Physician attitudes in nursing

Physician attitudes and patient attributes have combined to produce the characteristic “ sick role” expected of hospital patients. Parson??™s description of the sick role explains why patients often abdicate personal responsibility for their condition and recovery to a health care system more than willing to accept the authority to decide what is best for them (Sultz & Young, 2006, p. 6). In the hospital, otherwise assertive, independent individuals tend to assume a passive and dependent ??? sick role??? (Sultz & Young, 2006, p.

91). As a medical society, we have classically enabled them to continue to think and act this way. Only in recent years have the mindset and patient, family and community awareness and education started becoming more preventive and focused on health and wellness.

The new shift will hopefully increase positive feedback and involvement of patients in their health and wellness. For a hospital to operate efficiently and effectively, the three important influences in its governance — that is, medical staff, board of trustees, and administration — must work together in reasonable harmony. The major operating divisions of a hospital represent areas of the hospitals functions. Although they may use different names, the usual units are medical, nursing, patient therapy, diagnosis, fiscal, human resources, hotel services and community relations (Sultz & Young, 2006, p. 83). Many factors contribute to the tension between these departments within their daily operations. With so many different kinds of employees and so many interrelated systems and functions it is a small wonder that hospitals work at all, much less as well as they do.

With the multitude of tasks that are performed every day by the hundreds of employees in a busy hospital, misunderstandings and information breakdowns in patient care are inevitable (Sultz & Young, 2006, p. 90). Each department/division has an approach for success within their respective arena of health care. However, the individualized approaches develop silos within the organization. They operate individually in hopes of efficient and productive outcomes yet, in reality, what develops is numerous disconnected ??? plans for success???. It is difficult to formulate a consistent and acceptable formula for organizational success with a silo mentality. Unification within the organization must occur.

Now, hospitals substitute non-nurses for nurses to perform all but the most technical tasks. The implications for the nursing profession are numerous. Fragmented patient care, desensitized relationships toward the patient and family along with giving an assembly line perception to the patient are just a few consequences that have come about from the principles of improving efficiency and care to an ever growing population of patients and their needs. Sultz & Young state that one of the consequences of the rise of high-technology hospital care was the industrialization of patient care activities.

As a nurse, one of the reasons for choosing the profession is to have a patient focused, humanized and personal relationship with our patients and families but with the changes seen lately, that does not happen. Nurses have lost their traditional role of hands-on patient care. Once again, Sultz & Young bring out that responsibility and accountability for the total care of patients became increasingly diffuse. Opportunities for patients to fall into the cracks

between the host of caregivers increased, and more midlevel managers were necessary to oversee operations.

Any questionable gains in efficiency were achieved at the costs of patient satisfaction, communication, and personal care (Sultz & Young, 2006, p. 103). Advantageously, more patients can be ??? shuttled??? through their health care experience but at the cost of depersonalization. More disadvantages occur from the changes such as, but not limited to, increasing patient complaints, fragmented communication, duplication in care, and loss of treating the patient as an individual.

Thankfully, the trends are swaying back toward patient-focused care. Hospitals are recognizing that it is important to be responsive to patient concerns and heavily weigh the perceptions of their experiences as the patient. To lure patients who now have more options, hospitals are focusing on friendlier staff, better food, and more amenities (Sultz & Young, 2006, p. 105). There are many major factors that have resulted in the shift in utilization from inpatient hospitalization to ambulatory care services. New medical and diagnostic procedures and technologic advancements have allowed procedures previously requiring hospitalization to be performed on an outpatient basis. Now the majority of all surgical procedures are performed on an ambulatory basis (Sultz & Young, 2006, p.

129). Changes with financial mandates as well as the surge of managed care have influenced some of the shift toward ambulatory and outpatient patient care and procedures. These changes have affected many hospitals, some positively and some negatively.

The smaller organizations have not had the resources to facilitate ambulatory services outside of emergency department care and have seen some financial losses. Most larger hospitals still operate clinic services on site, and many have retained ambulatory surgical services within the main facility in response to community need, physician demand, and teaching activity. In many cases, the conversion of underutilized inpatient units has also provided a cost-effective means of accommodating the shift to ambulatory surgical services and other ambulatory procedures within the hospital (Sultz & Young, 2006, p. 130). The expansion of hospital, HMO, and other organization-sponsored ambulatory services has significantly and negatively affected much individual practice due to required patient care coverage 24/7, ever-growing medical specializations, technological advances and the financial risks associated with managed care. Individual practices are not able to compete with larger, more diverse physician groups. Today, two thirds of primary care specialists work in group practices. Larger practice size enabled physician groups to compete more aggressively for contracts in the managed care marketplace, helped to control costs through greater administrative efficiency, and facilitated spreading the financial risks associated with managed care contracts (Sultz & Young, 2006, p.

135-136). Managed care organizations, with their population perspective, required hospitals to shift from a strategy of serving more individual patients with ever larger numbers of services to devising systems that emphasized efficient, effective, coordinated care for insured population groups. The demands of managed care organizations for efficiency, cost controls, coordination of services, and accountability for service outcomes

necessitated radical shifts in hospital strategic planning (Sultz & Young, 2006, p. 106). Hospitals have reorganized, and reconfigured the service delivery of their care.

There have been transitional shifts toward horizontal or vertical integration strategies and physician roles within the hospital organization have been developed, integrated and economically aligned. System integration mandates also required changes in the process of care delivery, decisions about capital investment, redesign of information and management systems, and renewed emphasis on health promotion and health maintenance. The implementation of integrated systems will unquestionably continue, driven largely by economic imperatives. Continuing study, observation, and research will be required to determine the long-range effects of these health care reforms on consumers and providers of health care services (Sultz & Young, 2006, p. 111-112).

Sultz, H. and Young, K., Health Care USA: Understanding Its Organization and Delivery (2006), 5e, Jones and Bartlett Publishers, Sudbury, MA.