



Original Articles

The impact of ethics and work-related factors on nurse practitioners' and physician assistants' views on quality of primary healthcare in the United States



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ABSTRACT

Purpose: Nurse practitioners (NPs) and physician assistants (PAs) provide primary care services for many American patients. Ethical knowledge is foundational to resolving challenging practice issues, yet little is known about the importance of ethics and work-related factors in the delivery of quality care. The aim of this study was to quantitatively assess whether the quality of the care that practitioners deliver is influenced by ethics and work-related factors.

Methods: This paper is a secondary data analysis of a cross-sectional self-administered mailed survey of 1,371 primary care NPs and PAs randomly selected from primary care and primary care subspecialties in the United States.

Results: Ethics preparedness and confidence were significantly associated with perceived quality of care ($p < 0.01$) as were work-related characteristics such as percentage of patients with Medicare and Medicaid, patient demands, physician collegiality, and practice autonomy ($p < 0.01$). Forty-four percent of the variance in quality of care was explained by these factors.

Conclusions: Investing in ethics education and addressing restrictive practice environments may improve collaborative practice, teamwork, and quality of care.

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1. Introduction

The Patient Protection and Affordable Care Act (PPACA) was passed by the U.S. Congress and signed into law in 2010 by President Barack Obama. This Act is expected to significantly lower health care costs and extend coverage to millions of U.S. citizens (Public Law, 2010). While this is a major legislative accomplishment in addressing healthcare costs, a national shortage of primary care physicians coupled with an increasingly aging and chronically ill population will require an extended pool of clinicians qualified to meet the public's

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complex needs (AARP, 2009; Anderson & Horvath, 2004; Sataline & Wang, 2010; Wagner, 2001).

Nurse practitioners (NPs) and physician assistants (PAs) provide primary patient care across the United States (U.S.) working both independently or under physician guidance. Today there are over 100,000 NPs and PAs practicing in the U.S. (American Academy of Physician Assistants, 2013; U.S. Department of Health & Human Services, 2010) meeting the primary, preventative, and chronic health care needs of American citizens, often in medically underserved geographical regions. However, very few studies address the roles of primary care NPs and PAs in the U.S. and the ethical challenges this role brings to patient care delivery. In fact, disagreement remains between NPs and physicians on the role of advanced nurse practitioners and their scope of practice within the healthcare arena. For instance, in a recent national survey NPs believe that they provide safe, efficient, and quality care while two-thirds of MDs (66.1%) report that physicians provide a higher-quality examination and consultation than NPs alone (Donelan, DesRoches, Dittus, & Buerhaus, 2013). Moreover, physicians are less likely to believe that NPs should have hospital

admitting privileges, lead medical homes, or be paid in a similar fashion for providing the same services (Donelan et al., 2013). It is difficult to develop team-based collaborative care initiatives when philosophical differences and contrasting perceptions exist among healthcare disciplines.

In an 11-point actionable plan to improve access, quality, and cost effective care to consumers while reducing the national deficit and addressing the nation's fiscal crisis, Emanuel and colleagues (Emanuel et al., 2012) recommend increasing the role of advance practitioners, such as NPs and PAs. To meet the goals of this initiative, however, the training of NPs and PAs will require educational models that reflect the realities of clinical practice and the difficult ethical challenges they encounter each day—allocation of scarce resources, the costs of caring for the uninsured and underinsured, helping patients and their families transition to supportive palliative and hospice care, informed consent to treatment and research, prescription drug costs, conflict in professional relationships and many other complex issues. Otherwise, the stress these issues engender could negatively influence quality care and patient safety.

Little is known about how important ethics and related factors (i.e., ethics preparedness, ethics confidence, physician support, patient demands, and practice autonomy) are to the provision of quality care in the experiences of NPs and PAs. Our previous research with these two groups indicates that they experience similar ethical challenges. These include, but are not limited to, insurance constraints, conflicts in professional relationships, informed consent, and allocation of resources (Ulrich et al., 2006). In 2005, Laabs reported on a variety of ethical issues that NPs encountered in primary care. Several patient-related issues were particularly troubling, stemming from patients' refusal of appropriate treatment as well as inappropriate patient requests, pressures to see an increasingly complex patient load, and uninformed patients (Laabs, 2005). However, the effect of these and other ethical issues on NPs and their patients remain to be answered. In another study, Grady et al. (2008) identified the importance of ethics confidence in moral decisions among nurses—some of whom had graduate degrees—and its relationship to moral action in practice, yet they did not specifically focus on NPs and PAs.

As we rely more heavily on NPs and PAs to fill the primary care physician void and meet the goals of the Patient Protection and Affordable Care Act, ethical issues will undoubtedly arise in team-based partnerships. Therefore, we conducted a secondary analysis of data from a national survey of 3900 primary care NPs and PAs to address the following research question: "What ethics and work-related factors influence NP and PA clinicians' views on quality of care in their clinical practice?" The purpose was to describe how NP and PA perceptions of their ethics preparedness, confidence, physician collegiality, and autonomy, along with the patient demands they encounter influence perceived quality of care in their clinical practice.

2. Study data and methods

2.1. Data source and sample

This study represents a secondary data analysis from a national sample of 3900 primary care and primary care subspecialty NP and PA providers in the United States during 2002–2003 (including family health, pediatrics, geriatrics, obstetrics or gynecology, internal medicine, and adult health) (Ulrich et al., 2006). The original study aimed to understand the ethical issues in NP and PA practice using a self-administered questionnaire; the sample was selected from the American Academy of Physician Assistants and a comprehensive NP list from Medical Marketing Services (<http://www.mmslists.com/main.asp>). The study followed Dillman's total design survey method with an overall adjusted response rate of 50.6% (Dillman, 1978). Institutional review board approval was received by the University of Virginia and the National Institutes of Health. For the purpose of this study, we used an analytic sample of 1,371 respondents that included

all variables of interest. Our methods are described in detail elsewhere (Ulrich et al., 2006).

3. Instruments

3.1. Outcome measure

A 10-item quality of care summary measure was adapted from items in the Community Tracking Study Physician Survey, a nationally representative telephone survey by the Center for Studying Health System Change (The Community Tracking Study (CTS) Physician Survey, n.d.) (scored from 10 to 50, with higher scores representing positive views on quality of care delivery). We added two items to reflect cost concerns in providing care and an item measuring communication with third party payers. The items reflect providers' perceptions about abilities to make clinical decisions that meet their patient's needs, level of communication with other providers and third party payers, balancing cost concerns with patient advocacy, and time spent with patients. Construct validity was assessed using exploratory factor analysis. Two factors accounted for 49% of the variance in the scale score. The first factor, consisting of 5-items, measured quality patient care with loadings ranging from 0.59 to 0.72. The second factor consisted of 5-items measuring communication with others and cost issues. Factor loadings for this subscale ranged from 0.46 to 0.80. The item "can make clinical decisions in the best interest of my patients without pressure to keep the cost down" also loaded moderately on the quality of patient care factor (loading = 0.47). Cronbach's alpha showed an internal consistency of 0.81 for the total scale and acceptable reliabilities for the subscales (0.74 for the patient care subscale and 0.70 for the communication/cost subscale respectively).

3.2. Independent measures

3.2.1. Demographic information

Data were collected on a number of socio-demographic and practice-related variables, including age, gender, ethnicity, income, type of practitioner (NP vs. PA), years in practice, years in current position, practice setting, employment status, for-profit and/or not-for-profit designation and insurance coverage (i.e., Medicaid, Medicare, private, uninsured and percent of patient population enrolled in managed care).

3.2.2. Ethics preparedness and ethics confidence

The Ethics Preparedness Scale, originally adapted from Buss, Marx, and Sulmasy (1998) and Waz and Henkind (1995) measured training, mentorship, and preparedness in ethics. The scale is scored from 1 (strongly disagree) to 5 (strongly agree) with higher scores indicating more ethics preparedness. Construct validity was supported by exploratory factor analysis which identified two factors (i.e., perception of readiness to handle ethical issues and adequate education and mentorship for addressing ethical issues) accounting for 62% of the variance in the scale. The internal reliability alpha for the total scale was 0.76, and both the readiness and mentorship subscales were internally consistent ($\alpha = 0.76$ and 0.83 , respectively).

Ethics confidence was measured by adding two items to the original six-item instrument developed from the work of Sulmasy, Dwyer, and Marx (1995) to assess the level of ethics confidence of practitioners. Item responses range from 1 (not at all confident) to 4 (very confident) with higher scores indicating a higher level of confidence. Exploratory factor analysis supported one factor structure, accounting for 59% of the variance in the scale (factor loadings ranging from 0.65 to 0.85). The internal consistency reliability of the instrument was excellent ($\alpha = .90$).

3.2.3. Work-related characteristics

Several self-report measures from the Physician Worklife Study addressed the patient demands of primary care practice, physician

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