

TAXONOMY OF NURSING CLINICAL CREDIBILITY

AS DESCRIBED BY NURSES AND PHYSICIANS

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A DISSERTATION

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE OF DOCTOR OF PHILOSOPHY IN NURSING

THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT HOUSTON

SCHOOL OF NURSING

BY

CLAUDIA DISABATINO SMITH, M.S.N., R. N.

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MAY, 2010

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Claudia DiSabatino Smith, M.S.N., R.N.

Taxonomy of Nursing Clinical Credibility as Described by Nurses and Physicians

May 2010

**Introduction:** Nursing clinical credibility, a complex, abstract concept is rarely mentioned in the clinical setting, but is implicitly understood by nurses and physicians. The concept has neither been defined nor explored, despite its repeated use in literature. A review of the extant literature formed the basis for a concept analysis of nursing clinical credibility, which is currently under review for publication.

**Methods:** Using taxonomic analysis, findings of a descriptive qualitative research study in which registered nurses and physicians identified attributes of nursing clinical credibility as it applied to nurses in direct care roles in a hospital setting, formed the basis for development of taxonomies of nursing clinical credibility. A secondary review of literature was undertaken to verify congruence of the taxonomic domains with the work of previous researchers who studied credibility and source credibility.

**Results:** Three taxonomies of nursing clinical credibility emerged from the taxonomic analysis. Using an inductive approach, two separate taxonomies of nursing clinical credibility emerged; one was developed from the descriptions of nursing clinical credibility by registered nurses, and the other from physicians' descriptions of nursing clinical credibility. A third and final taxonomy reflects commonalities within both taxonomies. Three domains were consistent for both nurses and physicians: trustworthiness, expertise, and caring. The two disciplines differed in categories and emphases within the domains; however, both disciplines focused on the attributes of

trustworthiness and caring, although physicians and nurses differed on components of expertise.

**Discussion:** Findings from this study of nursing clinical credibility concur with the work of previous researchers who identified trustworthiness and expertise as attributes of credibility and source credibility. Findings suggest however, that trustworthiness and expertise alone are not sufficient attributes of nursing clinical credibility. Caring emerged as an essential domain of nursing clinical credibility according to both nurses and physicians.

**Products:** Products of this research include a concept analysis, two discipline-specific taxonomies of nursing clinical credibility, a third final taxonomy, and a monograph that describes the development of the final taxonomy of nursing clinical credibility.

## SUMMARY OF STUDY

This study consisted of completing a taxonomic and componential analysis on qualitative research findings for the purpose of developing a taxonomy of nursing clinical credibility as it applies to nurses in the hospital setting. In the course of this study three group interviews were conducted with nurses and one with physicians, as well as individual interviews with nurses and physicians. Taxonomic analysis was conducted on data collected in these interviews, along with data from the researcher's pilot work, field notes and clinical observations. Two discipline-specific taxonomies of nursing clinical credibility were developed from the qualitative descriptions of nurses and physicians; one final taxonomy was developed from the commonalities of both discipline-specific taxonomies. The focus of this monograph is the final taxonomy of nursing clinical credibility.

The total sample size of both the pilot study and the dissertation study consisted of nine group interviews comprised of thirty-nine participants; 32 nurses participated in seven group interviews and seven physicians took part in two group interviews. Spradley's (1979) eight-step method of taxonomic analysis and componential analysis was used to analyze findings. An additional analysis was completed following taxonomic analysis in which the investigator returned to the literature to compare the investigator's findings with those of previous researchers who studied attributes of credibility and source credibility. Findings from this analysis of literature are compared to the final taxonomy of nursing clinical credibility which emerged from taxonomic and componential analysis.

Products of this study include a concept analysis, two discipline-specific taxonomies of nursing clinical credibility, a third final taxonomy, and a monograph that describes the development of the final taxonomy of nursing clinical credibility.

Department of Health and Human Services Public Health Services <b>Grant Application</b> <i>Do not exceed character length restrictions indicated.</i>		<b>LEAVE BLANK—FOR PHS USE ONLY.</b>			
		Type	Activity	Number	
		Review Group		Formerly	
		Council/Board (Month, Year)		Date Received	
1. TITLE OF PROJECT <i>(Do not exceed 81 characters, including spaces and punctuation.)</i> <b>Taxonomy of Nursing Clinical Credibility as Described by Nurses and Physicians</b>					
2. RESPONSE TO SPECIFIC REQUEST FOR APPLICATIONS OR PROGRAM ANNOUNCEMENT OR SOLICITATION <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES <i>(If "Yes," state number and title)</i> Nu T					
3. PRINCIPAL INVESTIGATOR/PROGRAM DIRECTOR			New Investigator <input type="checkbox"/> No <input type="checkbox"/> Yes		
3a. NAME (Last, first, middle) Smith, Claudia DiSabatino		3b. DEGREE(S) RN BSN MSN		3h. eRA Commons User Name	
3c. POSITION TITLE Doctoral candidate		3d. MAILING ADDRESS <i>(Street, city, state, zip code)</i> Claudia DiSabatino Smith [REDACTED] [REDACTED]			
3e. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT University of Texas Health Science Center at Houston					
3f. MAJOR SUBDIVISION School of Nursing					
3g. TELEPHONE AND FAX <i>(Area code, number and extension)</i> TEL: [REDACTED] FAX: [REDACTED]		E-MAIL ADDRESS: [REDACTED]			
4. HUMAN SUBJECTS RESEARCH <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		4b. Human Subjects Assurance No. HSC-SN-04-003		5. VERTEBRATE ANIMALS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
4a. Research Exempt <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		4c. Clinical Trial <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		5a. If "Yes," IACUC approval Date	
If "Yes," Exemption No.		4d. NIH-defined Phase III Clinical Trial <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		5b. Animal welfare assurance no. none	
6. DATES OF PROPOSED PERIOD OF SUPPORT <i>(month, day, year—MM/DD/YY)</i> From 01/01/06 Through 12/30/06		7. COSTS REQUESTED FOR INITIAL BUDGET PERIOD 7a. Direct Costs (\$) \$0		8. COSTS REQUESTED FOR PROPOSED PERIOD OF SUPPORT 8a. Direct Costs (\$) \$0 8b. Total Costs (\$) \$0	
9. APPLICANT ORGANIZATION Name Address			10. TYPE OF ORGANIZATION Public: → <input type="checkbox"/> Federal <input type="checkbox"/> State <input type="checkbox"/> Private: → <input type="checkbox"/> Private Nonprofit For-profit: → <input type="checkbox"/> General <input type="checkbox"/> Small Business		
			11. ENTITY IDENTIFICATION NUMBER DUNS NO. Cong. District		
12. ADMINISTRATIVE OFFICIAL TO BE NOTIFIED IF AWARD IS MADE Name Title Address Tel: E-Mail:			13. OFFICIAL SIGNING FOR APPLICANT ORGANIZATION Name Claudia DiSabatino Smith Title Doctoral Student Address The University of Texas Health Science Center at Houston School of Nursing 6901 Bertner, Houston, TX 77030 Tel: [REDACTED] FAX: E-Mail: [REDACTED]		



14. PRINCIPAL INVESTIGATOR/PROGRAM DIRECTOR ASSURANCE: I certify that the statements herein are true, complete and accurate to the best of my knowledge. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. I agree to accept responsibility for the scientific conduct of the project and to provide the required progress reports if a grant is awarded as a result of this application.	SIGNATURE OF PI/PPD NAMED IN 3a. (In ink. "Per" signature not acceptable.)	DATE 11-11-05
15. APPLICANT ORGANIZATION CERTIFICATION AND ACCEPTANCE: I certify that the statements herein are true, complete and accurate to the best of my knowledge, and accept the obligation to comply with Public Health Services terms and conditions if a grant is awarded as a result of this application. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties.	SIGNATURE OF OFFICIAL NAMED IN 13. (In ink. "Per" signature not acceptable.)	DATE

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Face Page

Form Page 1

Principal Investigator/Program Director (Last, First, Middle): **Smith, Claudia DiSabatino**

**DESCRIPTION:** See instructions. State the application's broad, long-term objectives and specific aims, making reference to the health relatedness of the project (i.e., relevance to the **mission of the agency**). Describe concisely the research design and methods for achieving these goals. Describe the rationale and techniques you will use to pursue these goals.

**In addition**, in two or three sentences, describe in plain, lay language the relevance of this research to **public health**. If the application is funded, this description, as is, will become public information. Therefore, do not include proprietary/confidential information. **DO NOT EXCEED THE SPACE PROVIDED.**

The purpose of this research is to develop a taxonomy of nursing clinical credibility, as it is described by registered nurses and physicians. This is the first step in a research trajectory to develop an instrument to measure nursing clinical credibility. The nursing shortage and the emphasis on patient outcomes highlight the importance of improving nurse retention and nurse-physician relationships. Clinical credibility is a precursor to effective communication among health care providers (Smith, 2005), which leads to collaboration among health care professionals (Baggs and Schmitt, 1997), and improved patient outcomes (Knaus, Draper, etc., 1986). Identification of nurses with clinical credibility will afford nurse administrators the means by which to identify training needs, and to recognize and reward clinically credible nurses, leading to nurse retention, collaboration and collegiality among health care professionals, improved workplace morale, and improved patient outcomes.

Objectives of the project are to identify attributes of nursing clinical credibility as it is perceived by nurses and physicians, and to develop a taxonomy of nursing clinical credibility as it is described by nurses and physicians. Specific aims are to: collect data from registered nurses and physicians identifying attributes of clinically credible nurses; analyze nurse and physician data identifying attributes of clinically credible nurses; and develop a taxonomy of nursing clinical credibility as described by nurses and physicians. Qualitative data will be collected through focus group sessions of nurses and physicians who work in clinical settings with registered nurses. Additional qualitative data collected during a pilot study in which the student researcher identified attributes of nursing clinical credibility as described by nurses will be used to build the taxonomy. Data will be analyzed through content analysis, looking for patterns and themes after verifying transcripts against original recordings. Findings from the analyses will be used to construct a taxonomy of nursing clinical credibility as described by nurses and physicians. A taxonomic listing of attributes of nursing clinical credibility will organize and clarify relationships between the attributes identified by nurses and physicians, and will ultimately identify those attributes by which the concept can be recognized and measured.

PERFORMANCE SITE(S) (organization, city, state)

Data collection will be conducted at St. Luke's Episcopal Hospital which is located in the Texas Medical Center in Houston, Texas. Focus groups will serve as the methodology for data collection. Focus group sessions consisting of six participants will be conducted in conference rooms on the campus of St. Luke's Episcopal Hospital.

Principal Investigator/Program Director (Last, First, Middle):

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**KEY PERSONNEL.** See instructions. *Use continuation pages as needed* to provide the required information in the format shown below. Start with Principal Investigator. List all other key personnel in alphabetical order, last name first.

Name	eRA Commons User Name	Organization	Role on Project
Smith, Claudia DiSabatino		Doctoral student SON	Principal Investigator

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**OTHER SIGNIFICANT CONTRIBUTORS**

Name	Organization	Role on Project
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**Human Embryonic Stem Cells**  No  Yes

If the proposed project involves human embryonic stem cells, list below the registration number of the specific cell line(s) from the following list: <http://stemcells.nih.gov/registry/index.asp>. *Use continuation pages as needed.*

If a specific line cannot be referenced at this time, include a statement that one from the Registry will be used.

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**Cell Line**

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**Disclosure Permission Statement.** Applicable to SBIR/STTR Only. See SBIR/STTR instructions.  Yes  No

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Page 3

**Form Page 2-continued**

throughout

Number the *following* pages consecutively

4a, 4b.

the application. Do not use suffixes such as

Principal Investigator/Program Director (Last, First, Middle): **Smith, Claudia DiSabatino**

The name of the principal investigator/program director must be provided at the top of each printed page and each continuation page.

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Check if  
Appendix is  
Included

Number of publications and manuscripts accepted for publication (not to exceed 10)

1

Other items (list):

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Page 4

Form Page 3

Principal Investigator/Program Director (Last, First, Middle): **Smith, Claudia DiSabatino**

**DETAILED BUDGET FOR INITIAL BUDGET PERIOD  
DIRECT COSTS ONLY**

FROM

THROUGH

PERSONNEL (Applicant organization only)		TYPE APPT. (months)	% EFFORT ON PROJ.	INST. BASE SALARY	DOLLAR AMOUNT REQUESTED (omit cents)		
NAME	ROLE ON PROJECT				SALARY REQUESTED	FRINGE BENEFITS	TOTAL
	Principal Investigator						
<b>SUBTOTALS</b>							
CONSULTANT COSTS							
EQUIPMENT (Itemize)							
SUPPLIES (Itemize by category)							
TRAVEL							

PATIENT CARE COSTS	INPATIENT	
	OUTPATIENT	
ALTERATIONS AND RENOVATIONS <i>(Itemize by category)</i>		
OTHER EXPENSES <i>(Itemize by category)</i>		

CONSORTIUM/CONTRACTUAL COSTS	DIRECT COSTS	
<b>SUBTOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD</b> <i>(Item 7a, Face Page)</i>		<b>\$</b>
CONSORTIUM/CONTRACTUAL COSTS	FACILITIES AND ADMINISTRATIVE COSTS	
<b>TOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD</b>		<b>\$</b>

**SBIR/STTR Only: FEE REQUESTED**

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Page

Form Page 4

Principal Investigator/Program Director (Last, First, Middle): **Smith, Claudia DiSabatino**

**BUDGET FOR ENTIRE PROPOSED PROJECT PERIOD  
DIRECT COSTS ONLY**

BUDGET CATEGORY TOTALS	INITIAL BUDGET PERIOD <i>(from Form Page 4)</i>	ADDITIONAL YEARS OF SUPPORT REQUESTED			
		2nd	3rd	4th	5th
PERSONNEL: <i>Salary and fringe benefits. Applicant organization only.</i>					
CONSULTANT COSTS					
EQUIPMENT					
SUPPLIES					
TRAVEL					
PATIENT CARE COSTS	INPATIENT				
	OUTPATIENT				
ALTERATIONS AND RENOVATIONS					
OTHER EXPENSES					
CONSORTIUM/ CONTRACTUAL COSTS	DIRECT				
<b>SUBTOTAL DIRECT COSTS</b> <i>(Sum = Item 8a, Face Page)</i>					

CONSORTIUM/ CONTRACTUAL COSTS	F&A					
<b>TOTAL DIRECT COSTS</b>						
<b>TOTAL DIRECT COSTS FOR ENTIRE PROPOSED PROJECT PERIOD</b>						<b>\$</b>
<b>SBIR/STTR Only Fee Requested</b>						
<b>SBIR/STTR Only: Total Fee Requested for Entire Proposed Project Period</b> (Add Total Fee amount to "Total direct costs for entire proposed project period" above and Total F&A/indirect costs from Checklist Form Page, and enter these as "Costs Requested for Proposed Period of Support on Face Page, Item 8b.)						<b>\$</b>

JUSTIFICATION. Follow the budget justification instructions exactly. Use continuation pages as needed.

**Specific Aims**

Clinical credibility is the impression that registered nurses (RNs) and medical doctors (MDs) form about a health care provider's job performance in the clinical setting.

Clinical credibility refers to the confidence and trust that one has in a health care provider with whom one interacts and observes in a clinical setting. The investigator defines RN clinical credibility as the impression that an RN is believable; that the RN is perceived to consistently emanate expertise, trustworthiness, a caring attitude, and word-action congruence in the clinical setting. RN clinical credibility is a construct that is comprised of the set of perceived behaviors and manifestations of several behavior-traits or concepts that health care providers associate with the behaviors of "one of the good nurses" in the clinical setting.

The terms, RN clinical credibility or clinically credible RN, are not commonly used in the clinical setting. The phrase, “one of the good nurses” is commonly used by RNs and MDs to refer to the RN in the clinical setting in whom they have confidence and trust; the RN with clinical credibility. The construct, RN clinical credibility, has not been defined in the literature, nor have the attributes that make up the construct been identified or defined. It is important to understand the qualities or attributes that RNs and MDs value in the RN who has been designated as “one of the good nurses”, or the clinically credible RN. Understanding the attributes that MDs associate with RN clinical credibility may lead to improved communication between RNs and MDs, improved relationships between RNs and MDs, and greater collaboration between RNs and MDs, which lead to improved patient outcomes (Baggs and Schmitt, 1997; Knaus, Draper, Wagner, and Zimmerman, 1986; Pronovost, et al. 2003). Recognition of RNs who emanate attributes of RN clinical credibility by other RNs, nurse managers, and nurse administrators leads to enhanced professional fulfillment and RN job satisfaction, and may improve the retention of RNs who feel valued by RNs and MDs.

Identifying attributes that define RN clinical credibility will result in an operational definition of the construct. Operational definitions serve as the means by which the behaviors observed in a concept may be measured (Chinn and Kramer, 1991). Behaviors identified in clinically credible RNs within the clinical setting are categorized within defining attributes. Development of a taxonomic structure of RN clinical credibility will clarify, refine and more accurately define RN clinical credibility, while categorizing and listing attributes and behaviors in a hierarchical format. A taxonomic structure will enable the investigator to clearly identify the defining attributes by which the construct



can be measured. A taxonomic listing of the behaviors manifested in the construct, RN clinical credibility, will not only organize attributes in a logical format, but may illustrate the relationships between and among attributes. Construction of taxonomic structure will reveal similarities and differences in the way that RNs and MDs describe the clinically credible RN, and the importance that each discipline attributes to the defining characteristics. Analysis and taxonomic development of the construct will identify relationships between the attributes of clinically credible RNs that are valued by RNs and by MDs within the health care setting, and will lead to a re-labeling of “one of the good nurses” to “the clinically credible nurse”.

The specific aims of the proposed research study are to: 1) identify attributes of clinically credible RNs as described by RNs and MDs through qualitative methods in focus group sessions; and 2) develop a taxonomic structure from data collected through qualitative means, that hierarchically lists behaviors and attributes of clinically credible RNs in the clinical setting, as described by RNs and MDs in focus group sessions in the proposed research study and in the investigator’s previous pilot study.

### **Background and Significance**

RN clinical credibility has not been defined, nor researched in the nursing or healthcare literature. Common understanding of the meaning of the construct, clinical credibility, is lacking, as is an operational definition (Humphreys, Gidman, and Andrews, 2000), and defining attributes. A construct is a cognitive category or generalization that encompasses numerous facts, representing a pattern or template that serves as a way of looking at the world (Schlenker, 1980). Credibility is a term that is commonly used

across all contexts, but whose attributes have eluded researchers for over five decades (Falcione, 1974; Burgoon, 1976; McCroskey, 1966).

Credibility, an attribute of personal integrity (Carroll and Jowers, 2001), is an essential trait for effective managers and leaders (Kanter, 1977; Kouzes and Posner, 1993, Boswell and Cannon, 2005). When coupled with skills and knowledge credibility affords one expert power (French and Raven, 1959 as cited in Roberts and Vasquez, 2004). RNs recognize the importance of establishing their credibility with MDs in the clinical setting (Benner, 1984; Buonocore, 2004), yet it has not been researched or discussed in the nursing literature.

The research questions for the proposed study are: 1) What are the attributes of clinically credible RNs, as they are described by RNs and MDs? 2) What is the taxonomic structure of the attributes of the clinically credible RN, as they are described by RNs and MDs?

### **Literature Review**

The core concept, credibility, has long been researched outside the fields of nursing and healthcare. Researchers in the fields of communication, business and management, and marketing have studied credibility for over five decades (Hovland and Weiss, 1951; Slater and Rouner, 1996), and have come to no agreement regarding the attributes of credibility (Falcione, 1974; Burgoon, 1976; McCroskey, 1966) except for the central or transsituational attributes of expertise and trustworthiness (Hovland and Janis, 1953; Whitehead, 1968). Transsituational attributes refer to those attributes that apply in every situation or discipline in which the concept has been studied (O'Keefe, 1990).

Credibility has been studied in relation to leadership behaviors (Falcione, 1974; Kanter, 1977; Schmidt and Posner, 1982) where behavioral terms were used to define credibility. Leaders are judged credible if they do what they say they will do (Kouzes and Posner, 1993). Word-action congruence, a behavioral manifestation of consistency, leads to trustworthiness, and ultimately to credibility. Credibility is seen as “competence plus power” (Kanter, 1977, p.169) in business circles, where phone calls of credible people are answered first, since it is assumed that they have something important to say (Kanter, 1977).

Source credibility, a related concept, refers to the believability of the message source. The message source refers to the vehicle by which a message is delivered. Message sources include: television news anchors, newspaper journalists, radio broadcasters, the chief executive officer of a company, professors, conference speakers, and RNs. Attributes of source credibility identified in factor analyses include: dynamism, safety, qualification (Whitehead, 1968; Berlo, Lemert, and Mertz, 1970), authoritativeness, character (McCroskey, 1966), knowledgeable, accuracy, fairness, and completeness (Jacobson, 1969; Lee, 1978). The context in which credibility is studied determines the applicable attributes, since findings are not generalizable across all populations (Falcione, 1974). Attributes that are applicable to chief executive officers may not be applicable to radio broadcasters, newspaper journalists, or RNs.

Nurse researchers identified trust, interest, knowledge and respect as antecedent conditions that serve as precursors to effective communication (Baggs and Schmitt, 1997). In a pilot study conducted by the investigator, focus groups of RNs used the same words to identify clinically credible RNs (Smith, 2005). The investigator hypothesizes

that health care providers, more specifically, RNs with clinical credibility, are essential factors in the equation that results in effective communication about patients.

One finds credibility referenced occasionally in the nursing literature (Ball and Cox, 2004; Benner, 1984; Boswell and Cannon, 2005; Buonocore, 2004; Fetter, 1994; Hegge, 1993; Roberts and Vasquez, 2004) however, neither a substantive study of credibility, nor clinical credibility, is found within the context of nursing or healthcare, outside of the investigator's pilot study. The National Joint Practice Commission identified competence, accountability, trust, communication and administrative support as factors contributing to collaborative practice (Baggs and Schmitt, 1988). Clinically credible RNs emanate all of the identified qualities, except for administrative support (Smith, 2005). One may conclude that clinically credible RNs, in the presence of administrative support, contribute to collaborative practice. Since people are likely to listen and respond more quickly to those who are perceived to be credible (Kanter, 1977), it follows that less time is required for the clinically credible RN to convince others of the need for quick action than is needed by the RN who has not yet established her/his credibility (Davidhizar, 1992). Clinically credible RNs are likely to be recognized as effective team members, as "one of the good nurses," who communicate effectively about patients and patient care. Research suggests that advanced practice nurses (APNs) who lack credibility also lack legitimate authority, an essential property for APNs who engage in advanced clinical nursing practice (Ball and Cox, 2004).

### **Hypothesis and Gaps in the Literature**

Clinical credibility, as it applies to health care providers in the clinical setting, is not referenced in the literature. References to the clinical credibility of nursing faculty are

repeatedly found in the nurse education literature (Humphreys, Gidman, and Andrews, 2000; Maslin-Prothero and Owen, 2001; Nahas, 2000; Goorapah, 1997), although the concept has not been analyzed or defined in the literature. The investigator suggests that the meaning of the concept as it is used to describe nursing faculty differs significantly from that used to describe RNs who practice as health care providers in the clinical setting. Clinical credibility, as it applies to nursing faculty members, refers to the faculty member's ability to function in the clinical area, demonstrating their knowledge of both theoretical and practical, or "hands-on" aspects of nursing practice (Nahas, 2000 based on the work of Crotty, 1993, and Green, 1982). "Hands-on" is used to denote technical expertise and connection with the patient, and represents the action of the RN's intent to help (Engebretson, 2002). This represents a significantly different meaning of the concept than the definition suggested by the investigator. The investigator proposes that clinical credibility, as it relates to RN health care providers, is operationally defined as: the impression that a RN is believable; that the RN is perceived to consistently emanate character, expertise, and work ethic in the clinical setting.

Other gaps exist in the literature in regard to the role that RN clinical credibility has on: nurse-physician communication; collaboration between RNs and MDs; nurse-patient communication; and patient outcomes. Researchers discuss the importance of the: credibility of the leader of the organization (Kanter, 1977; Kouzes and Posner, 1993; Boswell and Cannon, 2005); administrative support in the organization (Baggs and Schmitt, 1988); communication skills of the participants (Baggs and Schmitt, 1997; Hascup, 2005); and lack of agreement regarding the presence or lack of collaboration in the clinical setting (Baggs, Ryan, Phelps, Richeson, and Johnson, 1992; Baggs, Schmitt,

Mushlin, Mitchell, Eldredge, Oakes, and Hutson, 1999). The literature does not speak, however, to the clinical credibility of team participants.

If participants of the nurse-physician dyad do not respect each other for their clinical credibility, it is not likely that collaboration will occur. Healthcare providers know who “the good nurses” are. They are the RNs with clinical credibility. But does each member of the dyad identify the clinically credible RN the same way? It is important to recognize that variance may exist in the expectancy-guided model of the clinically credible RN in the mind of each member of the dyad. The hypothesis for the research study is: There is a taxonomic relationship among and between attributes of clinically credible RNs who are health care providers in the clinical setting, as perceived by RNs and MDs.

### **Theoretical Frameworks**

Three theoretical frameworks inform the proposed research study. Schema theory, from the discipline of social psychology, serves as the theoretical framework for the process of impression formation (Srull and Weir, 1989), while identity theory, developed within the discipline of sociology, supports interdisciplinary sampling to determine varying viewpoints based on social roles and identities of the perceiver (Stryker, 1980; Burke, 1991). Impressions formed about an RN’s clinical credibility, must be considered within the social contexts in which other interdisciplinary health care providers perceive the RN. It is the lens of their individual identities and discipline that result in health care providers perceiving the same RN differently. Neither schema theory nor identity theory alone, provide theoretical support for the dynamic, interdisciplinary process of the formation of an impression regarding RN clinical credibility. The third theoretical framework, categorization theory (Mirvis and Rosch, 1981) provides theoretical

substance to support the development of taxonomy to organize information into categories, in an effort to simplify a complex subject.

The theoretical framework of *schema theory* details how mental representations develop from perceived stimuli, are stored in memory as categorical representations, later retrieved, and are used to form evaluative judgments or impressions. Impression formation (Asch, 1946; Srull and Wyer, 1989) is a cognitive process by which one forms an evaluative judgment about a perceived target. Perceiver refers to the person who observes and becomes increasingly aware of the target person, who is being perceived. Schema refer to the knowledge structures that people use to represent other people, and provide default assumptions about their characteristics, traits, and relationships under conditions of incomplete information (DiMaggio, 1997).

Impressions are formed through an information-processing mechanism in which a perceiver receives stimuli from the social environment and processes that information. Figure 1 demonstrates the process of impression formation according to *schema theory*. Impression formation occurs when a perceiver initiates action to observe or interact with a target person, takes action to observe or interact with the perceived target person, makes attributions regarding the person's manifest behaviors, and integrates a conundrum of information to form a unified impression of the perceived target. Perceivers move through the information-processing continuum by inferring traits, attitudes, motives and other dispositional characteristics that they attribute as the basis for the target person's actions (Jones and Davis, 1965). Attribution is the process by which a perceiver makes a connection or relation between the target person and another source, inferring that one was the cause for the other (Heider, 1976; as cited in Schlenker, 1980). Impression

formation is a complex, multivariable process, the study of which is grounded in decades of social psychology research.

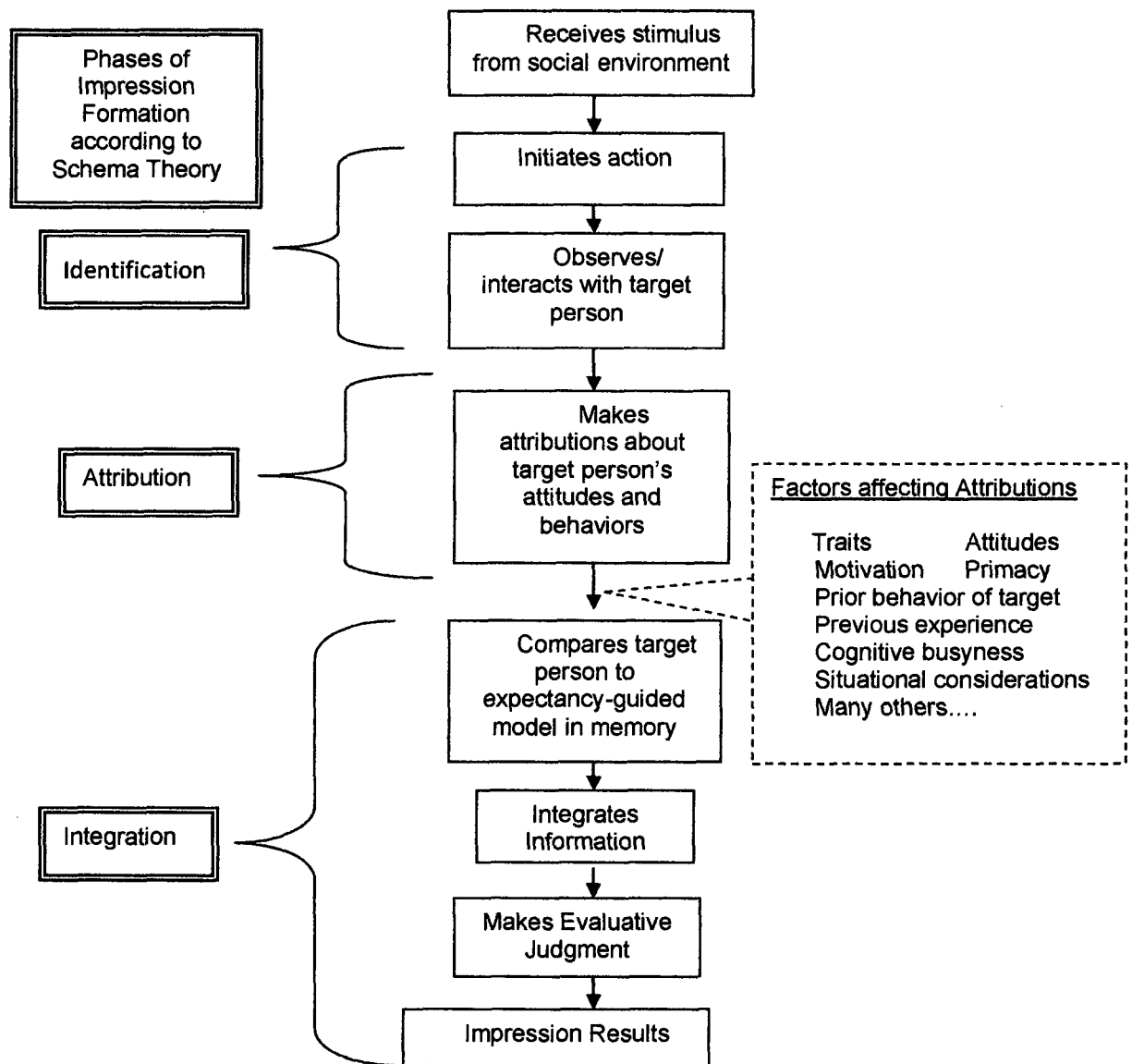


Figure 1. Impression Formation according to Schema Theory.

Perceivers observe the behaviors of the target person and use an expectancy-guided model to make inferences and predictions regarding the target person's past and future behaviors. An expectancy-guided model is an internal, mental image that the perceiver has of a person who met his expectations by exhibiting the desired characteristics and



behaviors in a previous encounter. The perceiver's expectancies guide the retrieval of original information in memory, and lead to the recall of a past experience that is consistent with one's expectancy (Hirt, 1990). The expectancy-guided model of a clinically credible RN serves as the gold standard for the perceiver who is evaluating the clinical credibility of a target RN. The perceiver compares the qualities and behaviors of the target RN against the expectancy-guided model (the gold standard) in memory, to determine if the target RN meets their expectation of a clinically credible RN. An impression of clinical credibility results when the target RN meets or exceeds the expectations of the perceiver's internal expectancy-guided model of a clinically credible RN.

Impressions are unified conceptions (Asch, 1946) that are structured around an evaluative dimension in which perceivers make social judgments regarding the perceived person. Social judgments are a product of the unique social identities and roles of the individual perceiver, and result in variability among impressions formed by different perceivers about the same target person. The variability that results from the effect of one's identities and social role(s) on the cognitive process of impression formation is not discussed in schema theory. This unique dimension of impression formation can best be explained from the sociological perspective, which necessitates consideration of an additional theory.

Identity theory, a microsociological theory, examines the dynamic interaction of self, society, and social behavior. Identity theory focuses on the identities that make up the self, the effect of society on self, and how self affects social behaviors. Identity theory evolved from the work of George Herbert Mead, and represents the efforts of two

contemporary sociological theorists, Sheldon Stryker (1980) and Peter Burke (1991), who strove to make Mead's work measurable. Stryker examines how social structures affect the self, and how the self affects social behavior, while Burke focuses on the internal dynamics of self-processes as they affect social behavior (Stryker and Burke, 2000). Identity theory provides theoretical support for variable impressions of an RN's clinical credibility depending on the social identities and roles of the perceivers. Identity theory provides justification for interdisciplinary sampling in determining attributes of RN clinical credibility as viewed by RNs and MDs.

Identity theory uses social identities and roles as the structural component of society, and links social cognition to social structure to explain the individual variation that is experienced in society. Figure 2 demonstrates the impact of the individual's salience with social categories and social role in the perception of the RN's clinical credibility, as the RN is compared to the individual's internal expectancy-guided model of a clinically credible RN. The perceiver's eyes and viewpoint are tempered by the social categories and identities/roles to which the perceiver belongs, and which contribute to the perceiver's identity. Social categories are comprised of people with whom the perceiver identifies and shares basic commonalities. Social categories may include political affiliation, gender, ethnicity, age, race, religion, and social status, and override all other characteristics of a person (Stryker and Burke, 2000). Social categories provide the first level of society's impact on one's identities as they influence the positions that people can hold, the relative importance of their role identities, and the nature of their interactions with others (Hogg, Terry, and White, 1995). The meaning and expectations

associated with a particular role guide the behavior of those with whom the role is salient (McCall and Simmons, 1978; Stryker, 1980).

The perceiver's expectancy-guided model is affected by the social categories and identities/roles with which the perceiver identifies. The identities/roles with which the perceiver most closely identifies are said to be most salient. Salience with a social category or role may vary within social contexts (Callero, 1985), and within individuals depending on the connectedness and shared meanings with the social category or role (Bettencourt and Sheldon, 2001). Certain social roles have more power and authority associated with them than others. The role of MD is a socially privileged position that automatically grants credibility, power, and authority to MDs (Anderson, 1995, as cited in Ceci, 2004). The role of the RN, as subordinate to the MD, is one that constrains and limits power, authority, and credibility of the RN, (Ceci, 2004). The power and authority associated with the specific role adds variability to the development of the expectancy-guided model that may be described by RNs versus MDs, further justifying the plan to sample both RNs and MDs.

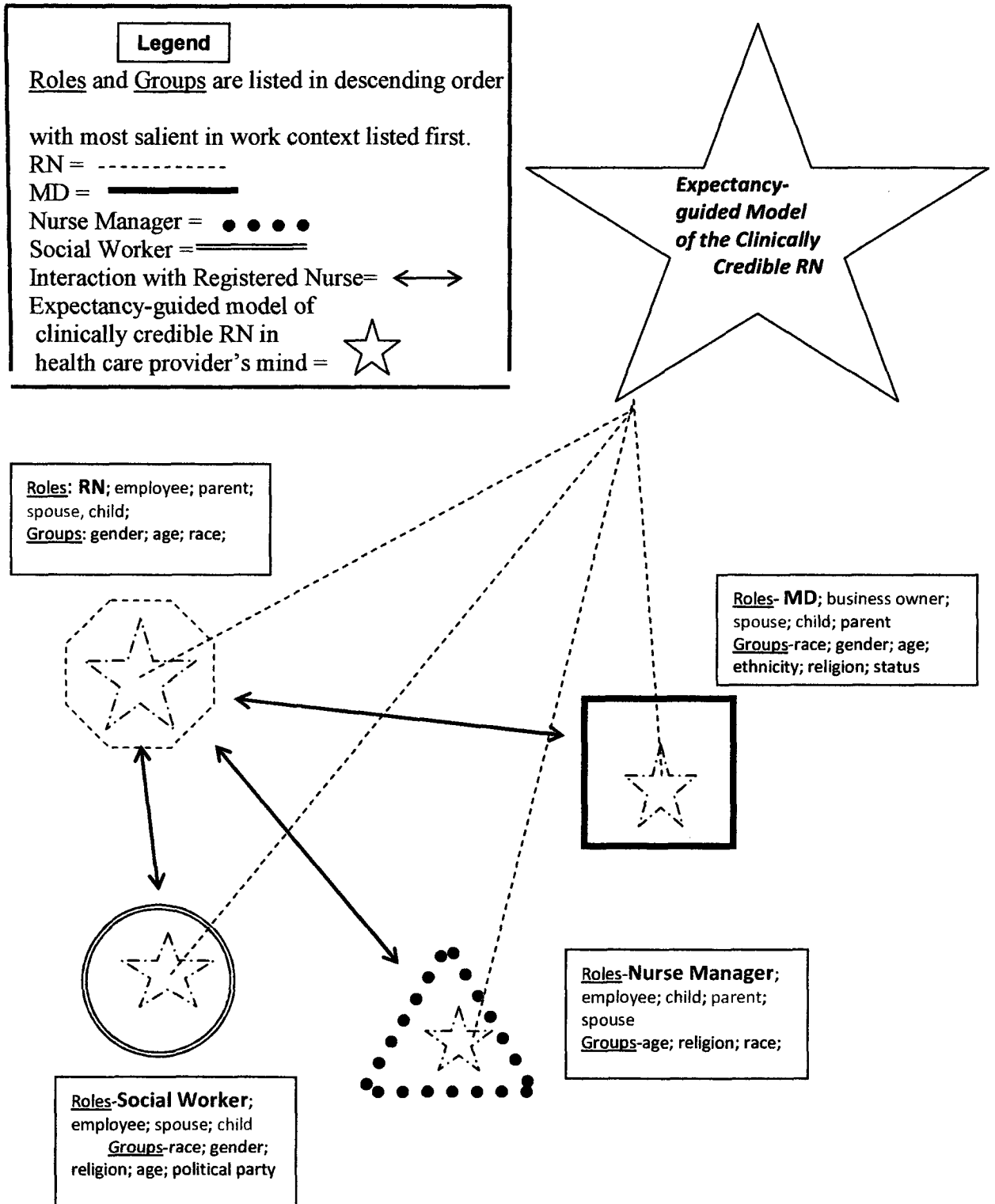


Figure 2. Effect of identity theory on the Expectancy-Guided Model of a clinically credible RN in the mind of interdisciplinary health care providers.

The gender of the perceiver and the target RN is the key determinant in the salience of gender as a social category in identity theory, and whether gender-linked expectancies and behaviors are triggered. Schemas and expectancies associated with same-sex interactions are different from those of mixed sex interactions (Carli, 1990). Mixed sex interactions can be expected to trigger schemas and expectancies that are different when the gender of the perceiver is female, from those that are triggered when the gender of the perceiver is male. Gender is but one key determinant that impacts the internal expectancy-guided model of a clinically credible RN and, ultimately, one's impression of an RN in the clinical setting. All of the components of *identity theory* that contribute to the identity of the perceiver affect impression formation during the attribution phase of the cognitive process, as it is illustrated in Figure 1.

Grounded in schema and identity theories, the impression formation process is a complex, but organized, mechanism in which mental representations are formed from perceptual stimuli in social contexts and processed within the framework of the perceiver's identities/roles, are stored in memory, and retrieved for later use in making evaluative judgments. The expectancy-guided model of the perfect clinically credible RN serves as the gold standard by which other RNs are judged. Research is needed to identify, examine, categorize and compare attributes identified in the gold standard as viewed by RNs and by MDs. Such information provides a significant step toward improving intradisciplinary and interdisciplinary relationships. Knowledge of attributes identified by each health care provider discipline provides an opportunity for RNs to tailor their efforts in such a way as to meet the gold-standard for each discipline, thereby building a spirit of effective communication, trust, mutual respect, and collaboration.

Principles of categorization theory (Mervis and Rosch, 1981) support the organization and classification of knowledge about RN clinical credibility. Central tenets of categorization theory include: 1) Cognitive economy (Neisser, 1976) leads people to seek to simplify complexity by organizing information into categories; 2) Hierarchical embedding (Neisser, 1976) occurs when detailed and specific information is embedded in progressively more abstract and inclusive categories; and 3) Schema provide the framework that guides the process of classification, links the symbol categories with human feelings, and triggers behavioral responses to the information categorized (Shetzer, 1993).

Classification is one of the most fundamental and a characteristic activity of the human mind, and is fundamental to all scientific disciplines (Crowson, 1970). Categorization serves to organize and order objects or events, reducing the complexity of human experience. Categorization is the process of arranging cultural symbols into categories or classes by types (Wehmeir, 2005). A category is a unit of classification in which an array of distinguishable symbols is treated equally, and is related by inclusion (Mervis and Rosch, 1981; Spradley, 1979). Basic level categorizations are those that demonstrate the maximal amount of information about a symbol. Symbols may be categorized at each of several different hierarchical levels, but when the levels are related to each other by class inclusion, taxonomy is present (Mervis and Rosch, 1981). Researchers have demonstrated that basic level categories are acquired before those at other hierarchical levels (Mervis and Rosch, 1981).

The hierarchical level at which a symbol is categorized within a domain, can vary with its cultural significance and with the level of expertise of the investigator (Rosch et

al, 1975; Dougherty, 1978). This principle is of particular importance in the proposed study where cultural significance is expected to impact the selection of defining attributes of RN clinical credibility by MDs, and by RNs. The novice status of the investigator as an ethnographic analyst also contributes to the possibility of variance in the hierarchical level selected. The organized, hierarchical system of classification that taxonomic analysis provides will facilitate the organization and categorization of tacit, cultural knowledge of RNs and MDs regarding RN clinical credibility.

### **Significance**

Clinical credibility is the basis for accurate, respectful communication among professionals. Effective communication leads to collaboration (Baggs and Schmitt, 1997), and to improved patient outcomes (Knaus, Draper, Wagner, and Zimmerman, 1986; Baggs and Schmitt, 1997). Teams that communicate directly about patients realize improved patient outcomes (Knaus, Draper, Wagner, and Zimmerman, 1986; Pronovost, Berenholtz, Dorman, Lipsett, Simmonds, and Haraden, 2003). Clinical advancement systems based on perceived RN clinical credibility is one strategy for improving organizational outcomes through RN retention. Such systems reward nurses who have earned the respect of RN colleagues, MDs, and other clinical experts (McClure and Hinshaw, 2002). Retention of clinically credible RNs will: enhance nurse-physician relationships; improve the work environment; lead to more effective communication between RNs and other healthcare providers; increase collaboration between clinically credible RNs and MDs; improve patient outcomes and the retention of RNs who want to work with clinically credible RNs.

Development of a taxonomic structure of the attributes of clinically credible RNs will allow the investigator to classify defining attributes of RN clinical credibility according to each discipline, and according to level of importance within each discipline. Such clarity provides: RNs with the knowledge of attributes valued by RN colleagues and MDs, with which they may evaluate their own nursing practice in order to improve their own clinical credibility, resulting in a positive change in their clinical nursing practice; nurse educators with evidence with which they can develop strategies to teach student and staff nurses methods of attaining clinical credibility among MDs and RN colleagues; nurse researchers with the means to construct an instrument to measure clinical credibility of RNs through its defining attributes; nurse administrators with evidence of attributes valued by RNs and MDs with which to strategize retention efforts that recognize and reward clinically credible RNs; and outcomes managers with attributes characteristic of effective collaborative teams in order to assist in the selection of appropriate team members.

Research findings will provide faculty, students and staff nurses with information regarding qualities of clinically credible RNs most valued by RN and MD colleagues, setting up an opportunity for self-reflection and the opportunity to improve one's nursing practice. Such reflexive practices encourage satisfaction and fulfillment with one's nursing role. Satisfaction with nursing role improves nurse retention. A taxonomy of RN clinical credibility will underscore those defining attributes by which one recognizes the RN with clinical credibility. This will enable the investigator to devise subscales by which to measure each defining attribute in order to quantify the latent variable, RN clinical credibility. Development of an instrument that quantifies clinical credibility



enables nurse administrators to recognize and reward RNs who are evaluated by their nurse and MD colleagues as demonstrating higher levels of clinical credibility in the clinical setting. RNs with clinical credibility, as quantified by such an instrument, are more likely to be selected to serve as members on collaborative treatment teams that strive for collegial interdisciplinary relationships and enhanced patient outcomes.

Collaboration and effective communication about patients improve patient outcomes (Knaus, Draper, Wagner, and Zimmerman, 1986; Pronovost, et al. 2003).

### **Preliminary Studies/Progress Report**

The research proposal for the pilot study entitled, *Clinical Credibility: Identifying and Verifying the Attributes*, was submitted and approved by the Committee for the Protection of Human Subjects (CPHS) in February, 2004. Preliminary findings from the RN data of the investigator's pilot study, discussed in the following paragraphs, were disseminated through a research abstract in May 2005. The literature citation is: Smith, C. D. (2005). Identifying Attributes of Clinical Credibility in Registered Nurses, *Nursing Administration Quarterly*, 29(2), 188-191.

Focus groups sessions were conducted with four groups of RNs in conference rooms on the campus of a large, not-for-profit community hospital in the Texas Medical Center, in Houston, Texas. Recruitment of participants was conducted through an announcement on the hospital intranet as well as through emails sent to a random sample of nurse managers, and distributed to all RN staff members of their respective nursing units. The sample consisted of 23 female RNs and 0 male RNs. Male RNs were actively recruited but elected not to participate. The participants were, on average, 40.1 years of age (SD=6.57), were Caucasian (48%), and held a bachelor degree in nursing (70%). Fifty-

two percent of the sample worked in ICU (n=12) and 48% worked in non-ICU acute care nursing units (n=11). Experience since graduation from a basic nursing program was 0-5 years (0%); 5-9 years (13%); 10-15 years (39%); 16-20 years (0%); and more than 20 years (35%).

Findings from the initial analysis suggest that RNs identify expertise, character, and work ethic as attributes of RN clinical credibility. The three attribute categories are comprised of multiple concepts and qualities that represent behaviors that have been described by RNs to be indicative of RNs with clinical credibility.

Previous researchers found transsituational (O'Keefe, 1990) attributes of credibility, those that are found in every study in which credibility has been studied, as expertise and trustworthiness. Participants in the pilot study identified qualities that more broadly represent character, rather than trustworthiness. Trustworthiness was identified as only one of the characteristics of clinical credibility along with honesty, integrity, dedicated, being approachable, having a professional attitude, and "is trusted". Findings suggest that the constellation of qualities that describe one's character may be a better predictor of clinical credibility than trustworthiness alone. The attribute category, expertise, includes competence, communication skill, and knowledgeable. Findings also indicate that, unique to nursing, work ethic emerged as an attribute of RN clinical credibility. Work ethic includes follow-through, effectiveness, and thorough. Participants of the pilot study described clinically credible RNs as those who are solution-oriented, are willing to help co-workers, pay attention to detail, "follow through", and will go the extra mile to get the job done.

Unexpected findings observed during the data collection phase of the pilot study, which included data collection from four groups of RNs and one group of MDs, indicate that core attributes of clinical credibility of RNs may vary with the healthcare provider group interviewed. Additional data collection is necessary in order to expand the RN and MD sample in order to determine the attributes by which RNs and MDs define RN clinical credibility. Research is needed to determine if MDs identify the clinically credible RN by the same attributes as those identified by RNs. Understanding core differences in one's expectation of the clinically credible RN may produce better communication, understanding, and collaboration among RNs and MDs, all of which lead to improved patient outcomes and organizational outcomes.

More extensive analysis of the existing RN data, along with additional RN focus groups and individual interviews will provide clarity and validation to the investigator's findings. Additional MD focus groups will provide a more representative sample, adding to the richness and diversity of findings. The investigator proposes development of a taxonomic structure of RN clinical credibility that will illustrate the hierarchical relationship of the attributes and their attribute categories. Taxonomy is a hierarchical listing, or system of classification. The complexity of the attribute structure of the construct clinical credibility lends itself to the development of a taxonomic structure, listing and categorizing the attributes and their relationship in a hierarchical format.

The proposed research study expounds upon the initial pilot study of the investigator, in which attributes of clinically credible RNs were identified by RNs. The pilot study and the proposed research study serve as steps along a research trajectory that has as its broad, long-term objective to develop an instrument with which to measure RN clinical

credibility. The additional focus groups and clarifying, individual interviews will provide rich data for analysis. The findings from the analysis will be used to construct a taxonomic structure that lists attribute categories and attributes in a hierarchical format. The taxonomy will serve as the next step in a research trajectory that includes development of an instrument to measure the latent variable, clinical credibility. Summary scales are designed from attributes by which the latent construct is operationally defined. Hierarchical categorization serves as the basis for identification of the defining attributes from which summary scales are built. The instrument to measure RN clinical credibility may consist of several subscales, which when summed will result in a valid measurement of the target construct. The conceptual groundwork done in preparation for instrument design is crucial to the ultimate validity and reliability of the instrument. The proposed research study serves to further the conceptual development of the construct.

## **Research Design and Methods**

### **Design**

The proposed research study is an explorative, descriptive qualitative study that will use focus groups of RNs and MDs as the method of data collection. Focus group sessions were chosen as the data collection methodology in an effort to maximize the collection of credible, relevant, high-quality data (Morrison-Beedy, Côté-Arsenault, and Feinstein, 2001).

The investigator proposes to conduct separate focus group sessions of RNs and MDs who have evidenced clinical credibility in RNs in the clinical setting. Focus group sessions of MDs will be conducted independently from focus group sessions of RNs to

encourage the candor of MD responses due to the work situation and status differences between RNs and MDs in the clinical setting. Likewise, RN focus group sessions will be held independently of MD focus group sessions to encourage the candid response of RNs who may be inhibited by the presence of MDs due to the imbalance in power between RNs and MDs (Ceci, 2004). An additional focus group comprised of RNs who have been employed by the institution less than three months will be conducted in order to explore the contrast in their perspective of the clinically credible RN versus that of RNs who have been employees for at least one year. The use of a contrasting perspective is expected to bring clarity to the identification of defining attributes of RN clinical credibility.

Data collected in the proposed research study, and in a previous pilot study designed to identify attributes of clinical credibility will be analyzed for content and themes. The findings from both studies will be used to formulate a hierarchical structural model of RN clinical credibility.

### **Sample**

A purposive sample of RNs recruited through a flyer sent to nurse managers and distributed to RNs who work on patient care units at one large, community teaching hospital within the Texas Medical Center in Houston, Texas will be the sampling methodology for the recruitment of RN participants. The methodology used to recruit MDs will be purposive sampling consisting of MDs accessed through key MD informants. The investigator will send letters either electronically or via fax to the office of the proposed participant. Prospective participants will be informed about the study and invited to contact the investigator electronically or by telephone to indicate willingness to participate in the proposed research study. The methodology for MD recruitment will

vary from that used to recruit RN participants due to the general inaccessibility and unwillingness of elites to participate in research studies (Odendahl and Shaw, 2002).

Focus groups will consist of approximately 6 participants (Morgan, 1997), representing a cross-section of nursing units and MD medical/surgical specialties. Efforts will be made to ensure a broad variation in the sample with particular attention to the axes of gender, age, and race. The MD sample will be comprised of MDs who have full practice privileges at the participating hospital and who work in a clinical setting at least weekly with RNs who provide healthcare to patients. The RN sample will be comprised of RNs who have worked for a minimum of one year in a clinical setting in an acute care hospital where they administer nursing care to patients.

Focus group sessions will be conducted until the investigator determines that the interview data provides a trustworthy answer to the research questions or until the investigator is able to anticipate responses by participants of subsequent sessions (Morgan, 1997). The investigator will announce at the outset of each focus group session that participation in the focus group session implies consent to participate, and that participants who do not consent to be recorded may feel free to leave now, and may elect to leave at any time during the focus group session.

Demographic Data Form: The following written information will be collected on each participant by self-disclosure at the outset of the focus group session: gender, age, ethnicity, years of experience in profession, years at the participating hospital, profession, highest degree held.

**Setting**

The focus group sessions will be conducted in conference rooms on the campus of a large, teaching hospital within the Texas Medical Center in Houston, Texas. Participants who consent to participate in the study will be audio-recorded within the focus group session in a comfortable, private conference room behind closed doors.

**Data Collection**

The investigator will use an interview guide in the focus group sessions, consisting of a semi-structured list of questions. Questions used in previous focus group sessions of RNs and MDs that were effective in generating new information about clinical credibility will be used, along with other probing questions that are designed to increase the depth of participant responses about RN clinical credibility. An iterative questioning approach that builds on previous participant responses will be utilized. Questions will be revised according to comments, questions, and resultant discussion of participants in order to elicit and confirm new information. Each focus group session will last approximately one and a half hours, and will be recorded on two audio-recording devices. Two recording devices will be utilized to avoid loss of data due to technological difficulty or human error. Follow-up interviews with individual participants may be conducted for clarification and verification of accuracy if necessary, and to increase the depth and breadth of participant responses.

Focus group data collected earlier from five previous focus groups consisting of twenty-three RNs (2 groups of ICU and 2 groups of non-ICU) and 1 group of MDs will also be included in the analyses. Transcripts from all of the focus group sessions and any individual interviews will be verified against the audio recordings.

The study was reviewed and previously approved by CPHS, including two addendums for continuation of the project and addition of methods for contacts for participation. These documents are available upon request. An additional addendum will be submitted to CPHS to gain approval to: suspend the use of the previously submitted informed consent form, and use the participants' participation in the focus group sessions as implied consent; conduct additional focus groups of RNs with less than three months in the institution; conduct additional focus group of RNs with at least one year of experience; include field notes to be considered as part of data collected during research; secure permission of participants to use actual recorded voices in focus group sessions for educational purposes outside the Houston metropolitan area.

### **Data Analysis**

Recordings of focus group sessions will be transcribed word per word from the dual audio recordings. Any names used by participants in the tapes will be expunged from the transcript. Thorough analysis based on iterative examination of the transcripts will be done with the goal of explicating and understanding the concepts of interest. Analysis will be conducted on each recorded focus group session. Data will be analyzed using content analysis, and will be examined for themes and patterns. Codes will be assigned to the categorical properties of clinical credibility. Properties will be put on a continuum to highlight their array of differences. Central attributes will be identified; causal conditions will be explored; conditions that result from the central attributes will be noted; the context as well as the intervening conditions will be listed; consequences will be named for clinical credibility.

Findings from the focus group sessions will serve as the baseline data for taxonomic analysis by which the investigator will determine the classification of attributes of



clinically credible RNs, as described by RNs and MDs. A hierarchical taxonomic structure will be devised from the data through the use of the Developmental Research Sequence (Spradley, 1979). Transcripts will be iteratively analyzed through the use of descriptive, structural, and contrast questions in order to conduct a systematic examination of the data to determine the organization of tacit cultural knowledge related to RN clinical credibility as it is described by RNs and MDs. Domain analysis will be conducted to reveal domains, the larger units of cultural knowledge through the use of semantic relationships. Taxonomic analysis will uncover the internal structure of the domains and lead to contrast sets by demonstrating the relationships among all of the subsets in the domain. Componential analysis will elucidate attributes of the concept that indicate differences within the domain. Theme analysis will identify the relationships among the domains, and their relationship to the whole concept of RN clinical credibility. The resultant knowledge will provide a clearer understanding of the attributes of RN clinical credibility, their relationships to each other and to the concept of clinical credibility, and of the value placed on the individual attribute categories by RNs and MDs.

#### **Plan for Data Management**

Audio recordings, demographic surveys, signed consents, transcripts of recordings, and field notes will be kept in a locked file cabinet in a locked room through the duration of the research study not to exceed seven years. The investigator will be the only person with access to the original audio recordings, in which a participant name may be mentioned.

**Limitations**

Disagreement between participants about the attributes of the construct of clinical credibility may arise as a limitation of the proposed study. The investigator will attempt to clarify and note such disagreements. Disagreement between disciplines, between RNs and MDs, may be observed due to the difference between the traditional hierarchical reporting structure that exists between RNs and MDs.

**Hazards or precautions**

The proposed research study does not pose any hazards to the health or well being of the participants. A breach in the confidentiality of the participants is the greatest danger posed by the study. This could occur if participants outside of the study revealed the identity and any comments made by participants. In an effort to control for the event, the investigator will read a statement to remind all participants to maintain the confidentiality of other participants by not identifying participants or particular comments made by participants outside the focus group session.

**Timetable**

The timetable for completion of the proposed research study is six months from the time of approval of the research proposal by the dissertation committee.

**Human Subjects Research****Protection of Human Subjects****1. Risks to the Subjects.****a. Human Subjects Involvement and Characteristics.**

The investigator proposes to conduct focus group sessions consisting of RNs and MDs who have evidenced RNs with clinical credibility in a clinical setting. Focus groups

will be utilized as the data collection methodology to identify attributes of RN clinical credibility, as described by RNs and MDs. Data, previously collected in a pilot study conducted by the investigator, in focus group sessions of RNs and MDs, will be used in addition to data collected in the proposed study in order to develop a hierarchical taxonomic structure of RN clinical credibility.

A purposive sample consisting of MDs accessed through key MD informants and snowballing will be the sampling methodology used for the MD group. A purposive sample consisting of RNs recruited through a flyer sent electronically to nurse managers and distributed to RNs who work on nursing units will be the sampling methodology for the RN group. Focus groups will consist of approximately 6 participants (Morgan, 1997) representing a cross-section of nursing units and medical/surgical specialties. Particular effort will be made to recruit RN participants of the male gender, and MD participants of the female gender in an effort to include data that may be representative of a minority among the participant groups.

Focus group sessions will be conducted until the investigator determines that the interview data provides a trustworthy answer to the research question, or until the investigator is able to anticipate responses by participants of subsequent sessions (Morgan, 1997). All focus group sessions will be conducted in conference rooms on the campus of a large, teaching hospital within the Texas Medical Center in Houston, Texas.

*b. Sources of Material.*

Focus group sessions will be recorded on two audio recording devices in an effort to capture all conversation, and to avoid loss of data through the failure of one recording device, or of human error. The investigator will record the focus group sessions

beginning with a statement in which the investigator informs the participants that participation in the focus group session represents the implied consent of the participant, and that participants are requested to maintain the confidentiality of other focus group members in order to protect the participants' identity. Participants will each complete a demography survey, and if willing to have their voice recording used for educational purposes, will initial and sign a consent form.

Focus group sessions will be audio recorded from beginning to end and are being recorded solely for use by the investigator. In the event that an individual interview with a participant is conducted, the individual interview will also be recorded using two audio recording devices. Participation in the interview will imply consent of the participant. Participants of individual interviews who are willing to have excerpts of their voice recording used for educational purposes will initial and sign a consent form. Focus group sessions will consist of questions asked from a semi-structured interview guide, along with additional iterative exploratory, probing, and clarifying questions as determined by the investigator. Questions will be revised according to feedback from the focus group participants. Names will be expunged from the transcript of the audio recording of the proceedings. Participants will not be identified by the investigator in discussion or in any publications that arise from the proposed research study. The investigator will make every effort to protect the anonymity of the participants. A statement will be made at the outset of the focus group session asking that participants maintain the confidentiality of other participants of the focus group session.

Audio recordings, demographic surveys, signed consents, transcripts of recordings, and field notes will be kept in a locked file cabinet in a locked room through the duration

of the research study, for a period not to exceed seven years. The investigator will be the only person with access to the original audio recordings, in which a participant name may be mentioned.

*c. Potential risks.*

No risks have been ascertained for the participants in relation to participating in the proposed research study. No alternate procedures exist for the proposed research study.

**2. Adequacy of Protection against Risks.**

*a. Recruitment and Informed Consent.*

Prospective MD participants will be identified through contact with key MD informants and snowballing. The investigator will send letters either electronically or via fax to the office of the proposed MD participant. Prospective MD participants will be informed about the study and invited to contact the investigator electronically or by telephone to indicate willingness to participate in the proposed research study.

Prospective RN participants will be recruited through a flyer sent electronically to nurse managers and distributed to RNs who work on nursing units at one large, community teaching hospital. RNs will be asked to contact the investigator by telephone or by electronic mail to indicate interest and/or willingness to participate in the proposed research study.

Financial incentives are not included in the research proposal for RN or MD participants. However, letters of participation are made available to RN participants who wish to have a record of their participation in the research study for their performance appraisal and/or clinical ladder advancement.

A statement will be made at the outset of each focus group session informing participants that participation in the focus group session represents implied consent of the participant. Participants will be advised that they are free to leave now, and at any time during the focus group session, if they decide that they do not want to participate and be audio recorded.

*b. Protection against Risk.*

Names will be expunged from the audio record of the proceedings. Participants will not be identified by the investigator in discussion, or in any publications that arise from the proposed research study. The investigator will make every effort to protect the anonymity of participants. A statement will be made at the outset of the focus group session asking that participants maintain confidentiality of fellow participants, and that comments of individual members of the group remain within the focus group session will be made. Due to the professional status of the participants of the focus group session it is unlikely that confidentiality will be an issue. In the event that a participant's identity became known outside the focus group, damage to the participant or her/his name is unlikely due to the general nature of the topic of discussion. Adverse effects to the participants are not likely or expected. Alternate procedures have not been identified.

**3. Potential benefits of the proposed benefits to the subjects and to others.**

Participants of the proposed research study and other health care providers may benefit as they become more aware of the concept of clinical credibility, as it pertains to RNs and MDs. Discussion about the attributes of RN clinical credibility may bring about a reflection of the participant's own professional practice, and may indirectly affect their professional behaviors. Further, discussion about clinically credible RNs may lead to a

raised level of awareness of RNs in the clinical setting who possess the discussed attributes, leading to an increased appreciation of clinically credible nurses. Other non-participant MDs and RNs who become aware of the findings of the proposed research study may develop an increased awareness of the value of clinically credible health care providers in the clinical setting. As health care providers become more aware of the attributes of clinical credibility that are valued by other practitioners they are more likely to reflect on their own practice and aim to strengthen those valued attributes. Such reflection may lead to improved practice, improved communication among practitioners and among patients and practitioners. The likelihood of risk to the participants is so minimal that the advantages of the research study far outweigh the risks.

#### **4. Importance of the Knowledge to be gained.**

The knowledge gained from the proposed research study will be used to develop an instrument with which to measure RN clinical credibility. Such an instrument gives nurse managers and nurse administrators the ability to quantify clinical credibility of RNs in the clinical setting. Quantification of RN clinical credibility enables nurse administrators to develop clinical ladders and performance evaluations based on attributes valued in the clinical setting. Recognition and reward for RN clinical credibility is one strategy to increase RN retention. Quantification of RN clinical credibility will enable nurse managers to select clinically credible RN staff members to positions on collaborative practice teams in an effort to increase collaboration among team members and improve patient outcomes.

The knowledge gained from the proposed research study will also serve as the foundation for further intradisciplinary and interdisciplinary discussion and research in

the areas of communication, collaboration, and collegiality within the health care workplace. The findings of the proposed research study serve as the basis for further research regarding attributes of RN clinical credibility identified and valued by nurse managers, nurse administrators, allied health professionals, patient care attendants, and patients. Risks to the participants are extremely unlikely and minimal, which maximizes the benefit of the proposed research study.

### **Inclusion of Women and Minorities**

Efforts will be made to seek out MDs who are of the female gender and MDs who represent minority races and/or ethnicities to participate in the focus group session of MDs. Efforts will be made to seek out RNs of the male gender to participate in the focus group session of RNs in the proposed research study since they represent a clear minority population within the nursing discipline. The large number of male MDs with full practice privileges in the population of the participating hospital MDs far outweighs the number of female MDs, providing a significant challenge for the investigator to recruit female participants. Direct contact with key informants will highlight the desire to recruit female MDs to the sample. Male RNs were actively recruited for the pilot study but declined participation. Renewed efforts will be made to recruit male RNs to the study sample. The interest in, and positive response to, the research study generated by RN participants of the previous pilot study may provide the impetus to encourage male participation. Minority representation in the previous pilot study consisted of: RN sample - 52% non-Caucasians, with 100% female participants; MD sample – 20% non-Caucasians, with 100% male participants.

### **Inclusion of Children**

Children are not included in the proposed research study.



**Justifications for Exclusion of Children**

The proposed research study is not an appropriate vehicle in which to consider children due to the professional nature of the participant population. The research study is focused on RNs and MDs. Data will be collected from RNs and MDs only.

**Vertebrate Animals**

Not Applicable.

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## Appendices

Appendix A. Informed Consent

Appendix B. Demographic Survey

Appendix C. Copy of publication: Smith, C. D. (2005). Identifying Attributes of Clinical Credibility in Registered Nurses, *Nursing Administration Quarterly*, 29(2), 188-191.

**Appendix A****Informed Consent to Take Part in a Research Study**

## **Informed Consent to Take Part in a Research Study**

**Study Title: Clinical Credibility: Identifying and Verifying the**

### **Attributes**

**HSC-SN-04-003**

#### **Invitation to Take Part:**

You are being invited to take part in a research project called, “Clinical Credibility: Identifying and Verifying its Attributes” conducted by Claudia Smith, RN, MSN, CNA, who is a doctoral student in the School of Nursing at the University of Texas Health Science Center at Houston.

Your decision to take part in the study is voluntary and you may refuse to take part, or choose to stop taking part, at any time. A decision not to take part, or to stop being a part of the research project will not affect your employment at this hospital.

You may refuse to answer any questions asked or written on any forms.

This research project has been reviewed by the Committee for the Protection of Human Subjects (CPHS) of the University of Texas Health Science Center at Houston as HSC-SN-04-003.

#### **Purpose of the Study:**

The purpose of the project is to describe clinical credibility within the context of nursing.

#### **Study Procedures:**

Agreement to participate in the research study indicates your willingness to participate in one focus group session that will take about two hours. Focus groups will be held on the campus of St. Luke’s Episcopal Hospital. The focus group sessions will

be audio taped. Participants will be assigned to a focus group according to profession. Focus group categories include: registered nurse- ICU; registered nurse- non-ICU; physician; allied health professional.

Participation in the research study will include completion of an eligibility form and a demographic survey. Approximately 48 participants are expected to be involved in the study. Withdrawal from participation in the research study shall consist of the decision not to take part in the focus group session.

**Risks:**

Risks involved in taking part in the study include a possible loss of confidentiality that may arise if focus group members divulge the name of other focus group members who take part in the study. The only alternative is not to take part in the study.

**Benefits:**

You will receive no direct benefit from being in this study; however, your taking part may help clarify the meaning of the term, clinical credibility, as it is seen and understood by the healthcare professionals.

**Alternatives to Taking Part:**

The alternative to taking part in the study is not taking part in the study.

**Confidentiality:**

You will not be personally identified in any reports or publications that may result from this study. Any personal information about you that is gathered during this study will remain confidential to every extent of the law. A special number will be used to identify you in the study and only the investigator will know the name that corresponds with the assigned number.

Please understand that the Committee for the Protection of Human Subjects may review the audiotapes or transcriptions of the focus group sessions for the purposes of verifying research data. However, identifying information will not appear on records retained. You will not be personally identified in any reports or publications that may result from this study. Audiotapes will be destroyed once they have been transcribed, verified, and analysis is complete.

**In Case of Injury:**

If you suffer any injury as a result of taking part in this research study, please understand that nothing has been arranged to provide free treatment of the injury or any other type of payment. However, all needed facilities, emergency treatment and professional services will be available to you, just as they are to the community in general. You should report any injury to Claudia Smith, RN, MSN, CNA at [REDACTED] and to the Committee for the Protection of Human Subjects at [REDACTED]. You will not give up any of your legal rights by signing this consent form.

Please direct any and all questions regarding the research study to the principal investigator for the study, Claudia Smith, RN, MSN, CNA, who may be reached by phone at [REDACTED] or by email at [REDACTED].

Sign below only if you understand the information given to you about the research and choose to take part. Make sure that any questions have been answered and that you understand the study. If you have any questions or concerns about your rights as a research subject, call the Committee for the Protection of Human Subjects at [REDACTED]. If you decide to take part in this research study, a copy of this signed consent form will be given to you.

**Printed name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**Printed name of person obtaining consent:**

\_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

This study (HSC-SN-04-003) has been reviewed by the Committee for the Protection of Human Subjects (CPHS) of the University of Texas Health Science Center at Houston. For any questions about research subject's rights, or to report a research-related injury, call CPHS at [REDACTED].

**Appendix B**  
Demographic Survey

## Demographic Survey

Identification Number \_\_\_\_\_ Facilitator \_\_\_\_\_ Date \_\_\_\_\_

Profession \_\_\_\_\_

Length of time in profession \_\_\_\_\_

Length of time at St. Luke's Episcopal Hospital \_\_\_\_\_

Number of hours spent interacting with registered nurses in clinical setting each

week \_\_\_\_\_

Age \_\_\_\_\_

Gender \_\_\_\_\_

Race \_\_\_\_\_

Highest Degree Held \_\_\_\_\_



**Appendix C**

Copy of publication: Smith, C. D. (2005). Identifying Attributes of Clinical Credibility in Registered Nurses. *Nursing Administration Quarterly*, 29(2), 188-191.

## Research Abstracts

*Theresa L. Carroll, PhD, RN*

*Editor*

### Identifying Attributes of Clinical Credibility in Registered Nurses

Credibility is an important trait for effective managers and leaders.<sup>1,2</sup> It is an attribute of personal integrity, 1 of 6 leadership essentials identified in a study of women in leadership positions.<sup>3</sup> Credibility, the basis for accurate, productive, respectful communication among professionals, leads to effective communication and, ultimately, to collaboration.<sup>4</sup> Effective communication about patients and collaboration among healthcare providers lead to improved patient outcomes.<sup>4-6</sup> Registered nurses (RNs) recognize the importance of establishing their credibility with healthcare providers in the clinical area.<sup>7</sup> Nurses and physicians in the clinical setting recognize and value the nurse with clinical credibility, despite the fact that they do not label the trait "clinical credibility." RNs with clinical credibility are often referred to as "one of the good nurses" by physicians, nurses, and other healthcare colleagues.

Identifying attributes of clinical credibility within the context of nursing will aid in the recognition and proper labeling of the construct within healthcare. Being able to identify attributes of clinically credible RNs will enable practicing RNs to be acknowledged and rightfully recognized by their colleagues as well as their employers. Nurse educators may use the findings of this study to teach strategies for building and maintaining one's credibility in the clinical setting. Identification of attributes will lead to quantification of clinical credibility, which is important because it may provide nurse administrators with a means of

rewarding and retaining valued bedside clinicians through the development of career ladders, based on RN clinical credibility. Measurement may lead to the ability to predict clinical units where more effective professional relationships occur and where patients may realize better outcomes.

Results from the initial analysis presented in this abstract explore clinical credibility from the staff RN perspective. These results are part of a larger study that explores the attributes of clinical credibility of RNs as described from the perspective of nurse managers, physicians, allied health providers, and patient care attendants.

### SPECIFIC AIMS

The specific aims of this study were to (1) identify the constellation of attributes that comprise the construct, clinical credibility in RNs from the perspective of RNs and (2) verify, within the context of nursing, the transsituational attributes of credibility identified by previous researchers, namely, expertise and trustworthiness. *Transsituational attributes*<sup>8</sup> refer to attributes of a concept that pertain to all disciplines in which the concept has been studied.

### RESEARCH DESIGN AND METHODOLOGY

#### Design and sample

This descriptive exploratory study used focus groups to achieve the aims of the study.

Criterion sampling was used to select participants for the study. RNs who met the criteria (1) worked at least 1 year in nursing; (2) worked with at least one expert RN who they consider to have clinical credibility; (3) interacted with RNs in the clinical setting at least on a weekly basis; and (4) were able to identify and describe an RN who they consider to have clinical credibility.

Focus groups consisted of 2 groups of intensive care unit (ICU) RNs and 2 groups of non-ICU RNs who were recruited through the hospital intranet, and by "word of mouth" by nurse managers and study participants.

### Methods

Following approval by the university and hospital institutional review boards for the protection of human subjects, the researcher conducted focus groups that consisted of 3 to 8 participants, who were asked to discuss the following questions:

- In the last few years, we have heard and read a lot in the press about the credibility of leaders. When you hear the term *credibility*, what comes to mind?
- Think back to the last time that you worked with one of the "good nurses"...you know the ones that I mean...the nurse who has real credibility. What is it about that nurse that is different from other nurses?
- Think about a recent experience when you worked with a nurse who was not clinically credible. What happened that made you realize that the nurse had no credibility with you?
- What expectations do you have about the nurse with clinical credibility?

Sessions lasted approximately 2 hours and were tape-recorded and transcribed. Reliability of the transcription was established by comparing each transcript for content and accuracy with the tape-recorded session. Analysis of the data from each focus group session was conducted for related concepts and themes.

### Results/description of the sample

The sample consisted of 23 female RNs. (Male nurses were actively recruited but elected not to participate.) The participants were, on average, 40.1 years of age ( $SD = 6.57$ ), were Caucasian (48%), and held a bachelor degree in nursing (70%). Fifty-two percent of the sample worked in ICU ( $n = 12$ ) and 48% worked in non-ICU acute care nursing units ( $n = 11$ ). Experience since graduation from a basic nursing program was 0-5 years (0%); 5-9 years (13%); 10-15 years (39%); 16-20 years (0%); and more than 20 years (35%).

### RESULTS

Findings from the initial analysis suggest that RNs identify work ethic, expertise, and character as attributes of clinical credibility. Findings indicate that, unique to nursing, work ethic emerges as an attribute of clinical credibility.

Previous research outside of nursing has identified expertise and trustworthiness as attributes of credibility. Expertise and trustworthiness have been named transsituational attributes since they have been identified in every discipline in which credibility has been studied.

#### Attribute: Work ethic

Statements that were interpreted as work ethic described clinically credible RNs as those who have organization skills; pay attention to detail; are very thorough; efficiently get things done; follows through, and does not let things "fall through the cracks"; are well prepared; are able to manage any patient/family situation; are solution-oriented; are hard workers; are willing to help other coworkers; and will go the extra mile to get the job done. Study participants noted that a nurse could be competent but lazy and uncommitted, and they would not be perceived to be clinically credible. It appears that work ethic is an important component of clinical credibility.

researchers that expertise is a transsituational attribute, but suggest that character replace trustworthiness as a transsituational attribute. *Character* refers to the aggregate of traits and features that form the individual nature of a person.<sup>8</sup> Trustworthiness is one of those traits found in a person with character. Findings in this abstract represent the perceptions of RNs about the clinical credibility of RNs. These findings represent the initial analysis of one segment of a larger research study. The larger

research study will explore what physicians, nurse managers, allied health professionals, and patient care attendants perceive as attributes of clinically credible RNs.

—*Claudia DiSabatino Smith, RN,*  
*MSN, CNA, BC*  
*School of Nursing, University of Texas*  
*Health Science Center at Houston*

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Taxonomy of Nursing Clinical Credibility

Claudia DiSabatino Smith, MSN, PhD(c), RN; Doctoral Student; The University of Texas Health Science Center at Houston School of Nursing; [REDACTED]

Joan C. Engebretson, Dr PH, RN; Professor; The University of Texas Health Science Center at Houston School of Nursing; [REDACTED]

James P. Turley, PhD, RN; Associate Professor; The University of Texas Health Science Center at Houston School of Health Information Sciences;

[REDACTED]

Lillian R. Eriksen, PhD, RN [REDACTED] The University of Texas Health Science Center at Houston School of Nursing

Theresa L. Carroll, PhD, RN; Professor; The University of Texas Health Science Center at Houston School of Nursing; [REDACTED]

Sigma Theta Tau International, Chapter: Zeta Pi

Correspondence to: Claudia DiSabatino Smith, [REDACTED]

[REDACTED]

## Abstract

**Purpose:** The purpose of this research is to develop a taxonomy of nursing clinical credibility that emerged from the commonalities of two discipline-specific taxonomies.

**Taxonomic analysis of qualitative research findings in which nurses and physicians described attributes of nursing clinical credibility, as it applies to nurses who are in direct care roles in a Magnet hospital setting, formed the basis for the two discipline-specific taxonomies.**

**Design:** Data collected in an ethnographic qualitative research study in which nurses and physicians identified attributes of nursing clinical credibility provided the basis for the taxonomies. The qualitative study utilized group and individual interviews and field work to understand how nurses and medical doctors constructed the concept, nursing clinical credibility. Thirty-nine study participants were recruited through purposive sampling in a large, community, ANCC Magnet® designated teaching hospital.

**Methods:** Taxonomic analysis of the data was undertaken to describe the resulting cognitive constructions. A modification of Spradley's eight-step method (1979) of taxonomic analysis was used to analyze qualitative data and to formulate two separate discipline-specific taxonomies. Comparative analysis of the commonalities of the two discipline-specific taxonomies resulted in an emerging common taxonomy, disclosed in this manuscript.

**Findings:** Attributes of nursing clinical credibility identified by both disciplines are categorized within three domains: trustworthiness, caring, and expertise. Physicians assume a nurse's trustworthiness unless the nurse demonstrates otherwise; nurses must

prove their trustworthiness to other nurses. Nurses described trustworthiness as critical to nursing clinical credibility; while physicians described caring as the critical attribute of nursing clinical credibility. Nurses and physicians value expertise differently; physicians value clinical experience, while nurses value knowledge. Nurses and physicians concur that clinically credible nurses are able to communicate knowledge effectively with other professionals; physicians, however, suggest that English language skills are essential to nursing clinical credibility.

**Clinical Relevance:** Nursing clinical credibility is a precursor to effective communication between nurses, and among nurses, doctors, and other healthcare professionals that enables collaboration which leads to improved patient outcomes. Knowledge of the attributes of clinical credibility enables: nurses to develop awareness of those characteristics valued by nurses and doctors; nurse teachers to devise strategies by which to teach future nurses so that nursing clinical credibility is developed and nurtured; researchers to develop an instrument by which to measure nursing clinical credibility; nurse administrators to recognize, reward, and retain staff nurses who emanate attributes of clinical credibility, and develop healthcare systems where nursing clinical credibility is nurtured and valued.

**Key Words:** nursing clinical credibility taxonomy, clinical credibility taxonomy, credibility, nurse credibility taxonomy, nursing clinical credibility.

### Taxonomy of Nursing Clinical Credibility

The clinical credibility of nurses is rarely mentioned in the clinical setting, although the concept is implicitly understood by registered nurses (nurses) and physicians. Over time physicians develop trust in certain nurses who are viewed as special nurses, but who are not necessarily representative of all nurses (Sullivan, 1998). Likewise, most nurses know which nurse they would seek out when solving a difficult problem, or when they find themselves facing an uncertain clinical situation (Benner, Tanner, and Chesla, 1996). In both instances the nurses are valued for their clinical credibility by nurses and physicians who have interacted with them in the clinical setting. Clinically credible nurses are those whose nursing practice sets them apart from the average nurse, placing them in an elite category of nurses who are often dubbed as special or good nurses.

Nursing clinical credibility is defined as a judgment about the job performance of a nurse based on one's preconceived notions about the ideal nurse, and from one's interactions with the nurse in the clinical setting. It signifies the level of confidence and trust that one has in a nurse who demonstrates clinical competence, trustworthiness, follow-through, communication skills, and concern and caring toward patients, nurse colleagues, and physicians (Smith, Engebretson, Turley, Eriksen, and Carroll, under review). Clinical credibility is repeatedly mentioned in research reports of non-related nursing research; however nursing clinical credibility has not been thoroughly explored or examined. This deficit provided the justification to explore and better understand this concept. Such study findings may contribute to a better understanding of discipline-



specific cognitive constructions of nursing clinical credibility that affect nurse-nurse and nurse-physician relationships in the clinical setting.

In addition to addressing the gap that exists in literature in regard to research-based attributes of nursing clinical credibility, the research question also emerged from discussions with nurses and physicians in the clinical setting about the concept, nursing clinical credibility. One physician shared that the nurse's clinical credibility determines how frequently the physician phones or visits to check on the status of an acutely ill patient. "I had to know that I could trust her [to watch the patient closely]. Depending on the nurse assigned to the patient, I might have to phone more often to check on them." This physician's viewpoint was in congruence with Kanter (1977) who wrote that people listen to those with credibility; their phone calls are answered first, because it is assumed that they have something important to say. In the healthcare setting, the nurse's clinical credibility may affect the expediency by which phone calls to a physician are returned, and whether the nurse's concerns and suggestions regarding patient care treatment are considered by the physician. A better understanding of the attributes of nursing clinical credibility may contribute to better understanding of those characteristics valued by nurses and physicians in the clinical setting.

The Institute of Medicine (2001) recommended that clinicians actively collaborate and communicate to ensure an exchange of information and patient care coordination. The clinical credibility of nurses is a precursor to effective communication between nurses, and between nurses, physicians, and other healthcare professionals. The nurse who lacks clinical credibility may not be perceived by other healthcare professionals with

the same level of respect; respect is one factor that influences effective communication (Baggs and Schmitt, 1997). Effective communication paves the way for increased collaboration between nurses and physicians (Baggs and Schmitt, 1997), which contributes to improved patient outcomes (Knaus, Draper, Wagner & Zimmerman, 1986). This is important because effective communication about patients among healthcare professionals has been shown to significantly improve patient outcomes (Pronovost et al, 2003). It contributes to significant reductions in errors and in nurse turnover, and results in improvements in quality of care and productivity (Maxfield, Grenny, McMillan, Patterson, and Switzler, 2005). Nursing clinical credibility enables effective communication between healthcare professionals, which is critical to ensure patient care quality and safety.

Knowledge of attributes of nursing clinical credibility enables nurses to recognize and articulate those qualities that are critical to effective communication with other healthcare professionals. A better understanding of the attributes of nursing clinical credibility enables nurse educators to devise strategies to teach and foster the development of nursing clinical credibility in future nurses. Better understanding of the components of a concept which nurses and physicians implicitly understand, enables them to thoughtfully consider their own clinical behaviors and practices. Such individual reflection may lead to more effective communication among nurses, between nurses and physicians, and with other healthcare professionals.

A descriptive, qualitative research study was conducted to identify attributes of nursing clinical credibility based on the descriptions of nurses and physicians and field

notes. The purpose of this manuscript is to describe the overall findings of the study, compare nurse's and physician's descriptions of the attributes of nursing clinical credibility; and to compare and contrast a common taxonomy developed from the two discipline-specific taxonomies.

### **Conceptual Framework**

Two theories provide the substantive theoretical underpinnings or analytic lens for the study of nursing clinical credibility. Schema theory, a theoretical framework from social psychology, is a well established basis for the cognitive process of impression formation (Asch, 1946; Srull and Wyer, 1989). Additionally, identity theory, from the sociology discipline, provides a basis for the effects that social interaction has on the formation of mental representations or schema (Stryker, 1980; Burke, 1991; Stryker and Burke, 2000). Together, schema theory and identity theory provide theoretical support for the formation of impressions and judgments regarding nursing clinical credibility by interdisciplinary health care providers who observe and interact with the nurse in the clinical setting. The impression formation process is a complex, but organized, mechanism in which mental representations are formed from perceptual stimuli in the clinical setting. They are processed within the framework of the observer's identities/roles and preconceived ideas, stored in memory, and retrieved for later use in making evaluative judgments about the nurse's clinical credibility. The effects that an observer's identity, role, and preconceived notions have on the mental representation precipitated the need to interview two different disciplines in order to gain insight as to each discipline's mental representation of a clinically credible nurse. Together the two

theories provide the conceptual framework for the qualitative research study. If each discipline associates a clinically credible nurse with a different set of attributes this may add to a better understanding of interdisciplinary confusion and strife. It is important to recognize that variance may exist in the expectancy-guided model of the clinically credible nurse in the minds of nurses and physicians. This research study was designed to explore the attributes of nursing clinical credibility as it relates to nurses who are in direct care roles, from the notions described by nurses and physicians.

### **Literature Review**

The literature was reviewed for attributes of nursing clinical credibility using the World Wide Web and the MEDLINE and SCOPUS databases. The terms credibility and clinical credibility are used inconsistently and interchangeably in literature, as evidenced in articles by Garbett and McCormack (2001) and Gillespie and McFetridge (2006), who used the terms interchangeably within each of the articles. Search terms consisted of different combinations of: clinical, credibility, RN, clinical credibility, nurse, and attributes. Forty-eight articles that mentioned credibility or clinical credibility were located, although only seven articles were pertinent to the analysis. Five of the eliminated articles discussed program credibility. Thirty articles mentioned clinical credibility as it related to nurses in the advanced roles of educators, leaders, and advanced practice nurses; roles with significantly different scopes and responsibilities from that of nurses who function in direct care roles. Seven eliminated articles mentioned nursing clinical credibility as it related to nurses in direct care roles; however neither the concept nor its attributes were discussed in any of the seven articles. Of the seven articles that are

included in this review, three reported findings of research studies on other topics in which clinical credibility was discussed, and four were anecdotal articles. Although nursing clinical credibility is frequently mentioned in literature it has not been thoroughly examined; there was a paucity of studies that specifically studied nursing clinical credibility. Attributes of nursing clinical credibility did emerge, however, from the seven articles pertinent to this review.

Benner (1984) used data collected through field notes, questionnaires, and narratives of 1200 direct care nurses to explore and develop a model of skill acquisition in nursing. In her sentinel work, Benner (1984) wrote of nurses who talked about the need to establish their own credibility with physicians through clinical competence. In the same report she described the powerful role that nurses play in the healing process. "...if the nurse is lacking in diagnostic, monitoring, or therapeutic skills – and, most serious of all, if the nurse does not care – the patient's chances for recovery or for dignity and comfort in dying, are slim"(Benner, 1984, p. 216). Benner's findings validated a statement attributed to Dr. Madeleine Leininger who wrote in 1979, "Caring is the essence of nursing practice." Clinical competence and caring both emerge from literature as attributes of nursing clinical credibility.

Harvey and Kitson (1996) examined factors that influence the implementation of a quality system using a qualitative research design. The researchers concluded that if program implementation is to be successful it is critical to select an implementation nurse who is perceived by the clinical staff to be approachable and clinically credible; clinical

credibility was not defined by the authors. Findings from this study suggest that being approachable is an attribute of nursing clinical credibility.

Using a grounded theory methodology, Apker, Propp, Zabava Ford and Hofmeister (2006) examined the ways in which nurses communicate professionalism in their interactions with other healthcare team members. Findings from the study suggest that professional communication is a component of professionalism. The researchers concluded that nurses who use professional communication are perceived as credible by other healthcare team members.

Nursing clinical credibility was mentioned in four anecdotal articles; although the articles were not research-based, attributes were identified in the text of each of the articles. Edmond (2001) proposed in a review article that clinically credible staff nurses should be used in clinical preceptor roles with newly graduated staff nurses and student nurses because clinically credible nurses are accepted by their peers. Being accepted by one's nurse peers is implicit in nursing clinical credibility and emerges as an attribute.

Davidhizar (1992) suggested in a commentary article that nurses build clinical credibility by demonstrating honesty, clear communication, and follow-through in the clinical setting. Clear communication is different from the professional communication researched by Apker, Propp, Zabava Ford and Hofmeister (2006). Clear communication, honesty, and follow-through emerge from Davidhizar's (1992) article as attributes of nursing clinical credibility.

Hegge (1993) advised new graduate nurses to strive to exceed performance expectations in order to be perceived as clinically credible by their nurse manager. In

addition she suggested novel strategies for inexperienced nurses to impress nurse colleagues and earn credibility with them. Exceeding expectations emerged as an attribute of nursing clinical credibility. Clinical credibility is a necessary component of nurses who function in direct care roles if they are to be clinically effective, according to Bailie (1994). Clinical effectiveness may be one consequence of nursing clinical credibility.

Several attributes of nursing clinical credibility emerge from the reviewed literature in which nurse credibility was mentioned. Attributes mentioned in reports of nursing research studies that explored topics other than clinical credibility were: competence (Benner, 2001); caring (Benner, 2001); approachable (Harvey and Kitson, 1996); and professional communication (Apker, Propp, Zabava, Ford & Hofmeister, 2006). Attributes emerging from non-research articles consisted of: follow-through, honesty, clear communication (Davidhizar, 1992); peer acceptance (Edmond, 2001); and exceeds performance expectations (Hegge, 1993). It is important to note that while nursing clinical credibility was mentioned frequently, it was rarely discussed, and never researched in nursing literature. Despite the paucity of conceptual development and focused research, however, nursing clinical credibility is recognized as an essential component of nurses who are in direct care roles (Harvey and Kitson, 1996; Bailie, 1994), and for clinical effectiveness (Bailie, 1994). Little substantive knowledge exists about nursing clinical credibility or its attributes related to nurses who function in direct care roles. This gap in literature and lack of validation of anecdotally-acquired attributes justify the conduct of the descriptive, qualitative research study. Taxonomic analysis of

study findings provided the basis for the constructions of two taxonomies of nursing clinical credibility, and a third taxonomy constructed from the commonalities of the taxonomies, which is discussed in this manuscript.

## **Research Design and Methods**

### **Design and Sampling**

This qualitative study examined the cultural constructions of the clinical credibility of nurses who function in direct care roles, from the perspective of nurses and physicians in a hospital setting. Group interviews were the primary data collection methodology used since they provide group interactions to the researcher's question and are particularly effective when working with populations who have experienced limited power and influence (Morgan and Krueger, 1993), such as in the case of nurses in a hospital setting. Group interviews were conducted with each profession separately to avoid the power differential associated with the professional dominance of physicians (Freidson, 1970); the subordination of nursing to medicine (Schwartz, deWolf, and Skipper, 1987); the link between the professional marginality of nursing and gender (Ritzer and Walczak (1986); and the challenges associated with engaging and recruiting physicians to participate in research studies (Odendahl and Shaw, 2001).

Group interviews were followed by individual interviews with specific study participants in an effort to drill deeper into certain areas and to clarify discussion points which arose in the group interviews. In addition, data collected in field notes and clinical observations were used to add clarity and contextual richness to the data collected from study participants in group and individual interviews.



After approval by both the university and hospital institutional review boards, nurse participants were recruited through hospital intranet announcements and through electronic mailings to registered nurses in direct care roles. Different recruiting methods were used in the recruitment of nurse and physician study participants relative to the physicians' status as professional elites (Odendahl and Shaw, 2001) and the challenges involved in engaging them in participating in a research study and in increasing the likelihood of their participation. Recruiting techniques included contact with key physician leaders, presentations to physicians at hospital committee meetings, and a hospital intranet announcement. Criterion-based purposive sampling (Sandelowski, 2000) was used to recruit participants to ensure that participants had information-rich experiences with clinically credible registered nurses in the clinical setting. This was accomplished through a check-box on the Eligibility Form in which participants checked the box to indicate if they "Have worked with at least one expert registered nurse in a clinical setting who you consider to have clinical credibility."

Subtle power dynamics which are encountered when trying to recruit and interview professional elites often create less-than-ideal interview conditions such as a shortened time frame (Odendahl and Shaw, 2001) for a group interview session. Adaptations were made to the interview schedule such that physician sessions were scheduled to last one hour, while nurse sessions were scheduled for two hours. Nurse interview groups were further sub grouped according to the length of time employed at the hospital (less than three months and greater than one year) and by their general practice setting (ICU/specialty and non-ICU/specialty) in keeping with principles of purposive sampling.

Nine group interview sessions were conducted with a total sample size of 39 participants; seven groups of nurses and two groups of physicians. Thirty-two nurses and seven physicians were grouped into discipline-specific sessions based on their area of experience, years of experience at the hospital, and availability. The sample consisted of one male and 31 female nurses, and seven male physicians. Despite the significant gender imbalance in the groups, the low number of male nurses and female physicians is representative of the disciplines' demographic makeup at the hospital where the study was conducted.

### **Data Collection**

Data collection primarily consisted of audio recorded group and individual interviews, and also included field notes which provided clarity and depth, and assisted in the verification and interpretation of findings. Audio recorded group interview sessions were planned to include a maximum of six participants per group to enable effective participation and discussion, however, the number of participants who actually participated in group interviews ranged from two to eight participants per group session. Numbers varied primarily due to absence of participants, however in one session two participants each brought an additional prospective participant with them to their scheduled interview session. Group interviews continued to be scheduled until interview data provided saturation and redundancy (Morgan, 1997), which resulted in seven group interviews for nurses and two group interviews for physicians. A semi-structured list of descriptive interview questions was developed to encourage participants to talk about the concept as it is understood by the study participants as suggested by Spradley (1979). The

interview guide used in the group interview sessions is included in Appendix A. Using a semi-structured interview approach enabled the researcher to probe into areas that emerged in discussion. One example of a Specific Grand Tour question (Spradley, 1979) that was asked of both nurses and physicians was: "Think back to the last time that you worked with a nurse that was not clinically credible. What happened that made you realize that the nurse had no credibility with you?" Questions were revised and adapted to direct further discussion and explore emergent issues. Additional probes were added based on the emergent analysis and were used in subsequent interview groups. One example of an additional probe related to a request that participants list on a piece of paper three or four of the most important attributes of nursing clinical credibility. Rich discussion among participants, which occurred during the second group session, lead the researcher to rephrase the question to ask that participants list *in priority order* the three or four most important attributes of nursing clinical credibility, drilling deeper with subsequent group sessions to further explore this area.

### **Data Analysis**

Audio recordings were transcribed word-for-word and were verified with the original recordings for accuracy. Transcriptions from nurse and physician group interviews were initially analyzed separately in order to uncover and explicate the ways that each individual discipline understands and cognitively constructs nursing clinical credibility as they encounter it in their day to day clinical practice, following analytic processes described by Van Maanen (1979, as cited in Miles and Huberman, 1994). Codes were generated from the data, and patterns and categories of attributes were identified.

Findings from each discipline were later compared in an effort to explore the differences in the participants' responses as they relate to professional role identity and the status of power.

Further taxonomic analysis and categorization of the data was necessary to clarify the hierarchical relationship between the wealth of descriptive qualities of nursing clinical credibility which emerged from the initial data analysis. Categorization is one of the most basic functions of living creatures (Mervis and Rosch, 1981), and taxonomic structures are one way to classify and categorize large amounts of data that relate to a core dimension (Haas, Hall, and Johnson, 1996). Such taxonomies allow large amounts of information to be collapsed into convenient categories that are easier to process, store and comprehend (Carper and Snizek, 1980). Using inductive strategies, categories were selected from the concrete attributes in the data to generate more abstract categories (Fawcett, 1978), which provided the organizing structure of the taxonomy. A combination of ethnographic strategies produced a more holistic, surface analysis of the entire concept all the while studying the three emergent domains of clinical credibility. Iterative peer debriefings provided additional rigor to the study. One illustration of a peer debriefing which occurred during later stages of taxonomic development contributed to the study's rigor. It concerned the taxonomic location of kindness as an attribute of trustworthiness instead of an attribute of caring. After such a peer debriefing the researcher returned to the data and clarified the participants' use of "kindness" as a component of trustworthiness to mean kindness toward nurse colleagues. Kindness

toward nurse colleagues was an essential component of earning one's trustworthiness, but the term was not discussed as it relates to kindness to patients, or as an attribute of caring.

Taxonomic analysis was conducted using a modification of Spradley's eight-step method (1979) to further analyze the field notes and interview data. After selecting the domains to be analyzed, a more in depth study of the emergent domains followed, which is the first step of taxonomic analysis. In the second step of taxonomic analysis attribution was selected as the semantic relationship or substitution frame, which guided the selection of linguistic terms throughout taxonomy development. In the third step of taxonomic analysis the attribution substitution frame (x is an attribute of y) was used to search for subsets within each major domain, and the means-end substitution frame (x is a way to do y) was used to search for subsets within the included terms of the attribution subset. In the fourth step structured interview questions were employed to verify the relationships within the subsets; these relationships were used in the fifth step to construct a tentative taxonomy from preliminary findings. In Spradley's (1979) sixth step of verifying the taxonomy with participants, the researcher tested the taxonomic structure with interview participants in subsequent group and individual sessions. Additional structural interviews and observations, which were conducted in later interview sessions and field work, provided clarity and confirmation for the researcher. The completed taxonomy is the final step in Spradley's eight-step method of taxonomic analysis and componential analysis (Spradley, 1979). Componential analysis refers to the systematic search for the components of meaning in the attributes, among the contrasts that are noted within members of a specific category (Spradley, 1979). Two discipline-specific

taxonomies were developed from emergent findings which illustrate subtle, but distinctly different perspectives about the domains of nursing clinical credibility. The completed taxonomies were explored in relation to the differences and commonalities described by each professional discipline, and more specifically, according to the relationships between the included terms within each domain.

### **Findings**

Taxonomic analysis of study findings resulted in two separate discipline-specific taxonomies of nursing clinical credibility, representing similar, but subtly different constructions of the concept. A more detailed discussion of the discipline-specific taxonomies and a discussion of the differences in the taxonomies will be in a forthcoming paper. Both discipline-specific taxonomies are contained in Appendix B. The common taxonomy discussed in this paper demonstrates the commonalities of the two completed taxonomies within the levels of the domains with two levels of subsets, and illustrates the relationship of the attributes of nursing clinical credibility within those levels. Study findings are organized and discussed according to the order of their appearance in the common taxonomy of nursing clinical credibility that is illustrated in Table 1.

Three domains emerged from the final taxonomic analysis: trustworthiness, caring, and expertise. The three domains comprise the first level of a common taxonomy when incorporating the congruent elements of the taxonomies for both physicians and nurses. The subtle group notions and nuances that account for discipline-specific variations that were noted in the construction of the taxonomy are discussed under each domain in which they were encountered.

**Trustworthiness**

Trustworthiness emerged as the organizing domain; a large domain that seems to pull together the relationships of the other domains (Spradley, 1979). Trustworthiness emerged as the cornerstone of nursing clinical credibility; the critical attribute which serves as the foundation of nursing clinical credibility. Trustworthiness is a state of being reliable and worthy of one's confidence as it relates to one's integrity and personal abilities. Trustworthiness was described by nurses as the single most important attribute of nursing clinical credibility. Nurses described clinically credible nurses as those who are "trusted by the [nursing] staff". Participants agreed that being trusted was essential. "If you are relieving that [clinically credible] nurse you feel you don't have to go back and make sure...that [everything] is done...You can finish and leave, and you don't have to worry" because nursing clinical credibility is built on a framework of trustworthiness. Without trustworthiness a nurse is not considered as having nursing clinical credibility. Throughout discussions in which physicians in group interview sessions identified attributes of nursing clinical credibility they did not articulate the actual cover term, trustworthiness. Instead, physicians openly affirmed that they "can trust what she [the clinically credible nurse] tells me" and for the most part, what the patient tells them.

In an individual interview with one physician, he admitted that most physicians just assumed that nurses were trustworthy. "There is an implied trust in your colleague." He went on to suggest that simply by the virtue of their being nurses that they were deemed trustworthy, unless they proved otherwise. They have "that Florence Nightingale attitude about things; that they really want their patients to do well. They want to do

whatever is necessary to get that patient in and out of the hospital with a good experience and a good outcome.” Physicians identified other attributes of nursing clinical credibility, which affirmed their trust in particular, special nurses. “If that nurse cares about the patient, I know that I can trust that nurse”.

One nurse in the first group interview session made an astute observation that effectively captured the sentiment of study participants when she proclaimed of the clinically credible nurse, “You would trust them to take care of your own mother!” Nurse and physician participants in subsequent group interview sessions agreed with the observation of the insightful nurse. Nurse participants explained that nurses who lack trustworthiness are not considered clinically credible. Physicians suggested that nurses who demonstrate attributes which appear in the subsets within the second and third domains of caring and expertise develop the trust of physicians. One earns trustworthiness, the confidence and trust of nurse and physician colleagues, by demonstrating all of the components of trustworthiness. Components are constituent parts which are necessary to comprise the domain. Components of trustworthiness are listed in the second level of the taxonomy and are labeled: 1. honesty; 2. fairness; 3. reliability; and 4. kindness.

### **1. Honesty.**

Nurses used the term “honesty” to describe one component of trustworthiness. Honesty is defined as a quality which one achieves through one’s conduct, and is specifically related to one’s integrity and truthfulness, as opposed to lying or stealing. Nurse participants in this study elaborated many examples of ways to know that someone



is honest, some of which are listed in the third level of the taxonomy. Nurses described clinically credible nurses who exemplified honesty as those who are “willing to admit what they don’t know” and come forward to “own up to their mistakes” in the event that they make an error. Participants clarified that “Lying causes a total loss of credibility.” “It’s about having character” and “integrity” one nurse explained. Physicians recognized honesty as an important component of trustworthiness when one commented, “She may not know everything, but at least what she tells me, I can trust”. In another example which illustrates the trust and confidence that physicians place in the honesty of clinically credible nurses, a physician shared that when asking the clinically credible nurse “What happened last night?” “They tell you. And you feel very comfortable that that is really what happened!”

## **2. Fairness.**

Nurses earn trustworthiness when they are perceived to be “fair” in their interactions with patients and with other healthcare colleagues, according to nurse participants whose average age was 39.5 years. Fairness, another component of trustworthiness found in the second level of the taxonomy, is defined as the quality of being equitable and impartial in dealings with others (Oxford English Dictionary, 1989). Participants used several included terms to describe ways that clinically credible nurses demonstrate fairness. Perhaps the clearest emergent example was in the description of one nurse who said, “She will treat you right.” While participants shared other examples that may describe demonstrations of fairness, this may be an area for further study because the descriptions were not as poignant when they discussed clinically credible

nurses who were “flexible” and “more tolerant” with less experienced nurses and physicians. Physicians specifically viewed the clinically credible nurse as “patient” and “more understanding” of inexperienced medical residents, and one who did not “take advantage” of the less experienced physicians. A clinically credible nurse “works well with others” despite the differing opinions and challenging situations one encounters with some healthcare colleagues. Fairness was reflected in exemplars that recounted “non-judgmental” approaches toward patients and their families, and the ability to “see the patient as a whole.” One nurse validated this component of trustworthiness when she admitted, “fairness is very, very important to me.”

### **3. Reliability.**

Reliability was repeatedly described by nurses and physicians as an essential component of trustworthiness, as it relates to nursing clinical credibility. Reliability, located in the second level within the taxonomy, is defined as the quality of being perceived as being consistent and dependable. The included terms are examples of ways of demonstrating reliability, which are illustrated in the third taxonomic level. “Reliable” nurses “can be depended upon” and they are “consistent, very consistent.” One nurse discussed the “consistency” seen in nurses with clinical credibility, “When you see a credible nurse you see that same person day after day after day. They’re not “yes” today and “no” tomorrow.” “If you’re a credible nurse at 24 (years old), that’s the same nurse you are going to see at 54 (years old)”. Physicians, meanwhile, discussed the nurse’s reliability as a component of trustworthiness when they referred to the clinically credible nurse as one who has “a track record of positive experiences” with the physician. They

admitted that physicians “learn quickly who you can count on.” They openly discussed their reliance on the clinical skills of direct care nurses. “Since the nurses are at their bedside so much more, you depend on them to pick up the subtle changes.” Physicians confessed that patients’ reports also influenced their view of the nurse’s reliability, “[I] do not just accept everything that they say because usually there is more to the story... but you always listen to the patient.” The patient’s report “does seem to influence” me. This is “especially true when you already are maybe not sure [about the nurse] and all it takes is a patient to confirm that for you”.

#### **4. Kindness.**

Kindness, another component of trustworthiness located in the second level of the taxonomy, is defined as the quality of exhibiting tenderness or fondness, favor or friendship and affection toward other people. Nurses described ways that clinically credible nurses demonstrate kindness to other nurses through the use of included terms like “extremely approachable,” “not mean” to other colleagues, and they “don’t make you feel stupid” when you ask a question. These included terms are found in the third level of the taxonomy. Physicians rarely discussed kindness, but alluded to the nurse’s kindness toward patients when one described the nurse who had “patience” with patients and their sometimes challenging family members.

Participants provided several exemplars that illustrated the components of honesty, fairness, reliability and kindness aggregating within the domain of trustworthiness. More than one nurse suggested nurses who didn’t demonstrate kindness to other nurse

colleagues could not be trustworthy to care for patients. For this reason kindness was aggregated under trustworthiness rather than within the domain of caring.

### **Caring**

Caring, the second domain in nursing clinical credibility taxonomy was frequently discussed by both nurses and physicians. Participants in both disciplines readily used the phrase “the nurse cares” to convey the sentiment that clinically credible nurses demonstrate their concern through the use of caring behaviors toward patients and their families, physicians and the nursing staff of their respective patient care units. In this manuscript caring is defined as a quality in which one is interested and concerned, and then troubles oneself on behalf of patients, patients’ families, physicians, and nurse colleagues. The words of one physician, who was differentiating between nurses with nursing clinical credibility and those without it, were particularly powerful. “You get that sense that they are really concerned about caring for the patient.” Within the caring domain two components of caring were identified: 1. engagement and 2. relationship focus.

#### **1. Engagement.**

Engagement refers to a positive, fulfilling, work-related state of mind that is characterized by the dedication, absorption, efficacy, and vigor (Schaufeli and Bakker, 2004) with which the nurse approaches nursing work. The definition of engagement that emerged from this study is congruent with that of Schaufeli and Bakker. Nurses did not use the cover term, engagement, but used instead words like “interest”, “excitement” and “enthusiasm” to describe the attitude of nurses who devote themselves to nursing work.

Physicians, on the other hand, referred to the nurse who is “engaged with the patient” when referring to the nurse with clinical credibility. One nurse effectively summed up the ways that clinically credible nurses demonstrate engagement when she shared, “You have to believe in what you’re doing. I think you have to really truly believe in your job, and believe that you’re there to take care of your patients, because if you’re not there to do that, I think it comes across in your actions.” Nursing work is further defined in reference to the focus of the caring relationships which nurses choose to develop. Aspects of engagement, which emerged as ways to demonstrate engagement, include dedication, absorption, efficacy, and vigor, which are illustrated at the third level of the taxonomy in Table 1. Ways to demonstrate aspects of engagement are not illustrated in the common taxonomy illustrated in Table 1 due to space limitations, although they appear in the more detailed discipline-specific taxonomies which appear in Appendix B. Minimal discussion of the ways to demonstrate specific aspects of engagement is included in this manuscript for the purpose of illustrating descriptions by study participants.

*a. Dedication.*

Dedication is the act of devoting oneself and one's time and efforts to nursing; it is one of the ways that nurses demonstrate engagement, a component of caring. Dedication, however, is characterized by a sense of enthusiasm, a feeling of significance and pride (Schaufeli and Bakker, 2004), terms that were often used to describe ways that demonstrate the dedication of the clinically credible nurse. Physicians addressed the dedication and absorption of the engaged clinically credible nurse, “This person is really interested in what they’re doing. They’ll take that extra step, if need be, to do a good

job.” Physicians, like nurses, differentiated the “caring nurse” from other nurses, and recognized their engagement through their dedication. “A lot of times you can see a nurse does everything that is requested, but when you see that they have gone the extra mile, then that rings a bell with us and I think at that point we begin to think, ‘this is someone special’.” Numerous participants discussed the dedication of the clinically credible nurse and the phrase that the nurse will “go the extra mile” to get things done was repeated in several groups. The nurse with nursing clinical credibility is “willing to do more when you don’t necessarily have to.” Nurses attested to the dedication of those with nursing clinical credibility. “They’re just willing to, just to put everything into what they do; second best is not good enough” to them. One physician reflected, “Nursing is very hard work... and if you are not really devoted to it, I don’t think you would last. I think you would find an easier way to get your dollars.” Likewise, an experienced nurse differentiated the average nurse from one with nursing clinical credibility. “They put their heart and soul into nursing.” “It’s more than a job.”

*b. Absorption.*

Absorption is defined as a state of being entirely engrossed in something, and is characterized by such full concentration in one’s work that time passes quickly and one experiences difficulty detaching oneself from their work (Schaufeli and Bakker, 2004). Absorption, located in the third taxonomic level, is one of the ways that one demonstrates engagement. Absorption, an aspect of engagement, was aptly described by one nurse who shared that at the end of her shift, after giving report to the oncoming nurse, “I ended up putting my purse back up in my locker and staying with her [the oncoming nurse] until

5:30 in the afternoon.” “I just couldn’t leave.” In addition, several nurses reported calling the patient care unit on their day off to check on the status of a patient that they had cared for the previous shift. This serves as additional evidence of their absorption with their work with the patient. Like the ways of demonstrating dedication, these exemplars are included in the more detailed taxonomies in Appendix B.

*c. Efficacy.*

Nurses referred to efficacy as one way of demonstrating engagement when they affirmed that nurses with clinical credibility “get things done” and they “ensure continuity of care for their patient.” Efficacy is the power or the ability to get things done, and may be characterized as the nurse’s clinical effectiveness. Nurses referred to the clinically effective nurse as one who is “conscientious” and “pays attention to detail,” and they used the phrase “doesn’t let things fall through the cracks.” Nurses valued the clinically credible nurse’s vigilance which lead to patient care efficacy. Physicians also recognized the efficacy of the vigilant, fully engaged nurse when one commented, “The nurse [who] follows through with issues is really important to me.”

*d. Vigor.*

The engaged nurse not only is clinically effective, but approaches nursing work with a certain vigor and excitement. Vigor is defined as a state of mental or moral strength which involves energy, activity, or liveliness of the mind (Oxford English Dictionary, 1989), and is characterized in the work place by high levels of energy, mental toughness, and the commitment to invest personal time and effort (Schaufeli and Bakker, 2004). As one nurse shared about a clinically credible nurse colleague, she commented

that she “genuinely cares about the patient” and “is still full of energy,” “just as she was on her first day as a nurse.”

## **2. Relationship focus.**

Relationship focus is a component of caring, and is found in the second taxonomic level in the caring domain. Relationship focus is comprised of different types of caring relationships in which clinically credible nurses engage. Relationship focus refers to types of relationships or the people with whom situational conditions of kinship develop with the engaged nurse. The relationship focus in the caring domain of nursing clinical credibility refers to the focus of the caring relationships in which nurses engage; a relationship that nurses develop with patients, with the patients’ families, with physicians, and with nurses on the respective nurse’s patient care unit. Examples of ways in which nurses demonstrate relationships are not included in the common taxonomy illustrated in Table 1, but may be seen in the more detailed taxonomies in Appendix B.

### *a. Patients and their families.*

The clinically credible nurse “keeps up with what is going on with the patient” and “take[s] responsibility for that patient. I mean they feel like they own the outcome of that patient.” Such expressions by physicians articulate the engagement of clinically credible nurses with their patients. Patients comprise the most often discussed relationship focus within the caring domain. The relationship focus categories are illustrated in the third taxonomic level of this second domain of nursing clinical credibility, Physicians affirmed the value that they place on the nurse who is truly engaged with their patient when they confided that clinically credible nurses maintain “their patient’s interest as *their* premier



interest.” “It is pretty easy to spot the nurse who really has the interest of the patient at heart, and that nurse is extremely valuable to me.” “That is the most important thing. If that nurse cares about the patient, I know that I can trust that nurse.” This exemplar illustrates the nature of the way that the domains interact with each other and together emerge into nursing clinical credibility. Physicians recognized and clearly valued the clinically credible nurse “who really knows her patients well” and “is available, and if you have a question, they know the answer to it, or are willing to get the answer quickly.” Nurses, on the other hand, expounded upon the clinically credible nurse’s focus on their patients. “They’re ultimately...looking out for your patient. And they’re gonna[sic] make sure that everything that needs to be done for that patient is done for the patient! And if they can’t do it, then they’re gonna[sic] make sure that whatever needs to be done is clearly spelled out for the next person.” Nurses described clinically credible nurses as “caring nurses” who are “conscientious”, “thorough,” and “accountable” for their assigned patients. As mentioned previously, nurses recounted numerous exemplars of clinically credible nurses who regularly phoned the patient care unit to check on a patient’s status on the nurse’s day off, an indication of not only the nurse’s absorption, but also of the nurse’s relationship with the patient.

Aside from their focus on the patient relationship, the relationship with the patients’ families also emerged as an aspect in the nursing clinical credibility domain of caring. The importance of developing a relationship with patients’ families was discussed by nurses and physicians alike. Physicians noted that nurses with clinical credibility “have social skills with families.” They recognized the value of building a relationship with the

patient's family, as did nurses who commiserated about nurses who lacked nursing clinical credibility, and who lost opportunities to engage with family members. "The family sits right there, but they don't communicate with them." "They [nurses] walk on by as though they weren't there." One nurse shared that families expected nurses to interact with them. She confessed "I remember hearing families talk in the waiting area that some nurses don't talk to them even in casual conversation." Another nurse added, "It means a whole lot to a lot of people; just acknowledging people that are in the room when you walk in."

*b. Members of Healthcare Team.*

The relationship with members of the healthcare team is located in the third taxonomic level and consists of two types of healthcare team members; nurses and physicians. Members of the healthcare team refer to the people with whom the nurse interacts in the clinical setting in the provision of nursing care to patients. The two disciplines solely named in the interview sessions of both disciplines were nurses and physicians.

Nurses recognized that clinically credible nurses not only exhibit caring in regard to their patients and the patients' families, but also in reference to nursing colleagues on their respective patient care unit. Engagement with nurse colleagues, a subset of the members of the healthcare team within the relationship focus, according to nurse participants is evidenced by "a strong work ethic," and a philosophy of "teamwork." The nurse who is engaged in her work with other nurse colleagues is aptly described as, "They can see that [another nurse] is sinking, we need to go help." Another astute nurse

added, "They always seem to know what is going on with the other patients that are not theirs. They are not just focused on their 5 or 6 patients. They are truly lending a helping hand out to anybody that needs it." One nurse concluded, "She has her hand on the pulse of the unit," implying that the clinically credible nurse is engaged with the overall patient care unit, not simply her own patient assignment. Physicians also recognized the value of the nurse who engages on the activity in the entire patient care unit, when they referred to the clinically credible nurse with a more "global perspective." "I am looking for... a person who even though, it is not their patient, they are interested in patient care and they are interested in the whole thing."

Nurses recognized the importance of engaging with physicians as evidenced by the following nurse who commented that the clinically credible nurse "has invested herself in the patients and the doctors also, because she wants to make sure that the patients are taken care of, and that the doctor trusts her." Physicians, however, spent more time discussing some of the ways in which clinically credible nurses are engaged with them, and thereby build relationships with them."When they call you, they already have a basic set of information. They often have laboratory values for you and ...have done an initial, fairly complete evaluation.... You're not trying to dig out information. They are talking to you and they are giving you all of this stuff up front". Physicians differentiated those with nursing clinical credibility from other direct care nurses. "Nurses that will tell you about the little thing[s] ie...he didn't have a bowel movement yesterday [or] the family has this concern." Another physician confided that the nurse who is engaged with the physician gives them "a little bit of a heads up" about subtle changes that may have

occurred with their patient. “We depend on that, and if they don’t they lose credibility in my eyes.” One exasperated physician almost pleaded, “If I am at a patient’s bedside [I like them] to at least come up, introduce themselves and... give me 2 minutes, all I am asking is 1- 2 minutes with the nurse just to say, ‘The patient had a quiet night,’ or ‘The patient is doing fine,’ ‘There are no major issues,’ or ‘This is something that I am concerned about,’ ... that kind of stuff.” Physicians recognized the value of the nurse with clinical credibility who is engaged with them. “They are like a player on a team. They do all of the little things that maybe it is nobody’s particular job to do, but they will make it their responsibility. So nurses who take responsibility for their patients are the ones that are... diamonds.” Caring about patients, patients’ families, nurse co-workers and physicians dominated the discussion of both disciplines.

The components of engagement and a relationship focus aggregated within the caring domain based on the descriptions of participants who suggested that in order for a nurse to be perceived as caring they must engage in a relationship with patients, the patients’ families, and healthcare colleagues. The nurse who demonstrates dedication, absorption, efficacy and vigor in a relationship with patients, the patients’ families, and healthcare colleagues is perceived to be caring.

### **Expertise**

Expertise, the cover term for the third domain in the nursing clinical credibility taxonomy, was the most frequently mentioned word used by nurse participants in describing nursing clinical credibility; physicians, however, never mentioned the words, expert or expertise. Physicians, on the other hand, implied a type of expertise which they

extensively described as clinical experience. Expertise is defined as the state of having the specific knowledge, training, and skill sufficient to deal with situations and problems that arise within a particular discipline (Oxford, 1989). This dictionary definition aptly describes expertise as it relates to findings from this study. Nurses used terms like “clinical expert” to describe those nurses with nursing clinical credibility. Nurse participants defined nursing expertise as nurses who possess “expert knowledge” and “excellent clinical skills,” but who also “know where to find the answers,” to infrequently occurring questions that arise in the clinical setting. Although they did not discuss expertise or expert nursing practice as a dimension of nursing clinical credibility, physicians discussed several of the subgroups found within the domain of expertise. “They know the patient, they know what the problems are, and they anticipate the problems and are discussing those with you.” Another physician was quick to point out that “They don’t know everything, but...it is much more important to be mechanical... compulsive than it is to have extensive knowledge.” When referring to the nurse with nursing clinical credibility physicians agreed, “She may not know everything, but at least what she tells me, I can trust.” While this exemplar affirms the physicians trust in the clinically credible nurse, the exemplar provides additional insight regarding the physician’s perspective toward the nurse’s level of knowledge. Physicians recognized that some younger, less experienced nurses also have nursing clinical credibility. “A nurse at [age] 20 may not have as many answers as the more experienced nurse. On the other hand, if she knows that she doesn’t have the answers and knows to seek them out, that restores her credibility or maintains credibility.” Physicians, like nurses, recognized a

certain level of confidence in clinically credible nurses with expertise. “Those nurses tend to know what they know and tend to know what they don’t know.” Components within the third domain of expertise, located on the second level of the common taxonomy, consist of: A. knowledge, B. clinical experience, C. skilled communication, and D. inquiring spirit.

### **1. Knowledge.**

Nurses discussed the knowledge of clinically credible nurses particularly as it related to their specialty area expertise when they said, “They have the knowledge... for that [specialty] area to take care of their patients safely.” Knowledge is defined as the sum of what is known from the acquisition of information through research, study, or experiential learning. Nurses referred to clinically credible nurses as “great resources,” and were quick to add, “If you don’t know something you can go to this credible nurse and she’s gonna’ [sic] know it! And if she doesn’t know it she’s gonna’ [sic] find out the answer for you.” Three different sources of nursing knowledge comprise the subgroups located within the third level of the common taxonomy: knowledge that comes with academic education, practice knowledge, and continuing education.

#### *a. Academic knowledge.*

Academic knowledge refers to the information that one has acquired through a formal, structured program of education within an academic institution. It refers to the knowledge gained through an academic course of study which leads to nursing licensure. Nurses recognized and valued the nurse with advanced education and certification. One nurse shared, “Here comes a nurse with a lot of designations. They come with CCRN and

CVRN, or CCBC, MSN. Then your first impression is, 'Wow!' She has done a lot!" The nurse went on to add, "Her initials that are credentials immediately might make an impression, and then when you see her function at the bedside is how you know whether her credibility is going to hold up, depending on her actions." Physicians, unlike nurses, generally agreed that the nurse's level of education was of no regard. One physician admitted, "Nurses have great variance in skill level and knowledge" and another declared, "I'd just as soon have a good LVN at the bedside!" Another physician added, "Some of the best nurses I have known have been LVN's. There are some LVNs that I would trust more than any RN. If they have that skill and caring attitude I was talking about, I don't care." One physician confided, "I am not sure I can tell that right away, in terms of knowing if she is a degreed nurse or if she is an RN or an LVN. Usually you will know if it's an LVN or RN, but I don't always know if they are a degreed nurse." Another added, "I don't think the degree, whether it is BSN, or a[n] APN. I don't think I could tell the difference, or at least at that moment of patient care. Now, if they talk about studies or this and that, I know the APN nurses would have a lot more to tell me about it, but at the point of contact, point of care with the patient, it doesn't really matter to me."

b. *Practice knowledge.*

Practice knowledge is the sum of what is known from the acquisition of information ascertained about hospital-specific policies and procedures, approved protocols, and the applied knowledge gained through working with routines, procedures and patients. Practice knowledge includes knowledge of how things are done within a certain institution. Nurses discussed the practice knowledge as it relates to expertise.

“You get in a bind and you need a question answered fast, like where is something, or how does something work? Or what do I do in case of an equipment failure? And you’ve got to solve it right then quickly. And I’d say more often I’d go to a credible nurse rather than a manager in our area.” One nurse rather aptly described practice knowledge in her comment “It also may have something to do with knowing where the textbook knowledge is and also knowing how to apply that to your real life situations where everything is not always falling into those “by the book” assessments or treatments.”

*c. Continuing education knowledge.*

Knowledge gained through continuing education refers to the sum of what is known from the acquisition of information ascertained outside of graduation from an academic nursing program. Examples of continuing education include specialty education specific to patient populations, educational sessions and workshops that present new or updated information, and discipline-specific information. Nurses recognized national certifications as validation of the nurse’s advanced knowledge and accomplishment, as long as the nurse’s clinical actions and behaviors demonstrated the advanced level of nursing practice which correlates with the focus of the certification. Continuing education, a subgroup of knowledge, is one type of knowledge which enables nurses to maintain a nursing practice that is “up-to-date” and “knowledgeable with patient population” as well as helps them to develop “a wide skills base.” Nurses identified continuing education as a critical dimension of expertise, and recognized that years of clinical experience may be less important in regard to one’s nursing clinical credibility than “how current you are.”



Nurses and doctors did not describe the knowledgeable nurse in the same way. Doctors considered the nurse with clinical experience as a knowledgeable nurse, while nurses did not consider the knowledgeable nurse by their years of nursing experience. Nurses considered the knowledgeable nurse as one with expertise in a specialty area, and more importantly, one with an inquiring spirit.

## **2. Clinical Experience.**

Clinical experience, a component of expertise, is defined by this researcher as the aptitudes, skill, judgment, and knowledge that results from actual observation or from what one has undergone in the clinical setting. Clinically credible nurses with clinical experience were viewed by other nurses as “a dependable resource for other nurses; for novice nurses or other experienced nurses too. When there’s a problem they go to the credible nurse to seek information or counsel.” Clinical experience, according to nurses, enables nurses to develop “critical thinking skills” and to “identify priorities of patients.” “The more experience you have the more knowledge you have, the more reliable you are, and the more competent information you have.” Nurses shared that clinical “competence” and “expert practice,” which may develop with years of clinical experience, are important aspects of expertise. They shared, however that “years of experience don’t mean so much” in regard to nursing clinical credibility. Several nurses commented that “just because you have been here 22 years doesn’t mean anything. You probably do have the skills. You have more skills than I do, but there is just some other areas that you are weak in and one of those is the credibility thing.” Participants identified two subgroups of

clinical experience which appear in the third taxonomic level as confidence and anticipate problems.

*a. Confidence.*

Confidence is a quality which is commonly demonstrated by one who has the skills and knowledge to deal comfortably with an arising clinical situation. One senses in the clinically credible nurse a definite “calmness by the bedside” that may be a result of “her knowledge, her experience, her skills, and confidence.” In essence, “that nurse knows how to do it right.”

Physicians, on the other hand matter-of-factly proclaimed, “There is no substitute for experience.” “When it is time to make a decision, they make their decision based on what is in front of them, not what their panic level tells them they should be doing.” “She needs to be confident in what they are doing,” and most clinically credible “nurses tend to know what they know and tend to know what they don’t know.” One physician explained that “Experienced nurses are just incredibly valuable and credible. Knowledge base means a lot, consistency means a lot, and flexibility means a lot.”

*b. Anticipates problems.*

Anticipates problems means the ability to expect or look for certain effects or situations to occur, usually based on previous experiences with similar clinical circumstances. The nurse with clinical experience realizes when events “should have been anticipated,” and the clinically credible nurse “trains you, picks up on those little things that we should realize, what we are walking into.” Physicians added that they are

able to “pick up the subtle changes, they know what the problems are, and they anticipate the problems.”

### **3. Skilled Communication.**

Some nurses challenged that the nurse’s “ability to communicate with others” and the nurse’s “willingness to share knowledge” with nurse colleagues is more important than the actual knowledge and clinical experience of the nurse. They further suggested that without the ability to communicate their knowledge to others their expertise would not likely be recognized. Skilled communication, a component of expertise, is the transmission or exchange of information, knowledge, or ideas, by means of speech, writing, electronic media, such that the person receiving the communication fully understands the intended message. Both physicians and nurses recognized that the nurse’s communication skills and English language skills are critical dimensions of the nurse’s expertise, a domain of nursing clinical credibility. These subgroups of Skilled Communication are located in the third level of the taxonomy.

#### *a. English Language Skills.*

Physicians discussed their concerns and the challenges encountered when interacting with foreign-born nurses who have a heavy accent. “They have got to make you know that they don’t understand. You have got to make sure that they, we’re on the same page.” English language skills refer to one’s knowledge of the English language and the ability to effectively use the English language for purposes of communication. Physicians admitted that a nurse’s clinical credibility is compromised when they experience difficulty understanding the nurse due to her lack of English language skills.

“If I can’t understand the nurse or they can’t understand me, it could be a good nurse, but it just automatically makes me more suspect.” Foreign-born nurses, on the other hand, expressed similar frustration when trying to communicate with some physicians. “Even if you *know* what you are saying, and you know you are right, if the doctor has a frame of mind that this kind of accent is not saying the right thing, he has made up his mind already. He is not going to listen [to] it from you.” Another insightful nurse recognized that heavy foreign accents affect her relationships with her customers; customers were identified as physicians, patients, and their families. She confided, “I have seen people with language barriers who have a very thick accent, and customers don’t always want to wade through it to try to get to you [to understand] about what they [the nurse] are saying, [It] changes the way that they relate to them.” Nurses and physicians agreed that telephone communications were particularly challenging. One physician affirmed, “If you are talking with [someone] for the first time on the telephone... you know within the first 15 or 20 seconds on the telephone whether this person really understands what they are calling you about. There has to be that sense of confidence that they understand the situation, they understand what you are saying, you understand what they are saying, and it instinctively puts a sense of confidence in that person, even if it is someone I have never spoken with on the phone before.”

*b. Communication Skills.*

Conversational skill refers to one’s ability to communicate clearly so that the intended message is relayed and understood by the listener. Aside from English language skills, physicians recognized conversational skills as an important subgroup of skilled

communication. “Nurses who are not able to communicate clearly, even if it is because of language barriers, make me wonder if everything we are talking about registers.” One physician cautioned, “They have to listen. They can’t be talking at the same time you are trying to talk.” Nurses emphasized the importance of being open to communicate when they said, “It’s important for people to feel like they can talk to you, and come back to you, and discuss things with you.” The nurse with conversational skill “encourages that communication among associates” and has the “ability to communicate well within their team.” They are a “good communicator and an especially effective listener.” Likewise, nurses discussed the importance of having conversational skills in interactions with patients. “I see a lot of patients who would rather have that nurse who is going to talk to them and care for them, rather than have other high skill levels.” One particularly poignant comment was made by a physician who recognized the conversational skill of the nurse with nursing clinical credibility, “She will challenge me when I am wrong; she will tell me what I don’t want to hear.”

### **3. Inquiring Spirit.**

Expertise in nursing clinical credibility consists not only of the components of knowledge, clinical experience, and skilled communication, but also includes that of an inquiring spirit. An inquiring spirit is a person who has a tendency or inclination to seek information and to learn by questioning. Two ways of demonstrating an inquiring spirit appear in the third taxonomic level, and both represent the semantic relationship ways to demonstrate an inquiring spirit: wants to learn, and asks questions and finds answers.

#### *a. Wants to learn.*

Wants to learn, one way of demonstrating an inquiring spirit, is characterized through the continual search for new and updated knowledge. Nurses described the clinically credible nurse as “constantly wants to keep educating herself.” They repeatedly mentioned the nurse’s “desire to stay current” and “interested and wants to learn” as essential to the nurse’s clinical credibility. The clinically credible nurse’s desire to learn was not mentioned in group interviews with physicians; however, field notes reveal an observation made by one physician who noted the inquiring spirit and resulting educational accomplishments and credentials of one such nurse. He pointed to the name and credentials listed on a professional poster which was displayed on the wall and commented to the researcher, “Gee, it is no wonder that nursing is so strong at our institution. Our nurses constantly want to learn! Look at all the initials after her name! I only have one degree - MD!”

*b. Asks Questions and Finds Answers.*

Asks questions and finds answers in another way to demonstrate an inquiring spirit. Asks questions and finds answers refer to the desire to learn by questioning and seeking information that solves unanswered queries. Study participants from both disciplines noted with frequency that nurses with clinical credibility were “interested.” Physicians noted “if you have a question, they know the answer to it, or are willing to get the answer quickly”. Nurses added that in their interest to learn they “take notes,” “asks questions,” and “doesn’t stop until she finds out the answer for you.”

Knowledge, clinical experience, skilled communication, and an inquiring spirit all aggregated within the domain of expertise because together they exemplify a nurse who

not only knows, but continues to question, and one who through actual nursing practice applies knowledge and can skillfully relay what is known to others. Together these components describe expertise.

### **Nursing Clinical Credibility: The Synergy of Three Domains**

Study findings indicate a synergy that occurs when the three domains, trustworthiness, expertise, and caring, intermingle to form nursing clinical credibility. Both nurses and physicians reported the ability to discern whether nurses genuinely cared. One experienced physician confided, “You can pick those people out, you know, [those] people [that] have a different agenda other than the patient. You can tell that a mile away.” In a different group session a physician shared his perspective of the essence of caring in nursing when he announced, “If you don’t care, you shouldn’t be in this profession period.” One physician concluded by saying, “It doesn’t matter how skilled the nurse is, or how many years experience she has, if she doesn’t want to be there and she doesn’t care about the patient, the rest doesn’t mean a thing.” Nurses’ comments were congruent with those of physicians. They said, “Competence alone is not enough! Competence is necessary but they need more.” One nurse adamantly proclaimed, “If you have excellent clinical skills, but you don’t have anything else... forget it!” She was referring to nurses with clinical competence that lack other attributes of nursing clinical credibility, specifically trustworthiness and caring.

### **Discussion**

Nurses and physicians easily recognized the concept, nursing clinical credibility, when the researcher used the phrase, “one of the really good nurses”; a phrase that

enabled them to envision an example of a nursing role model with whom they had previously worked. Reference to a 'good nurse' suggests that such a standard and definition exist for professional nurses; however no empirical data supports existence of such a standard (Smith and Godfrey, 2002). Neither nurse or physician participants nor other nurses in the field recognized or fully understood the term, nursing clinical credibility, at the outset of discussion, but quickly became comfortable with it and used the term throughout subsequent discussion.

Three predominant domains emerged from taxonomic analysis: trustworthiness, caring, and expertise. Findings from this study validate the findings of previous researchers who studied credibility for over five decades in the fields of communication, business and management, and marketing (Hovland and Weiss, 1951; Slater and Rouner, 1996). Their work suggested that trustworthiness and expertise are transsituational attributes of credibility; transsituational in the sense that the attributes apply in every situation or discipline in which credibility has been studied (O'Keefe, 1990). Research on credibility is important since credibility is the core concept of nursing clinical credibility. Attributes of credibility, aside from trustworthiness and expertise, vary with the context in which the concept is studied, and are not generalizable across all populations (Falcione, 1974). Findings from this study suggest that in the context of nurses who function in the clinical setting in direct care roles, caring is a discipline-specific attribute.

### **Trustworthiness**

Nurses and physicians related numerous stories and exemplars that highlighted the critical nature of trustworthiness as a defining attribute of nursing clinical credibility.



Subtle differences in the ways that nurses and physicians determined the nurse's trustworthiness were exposed. The expectation of nurses is that trustworthiness is proven through evidenced behaviors of honesty, kindness, dedication, reliability. This finding concurs with the work of other researchers who established the components as attributes of trustworthiness (Carlson, 2007). In describing kindness as an attribute of trustworthiness, nurses discussed kindness toward nurse colleagues, not kindness toward patients. Nurses who were kind to other nurse colleagues earned trustworthiness, and could be therefore be trusted to care for patients. Physicians, on the other hand, considered all nurses trustworthy unless they demonstrated otherwise. Physicians assume that all nursing school graduates ascribe to the Nightingale values and therefore are trustworthy. Physicians trust those "special" nurses who take a personal interest in the patient and the patient's outcome and genuinely care about patients and the patients' families. Physicians referred to the "Nightingale attitudes" as of the basis for assumed trustworthiness associated with nursing clinical credibility. Evidence in literature suggests that trustworthiness is a defining attribute of character, and that character is the cornerstone of health care ethics (Loewy, 1997) virtue ethics theory (Smith and Godfrey, 2002), and "the Nightingale virtues" (Sellman, 1997). Although little has been written about trustworthiness or virtue ethics in nursing practice (Smith and Godfrey, 2002), literature validates that Nightingale values are embodied in moral agency and ethical nursing practice of expert nursing practice (Benner, Tanner, Chesla, 1996). Findings from this study suggest that the nurse's trustworthiness is the cornerstone of nursing clinical credibility, and that without trustworthiness there is no nursing clinical credibility.

Trustworthiness, the first domain of the taxonomy is a defining attribute of nursing clinical credibility and provides the supporting framework for the concept. It is through the second domain, caring, that nurses earn the trust of physicians and nurse colleagues.

### **Caring**

In describing nursing clinical credibility, and more specifically the nurse who cares, study participants validated attributes of engagement, which were identified by Schaufeli and Bakker (2004). Study participants in both professional disciplines repeatedly used the phrase, “go the extra mile” when referring to the attributes of engagement as they refer to nurses with nursing clinical credibility. Physician participants referred to this group of nurses as “special,” validating Sullivan’s (1998) work that posited that physicians develop trust in certain, but not all, nurses and refer to them as “special nurses.” Study findings suggest that physicians do indeed trust nurses who are fully engaged with their patient and “really know their patients well” and who are “available” to physicians and go out of their way to be sure that the patient receives the treatment prescribed by the physician. Nurses, on the other hand, discussed engagement as it related to patients and their families, and nurse colleagues in the patient care unit, but not particularly with physicians. Nurses more often described the engagement of clinically credible nurses as those who are “detail-oriented” and “follow through,” and provide conscientious care to patients while at the same time, being kind and “available” to support nurse colleagues.

Physicians described a higher level of engagement in nursing clinical credibility when they described the clinically credible nurse as one who takes a personal interest in

the patients and their outcome. “They really want their patients to do well” and “take responsibility for that patient. I mean they feel like they own the outcome of that patient.” Owning the patients’ outcomes signifies the ultimate caring relationship with the patient and their family, nurse colleagues, and the patient’s physician, which are listed in the taxonomic subgroup, relationship focus. Both disciplines used the term “cares” to describe the nurse who “knows her patients,” “keeps up with what is going on with the patient,” and exhibits genuine concern about the patient and the patient’s progress.

No evidence in the literature was found that links caring with credibility. Credibility has been discussed as it relates to personal integrity (Carroll and Jowers, 2001), as an essential trait for effective managers and leaders (Kanter, 1977; Kouzes and Posner, 1993; Boswell and Cannon, 2005), and as a source of expert power when coupled with skills and knowledge (French and Raven, 1959). Benner (1984) mentioned in her sentinel work, *From Novice to Expert: Excellence and Power in Clinical Nursing Practice* that it was through competence that nurses establish credibility with physicians in the clinical setting. In another section of the same book Benner described the powerful role that nurses play in the healing process when she wrote, “...if the nurse is lacking in diagnostic, monitoring, or therapeutic skills – and, most serious of all, if the nurse does not care – the patient’s chances for recovery or for dignity and comfort in dying, are slim” (1984, p. 216). There was no evidence, however, of a relationship between the nurse who is caring and who has credibility. Leininger is quoted (1979) as writing “Caring is the essence of nursing practice.” Findings from this study suggest that caring

is essential to the discipline of nursing, and more specifically, for nurses in direct care roles, to nursing clinical credibility.

### **Expertise**

Expertise has long been recognized as an attribute of credibility (Aristotle, 332 BC, 1954) and source credibility (McCroskey, 1966), although neither have been studied in relation to nursing. Source credibility, a related concept which has been the subject of abundant research, refers to the believability of the message source. The message source refers to the vehicle by which a message is delivered, and depending on the context in which the message is delivered, may include: television news anchors, newspaper journalists, radio broadcasters, and chief executive officers of companies, college professors, and conference speakers. In the context of nursing source credibility refers to the believability of the direct care nurse who provides nursing care to a group of patients during the course of a shift. The nurse in this direct care role serves as the conduit between the patient/family and their physician, and between the nurse and other nurse colleagues. The messenger's source credibility has been demonstrated to have an effect on the message received (Berlo, Lemert, and Mertz, 1970), and in the context of nursing the nurse's clinical credibility may affect the message delivered, as well as impact the nurse's clinical effectiveness. Similarities are noted between attributes of expertise in nursing clinical credibility identified in this qualitative research study and those of source credibility, which were identified through factor analysis. Attributes of source credibility include dynamism, safety, qualification (Whitehead, 1968; Berlo, Lemert, and Mertz, 1970), authoritativeness, character (McCroskey, 1966), knowledgeable, accuracy,

fairness, and completeness (Jacobson, 1969; Lee, 1978). Qualification, character, knowledgeable, accuracy, fairness and completeness are all included terms of nursing clinical credibility, and contribute to the believability of the message source whether the context is nursing or another unrelated field.

The remaining attributes of source credibility did not emerge from the descriptions of attributes of nursing clinical credibility. The lack of generalizability however precludes one from making assumptions about them. It is notable that inquiring spirit, which is an important dimension of expertise in nursing, is not mentioned in study of source credibility. One of the hallmarks of expert nursing practice, an inquiring spirit, has been identified as a component of continuing nursing education standards of lifelong learning (Hogston, 1995). In addition, communication skills were categorized as an essential component of the domain of expertise because the nurse's ability to clearly communicate one's level of knowledge and understanding directly affects the impression about that nurse's clinical credibility. However, communication skill was not identified among the attributes of source credibility, despite the fact that much of the research on source credibility was conducted in the communication discipline.

Skilled communication dominated the conversation of both nurses and doctors. It is important to note that physicians were frustrated by the lack of English language and communication skills of some nurses in direct care roles, while nurses were frustrated by the difficulties they encountered in communicating patient information to some physicians. Nurses' descriptions were reminiscent of the Nurse-Doctor Game (Stein, 1967), a long-standing, ongoing story of poor nurse-physician communication. The

demographic composition of the nursing population of the hospital in which the study was conducted includes a relatively high incidence of foreign-born nurses, which may be a unique contextual aspect of this study, and may account for the strength of this finding.

A myriad of subsets within the three attribute domains comprise the concept of nursing clinical credibility. It is not solely based on the nurse's expertise or clinical competence, as suggested in previous research by Benner (1964) and Kramer and Schmalenberg (2003). Clinical competence is a critical dimension of nursing clinical credibility, but alone is not sufficient. In addition to expertise, nursing clinical credibility is comprised of trustworthiness and caring, both of which were deemed more critical to nursing clinical credibility than expertise.

### **Conclusion**

Findings from this study suggest that in addition to transsituational attributes, trustworthiness and expertise, described by previous researchers, that caring is a discipline-specific attribute of clinical credibility in the context of nursing. Findings further reveal a divergence in the way that the two disciplines recognize nursing expertise; nurses value knowledge, while physicians value clinical experience. These findings are important because as pivotal members of the healthcare team who are routinely involved in daily, difficult, yet oftentimes, critical conversations about patients, their cognitive construction of nursing clinical credibility impacts effective communication between two disciplines. While both recognize trustworthiness and caring as critical to nursing clinical credibility, nurses recognize and strive toward advanced education and certification in their specialty, while physicians recognize and respect

nurses with clinical experience who strive to find answers to their questions. It stands to reason then, that nursing clinical credibility indirectly impacts the patients' course through the healthcare continuum in regard to the patient's safety and quality care. Findings of this study may encourage open, frank discussion between nurses and physicians about nursing clinical credibility, and that it will facilitate effective communication about patients. The taxonomy of nursing clinical credibility provides a basis for: nurse educators to develop strategies to teach prospective nurses about developing desired attributes of nursing clinical credibility; nurse administrators to recognize, reward, and retain clinically credible nurses; and nurse researchers to examine and develop an instrument with which to approximate nursing clinical credibility.

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*Table 1*

## Taxonomy of Nursing Clinical Credibility

Nursing Clinical Credibility
1. Trustworthiness
1.1. Honesty
1.1.1. Admits when doesn't know
1.1.2. Owns up to mistakes
1.2. Fairness
1.2.1. Treats people right
1.2.2. Non-judgmental
1.2.3. Flexible with less experienced colleagues
1.3. Reliability
1.3.1. Consistent
1.3.2. Dependable
1.4. Kindness
1.4.1. Approachable
1.4.2. Not mean
1.4.3. Doesn't make you feel stupid
2. Caring
2.1. Engagement
2.1.1. Dedication
2.1.2. Absorption
2.1.3. Efficacy
2.1.4. Vigor
2.2. Relationship focus
2.2.1. Patients and their families
2.2.2. Members of healthcare team
3. Expertise
3.1. Knowledge
3.1.1. Academic
3.1.2. Practice
3.1.3. Continuing education
3.2. Clinical Experience
3.2.1. Confident - knows what does and doesn't know
3.2.2. Anticipates problems
3.3. Skilled communication
3.3.1. English language skill
3.3.2. Communication skill
3.4. Inquiring spirit
3.4.1. Wants to learn
3.4.2. Asks questions & finds answers

**Appendices**

Appendix A. Sample Interview Questions

Appendix B. Discipline-specific Taxonomies:

Taxonomy of Nursing Clinical Credibility from Nurses' Descriptions

Taxonomy of Nursing Clinical Credibility from Physicians' Descriptions



**Appendix A**

Sample Interview Questions

## Sample Interview Questions

Nurse Group Interviews	Doctor Group Interviews
1. Tell us your name and what you enjoy doing when you are not working here.	1. I am trying to put together a picture- a composite- of the nurse with clinical credibility as the nurse is seen by physicians. Describe for me the nurse with clinical credibility. What qualities does the nurse have?
2. In the last few years we've heard and read a lot in the press about the credibility of business leaders. When you hear the term credibility what comes to mind?	2. Think back to the last time that you worked with a nurse that wasn't clinically credible. What happened that made you realize that the nurse wasn't credible.
3. Think back to the last time that worked with "one of the good nurses" ... you know the ones I mean... the nurse who has real credibility. What is it about that nurse that is different from other nurses?	3. What is it that is different about the clinically credible nurse?
4. Think about a recent experience when you worked with a nurse that wasn't clinically credible. What happened that made you realize that the nurse had no credibility with you?	4. What are you looking for in a clinically credible nurse?
5. Take a piece of paper and list 3-4 of the most important qualities of registered nurses with clinical credibility. Then we'll share them with the group.	5. What sets them apart? Does education make a difference? Years of experience? Gender of the nurse? How about caring attitude? How about foreign accent?
6. Can you describe for me the nurse with clinical credibility? What sets him/her apart from other nurses?	6. In order of priority, what qualities or characteristics are most important in the clinically credible nurse?
7. If you were the moderator what question would you ask next?	
8. In thinking about what's been said today... what is the most important attribute of clinical credibility in RNs?	
9. What advice would you give to other nurses to help them to enhance their clinical credibility?	

**Appendix B**

Discipline-specific Taxonomies: Taxonomy of Nursing Clinical Credibility from  
Nurses' Descriptions; Taxonomy of Nursing Clinical Credibility from Physicians'  
Descriptions

Discipline-specific Taxonomies: Taxonomy of Nursing Clinical Credibility from  
Nurse's Descriptions

1. Trustworthy
  - 1.1. Honest/Truthful”
    - 1.1.1. “Admits when they don’t know”
    - 1.1.2. “Owns up to mistakes”
  - 1.2. “Fair”
    - 1.2.1. “Treats people equally”
    - 1.2.2. “Doesn’t discriminate”
  - 1.3. “Reliable”
    - 1.3.1. “Consistent”
    - 1.3.2. “Dependable”
  - 1.4. “Kind”
    - 1.4.1. “Approachable”
    - 1.4.2. “Not mean”
2. “Cares”
  - 2.1. “Engaged “
    - 2.1.1. Patient/family
      - 2.1.1.1. “Knows her patients”
      - 2.1.1.2. “Patient –focused”
      - 2.1.1.3. “Advocates for the patient”
      - 2.1.1.4. Clinically Effective – “Gets things done”
        - 2.1.1.4.1. “Motivated/Dedicated”
          - 2.1.1.4.1.1. “Doesn’t just do enough to get by “
          - 2.1.1.4.1.2. “Goes the extra mile”
          - 2.1.1.4.1.3. “Hard worker”
        - 2.1.1.4.2. “Conscientious”
          - 2.1.1.4.2.1. “Detail-oriented”
            - 2.1.1.4.2.1.1. “Follows through “
            - 2.1.1.4.2.1.2. Provides “continuity of care”
        - 2.1.1.4.3. “Organized”
    - 2.1.2. Patient care unit
      - 2.1.2.1. “Gets involved” in unit activities
      - 2.1.2.2. “Wants to take care of patients”
      - 2.1.2.3. “Energetic” “Team player”
        - 2.1.2.3.1. “Hand on the pulse of the unit”
        - 2.1.2.3.2. “Responsible”
        - 2.1.2.3.3. “Accountable”
        - 2.1.2.3.4. “Helps others” – “Flexible with assignment”
    - 2.1.3. Doctor

- 2.1.3.1. Provides doctors pertinent information
- 2.1.3.2. “Advocates for patients’ needs”
- 2.1.4. Nursing Profession
  - 2.1.4.1. “Coaches” and “Mentors “
  - 2.1.4.2. “Nurtures” other nurses
- 3. “Expertise”
  - 3.1. “Has a Spirit of Inquiry”
    - 3.1.1. “Wants to learn”
    - 3.1.2. “Asks questions”
  - 3.2. Knowledge
    - 3.2.1. Academic Education
      - 3.2.1.1. “Knows answers”
      - 3.2.1.2. “Knows how”/”where to find the answers”
    - 3.2.2. Continuing Education
      - 3.2.2.1. “Keeps current” – updates old information
    - 3.2.3. Practice Knowledge
      - 3.2.3.1. Applies new information in practice
      - 3.2.3.2. “Knows how to get things done” for assigned patients
      - 3.2.3.3. “Knows answers or where to find them”
      - 3.2.3.4. “Knows policies & procedures”
    - 3.2.4. Specialty Education –Knowledgeable about specialty subject
      - 3.2.4.1. Certification
      - 3.2.4.2. “Good test-taker”
  - 3.3. Experience in clinical setting
    - 3.3.1. “Competence”
      - 3.3.1.1. “Excellent procedural skills”
    - 3.3.2. “Conveys Confidence”
      - 3.3.2.1. “Knows what she knows”
      - 3.3.2.2. “Knows when to ask for help”
      - 3.3.2.3. “Asks for help when she needs it”
      - 3.3.2.4. “Calm presence”
      - 3.3.2.5. “Professional “
    - 3.3.3. Years of nursing experience
      - 3.3.3.1. Experience not valued in the absence of other attributes
      - 3.3.3.2. Years of nursing “experience means not so much”
  - 3.4. “Good Communication skills” – can communicate what RN knows
    - 3.4.1. Doctor
      - 3.4.1.1. Provides thorough information to MD
      - 3.4.1.2. Tailors report for MD based on MD’s preferences
      - 3.4.1.3. “Knows what she can ask, and what she can’t”
    - 3.4.2. Patient/family
      - 3.4.2.1. “Acknowledges them”
      - 3.4.2.2. “Involves them” in the care team

3.4.3. Nurses

3.4.3.1. "A good listener"

3.4.3.2. "Respectful" – "Doesn't make you feel stupid"

3.4.3.3. "Shares knowledge and expertise"

3.4.3.3.1. "Teaches"

3.4.3.3.2. "Demonstrates "

3.4.3.3.3. "Answers your questions"

Discipline-specific Taxonomies: Taxonomy of Nurse Clinical Credibility from  
Physicians' Descriptions

1. Trustworthiness –“Assume[s] that nurses are trustworthy”
2. Cares - “Can trust a nurse who Cares”
  - 2.1. Engaged
    - 2.1.1. Patient/family - Patient/family “tells me if nurse cares”
      - 2.1.1.1. “Knows her patients”
      - 2.1.1.2. Patient-focused - “Has the patient’s interest at heart”
      - 2.1.1.3. Clinically Effective – “Gets things done”
        - 2.1.1.3.1. Motivated/Dedicated
        - 2.1.1.3.2. “Owns the patient’s outcome”
        - 2.1.1.3.3. “Goes the extra mile”
        - 2.1.1.3.4. “Conscientious”
          - 2.1.1.3.4.1. “Detail-oriented”
          - 2.1.1.3.4.2. “Compulsive”
      - 2.1.2. The patient care unit
        - 2.1.2.1. “Has a global perspective”
      - 2.1.3. Doctor
        - 2.1.3.1. “Available”
        - 2.1.3.2. “Organized”
          - 2.1.3.2.1. “Has all the information before she phones me”
        - 2.1.3.3. Team player
          - 2.1.3.3.1. “Responsible”
          - 2.1.3.3.2. “Accountable”
          - 2.1.3.3.3. “Follows through”
          - 2.1.3.3.4. “Flexible” with policies and procedures
          - 2.1.3.3.5. “Reminds me of little things”
  3. Expertise
    - 3.1. Knowledge
      - 3.1.1. Academic Education
        - 3.1.1.1. “Degree doesn’t matter”
        - 3.1.1.2. “Just as soon have a good LVN”
      - 3.1.2. Practice Knowledge
        - 3.1.2.1. Knows policies and procedures
        - 3.1.2.2. “Knows hospital protocols”
      - 3.1.3. Specialty Education – Certification
        - 3.1.3.1. “Look at all the initials after her name!”
    - 3.2. Experience - “a track record of positive interactions”
      - 3.2.1. Competence
        - 3.2.1.1. “Has the answers or gets them”

- 3.2.1.2. “Anticipates problems”
- 3.2.1.3. “Experienced nurse is very valuable to me”
- 3.2.2. “Conveys Confidence”
  - 3.2.2.1. “Doesn’t panic”
  - 3.2.2.2. “Has a presence about her”
  - 3.2.2.3. “Knows what she doesn’t know”
- 3.3. Good Communication skills
  - 3.3.1. Doctor
    - 3.3.1.1. “She talks to me”
      - 3.3.1.1.1. “Challenges me when I am wrong”
      - 3.3.1.1.2. “Tells me what I don’t want to hear”
      - 3.3.1.1.3. “Reports subtle changes”
      - 3.3.1.1.4. “Tells me the little things – BM, pressure ulcer, etc...”
      - 3.3.1.1.5. “Listens” – “Doesn’t talk when I am talking”
  - 3.3.2. Patient/family
    - 3.3.2.1. “Has social skills with families”
  - 3.3.3. English language skills of foreign-born nurses
    - 3.3.3.1. Doctor
      - 3.3.3.1.1. “We can understand each other”
      - 3.3.3.1.2. “Makes you know if she doesn’t understand”
    - 3.3.3.2. Patient/family
      - 3.3.3.2.1. “Can understand her”



Nursing Clinical Credibility: A Concept Analysis

Claudia DiSabatino Smith, MSN, RN, The University of Texas Health Science Center at  
Houston School of Nursing

James P. Turley, PhD, RN, The University of Texas Health Science Center at Houston  
School of Health Information Sciences

Joan C. Engebretson, Dr. Ph, RN, The University of Texas Health Science Center at  
Houston  
School of Nursing

Lillian R. Eriksen, DSN, RN, The University of Texas Health Science Center at Houston  
School of Nursing

Theresa L. Carroll, PhD, RN, The University of Texas Health Science Center at Houston  
School of Nursing

Correspondence: Claudia D. Smith, 20715 Annapoosa Trail, Crosby, Texas 77532; phone:  
281-324-2404 FAX: 832-355-6670 cordersmith@hotmail.com

### Nursing Clinical Credibility: A Concept Analysis

Nursing clinical credibility is not often discussed in the clinical setting, but is a concept that is implicitly understood by registered nurses and physicians. Nursing clinical credibility has been used interchangeably with the term clinical competence in literature; although nurses and physicians seem to suggest that nursing clinical credibility involves something more than clinical competence. Conceptual confusion exists regarding these two different, but related concepts. A conceptual analysis of nursing clinical credibility was undertaken to establish the defining attributes of the concept that distinguish it from clinical competence, and to determine a conceptual definition of nursing clinical credibility. The purpose of this manuscript is to report findings of this concept analysis of nursing clinical credibility.

For example, nursing clinical credibility is one of several determinants used by nurses to decide which nurse colleague to ask to watch one's patients while the nurse leaves the patient care unit for a short break. Nurses need to feel that they can trust their colleague to closely watch their patients. Nurses want to work with other clinically competent nurses<sup>2</sup> and in addition, they want to work with those in whom they feel confident and find trustworthy. The ability to trust and to have confidence in someone is one component of credibility.<sup>3</sup> Nursing clinical credibility is one of the factors considered by physicians when they decide how often it is necessary to phone a nurse to check on a clinically compromised patient (Messerschmidt, personal conversation, 2-9-03). Nurses recognize the need to establish their credibility with physicians by proving their competence in the clinical area;<sup>4</sup> however, both physicians and nurses recognize and

value the nurse who is not only clinically competent, but who is often generally referred to as a “really good nurse,” one with nursing clinical credibility.

Nursing clinical credibility is a tacit phenomenon in clinical practice that has neither been examined nor conceptually analyzed in literature. A tacit phenomenon is one that is not explicitly stated or openly expressed, although it is generally implied or understood.<sup>5</sup> The concept clinical credibility is more often referenced in literature as a characteristic of nursing faculty who have adequate hands-on experience with patients, as opposed to those faculty members who lack actual, recent, direct care nursing experience in acute care settings.<sup>6,7,8</sup> Clinical credibility, as it relates to nurse educators, means either “being up to date with theoretical aspects while maintaining clinical skills, or developing a clinical role to ensure that teaching is based on current practice.”<sup>7 (p285)</sup> Despite the frequency with which it is referenced in regard to nurse educators, the critical attributes of clinical credibility have not been explored. The definitions suggested by Nahas<sup>7</sup> do not readily apply to nursing clinical credibility, that is, nurses who are in direct care roles. Maslin-Prothero and Owen<sup>6</sup> suggest that when the nursing staff of a patient care unit is confident in the nurse educator’s ability to supervise the student nurse in the care of a patient, the nurse educator is perceived as having clinical credibility. Maslin-Prothero and Owen<sup>6</sup> further suggest that nurse educators can earn clinical credibility with the hospital nursing staff by offering to provide training and education for staff nurses. Lack of a generally accepted definition of the concept and the paucity of research about the concept’s attributes contribute to the challenge of determining how to earn clinical credibility with staff nurses.

Concept analysis is a careful examination using available literature to distinguish between the defining attributes of a concept and its irrelevant attributes.<sup>1</sup> Defining attributes are a cluster of characteristics that are most frequently associated with the concept, and which appear repeatedly in reference to the concept being studied.<sup>1</sup> They are often included in a descriptive or operational definition of the concept. A descriptive definition describes the accepted meaning for a term already in use by employing terms that are usually readily understood by the reader.<sup>1</sup> This paper employs a method advocated by Walker and Avant<sup>1</sup> to conceptually analyze nursing clinical credibility as it relates to nurses who are in direct care roles and to determine the defining attributes of the concept by which it can be distinguished.

Nursing clinical credibility was not defined in any of the articles cited in this paper in which the term clinical credibility is mentioned or discussed. The term, nursing clinical credibility, is derived from a synthesis of the combined definitions of clinical and credibility as it applies in the context of nursing. Credibility is derived from the Latin verb, *credo*, which means to trust or believe.<sup>9</sup> Credibility is defined as “capable of being believed; believable; worthy of belief or confidence; trustworthy, reliable; having or deserving credit or repute; of good repute, creditable, reputable.”<sup>3</sup> (pp1137-1138) A person with credibility is judged to be believable, trustworthy, reliable, and respected. Credibility refers to the level of confidence and trust one has in the believability of the target person. One’s credibility is determined by people who have observed and interacted with the target person in a professional context, and who make an evaluative judgment about the person’s believability and trustworthiness. This implies that nursing clinical credibility must be earned, and that it is judged by those who are in a position to

make this judgment. The professional context relates to the setting in which one's credibility is judged. In the case of nursing clinical credibility, the target person is a nurse, and the professional context is the clinical setting where the nurse observes and interacts with patients, their family, and other healthcare providers.

Clinical credibility, therefore, refers to the credibility of a person who observes and treats patients in a clinical setting. Clinical is defined as "of or pertaining to the sick-bed, specifically to that of indoor hospital patients;"<sup>10 (p328)</sup> "of, or relating to the observation and treatment of actual patients rather than theoretical or laboratory studies."<sup>11 (p321)</sup>

Contemporary use of the word clinical may include other healthcare settings in addition to hospital or a sickbed setting, but involves "the observation and treatment of patients directly."<sup>11</sup> People involved in actual clinical observation and treatment may include a number of healthcare providers such as nurses, physicians, social workers, respiratory therapists, physical therapists, or patient care assistants. For the purpose of this analysis the focus will be on the clinical credibility of nurses who are directly involved in the observation and treatment of patients in clinical care settings.

### **Search Method**

The last two and a half decades of nursing literature was reviewed for attributes of nursing clinical credibility using the World Wide Web and the MEDLINE and SCOPUS databases. The following search terms were used in different combinations: clinical, credibility, RN, clinical credibility, nurse, and attributes. Forty-eight (48) citations were found in nursing literature that mentioned nursing credibility or clinical credibility although only seven citations were pertinent to the analysis. Twenty-seven (27) of the 48 citations pertained to the clinical credibility of nurse educators and not to nurses who

function in direct care roles. Citations that were not relevant to the role of direct care nurses or did not identify attributes of nursing clinical credibility were eliminated (6 citations), as were those that focused on advanced practice nurses (6 citations) and nurse leaders (2 citations), due to the significantly different scopes and expectations that correspond with those nursing roles.

Nursing clinical credibility is frequently mentioned in literature but it has not been examined, defined, or conceptually analyzed. There were no studies located that examined nursing clinical credibility. There were, however, seven manuscripts located that contain information about attributes of nursing clinical credibility pertinent to this analysis. These will be discussed in the subheading, Defining Attributes of the Concept.

### **Method of Analysis**

Walker and Avant<sup>1</sup> utilize an eight-step process in concept analysis that simplifies and modifies an eleven-step process that originated with Wilson.<sup>12</sup> Walker and Avant<sup>1</sup> provide very structured direction to guide novice analysts in the study of nursing concepts. The process directs the analyst to: 1) select a concept; 2) determine the purpose of the analysis; 3) identify all the uses of the concept; 4) determine the defining attributes; 5) construct a model case; 6) construct each of the following cases – related, borderline, contrary, invented, and illegitimate; 7) identify antecedents and consequences of the concept; and 8) define the empirical referents of the concept. The eight-step model designed by Walker and Avant<sup>1</sup> produces a precise analysis through an iterative process as the analyst repeatedly reviews and revises as necessary. The Walker and Avant<sup>1</sup> model provides a framework with which the author can analyze the complex concept of

nursing clinical credibility within the context of nurses who are in direct care roles. The framework will be used as an organizing format for this manuscript.

### **Steps 1 and 2. Concept Selection and Purpose**

Concepts are mental abstractions that depict human phenomena<sup>13</sup> and are composed of certain elements or attributes. Nursing clinical credibility is such a concept and it depicts a phenomenon that is a precursor to effective communication and serves as the basis for accurate, productive, respectful communication among healthcare professionals. Nursing clinical credibility enables effective communication among healthcare professionals that leads to collaboration,<sup>14</sup> and which ultimately leads to improved patient outcomes.<sup>15</sup> Knowledge of the attributes that define nursing clinical credibility will enable nurse managers and administrators as well as other healthcare providers to recognize and reward those clinically credible, and to utilize them as collaborators and role models. By defining the critical attributes of nursing clinical credibility, nurses can evaluate their own nursing practice and consciously work toward developing, nurturing, and demonstrating behaviors that characterize nursing clinical credibility.

An analysis of the concept nursing clinical credibility was undertaken in an effort to uncover defining attributes of the concept that distinguish it from nursing clinical competence, a related concept which is often used interchangeably with nursing clinical credibility. Conceptual confusion exists in recognizing the difference between nurses with clinical competence and those with clinical credibility. Dialogue with nursing colleagues about confusion relative to the difference between the definitions of a clinically competent nurse and “a really good nurse” (i.e., a clinically credible nurse) provide a convincing argument for further need to analyze the concept. Both nurse and

physician colleagues distinguish between nurses who are clinically competent in the care of patients and those nurses who are not only competent, but who stand apart from the rest; those whose behaviors clearly show concern about the patient and interest in the patient's outcome; those who went "the extra mile"; and who embody the ideals of the registered nurse. Clinical competence is necessary, but is not sufficient as a component of nursing clinical credibility.

It is not surprising that clinical nurses lack clarity regarding the difference between these two concepts because there is a general lack of consensus among researchers regarding a consistent, measureable definition of clinical competence.<sup>16</sup> Researchers cannot agree whether clinical competence refers to the nurse's potential or to the nurse's actual ability.<sup>16</sup> There seems to be no consensus as to whether competence relates to the nurse's knowledge, skills, and abilities or to the nurse's actual performance using the knowledge, skills and abilities.<sup>16</sup> For purposes of clarity and delineation, clinical competence will be defined as the job performance of a nurse who has the knowledge, skills and abilities to carry out the duties and responsibilities of the job in a manner that satisfies the demand of the clinical situation. Nursing clinical credibility, on the other hand, is defined by the researcher as a judgment about the job performance of a nurse based on the preconceived notions and interactions with the nurse in the clinical setting that signify the level of confidence and trust in the nurse. Clinical competence refers to the actual knowledge and skill with which the nurse performs the job; while clinical credibility refers to the perception that healthcare colleagues have about the nurse's job performance, relative to their preconceived notions associated with the nurse role.



A clinically competent nurse is not necessarily the same person to whom nurses and physicians refer when describing “the really good nurse”; i.e., a clinically credible nurse. Concept analysis will create meaning for the term, nursing clinical credibility; it will also facilitate the re-conceptualization of “the really good nurse” to mean the nurse with clinical credibility. Findings from this concept analysis provide healthcare professionals with the tools to articulate the difference between nurses with clinical competence and those with nursing clinical credibility.

Lack of common understanding regarding the meaning of nursing clinical credibility and absence of an operational definition present a dilemma for nursing faculty who strive to meet regulatory provisions in the United Kingdom.<sup>17</sup> The dilemma stems from government-mandated performance standards which require that nurse educators maintain clinical credibility, but do not provide a list of attributes against which the clinical credibility of nurse educators can be evaluated.<sup>17</sup> Concept analysis can provide nurse educators with information to develop strategies to teach nursing students about nursing clinical credibility and the importance of striving to foster its development.

Through the identification of its attributes, concept analysis clarifies and articulates the many aspects of the nursing clinical credibility. Identification of the critical attributes of clinical credibility leads to a better understanding of the qualities valued by nurses and other healthcare professionals. A clearer understanding of the concept will help nurses and other healthcare professionals articulate those particular qualities perceived in clinically credible nurses who are valued and respected. Recognizing and rewarding nursing clinical credibility may improve the retention of clinically credible nurses. Kramer and Schmalenberg<sup>2</sup> posit that nurses want to work with other clinically

competent nurses; however, the authors suggest that nurses want to work with nurses who are not only clinically competent, but who they consider to be clinically credible; those nurses in whom they have confidence and trust. Being considered clinically credible is a step beyond just being clinically competent.

A concept analysis of nursing clinical credibility will also add to the body of nursing knowledge, enabling nurse educators to develop strategies with which to gain clinical credibility with hospital nursing staff. It further provides practicing nurses with the knowledge by which they may evaluate their own nursing practice in regard to attributes of nursing clinical credibility.

### **Step 3. Uses of the Concept**

Review of the different uses of the concept permits the reader to fully examine the ramifications of the concept as it is currently used.<sup>1</sup> One use of the concept clinical credibility is seen in the academic setting where the concept is used to refer to nursing faculty members who have both theoretical knowledge and current, evidence-based, hands-on practice.<sup>7</sup> Clinical credibility refers to nursing faculty members who have domain knowledge, process knowledge, and current hands-on experience with patients. Domain knowledge is knowledge of the facts and theories that serve as the underpinnings of the subject area. Process knowledge is knowledge of how to do the procedures and accomplish the tasks required in the subject area. In the nursing profession, the term “hands-on” refers to actual physical interaction with patients by those in the nursing profession; in other words what nursing considers the essential aspect of nursing work.<sup>18</sup> Academic faculty members who lack any one of these three attributes; domain

knowledge, process knowledge, and current “hands-on” experience with patient care, are generally not considered clinically credible.

Another use of the term clinical credibility is seen in the area of scientific research. Medical and nursing researchers who conduct randomized control trials use the term to refer to a research study that has clinical significance. In research studies in which a significant positive or negative effect is observed in the study participants, the study is said to have clinical credibility.

Clinical credibility can also mean the impression that one has about the job performance of a healthcare professional which signifies the confidence and trust that one has in that professional. In part, this impression is based on the professional’s interaction with patients and other healthcare providers in a clinical setting. Healthcare professionals include disciplines such as nurses, physicians, dentists, social workers, respiratory therapists, physical therapists, and pharmacists.

#### **Step 4. Defining Attributes of the Concept**

Defining attributes are a cluster of characteristics that repeatedly appear in descriptions of the concept and are grouped into categories according to their patterns and themes. Defining attributes are critical in differentiating one specific concept from another similar or related concept.<sup>8</sup> Seven citations were located that mention attributes of nursing clinical credibility; five reported results of research studies and two were anecdotal articles. No research studies were located in which nursing clinical credibility was the focus of the research; however, attributes of nursing clinical credibility emerged from each of the seven articles located in literature. Attributes which emerged from these nursing research studies that explored topics other than nursing clinical credibility

included trustworthiness,<sup>19,20</sup> approachability,<sup>21</sup> competence,<sup>4</sup> professional communication,<sup>22</sup> and caring behaviors toward patients.<sup>4</sup> Attributes emerged from various research studies such as a concept analysis of practice development,<sup>20</sup> from a study of factors influencing effective implementation of quality improvement processes,<sup>21</sup> and from a study of nurse communication skill sets.<sup>22</sup> Follow-through, honesty, clear communication,<sup>23</sup> and exceeding performance expectations<sup>24</sup> were attributes which were found in anecdotal citations.

### **Step 5. Model Case of Concept**

A model case of the concept being explored is a pure, “real life” example of the concept that contains all of the defining attributes.<sup>1</sup> The setting of the following scenario is a neurological nursing unit in an acute care hospital and represents a model case of clinical credibility.

A family member of a young, female patient approached the nurses’ station to talk with the patient’s attending physician. The physician had just left the patient’s room and was documenting on the patient’s chart. The family member identified herself as a relative of the patient, and asked the physician how soon she should plan to bring the patient’s newborn baby to the hospital to bond with its mother who was the patient. The physician responded that before the baby could be brought, arrangements would have to be made to have the patient moved to a private room equipped with a bassinet in order to ensure privacy and to reduce the likelihood of exposing the newborn to contagions from other patients. The physician then began looking around the nurses’ station, then down the halls, looking one way and then the next, as if seeking someone specific. He finally said to the family members, “I am looking for Pam, one of the older nurses... no, I don’t

mean older. I mean she's one of the really good nurses; she's been here longer than these others. She really knows what she's doing, and she'll see to it that things get taken care of right away." He proceeded to physically describe Pam to the family members. At that point, a nurse who was assigned to the patient asked if she could help him, but he declined. The physician got up from the desk, motioned the family members away from the desk and toward a hallway, talking quietly with them while he continued to search the hallways for Pam. He told the family members that they would like Pam who is very efficient and really cares about her patients. He assured them that she could help them with their situation.

The nurse, Pam, in the aforementioned scenario, is perceived by the physician to have these attributes of nursing clinical credibility; competence, trustworthiness, follow-through, approachability, communication skills, and concern for her patients. Pam represents an excellent example of a registered nurse who is seen by the patient's physician to have nursing clinical credibility.

#### **Step 6a. Related Case of Concept**

A related case is very similar to the concept being studied, but which, on closer examination, is missing all or most of the critical defining attributes.<sup>1</sup> The following case is set in an (ICU) at the change of shift in an acute care hospital. One of the patients in ICU was scheduled for a Swan Ganz pulmonary arterial pressure catheter insertion and the room had already been set up for this procedure. The cardiologist arrived to perform the procedure, but Frances, the nurse scheduled to assist him still had not arrived for work. Instead, the charge nurse accompanied the cardiologist to the room and there were joking references between the charge nurse and the cardiologist relative to Frances's

tardiness. As the physician greeted the patient and re-explained the procedure to him, Frances arrived on the unit. She glanced at the assignment sheet, saw that the charge nurse was in the patient room with the cardiologist and quickly placed her personal belongings in her locker, grabbed her stethoscope, pocket protector, and assignment sheet and hurried into the room. As the charge nurse left the room Frances slipped into her role at the patient's bedside. The Swan Ganz insertion proceeded smoothly, without complication. Frances performed adeptly, accommodating the needs of the physician while reassuring the patient.

In the scenario described above one can see evidence of Frances's competence and communication skill. She had no difficulty accomplishing the task or communicating with the charge nurse or physician, and yet neither the charge nurse nor her nursing colleagues trusted Frances. The fact that they cannot rely on her to arrive on time for work compromises her trustworthiness with them. The scenario does not reveal evidence of follow-through or caring behaviors toward the patient or her nurse colleagues, but it does demonstrate evidence of her clinical competence. Her coworkers and charge nurse do not perceive her to have nursing clinical credibility, essentially because they could not depend on her to be there when they needed her. This related case of nursing clinical credibility displays many of the defining attributes, but lacks evidence of at least two critical attributes, trustworthiness and caring behaviors toward patients and nurse colleagues.

#### **Step 6b. Borderline Case of the Concept**

A borderline case is one that contains some, but not necessarily all of the defining attributes of the concept. Borderline cases, however, may contain all of the defining

attributes but represent an inconsistent view of the concept under study.<sup>1</sup> The following scenario demonstrates a borderline case that does contain all of the defining attributes and which occurred on a rehabilitation unit in an acute care hospital.

An elderly woman who had a knee replaced experienced a difficult recovery period involving severe pain and frequent bouts of nausea and vomiting. When the orthopedic surgeon felt the patient was finally ready to transfer to the rehabilitation unit for intensive therapy, the entire family was a little anxious because nothing, thus far, seemed to have gone smoothly. Upon being transferred into the rehabilitation unit Lespedeza, the primary nurse, introduced herself to the patient and family. The patient's son and daughter-in-law were both employed as nurses in different departments within the same hospital. When Lespedeza was introduced to these two family members as the primary nurse on the case, the one thought that ran through their minds was "Why couldn't we have gotten lucky and had Mary as Mom's primary nurse? Everyone knows that Mary has a great reputation as a wonderful nurse!" Unfortunately, Lespedeza did not share that same reputation. She seemed extremely quiet around them and was not very forthcoming. English was her second language and it was sometimes difficult for her to communicate. Lespedeza welcomed and instructed the patient about the rehabilitation unit, but the patient seemed less than interested to be there, and once Lespedeza left the room asked the family how soon she could go home.

Throughout the course of several weeks it appeared to the son and daughter-in-law that the patient was deteriorating. No major complications developed, but the family noticed subtle changes in her demeanor. During visits, the family did not encounter Lespedeza; she was off duty, off the floor, or working with another patient at the time of

the family's visit. Other nurses willingly provided information to the family about the patient's vital signs, lab results, and other pertinent data, but the family remained concerned about the patient's lack of progress. The patient's son arrived late one afternoon to find Lespedeza auscultating his mother's lungs. As he silently watched from the door he observed Lespedeza as she assessed his mother. Lespedeza gently and softly, albeit painstakingly attempted to communicate with the elderly patient as she continued to complete a physical assessment. The patient's son was amazed to witness firsthand the skill and professional demeanor that Lespedeza demonstrated as she worked with his mother. When Lespedeza noticed the patient's son standing in the doorway she beckoned to him to enter the room. Despite her prior lack of assertiveness in providing information to the family, Lespedeza thoroughly answered each of the son's questions regarding his mother's lack of progress when the son initiated a conversation and asked specific, pertinent questions about his mother. She shared that the patient was not sleeping well, seemed disinterested in her surroundings, and did not interact with other patients during the group sessions. As they conversed the patient's physician entered the room, Lespedeza greeted him demurely, and then quickly left the room without reporting her findings to the physician. She summoned the charge nurse to round with the physician, but did not disclose the assessment findings to her; nor did she return to the patient's room during the physician's visit. The physician talked to the patient and patient's son about the patient's progress until the charge nurse hurried into the room. The charge nurse and physician then discussed and made decisions about the patient's care without any knowledge of Lespedeza's assessment or her concerns about the patient.



Lespedeza was approachable and honest, and appeared to be clinically competent. She also demonstrated concern and caring behaviors toward the patient and family. Lespedeza demonstrated the critical attributes of nursing clinical credibility. Her communication skills, however, hampered her ability to articulate her competence, to be clinically effective, and to advocate for the patient. These factors hindered her from gaining the confidence and trust of the physician, nurse manager, or the patient and patient's family. Lespedeza had several of the attributes of nursing clinical credibility, yet was not viewed by healthcare colleagues or the patient's family as clinically credible.

### **Step 6c. Contrary Case**

Contrary cases are clear examples of what the concept is not. They demonstrate examples of cases that have none of the defining attributes.<sup>1</sup> The lack of critical attributes demonstrates an absence of nursing clinical credibility for the involved nurse. The following example took place on a medical patient care unit in an acute care hospital.

Frustrated with the change-of-shift-report from a nurse colleague, Michelle requested a meeting with the nurse manager. Michelle complained that Rosella, a newly-employed night nurse, reported that a patient's urinary catheter output measured 450cc of blood-tinged urine; however, the patient did not have a urinary catheter, but wore diapers. Michelle recounted Rosella's report of a patient who had dyspnea, and in whom she assessed bilateral lung crackles. Rosella had failed to notify the physician and get treatment orders at the time of her assessment of the patient. At the conclusion of Rosella's report to her, Michelle immediately proceeded to check the condition of the patient, and did find her to be dyspneic. Rosella had not even bothered to put on her nasal cannula and connect her to oxygen. When Michelle came out of the room and

looked for Rosella, she was already gone. Michelle reported that Rosella seemed to have a good deal of difficulty getting her work done, but had no problem at all leaving when it was time to go home. She stated that she was very concerned about Rosella's competence. As Michelle and the nurse manager continued to talk, the nurse manager asked if she had any other reason to doubt Rosella's abilities. Michelle said, "Well, yes, I do. One morning last week she asked me if I would hold a patient on his side while she gave him an injection. We entered the patient's room together and approached the patient's bed. She didn't even speak to the patient, but drew back the covers and waited for me to roll the patient over. When she went to give the injection her hands were shaking so badly that I was afraid that she was going to stick me! I felt really worried for the patient."

In her description of Rosella's job performance, Michelle indicated that Rosella lacked nursing clinical credibility. Michelle questioned her competence, her communication skills, her trustworthiness, her follow-through, and her lack of caring behaviors. Rosella demonstrated very few of the attributes of nursing clinical credibility. The above is an example of a contrary case of nursing clinical credibility.

#### **Step 6d. Illegitimate Case**

An illegitimate case is one in which the concept is used incorrectly or out of context despite the fact that some of the attributes may be present.<sup>1</sup> The following case is set in an ICU and provides an example of an illegitimate case of clinical credibility:

A few members of The Product Selection Committee of an acute care hospital visited the ICU to talk with staff nurses about the existing cardiovascular monitoring system. They were seeking information about the current monitoring system in preparation for

meetings with sales representatives who were recommending that they update and purchase an alternative system.

One of the committee members approached a staff nurse and questioned the nurse about several different aspects of the system including its durability, reliability, and accuracy of recorded data. The staff nurse, a proponent of the current cardiovascular monitoring system responded, "Our current system is extremely clinically credible. I can count on it working properly every time. The monitor screens are easily readable, as is the data recorded by the monitor's printer".

In the case described above there is no evidence of clinical credibility as it relates to nursing clinical credibility. Despite the nurse's confidence in the monitoring system none of the attributes of nursing clinical credibility are present.

#### **Step 6e. Invented Case**

An invented case uses the concept outside its normal context. It may often read like a science fiction story instead of an encountered experience.<sup>1</sup> The following scenario meets the requirements of an invented case:

An in-service was recently presented in order to educate nurse managers in the functionality of a new medication delivery system. The newly developed robotic system not only opened the appropriate drawers when the nurse entered the patient's name as the old system had done, but also proceeded down the hallway and entered the patient's room at the appropriate time for medication administration. The robotic arm protruded from its metal body to scan the patient's armband after which the appropriate drawers opened to reveal the proper dosage of each medication scheduled for that particular time. The medication was then administered to the patient. Following dose administration, the

medication delivery system recorded the dosage electronically in the patient's medical record. The robotic system effectively alleviated the need for registered nurses to administer oral medications. The new system was greeted with pleasant surprise and was deemed by some to have nursing clinical credibility.

While demonstrating one attribute of clinical credibility, expertise, the concept entails much more than performing one task efficiently. The monitoring system does not have any of the human characteristics represented by the defining attributes. Its expertise lies in the hands of the programmers who programmed the robot and those who entered the pertinent patient data and medication orders. It is, therefore, an example of an invented case of clinical credibility.

#### **Step 7. Antecedents and Consequences**

The Oxford English Dictionary defines an antecedent as "a thing or circumstance which goes before or precedes in time or order; often also implying causal relation with its consequent."<sup>25</sup> According to this definition, an antecedent occurs or is present before a healthcare professional can judge whether a nurse has clinical credibility. Attributes of the concept cannot be antecedents of the concept.<sup>1</sup> Two antecedents of nursing clinical credibility are the concepts interaction and reputation. Interaction is an antecedent of nursing clinical credibility because prior to making a judgment regarding the nursing clinical credibility of a nurse, one generally has experienced some interaction with that particular nurse. If one has not interacted with the nurse whose clinical credibility is being judged, the nurse's reputation is oftentimes used as the decision point. In the absence of a personal interaction with the target nurse, the nurse's reputation may serve as an antecedent of nursing clinical credibility. Reputation is the product of a judgment

made by others about the performance of a particular target nurse. Both interaction and/or reputation are generally present before a judgment is made regarding the target nurse's clinical credibility.

Consequences are the events or incidents that occur as a result of the concept.<sup>1</sup> Consequences of nursing clinical credibility may include expert power, increased confidence and improved self-esteem of the target nurse, enhanced professional relationships with nurses, physicians, and other health care providers, and collaboration with other clinically credible colleagues.

### **Step 8. Empirical Referents**

Empirical referents are categories of phenomena that occur when the concept being studied is encountered.<sup>1</sup> Empirical referents are the observable manifestations that signify the presence of the concept being studied and represent the attributes by which it may be measured. Empirical referents of nursing clinical credibility are observed as a result of interactions between a nurse with clinical credibility and other nurses, physicians, and healthcare colleagues. Confidence is one example of an empirical referent of nursing clinical credibility. The nurse with nursing clinical credibility develops self-confidence as healthcare colleagues demonstrate their confidence and trust in the nurse. Empirical referents may be the same as the critical attributes, and are often used in the development of an instrument to measure or quantify an abstract concept.

In addition to the development of self-confidence in the target nurse other empirical referents emerge in the presence of nursing clinical credibility. They include: the nurse is perceived as the competent, "go-to person" in the patient care unit by nurse and physician colleagues; the nurse is trusted by nurses and physicians; the nurse is frequently

consulted for advice by nursing colleagues; the nurse exceeds the expectations of nurses and healthcare colleagues in demonstrating concern and caring behaviors to assist patients and co-workers; and the nurse is vigilant to the needs of patients and co-workers and intervenes appropriately.

### **Conclusions**

Conceptualization of nursing clinical credibility enables the re-conceptualization of “the really good nurse” as the nurse with clinical credibility, making explicit a phenomenon that nurses and physicians in clinical practice have tacitly known. Concept analysis provides the vehicle by which one can visualize and make explicit the dimensions of complex abstract concepts, like nursing clinical credibility, which up until the present time has been described and referred to in general, vague, and imprecise terms.

This concept analysis clarifies the difference between two related, but different concepts, nursing clinical credibility and clinical competence. The two concepts are not the same and should not be used interchangeably. Clinical competence refers to the actual knowledge and skill with which the nurse performs the job in the clinical setting. Clinical competence is a necessary, but certainly not the only component of nursing clinical credibility. Nursing clinical credibility refers to the perception that healthcare colleagues have about the nurse’s job performance, which are generally based on their preconceived notions associated with the nurse role. Nursing clinical credibility refers to a nurse who not only has clinical competence, but who, in addition to being competent, is also perceived as trustworthy, approachable, honest, clinically effective, and who also

demonstrates concern and caring behaviors toward patients, nurse colleagues, and other healthcare providers.

Defining attributes of nursing clinical credibility which emerge from anecdotal literature and unrelated research studies include: trustworthiness,<sup>19,20</sup> approachability,<sup>21</sup> competence,<sup>4</sup> professional communication,<sup>22</sup> caring behaviors toward patients,<sup>4</sup> follow-through, honesty, clear communication,<sup>23</sup> and exceeding performance expectations.<sup>24</sup> Further research is indicated to explore the concept, nursing clinical credibility, and to validate the defining attributes identified in the literature.

A definition of nursing clinical credibility arises from this concept analysis. Nursing clinical credibility is a judgment about the job performance of a nurse based on one's preconceived notions about the ideal nurse, and from one's interactions with the nurse in the clinical setting. It signifies the level of confidence and trust that one has in a nurse who demonstrates clinical competence, trustworthiness, follow-through, communication skills, and concern and caring toward patients, nurse colleagues, and physicians.

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## CURRICULUM VITAE

CLAUDIA DISABATINO SMITH, MSN, PhD(c), RN, NE-BC

***LICENSURE AND CERTIFICATIONS***

Registered Nurse - Texas 434383

Certified in Nursing Administration NE-BC 1999-2014

***EDUCATION***

Mercy School of Nursing Canton, Ohio 44708	Diploma 1968-1972
University of Texas Medical Branch School of Nursing Galveston, Texas 77550-2774	1989-1992 B.S.N. cum laude
University of Texas Health Science Center School of Nursing Houston, Texas	1999-2001 MSN
Major: Gerontology Role: Nursing Administration	
University of Texas Health Science Center School of Nursing Houston, Texas	2002-present PhD(c)
Dissertation: RN Clinical Credibility	

***HONORS and AWARDS***

Texas Nurses Association, District 9, one of 20 Outstanding Nurses of 2005 selected from all areas and specialties within district 9 (Houston area)

Sigma Phi Omega, National Academic Honor and Professional Society in Gerontology, Beta Beta Chapter, Houston Texas May, 2000.

Included in Who's Who in American Nursing, 1995.

Sigma Theta Tau International Honor Society of Nursing, Alpha Delta chapter, May, 1991.

Phi Theta Kappa National Honor Fraternity October, 1988.

Outstanding Young Women of America, 1987. One of fifty-one women in the state of Texas to be honored for involvement in profession, community, and personal achievements.

Outstanding Student Nurse, Mercy School of Nursing, 1972. Runner-up Outstanding

Student Nurse of Stark County, Ohio 1972.

### ***PROFESSIONAL AFFILIATIONS***

Southern Nursing Research Society                      2004- present

American Nurses' Association, member              1999-present

    Texas Nurses Association, member              1999-present

        District 9 Government Affairs committee - 2001-present

            By-Laws Committee – 2007-present

Sigma Theta Tau International Alpha Delta chapter 1992-2000

    Zeta Pi chapter 2000-present

        Vice President 2005-2007

### ***PUBLISHED ABSTRACTS***

Optimizing Nursing Quality and Outcomes through a Best Practice Council. Second Author. Published in the proceedings of Sigma Theta Tau International Nursing Congress, Singapore, July, 2008

Education + Mentoring + Technology = Staff Nurse-Driven Evidence-Based Projects. Published in the proceedings of Sigma Theta Tau International Nursing Congress, Singapore, July, 2008

Clinical Credibility: The Key to Collaboration Published in the proceedings of Sigma Theta Tau International Nursing Congress, Vienna, Austria

The Acculturation of International Registered Nurses through a Nurse Residency Program ... from the Perspective of the Participants. Published in the proceedings of Sigma Theta Tau International Nursing Congress, July, 2006.

Clinical Credibility: Strengthening the Image of Nursing. Published in the proceedings of the ANCC Magnet Conference, March, 2006.

Acculturating Internationally Recruited Registered Nurses. Published in the proceedings of the Professional Nursing Educator's Group Annual Conference, November, 2005.

Increasing RN Sensitivity to Age and Cultural Differences of Patients and Staff. Published in the Proceedings of the Professional Nursing Education Group Annual Conference, November, 2005.

Designing a Way to Measure Clinical Credibility: A Work in Progress. Published in the proceedings of the Southern Nursing Research Society, February, 2004.

Credibility in Business vs. Clinical Credibility in Nursing. Published in the proceedings of the Nursing Administration Research Conference, October, 2003.

### ***PUBLICATIONS***

Identifying Attributes of Clinical Credibility in Registered Nurses. (2005). *Nursing Administration Quarterly*, 29(2), 188-191.

Decentralization and Shared Governance. In D. L. Huber (Ed.), *Leadership and Nursing Care Management* (3<sup>rd</sup> ed.). 2006. Philadelphia: Elsevier.

Decentralization and Shared Governance. In D. L. Huber (Ed.), *Leadership and Nursing Care Management* (4<sup>th</sup> ed.). 2009. Philadelphia: Elsevier.

### ***PRESENTATIONS***

Southern Nursing Research Society, February, 2010, Austin, Texas, Poster Presentation: Identifying Attributes of Nursing Clinical Credibility

ACCN Magnet® Conference, October, 2009, Louisville, Kentucky, Poster Presentation: A Nursing Research Fellowship: The Vehicle to Discovery and Understanding

ACCN Magnet® Conference, October, 2009, Louisville, Kentucky, Podium Presentation: Climbing the Ladder to a Professional Development Model

Sigma Theta Theta Tau International Biennial Meeting, September, 2009, Indianapolis, Indiana, Podium Presentation: Developing a Culture of Inquiry through a Nursing Research Fellowship

National Database for Nursing Quality Indicators 3<sup>rd</sup> Annual Conference, January, 2009, Dallas, TX. Poster: Best Practice Council – An Interprofessional Model to Improve Quality and Safety

Sigma Theta Theta Tau International Nursing Congress, July, 2008, Singapore, Symposium Presentation Co-Author: Optimizing Nursing Quality and Outcomes through a Best Practice Council

Sigma Theta Theta Tau International Nursing Congress, July, 2008, Singapore, Podium Presentation: Education + Mentoring + Technology = Staff Nurse-Driven Evidence-Based Projects.

Academic Center for Evidence-based Practice Conference, June, 2008, San Antonio, TX, Poster: Coaching & Mentoring Support Staff Nurse-Driven Geriatric EB Projects.

Sigma Theta Tau International Nursing Congress, July, 2007, Vienna, Austria, Podium Presentation: Clinical Credibility: The Key to Collaboration.

Sigma Theta Tau International Nursing Congress, July, 2006, Montreal, Canada. Podium Presentation: The Acculturation of International Registered Nurses through a Nurse Residency Program...from the Perspective of the Participants.

ACCN Magnet® Conference, March, 2006, Miami Beach, Florida, Podium Presentation: Clinical Credibility: Strengthening the Image of Nursing.

Professional Nursing Educator's Group Annual Conference, November, 2005, Houston, Texas, Podium Presentation: Acculturating Internationally Recruited Registered Nurses. Co-presenter.

Professional Nursing Education Group Annual Conference, November, 2005, Houston, Texas, Poster Presentation: Increasing RN Sensitivity to Age and Cultural Differences of Patients and Staff.

Southern Nursing Research Society, February, 2004, Louisville, Kentucky, Poster Presentation: Designing a Way to Measure Clinical Credibility: A Work in Progress.

Nursing Administration Research Conference, October, 2003, Chapel Hill, North Carolina, Poster presentation: Credibility in Business vs. Clinical Credibility in Nursing.

Texas Consortium of Geriatric Education Centers, poster presentation entitled, Guide for the Development of a Community Outreach Program for Caregivers of the Older Adult, Galveston, Texas October 25, 2001.

Association for Gerontology in Higher Education, poster presentation entitled, Guide for the Development of a Community Outreach Program for Caregivers of the Older Adult, San Jose, California February, 2001.

***EXPERIENCE***

3/08-present	Director, Nursing Research St. Luke's Episcopal Hospital, Houston, Texas
6/03-3/08	Education Specialist St. Luke's Episcopal Hospital, Houston, Texas
9/02-6/03	Graduate Research Assistant University of Texas Health Science Center at Houston School of Nursing, Houston, Texas
2/02-6/02	Director of Clinical Services Triumph Hospital Baytown, Texas
7/01-2/02	Chief Nursing Officer BayCoast Medical Center, Baytown, Texas
7/00- 7/01	Director of Education and Employee Health BayCoast Medical Center, Baytown, Texas
1/96- 7/00	Director of Medical/Observation Nursing, San Jacinto Methodist Hospital, Baytown, Texas
2/92- 1/96	Assistant Director Intensive Care Unit, San Jacinto Methodist Hospital, Baytown, Texas
1/90- 2/92	Staff Nurse Intensive Care Unit San Jacinto Methodist Hospital, Baytown, Texas
8/89- 12/89	School Nurse – Substitute Goose Creek Consolidated Independent School District Baytown, Texas
2/88- 5/89	Community Relations Supervisor Visiting Nurse Association, Houston, Texas
1/87- 2/88	Professional Education Consultant Visiting Nurse Association, Houston, Texas
8/85- 12/87	Community Health Nurse Visiting Nurse Association, Baytown, Texas
6/72-3/84	Staff nurse San Jacinto Methodist Hospital, Baytown, Texas, Gulf Coast Hospital, Baytown, Texas, St. Elizabeth Hospital,

Youngstown, Ohio, Mercy Hospital, Portsmouth, Ohio and Ohio  
State University Hospital, Columbus, Ohio.

***COMMUNITY INVOLVEMENT***

Lee College Board of Regents	1980-1992
Board Chairman	1990-1992
Association of Community College Trustees	1980-1992
Texas State Chairwoman	1987-1990