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Gatekeeping practices of nurses in operating rooms

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ABSTRACT

This paper explores the gatekeeping practices used by operating room nurses to control information flow in their everyday clinical practice. In nursing, gatekeeping appears only sporadically in the literature and usually emerges as a secondary concept rather than being the primary focus of studies. As gatekeeping is a communication practice that has the potential to impact directly on patient safety, a more in-depth exploration of its pervasiveness and effect needs to be undertaken. Accordingly, in this paper we aim to provide an in-depth understanding about gatekeeping practices in operating room nursing by drawing on a 'network' model of gatekeeping to highlight the power relationships between stakeholders and how information is controlled. To illustrate our points, we provide four different examples of gatekeeping at an interpersonal level of interaction. Data are drawn from an ethnographic study in Australia that explored nurse–nurse and nurse–doctor communication at three different operating room departments. We explore the impact of gatekeeping on social and professional relationships as well as how it has practical and ethical ramifications for patient care and the organisation of clinical work. The findings show that nurses are selective in their use of gatekeeping, depending on the perceived impact on patient care and the benefit that is accrued to nurses themselves.

Introduction

Gatekeeping is a communication tactic that involves limiting or facilitating access to information. The term gatekeeping was first used by Kurt Lewin (1947a, 1947b) in the 1940s in reference to housewives as the people who selected what food ended up on the family dinner table. Lewin proposed that his concept had implications far beyond food choices and that his idea could be applied to the flow of news and how items are selected and rejected as they pass through 'channels'. Applied at the mass communication level, gatekeeping came to be understood as "the process by which billions of messages that are available in the world get cut down and transformed into the hundreds of messages that reach a given person on a given day" (Shoemaker, 1991, p. 1). Since its inception, concepts of gatekeeping have developed in various fields of scholarship including political science, communication, sociology, information science, management and law, and in a broad sense it came to be understood as "all forms of information control that may arise in decisions about message encoding, such as selection, shaping, display, timing, withholding … " (Donohue, Tichenor, & Olien, 1972, p. 43). The concept of gatekeeping has been further developed (Barzilai-Nahon, 2004, 2008, 2009) to provide a means of in-depth analysis of information control, a point that is a focus in this paper.

In nursing, gatekeeping appears only sporadically in the literature (Farley, 1987; May, Ellis-Hill, & Payne, 2001; Sinivaara, Suominen, & Routasalo, 2004; Street, 1992) and usually emerges as a secondary concept in data rather than being the primary focus of studies. In medicine, the term has a slightly different meaning and is used in relation to providing or limiting access to healthcare. Overall, across all healthcare disciplines, there has been a lack of analytical frameworks with which to examine the phenomenon of gatekeeping and, as a consequence, relatively few attempts to create a common ground for discussion and critical review of the concept (Barzilai-Nahon, 2004). Furthermore, studies exploring gatekeeping in healthcare are important because of the possible impact on patient safety. Poor communication, which may include gatekeeping, has been shown to be one of the leading causes of clinical errors (Joint Commission on Accreditation of Healthcare Organizations, 2007).

Accordingly, in this paper we aim to provide an in-depth understanding about gatekeeping in relation to the operating room context, and show how it has practical and ethical ramifications for patient care, clinical work and professional relationships. In the first part of this paper we provide an overview of how gatekeeping has been referred to in the nursing literature and briefly explain

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how the concept is referred to in medicine. Next, we provide an outline of theoretical frameworks of gatekeeping and greater clarification about how we understand and use the concept for the purposes of this paper. We then examine gatekeeping practices in operating room nursing by drawing on data from an ethnographic study of communication processes in the clinical environment. Lastly, we discuss the implications of gatekeeping in terms of the power that is available to nurses and colleagues as they engage in gatekeeping, the professional ethics of the practice, and interprofessional and social relationships.

Gatekeeping in healthcare: nursing and medicine

Only a few authors have written about the concept of gatekeeping in nursing. One such author, Annette Street (1992), noted the concept when undertaking a critical ethnography of clinical nursing practice in general medical and surgical hospital wards. Gatekeeping involved nurses withholding or providing incomplete information about the location of equipment and supplies. Normally a taken-for-granted concept, gatekeeping practices became more noticeable when a hospital ward was relocated to a new site. Any underlying advantage that had accrued to individual nurses through the gatekeeping practices used in the old ward was negated by the need for all nurses to create new storage routines. As a consequence, nurses competed with each other to gain information about where equipment was located, by sometimes arbitrarily relocating supplies. Advantage was gained by "creating a dependence on the owner of the knowledge for ongoing information necessary to engage in effective clinical practice" (p. 109): nurses wielded power over those who did not have information about where supplies were stored.

May et al. (2001) explored the gatekeeping practices of nurses in their dealings with informal carers in a rehabilitation ward. They described how, upon a carer's request to speak with non-nursing healthcare workers such as a social worker, nurses screened the request by establishing the legitimacy of carers' enquiries. In doing so, nurses retained control over the decision to make contact with a colleague. Gatekeeping influenced how social relationships were framed as nurses constructed themselves as authoritative in their relationship with carers. Nurses became more than a "knowledgeable intermediary" by making decisions on behalf of absent team members. From this perspective, the authors suggested that gatekeeping was seen as collaborative as nurses supported their colleagues by limiting information flow to them, which subsequently helped to control workload by avoiding unnecessary interruptions to clinical practice.

In an ethnographic study examining the interrelationship between knowledge and decision-making in a critical care unit, Manias and Street (2001) described how nurses engaged in gatekeeping practices to help them remain in control. Nurses 'staged' the release information to medical staff by selectively imparting their knowledge. This 'staging' encouraged inexperienced critical care doctors to make decisions that worked in favour of nurses, as nurses guided doctors towards a particular, predetermined outcome. The effect was to avoid open disagreement and confrontation between nurses and doctors and subsequently to harmonise interdisciplinary relationships. Similarly, Sinivaara et al. (2004) described how midwives withheld information about managing labour when communicating with women in delivery rooms, but recognised that judging how much information women needed to make informed decisions was an individualised matter and difficult to determine.

In the medical literature, gatekeeping has focused on how physicians control access to healthcare (Glasgow, 1996; Willems, 2001), and is often discussed in ethical terms, a dimension that is largely absent in the nursing literature. For instance, Pellegrino (1986) explained that physicians are positioned at the entry point, or gate (Barzilai-Nahon, 2008, p. 1496), through which patients must pass to receive care and services. Hence, gatekeeping in medicine can be controversial as it can be used to restrict use of medical services. It also has economic considerations that can impact on clinical decision-making when physicians make choices between treatment options and the associated cost of each.

To summarise, in medicine gatekeeping is usually discussed in terms of access to services and treatments, and how physicians control this. In nursing, while examples of gatekeeping have been cited in the literature, it is usually not the primary focus of studies. There has been little attempt to situate nurses' gatekeeping in a theoretical framework or offer a detailed explanation of its impact on individuals, work practices, or the social environment. In operating rooms, as in other clinical areas, gatekeeping may have a profound impact on patient care. Before beginning our discussion of these factors, in the section that follows we outline theoretical models of gatekeeping to situate our understanding of the concept in the broader discussion of the paper.

Models for analysis of gatekeeping

Models for analysis of gatekeeping can be thought of as 'traditional' (Shoemaker, 1991) and 'network' in nature (Barzilai-Nahon, 2004, 2008, 2009). In a traditional sense, Shoemaker synthesised the gatekeeping literature to form a five-level hierarchical model. These elements are: individual, communication routines, organisational, social/institutional, and social system levels of gatekeeping. At the individual level, the focus is on the extent to which people are responsible for gatekeeping selection, and analysis centres on the gatekeeper's personality, their background, values, role and experiences. At the level of communication routines, analysis is on the "patterned, routinized, repeated practices and forms that [media] workers use to do their jobs" (Shoemaker, 1991, p. 48). Here, information characteristics such as clarity of the message or whether information is visual are important, in which case it is less likely to be subjected to gatekeeping. The organisational level of gatekeeping refers to the repeated communication-related decision-making patterns made internally by people within the organisation that help constitute the organisation as a symbolic environment. Organisational forces that affect gatekeeping may include policy, standards of the different professions, and value of the message. In contrast, at the institutional level, gatekeeping is affected by market pressures, audiences, governments, politics and interest groups. Lastly, at the social system level, gatekeeping can be understood and analysed from the perspective of ideology, culture and social structures. Table 1 shows the factors that impact on gatekeeping in a traditional sense, from the perspective of Information Science, Management and Communication literature. These factors extend beyond Shoemaker's model, and include external factors such as cost and time constraints.

Network models originated from the distribution of information through the Internet and have been adapted to incorporate social analysis. Building on the traditional models from different disciplines, including Shoemaker (1991), Barzilai-Nahon (2004, 2008, 2009) proposed a multidimensional, network model that places greater emphasis on the relationship between the gatekeeper and those upon whom gatekeeping is exercised. In network gatekeeping the actual gatekeeping process or activities used to carry out the act can be examined. These processes include: selection of one message over another, withholding, manipulation, deletion, censorship or disregarding of information, the timing of delivery, adding or uniting information, localising or adapting information for particular target audiences, and conveying information through