discuss

being mindful of it in terms of personal knowledge being an integrated component in coming to a decision.

Finally, contrasting the experiences above with striking a balance in coming to a decision, further differences are noticeable. These nurses felt that system mechanisms such as protocols and authorization and advice guidelines ensured that their decisions were correct. Their role was to balance what they came to know about their patients with the resources of their organizations. These nurses rarely spoke of self realizations. Their “systems” had both the knowledge and experience to come to decisions and these nurses were comfortable in implementing their organization’s process of triaging and advising patients.

All nurses discussed how their relationships with patients were critical to their decision-making. Some nurses incorporated their sense of self-knowing deeply into the essential theme of connecting. Others incorporated their sense of self-knowing to a lesser degree. Still others stated that they rarely incorporated a sense of self-knowing into connecting with patients, but were the connectors between the patient and the health care system. While the incidental nature of connecting varied, never-the-less, it was important to decision-making.

Illuminating the meaning of decision-making among telephone advice/triage nurses sheds light upon what it is like to make to decisions in terms of types of decision-making knowing, nurses’ sense of being, and aspects of their cognitive development. Reflections upon this study will now be offered in terms of strengths, limitations, and implications for nursing practice, education, and research.

CHAPTER VI

REFLECTIONS ON THE STUDY

Meanings and understandings of the experience of decision-making have the potential to advance our knowledge about decision-making as well as cognitive development. Possibly because the everyday experience of decision-making is so common, it is taken for granted and has not been widely investigated among nurses. The decision-making experience among telephone advice triage nurses has been uncovered and explored with this study. The purpose of this final chapter is to conclude the study by reflecting upon the strengths and limitations, as well as the implications of the study.

Strengths of the Study

A phenomenological method was chosen to study the lived experience of decision-making among telephone advice triage nurses. One strength of this study lies in that method. Through the philosophical perspective of Merleau-Ponty's phenomenology of perception and the process of Van Manen's researching lived experience, the internal structure of the lived experience was explored. Participants discussed meaningful experiences which resulted in rich data contributing to an understanding of the experience from an epistemological and an ontological orientation.

To maintain the strength of the method the investigator used bracketing and maintained an audit trail. Various investigator beliefs and preconceptions

were bracketed while studying the phenomena. Increased sensitivity to these beliefs and preconceptions was maintained throughout the study. The bracketing was revisited prior to each interview and at various times during data analysis. An audit trail, through the use of methodological and observational notes as well as reflective analytical writing, was maintained so that analytical findings could be supported and bias evaluated.

As a result of using this phenomenological method, eight essential themes emerged, together illustrating the multidimensional, contextual, and simultaneous nature of decision-making. Nurses' perspectives, as incidental themes, provided thick descriptions of their experiences.

Another strength of this study was that nurses were given the opportunity to discuss their experiences and share their feelings about their role, their patients, and their decision-making. Many stated that no one had ever asked them, at any point in their career, what it felt like to do what they do. Each nurse in this study expressed appreciation for being included as a participant in this study.

The final determining factor for the overall strength of this study will come when telephone advice/triage nurses evaluate the study. If telephone advice/triage nurses determine that they have been provided a voice which communicates the essence of their experiences with decision-making, this study will have realized its goal and aims.

Limitations of the Study

While the phenomenological method brought strength to this study, it also brought limitations. Due to the qualitative nature of the design, findings should not be applied to other groups of telephone advice/triage nurses or other nurses.

The nature of qualitative studies necessitates the involvement of the investigator in the study. Some would interpret this involvement as bias thereby believing that the method is a limitation of the study. Because phenomenology involves interpretive description on the part of the investigator, bias within a study such as this would therefore be impossible to eliminate (Thorne, Kirkham & MacDonald-Emes, 1997).

Even with elaborately designed audit trails, concerns regarding subjective feelings on the part of the investigator still remain with qualitative studies. Subjective feelings always have the potential to limit the investigator's ability to discover the spontaneity of lived experiences (Van Manen, 1990).

While strategies can be designed into qualitative studies to address some limitations, two questions can essentially remain unanswered at the conclusion of studies such as this one. Both questions bring into focus the credibility of the data on the part of the participants. First, is it possible that the nurses in this study had grown so accustomed to their everyday experiences that they were no longer aware of some of them? And second, is it possible that awareness of experience existed, but the ability to articulate meaning did not? An affirmative answer to either question would mean that this study would not capture the full experience of decision-making among the nurses in this study. Primary strategies to address both of these questions included conducting two interviews with each participant and reviewing first interview transcripts in order to re-focus follow-up questions if needed. However, the nature of data collection itself with qualitative studies can be viewed as a study limitation.

Implications of the Study

This study offered insights into what it is like to make decisions as a telephone advice/triage nurse. Since little was known about the role of the telephone advice/triage nurses, their decision-making experiences, or how their decision-making might reveal aspects of cognitive development, the significance of this study is that it provided additional insights into these areas. Because the decision-making and developmental findings generated by this study do not have direct application to nursing processes, implications for nursing will be presented in terms of issues which were raised as well as what can be continued to be learned about decision-making and cognitive development through the use of the study's approach of interviewing and listening to nurses to dialog about their experiences.

Nursing Education

The findings from this study have a number of implications for nursing education. The dialog approach used in this study can be used with students. First, dialog with students about their decision-making experiences has the potential to increase nursing educators' awareness of students' decision-making considerations as well as the variability within those considerations. For example, where nursing educators may tell their students to involve patients in decision-making, they can now be open to the possibility that some students may in fact feel very uncomfortable with doing this. Allowing time for students to dialog about what it is like to involve and not involve patients in decision-making may also help individual students to envision various ways in coming to decisions.

Second, the findings from this study, while not directly applicable to teaching telephone advice/triage nursing, can be utilized to develop nursing

students' awareness of the role of telephone advice/triage nursing. Nursing instructors can begin discussing the emerging role with students. With decreasing lengths of hospital stays, rapid discharges, and fewer provider clinic appointments being available, any nurse working in any health care setting has the potential to triage and provide advice to patients over the phone. New nurses are most at risk for making erroneous decisions and pose the greatest risk to organizations because of lack of their experience in making decisions as telephone advice/triage nurses. Nursing education can now look at this role and how the decision-making experiences they currently offer students might be applicable to telephone triaging and advising.

The methodological approach in this study which allowed nurses to share their experiences with decision-making offers support to nurse educators for supporting the unfolding of cognitive development among their students. Educators can use student dialog about decision-making experiences to become more aware of the variability in cognitive development among nursing students and observe that variability in students who are coming to decisions in classroom or clinical settings.

Exercises such as asking students to share their perceptions about what it is like to perform a patient assessment as a nursing student would allow nursing students to see the various ways nurses come to decisions about assessing patients. Presenting clinical opportunities which have the potential to increase students' awareness of multiple variables and a sense of self in coming to decisions can contribute to the unfolding of their development.

Educators can explore connecting relationships students have developed with patients. Being open to the variety of those types of relationships and

leading discussions which allow students to discuss their perceptions about how those connecting relationships contributed to the meaning of being nursing student would be some approaches which this study would support.

Finally, this study has raised issues regarding deviating from protocols, prescribing drugs, and practice accountability. Other expanded roles for RNs, including the advanced practice role for nurse practitioners, prepare nurses to deal with ambiguity, to furnish prescription drugs, and take accountability for their practice through certification processes. This study has brought to light that no such educational preparation was available for these nurses. Academic and health care organizations need to partner, first to examine the role of telephone advice/triage nursing and secondly, to develop strategies to advance the preparation of nurses for this role should it remain as it is currently.

Nursing Practice

The nurses in this study stated that the opportunity to explore the nature of their decision-making experiences had never been offered by the leaders in their organizational settings. Therefore, asking telephone advice/triage nurses what it is like to make decisions could have a number of implications for nursing practice.

Through dialog with nurses about their decision-making experiences, nursing administrators and managers may become aware of how nurses within their organizations come to decisions in different ways. They may evaluate that some of those ways might be placing the patients, nurses, and organizations at risk.

For nursing administrators and managers, the fact that protocols and guidelines do and do not support nurse decision-making should be explored.

There may be nurses who, in coming to decisions, are aware that rigidly following a protocol could pose risks for a patient. There may be other nurses within the same practice setting who may not be able to determine what, if any, risks exist in following a protocol. Nurses who may never be willing to deviate from protocols, may not be making the right decision in the best interest of patient, themselves, or the organization. With increasing competition in the managed care arena, nurses who are on the front line with patients and are inflexible in coming to decisions may also be contributing to losing health plan members as well as to reputation-damaging litigation. Dialog with nurses has the potential to shed light upon decision-making struggles and offers nurse administrators, managers, and organizational educators the opportunity to evaluate if nurses are prepared fully for their important jobs.

Being open to evaluating nurses for flexibility in decision-making as well as nurses connecting with patients could provide insight into nurse cognitive development. Increasing awareness of all the possibilities in coming to decisions and connecting with patients could be achieved through dialog among the nurses. Additional approaches include role modeling and talk-aloud strategies by nursing leaders themselves while being engaged in decision-making. Providing opportunities for dialog and for observing nurse leader decision-making in action offer the potential to support the unfolding of cognitive development among nurses.

Nursing administrators and managers should allow time at staff meetings and at other opportune times for nurses to discuss and share their feelings about what it is like to make decisions as a nurse. Taking the time to dialog with the nurses will offer nurse administrators and managers opportunities to understand

what it is like for nurses come to decisions, how their sense of self is or is not integrated into being a decision-maker, and what challenges nurses face in their roles as important decision-makers for their organizations. Coming to a better understanding of decision-making and possibly cognitive development among their nurses may hold the key for nurse administrators and managers in promoting critical thinking, managing change, and caring on patient care units, in clinics, and over the phone.

Nursing Research

Several implications for nursing research can be drawn from the study. Areas for further research include examining the role of the telephone advice/triage nurses, decision-making, cognitive development, and from a broader perspective, nurse knowing. While much has been learned about telephone advice/triage nursing, questions remain.

First, according to the nurses in this study, the role involved three aspects: triaging patients, authorizing treatments, and providing advice. Nurses' perceptions regarding these role aspects varied and it is not yet clear as to how the role is or should be framed around these three aspects for optimal patient outcomes. Further research is needed to examine this issue so that organizations can move ahead in clarifying the role for both nurses as well as patients.

The objectives for having telephone advice/triage positions within an organization seems to involve a desire to improve efficiency, to decrease utilization of expensive services, and to improve patient satisfaction within the overall system of health care delivery. While these are admirable objectives, little is known about the role in terms of outcomes for these objectives. Considering that many nurses in this study felt uncertain as decision-makers, validated

decisions with other providers, and made decisions to bring many patients into various settings be assessed, the role may have a minimal impact upon these objectives. In fact, should the economic impact be low, the role of the telephone advice/triage nurse may be an added layer to an already costly health care system. On the other hand, if there is little direct negative economic impact in having the role, there could possibly be very large indirect advantages for organizations in maintaining the role. For example, those nurses in this study who spoke about being in tune, really knowing what was going on with their patients, and being confident in their decision-making may be offering a level of care many patients seek from health care today. In addition to what nurses and organizations have to say about the role, much can also be learned from the patients' perspectives and should be followed up with further research.

The educational preparation of nurses in this study varied widely. Investigations utilizing larger sample sizes would be helpful in identifying trends in educational backgrounds. Expanding those investigations to include decision-making and patient outcomes would provide valuable information for health care and academic organizations regarding role preparation.

Second, this study brought to light eight essential themes of what it was like for these nurses to make decisions. The essential and incidental themes described within the study's findings have yielded a description of the lived experience of decision-making among telephone advice triage nurses. Most importantly, there do appear to be distinctive characteristics to the nurses' experience with decision-making. The study's themes only support some of the work already identified in the area of decision-making. Therefore, interviews with telephone advice/triage nurses have made it evident that the current models of

decision-making do not adequately explain the experience of decision-making among telephone advice/triage nurses.

While descriptions generated from phenomenological methods are not the whole of knowledge, nursing science cannot move ahead without descriptive foundations generated by phenomenological research (Omery & Mack, 1995). The themes from this study are representative shared meanings illustrating internal structures of the experience of decision-making and as such descriptive foundations (Boyd, 1993; Van Manen, 1990). In future studies, the essential themes (considered as the descriptive structures of decision-making) can serve as stepping stones for generating mid-range theory and building upon the foundation of nursing knowledge concerning the phenomenon of decision-making.

In addition, the findings from this study have raised a number of specific, critical issues for future decision-making research. These include knowing when, if ever, a telephone advice/triage nurse should deviate from protocol, what role critical thinking plays in decision-making, what role certainty and confidence play in decision-making, and finally how all of these might be linked to patient outcomes.

Third, cognitive development among telephone advice/triage nurses was understood in terms of their decision-making experience. While the study's findings support some of the work done by others such as Perry (1970) and Belenky, et al (1997), developmental issues remain to be investigated through further research. These issues not only concern processes important to nursing such as critical thinking, reasoning, and judgment, but also include if and how awareness of a non-hierarchical schema might assist in promoting cognitive

developmental unfolding among nurses. For example, considering critical thinking, future research may be able to answer questions concerning relationships between awareness of personal knowledge and critical thinking. In addition, future descriptive factor-searching studies may be able to identify characteristics which could generate a scheme for unfolding cognitive development among nurses.

Finally, in terms of both decision-making as well as cognitive development, nurse knowing was brought to light by nurses who discussed how their professional as well as personal knowing was part of their decision-making. Being mindful of who they were as nurse decision-makers included both formal and informal knowledge. Most nurses who were mindful of their professional and personal knowing, were also confident in their decision-making. Nurses who rarely discussed personal knowing, who sought more and more specific clinical knowledge, were the nurses who expressed a sense of uncertainty in being decision-makers. These findings raise the issue of how nurse knowing might be related to nurses' sense of being decision-makers and support the notion that further research is needed in the area of nurse knowing.

The findings from this study raise numerous issues regarding the role of telephone/advice triage nursing, decision-making, cognitive development and nurse knowing. Questions surrounding these issues can be addressed through additional qualitative investigations. Once additional support for the findings from this study can be established, educational and practice intervention investigations can be pursued.

Telephone advice/triage nurses are expected to make decisions with each and every patient encounter. The decisions these nurses make have the potential

to save health care dollars which is important to organizations as well as their paying members. Affecting positive patient outcomes are equally as important as the fiscal aspects of health care. Many nurses in this study worried about negative patient outcomes and many times felt uncertain about being a decision-maker. If the goal of health care today is to provide the highest quality of care in the most efficient and cost effective manner, it is imperative that academic and health care organizations provide educational and support mechanisms for these nurses to manage their practice and become certain and confident in their decision-making.

Nurses must come to understand that ways of deciding vary among nurses. According to most nurses in this study, expensive computerized protocols and guideline manuals are not the way to ensure definitive care for all patients. Asking nurses what it is like to make decisions and listening to what nurses say will assist the nursing profession to better understand nurse decision-making. Understanding the experience nurse decision-making will provide nurses with the opportunity to plan for the future of nursing, keeping nurses in the forefront of health care delivery.

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Table 1

Essential and Incidental Themes

Essential Themes	Incidental Themes
Connecting	<ul style="list-style-type: none"> • being in tune • tacking to stay on course • doing business
Involving Patients in Decision-making	<ul style="list-style-type: none"> • varying patient involvement • making decisions for patients • telling patients what to do
Deviating From Protocol	<ul style="list-style-type: none"> • willing to deviate from protocol • hoping for a good fit • making the protocol fit
Validating the Right Call	<ul style="list-style-type: none"> • justifying decision to self • seeking validation for decisions • a non-issue: checks and balances
Living with responsibility	<ul style="list-style-type: none"> • feeling self-accountability • taking responsibility • feeling unwanted responsibility • facilitating others' responsibility
Knowing What's Really Going On	<ul style="list-style-type: none"> • knowing patient and self • going by what they tell you • knowing all that can be known • never really knowing what's going on
Coming to a Decision	<ul style="list-style-type: none"> • making justifiable decisions • validating the right call • striking a balance
Being a Decision-maker	<ul style="list-style-type: none"> • feeling self-confidence • feeling self-uncertainty • feeling self-certainty

APPENDIX A: WRITTEN CONSENT FORM

CONSENT FORM

Ann Mayo is a student in the Doctor of Nursing Science Program, Philip Y. Hahn School of Nursing at the University of San Diego. She is completing this research study as part of her Doctoral Dissertation. The purpose of this study is to examine decision-making by telephone advice/triage nurses. To complete the study, she would like to interview nurses who work as telephone advice/triage nurses.

If I agree to be in the study, I will be interviewed twice for about one hour on each of the two occasions. The questions will concern my experiences with decision-making as a telephone advice/triage nurse. Should there be any questions that I do not wish to answer, I may refuse.

I agree that my responses will be tape recorded and typed on paper for the study. The tape and typewritten transcripts will be kept in a locked file cabinet and destroyed after data analysis.

I understand that names will be kept separate from interviews and my confidentiality protected. Any presentations or publications resulting from this interview will not identify me in any way.

I understand that I may be quoted but my name will not be associated in any way with the findings of this study.

I understand that participating in this study poses no known risks to me. I understand that I will derive no direct benefit from being in the study but that Ann Mayo hopes to learn more about telephone advice/triage nurse decision-making.

I understand that participation in this research is voluntary and that I have the right to refuse to participate and the right to withdraw at any time without jeopardy. Should I choose to withdraw, my tape will be destroyed immediately. There is no agreement written or verbal beyond that expressed on this consent form.

I have talked with Ann Mayo about this research study and have had my questions answered. I may reach her at 488-6340 if I have more questions at a later time.

I, the undersigned, understand the above explanations and on that basis, I give consent to my voluntary participation in this research study.

Signature of Participant

Date

Location (e.g. San Diego)

Signature of Principal Investigator

Date

APPENDIX B: INTERVIEW GUIDE

INTERVIEW GUIDE

Primary Questions for Interview #1

1. Reflect upon your own experiences as a telephone advice/triage nurse. Tell me about a situation where you made a decision. Take a few minutes to think about this situation which involved making a decision. In choosing that situation, please let it be one that stands out in your mind because it reminds you of what it “means” to be a telephone advice/triage nurse. Does that decision hold any other meanings for you? Any personal meanings?

Probe Questions for Interview #1

1. I understand that you cannot see or touch your patients while you make decisions. What is that like?
2. What kinds of decisions do you make in your role as a telephone advice/triage nurse? Tell me about some of those decisions. Tell me about some decisions you feel are easy to make. Why are they easy? Tell me about some decisions you feel are hard to make. Why are they hard?
3. Tell me about the things you think about while you trying to make a decision. From your perspective, are there any things which help you to make decisions? Any things which hinder your decision-making?
4. Is there anything else you would like to share during this interview about your decision-making experiences?

Examples of instance-specific probe questions (instances may vary among nurses):

Was this the first time you had to make this kind of decision?

Did anyone help you to come to your conclusion? Who?

Did you follow the computerized protocol in deciding upon the patient’s disposition? Why or why not?

How long did you talk to the patient before you decided what to do?

Did the patient say anything that may have influenced your decision?

Probe Questions for Interview #2

1. Before we begin, is there anything you would like to ask me or share with me about decision-making from our last interview?
2. Last time we talked about Anything else you would like to share or have thought about? Anything you would like to clarify with me about this?

INTERVIEW GUIDE

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3. I have a few more questions I would like to ask you about the decision-making experiences you shared last week. (Questions will be follow up questions to previous interview content only.)

Examples:

Last week, you said that you really felt connected to that one patient; tell me more about that. What does it mean to be connected to a patient? Have you had that feeling at any other time?

You said last week that you sometimes use your fellow peers to help make decisions regarding sick children; what has it meant to you to have fellow nurses here in the room, helping you to decide what to tell mothers of sick children?

4. Is there anything else you would like to share during this interview about your decision-making experiences?

Demographic Questions

1. Tell me about your nursing background. (Probes: basic nursing degree, current degrees, years of experience, years of experience in telephone work, previous positions?)
2. Tell me about your practice setting. (Probes: specialty focus of patient population, computers, algorithm manuals, calls per hour/day, types of calls)
3. What age range are you in? 20-30, 31-40, 41-50, 51-60, over 60 years of age?
4. Do you consider yourself a member of an ethnic group? If so, which?