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The ‘as-if’ world of nursing practice: Nurses, marketing and decision-making

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Abstract
The “as-if” world of nursing is a well-constructed, institutionally preserved and defended myth that asserts clinicians who are “just nurses” do not make decisions in the absence of “doctor’s orders.” Drawing on data from an ethnography exploring the interactions between nurses and industry, we explore the finding that many nurses did not identify as “decision makers” and were mystified by the attention of sales representatives. Many nurses experienced marketing as benign as there was no “decision” to sway. Nursing must deconstruct the “as-if” non-decisional myth by confronting conflicts of interest and owning fully its rightful clinical and advocacy roles.

**Keywords**

Registered nurses; decision making; power; conflict of interest; ethics; industry relations; marketing
Introduction

During the talent portion of the 2015 Miss America pageant, Kelley Johnson, dressed in scrubs with a stethoscope around her neck, delivered a monologue wherein she asserted that she was “never going to be just a nurse.” Her speech triggered a media storm, particularly after hosts on *The View* questioned why she was wearing a “doctor’s stethoscope.” Nurses, in a show of support, flooded social media with photos of themselves using their stethoscopes. This focusing event suggests that many nurses are all too familiar with being regarded as “just a nurse.”

As nurses and researchers, we have long wondered at the persistence of the well-constructed, institutionally preserved and defended myth that clinicians who are “just nurses” do not make decisions or initiate various activities in the absence of “doctor’s orders.” For example, the second author recalled a day in the emergency department at a Level I Trauma Center that illustrates the mismatch between a staff nurse’s reality and what we call here the “as-if” world of nursing practice – the pretext that nurses do not make treatment decisions. On admission orders for a noncritical patient with an extremity injury and no history of pulmonary problems, the physician wrote: “Breathe room air.” Better than not breathing, certainly, but hardly necessary except to sustain the vigorous fiction that the nurses otherwise would have been helpless to know what the patient should breathe. Emergency nurses routinely administer oxygen to a patient who is short of breath, prior to the patient even seeing a physician. Critical care nurses identify the need for and administer medications, with and without so-called “standing orders.” Yet the medico-legal community sustains the procedural fantasy that it is only after a physician examines the patient that such treatments (and many others) are “really” initiated.

The study discussed here reveals that the “as-if” world of nursing practice is alive and well in another aspect: nurses have been largely silent about and omitted from recent policies
related to the disclosure and management of conflicts of interest in clinical practice.\textsuperscript{1-4} This omission functions to sustain the “as-if” myth in two ways: it appears as-if nurses who do not prescribe do not interact with industry representatives and as-if the potential consequences of marketing influence on nurses’ decision making are not of sufficient importance to warrant policy attention.

Registered nurses, comprising the largest proportion of health professionals, are arguably the most important health professionals in this era of health reform, situated at the hub of multidisciplinary teams and focused on the prevention and management of increasingly common and costly chronic diseases.\textsuperscript{5} This also makes them desirable targets for industry marketing. The pervasive “as-if” myth, however, serves to obscure nurses’ power in the eyes of policymakers, allowing nurses’ interactions with industry to take place with minimal oversight, and with potentially serious consequences for patient safety and healthcare costs.\textsuperscript{6}

**Conflict of interest and nursing practice**

Globally, policymakers are initiating mechanisms to make the relationships between clinicians and industry more transparent in an effort to address conflicts of interest associated with increased healthcare costs and threats to patient safety.\textsuperscript{7,8} Conflicts of interest occur in the context of fiduciary relationships, where an individual is asked to exercise judgment on another’s behalf.\textsuperscript{9} In healthcare, where discretionary judgment is a hallmark of clinical practice\textsuperscript{10} and an individual’s vulnerability is heightened, conflicts of interest have potentially grave consequences. Among physicians, conflicts of interest including the receipt of payments or gifts from industry have been linked to increased prescribing cost, non-rational prescribing, and more frequent prescription of heavily marketed medicines with limited safety track records.\textsuperscript{11-13} Prescribers frequently meet with and rely on industry information to support their practice;\textsuperscript{14-17} however, in a
study in Canada, France and the United States, sales representatives provided a minimally adequate amount of safety-related information in only 1.7% of all visits to physicians.\textsuperscript{18}

Despite being consistently ranked the most trusted profession,\textsuperscript{19} the nursing profession has been relatively silent in regards to the ethical issue of conflict of interest, and few nursing Codes of Ethics, research studies, or education programs take up the issue of how nurses should interact with industry.\textsuperscript{1-3} Yet, there is emerging evidence that nurses do interact with medical industry personnel and that nurses are important targets of industry marketing.\textsuperscript{6,20-22} Nurses frequently rely on industry information and industry-sponsored education about pharmaceuticals and medical devices.\textsuperscript{14,20} Such sponsored education is typically in support of a specific product or brand.\textsuperscript{23,24} Nurses’ role in purchasing medical products and equipment has been neglected as a topic of research, but marketing influence over this kind of decision making may also increase healthcare costs or expose patients to ineffective or even harmful devices.\textsuperscript{14} In this study, nurses reported that sales representatives are increasingly built into day-to-day practice, such as supporting cases in the operating room, and that patients may be put at risk when the line between sales and service is crossed, such as through the introduction of devices the hospital has not approved.\textsuperscript{6}

However, the focus of policy efforts remains on prescribers. For example, in the United States, the Physician Payments Sunshine Act (PPSA) requires companies whose products are covered under federal programs to disclose in a public, searchable database all payments valued at $10 or more that were made to medical doctors and teaching hospitals.\textsuperscript{25} Recently, lawmakers proposed the expansion of the PPSA to nurse practitioners, physicians assistants and other advanced practice nurses.\textsuperscript{26} But this mandate continues to omit registered nurses (RNs), pharmacists and other non-prescribing members of the healthcare team.\textsuperscript{4}
During the course of an ethnography exploring interactions between non-prescribing RNs and industry in clinical practice, we were often asked, “If nurses do not prescribe, why does marketing to nurses matter?” In this paper, we confront the “as-if” world of nursing practice and the tacit assumption that unlike their physician counterparts, nurses are ethically inconsequential in terms of power or control over resources. We show that in actuality, participants’ nursing practice entailed “running the hospital” and the complex care of patients, including a great deal of influence over treatment and administrative decisions, which made them desirable partners for sales representatives. However, we explore the ways that nurses attempted to reconcile this power and influence with the discourses and real-world constraints that circumscribed nursing practice to a sphere of lesser importance and authority, or made nurses’ work altogether invisible. We conclude with a re-thinking of the concept of conflict of interest in the context of a practice that takes place “in-between” patient, hospital, physician, industry and professional interests and where autonomous decision making is under recognized, but where the stakes of biased decision making are high.

Methods

Study design and setting

The overarching aim of this research project was to describe the interactions between nurses and industry in clinical practice and to analyse their potential impact on the cost, quality, and safety of care. We conducted an ethnographic study from January 2012 to October 2014 at 4 acute care hospitals representing a range of institution types (Table 1) in the metropolitan area of a western, US city and at the annual conference of the American Association of Critical Care Nurses. Interpretive phenomenology served as the methodology, which allowed for in-depth exploration of an understudied phenomenon within the context in which it occurs.
University of California, San Francisco Committee on Human Research approved the study (Study # 11-06480).

**Participants and recruitment**

We purposively sampled participants (n=72; Table 2) with direct and varied experiences interacting with industry in their practice, including managers, clinical nurse specialists (CNS), and staff nurses through institutional listservs, direct contact during fieldwork, and snowball sampling. We also recruited individuals who were not nurses, but who had insight into nurse-industry interactions such as professionals working in supply chain, administration, or industry.

**Data collection**

Consistent with interpretive phenomenology, the primary data collection methods were direct observation of RNs’ interactions with industry and interviews in which we asked for concrete stories of direct experiences with industry. We triangulated these strategies with focus groups of registered nurses and content analysis of documents including policies and marketing materials (Table 3).

QG, a registered nurse working in public health and qualitative researcher, conducted twenty-eight formal interviews, lasting 60-90 minutes, at participants’ workplaces, by telephone or in public spaces. These were audio recorded with permission. Participants read and signed the consent form prior to beginning the interview. Twenty-three individuals were interviewed informally during the course of fieldwork as they did not wish to be identified, nor audio recorded. Informal interviews lasted 15-90 minutes. QG disclosed her identity and purpose during these interviews and obtained verbal consent; no identifying information was recorded. Detailed field notes were made about these interviews after the fact. All interviews were semi-structured and guided by open-ended questions aimed at eliciting concrete stories such as: “Tell
me about the last time you interacted with industry”; “Tell me about a positive and a negative interaction with industry”; “Describe your ideal relationship with medical industry.”

QG conducted 102 hours of targeted observations during and after which fieldnotes were recorded. Opportunities to observe industry interactions in practice were identified by interview participants and included industry-conducted inservices, drug company-sponsored events, and purchasing committee meetings. QG disclosed her identity and purpose during these sessions.

We supplemented the interview data with 4 focus groups (n= 21; 60-90 min) with the aim of understanding nurse-industry interactions within professional contexts; thus, focus groups were conducted with nurse participants only. QG acted as the facilitator for the focus groups; a graduate student colleague was present to record additional fieldnotes. A catered lunch was served at each group. Participants read and signed the consent form prior to beginning. Focus groups were audio recorded.

We purposively sampled documents referenced during interviews or fieldwork to explore how they reflected social arrangements and structured institutional practices. We collected twelve publicly available policies, or were given copies by hospital administrators, were invited to take copies of committee meeting agendas and minutes, and collected 65 examples of marketing materials distributed to participants at their workplace and at the sampled conference.

Whether due to institutional isomorphism – the tendency for institutions to become more homogeneous in terms of structure, culture and output – or the lack of discourse or policy specifically guiding nurses’ interactions with industry, we experienced little difference in the nature of nurse-industry interaction across the sites, even at those with magnet status. Redundancy in the data began to occur during interviews at the third site, when participants shared narratives nearly identical to those encountered at the first two sites. We reached
saturation at the fourth site – an affiliate of a for-profit hospital chain – when participant shared similar narratives and we observed highly similar nurse-industry interactions. Thus, in this analysis we have tried to capture the range of experiences occurring in the various institutional policy climates, without taking the hospital as a unit of analysis.

**Data analysis**

A medical transcriptionist transcribed all audio-recordings verbatim. Transcripts, field notes and documents were imported into NVivo10. QG began interpretive work immediately after each interview or observation session, writing a global analysis in which lines of inquiry were developed inductively. Through discussion of these emerging lines of inquiry, we generated a set of 15 concrete codes such as “education” and “decision making,” which QG used to label the text, allowing for easy identification of portions of text for further, in-depth analysis. QG then conducted structured narrative analysis for all concrete stories, and thematic analysis based on the generated codes, which was iteratively reviewed and discussed fortnightly with RM and an analytic working group consisting of qualitative researchers. Narrative analysis consisted of identifying and analyzing the context and background of each story, how it unfolded, the concerns expressed, the outcomes, and the participant’s as well as the researcher’s reflections. Thematic analysis consisted of writing analytic memos: smaller memos were written on individual codes; these memos were then consolidated into larger memos based on codes that were grouped thematically. Thematic analysis in interpretive phenomenology aims to articulate meaningful patterns, stances or concerns rather than more elemental units such as phrases or abstracts units such as theoretical codes. A key interpretive theme that emerged from this work was the paradox of the “as-if” world – that nurses were frequently mystified by the experience of
marketing and often freely participated in marketing events on the basis that they did not make decisions and thus were not at risk for being influenced.

We used two analytic and qualitative writing strategies to explore this theme in a way that would be evocative and illustrative of core concerns that were shared by participants, while remaining grounded in the data and particulars of an individual’s context. The first were exemplars, which serve the role of operational definitions, and we aimed to explore the full range of experiences with the phenomenon of the “as-if” world. Second, we identified paradigm cases, or “strong instances of concerns or ways of being in the world, doing a practice, or taking up a project,” which allow for shifts of understanding on part of the researchers as a means to understand the whole of a nurses’ experience in novel ways. We next explore this core theme using a series of exemplars and paradigm cases.

Findings

Most participants took part in marketing activities such as industry-sponsored dinners and “lunch and learns,” receipt of product samples and gifts, or receipt of payments for participation on Speakers’ Bureaus. However, many seemed mystified at the attention from sales representatives. In interpreting this theme, we identified four patterns: 1) many nurses did not identify as individual “decision makers,” thus, there was no “decision” for marketing to sway; 2) nurses instead deemed their ability to effect change, to control resources, or to determine practices “influence”; 3) the institutions in which nurses worked frequently constrained the exercise of their knowledge, control, and authority; and 4) nurses’ perceptions of marketing highly varied, ranging from benign to validating to threatening.

Rejecting the identity of “decision maker”
Many participants explicitly asserted that they did not make decisions around treatment or purchasing, either of which would have made them desirable targets of marketing. However, these same nurses were frequently direct conduits to decision makers, had direct influence over the success of a product within an institution among end users, or served as requisite gatekeepers in a decision-making process. We came to realize that for many participants, their individual work was not experienced as “decision making,” despite their participation in countless decisions made during the course of day-to-day practice. They narrated decision-making processes using a collective “we,” their actions as participatory, and the interests they balanced as multiple as they took into consideration patients’, nurses’, and the hospitals’ interests. Decision makers, in contrast, were seen as individuals with formal authority, such as prescribers or those with signatory power.

During a focus group at a public, academic teaching hospital, a group of staff nurses debated the question: why would industry target nurses? Lorraine, a senior staff nurse with over 30 years of experience, worked on an oncology unit. She told the group about the pharmaceutical dinners she was frequently invited to by sales representatives, though she conceded, “I sort of wonder why they invite us because we’re not prescribers, and we don’t really have anything to do with what drugs get given.” Abigail, a young emergency nurse interjected, “That’s not true! Don’t you go to doctors, and you’re like, ‘I want this drug! Give me – the patient needs –’. ” “Well, not for chemo, you know?” interrupted Lorraine. Abigail, deferring to Lorraine and her experience, retreated on her position, conceding her lack of expertise, saying, “Oh, yeah. I wouldn’t know the first thing about that . . .” When prompted, Abigail, tempering her original position, explained,
I’m always recommending, you know? Or just strongly suggesting . . . I think that in some ways, you would kind of indirectly have an influence on what drugs the patient’s going to get, or you’ll ask your patient, ‘Oh, which drug works well for you? Obviously, you’ve been going through this chemo for a long time.’

Although Abigail attempted to confront the myth that only prescribers make treatment decisions with evidence of the influence she had in the context of relationships with patients, she was prompted to articulate her authority in shared and acceptable language that denoted lesser power than a physician ‘order’ or prescriptive ‘authority’: recommendation, suggestion, influence.

According to these nurses, the purpose of marketing was to influence an individual clinician’s decision making in favor of the product being marketed. For Lorraine, her invitation to pharmaceutical-sponsored dinners, designed to promote the prescription of a new oncology drug, could not be effective marketing as she felt she had no influence over chemotherapy treatment decisions. But for Abigail, treatment decisions were broader than a decision about initial course of chemotherapy treatment and included tailoring therapy to an individual patient’s response and experiences, and managing associated symptoms and side effects, all of which her practice directly addressed. While exploring the ambiguous scope of their authority, these nurses confronted tacit boundaries, which they reinforced for one another, and which served to circumscribe the way they could talk about – and exercise – the kinds of power available to them as “just nurses.”

Nurses rejected the characterization of “decision maker” even when their job description dictated that they act as institutional gatekeepers or designated them as having the authority to approve decisions, such as being a member of a purchasing committee. Vera, a critical care Clinical Nurse Specialist (CNS), did not identify as having purchasing authority, yet she sensed
that the impact of her “indirect” influence was significant clinically and fiscally. Among many projects, Vera managed her hospital’s Continuous Renal Replacement Therapy Program, which involved training the staff nurses on the use of complex equipment, working with the nephrologists to develop the policies and procedures around the therapy, and ensuring that the technology was up to date. While acknowledging that nurses could not “order” a particular therapy, she asserted that the collective financial impact of decisions made by nurses was evidence enough that these decisions were consequential and of interest to medically-related industry. When her program recently acquired a new medication pump, for example, her actions were foundational to all the other “direct” actions that followed: Vera researched the available pumps, selected which pumps to trial, led the clinical evaluation, and selected the pump that fared best during the evaluation. Once this pump was purchased, Vera was responsible for ensuring that staff nurses could safely and competently operate this pump, contributing to the success of this therapy in the care of patients with renal disease. However, she elucidated the difficulty in understanding how marketing targeted at nurses could shape critical treatment decisions. Vera explained,

It gets lost in the ‘I didn’t buy this, I’m not ordering this drug. I’m not ordering even this therapy,’ so it gets lost in, ‘Well, how are you this remote kind of nurse?’ ‘Well, I was leading the clinical evaluation, but I don’t prescribe the therapy.’ . . . There’s not a direct link there, but if you looked at how much we’ve paid for different therapies or device or supplies, that’s a big chunk of change.

Vera described her influence as indirect and any decisions she made as collaborative, thus—unlike physicians’ prescribing behaviour – it was difficult to trace the link from marketing to its effects in the context of nursing practice, making the impact of Vera’s highly influential decision
making invisible. In contrast to a pharmaceutical sales call that could later be linked to an increase in prescription volumes, Vera characterized her influence over institutional decisions as “remote.”

Many participants referred to “policy” as the basis for how they approached their interactions with industry; however, this represented more of a general awareness than specific policy knowledge and the vast majority could not name, nor had they read institutional or other industry relations policy. They were unsure how these policies affected their particular practice. Clara, a pediatric staff nurse, characterized her knowledge of the hospital’s industry relations policy as “vaguely aware.” She explained,

I never really felt like it affected me that much that I had to necessarily read the fine print . . . But because I’m not prescribing, it never really seemed to affect me directly, where I felt like I needed to be careful, re-read the policy and make sure I’m following it.

Conflicts of interest stemming from industry relations were the purview of “prescribers,” reinforcing the belief that only prescribers are making “decisions” that could be influenced by marketing.

Nurses had difficulty reconciling why industry targeted nurses given their apparently diffuse, informal, and lesser powers. Further, they wondered whether it was even possible for a nurse to be influenced in his or her “decision making,” given that they did not really make decisions. Not only did nursing’s influence over treatment and purchasing decisions “get lost” in the course of collective, participatory institutional processes, but so did the visibility and importance of much of a nurse’s work, knowledge and ability to control courses of action, even to nurses themselves. Therefore, they vacillated between offering examples of instances where
they lacked control and those where they wielded considerable power over treatment, purchasing, and practice decisions.

The power of “influence”

Instead of “decision making,” participants frequently used “influence” to describe the power with which they enacted change in their practice and their institution. “Influence” was also prominent within broader professional discourse. A major theme at the National Teaching Institute, hosted by the American Association of Critical Care Nurses (AACN), was nurses’ capacity to “influence.” The conference featured several sessions about influence, including a 2-day leadership seminar, presented by VitalSmarts, a workforce learning consulting company, in association with AACN, which was billed as providing “the ideal combination of strategies and skills designed to help create profound and sustainable positive changes and influence – with or without formal authority,” implicitly acknowledging that many of the conference attendees were not “decision makers.” Promoting skill sets for those “with or without formal authority” both reinforced and undermined the as-if myth that nurses do not have decision-making capacity.

Industry echoed the official conference theme of “influence” in the trade show: GE Healthcare hosted the ‘ExpoEd’ session “Personal Influence in Pursuit of Excellence.” Marilyn, a nurse leader and a paid speaker for GE Healthcare, explained that influence happened at three levels: the personal, the social, and the structural. She suggested that nurses focus on the personal and the social, acknowledging that the structural was “tricky” and “full of rewards and punishments.” Marilyn, in cautioning nurses against taking on formal structures and power relations, thus reinforced the idea that nurses’ power was most effectively asserted informally and at the individual level.
Companies were very interested in cultivating this kind of influence – influence that had wide informal social reach within institutions, and intimate knowledge of the organization’s structures, cultures, and personalities. Julie, the Vice President of Marketing for a pharmaceutical packaging company, which had sponsored the conference, outlined her marketing strategy, which took into account both formal and informal authority and the way that nurses were key insiders connecting the two. Her product – a pre-packaged IV medication, consisting of both the pre-mixed concentration of the drug and the infusion set – was marketed to different sets of gatekeepers, including nurses, due to the way that budgets were structured within different hospital departments such as pharmacy and medical-surgical. Julie emphasized nursing’s diffuse influence, traveling through a web of relations, which she had come to understand through her marketing relationships:

You, as a nurse – you essentially straddle both [departments]. Because you have to use both . . . And you give feedback to both of those departments. That’s why you guys are so key to being able to sit down with and understand, because, you’re the main artery to the patient. And I think it’s so important for industry to have a relationship with you folks, somehow, someway, have better access to you guys, because I think you folks can drive big, good decisions in product improvements.

Nurses existed simultaneously in-between and all over in the way that they “straddled” formal administrative units and had constant access to patients. Nurses as arteries enabled the flow of information and channelled their influence through these networks. Yet Julie, in emphasizing the need for “better access” to nurses, perhaps suggested either that existing systems constrained industry’s access to nurses, or that typically nurses were not recognized as having valuable knowledge or the ability to “drive big, good decisions.”
The experience of being in-between formal units of authority and yet all over in terms of access to patients, administrators and nurses’ physical presence across departments, shifts and days of the week, bolstered the experience of having influence, but not being a “decision maker”. Although nurses were characterized as “running the hospital,” this kind of power was described as behind-the-scenes and was not denoted formally. Part of the success of this kind of influence depended on it remaining invisible; in some ways, maintaining an indirect characterization of power allowed nurses to avoid overt conflict or challenges to existing power relations. John, an OR manager, explained the value of invisible influence:

In general, the nurses don’t have the power to purchase, but they can simply try and help the rep to understand the system and who to butter up if necessary or who to watch out for when they’re trying to get their product in the facility. It just goes on all the time.

Nurses possessed an insider’s knowledge of the system, which included key information embedded within existing interpersonal relationships – identifying decision makers and leaders; how to successfully form relationships with these individuals; and insight into their priorities, values and preferences. Nurses, used to coordinating multiple interests and orchestrating resources, had intimate knowledge of these pathways, which sales reps recognized as highly valuable expertise.

The “as-if” world of nursing practice

The discourse that nurses possessed limited power in the form of “influence” was bolstered by very real-world constraints and shaped by the institutions in which nurses practiced. Principally, participants bumped up against constraints on their ability to make decisions around the delivery of patient care and that inhibited their control over the resources needed to perform
that care. The physician order, in particular, was required for billing purposes for a number of practices over which nurses, in reality, had full purview.

Michelle, a CNS in a medical intensive care unit, articulated her frustration with obstacles to nurses practicing to their full scope. In so many areas of practice – patient monitoring, wound care, prevention of patient deterioration – she explained, nurses conducted the assessments, made treatment decisions, implemented therapies, and evaluated their outcomes. But at some point during the process, they had to acquire a physician’s order for these practices and frequently did so retroactively. Institutions typically required this for billing purposes, but also for cost control; the order allowed documentation and surveillance of practices that could be submitted for reimbursement. She explained,

I think there’s a lot that nurses have within their scope, according to the Board of Registered Nursing, but that it can get complicated by whether or not we need a doctor’s order, when a patient is in a specific institution . . . we have to have a doctor’s order to get a specialty Hill-Rom bed for a patient to prevent a pressure ulcer, when really it’s the nurse that’s doing the risk stratification and should be able to make that call.

For many nurses, practicing to their full scope required that they circumvent structural constraints through such workarounds. For example, they had specialty bed orders written for every patient so that nurses could execute the ‘order’ at their discretion, though ostensibly doing so under the guise of the physician’s “decision.”

Michelle did a great deal of work around electronic patient monitoring, which is a fast-growing and highly lucrative sector of healthcare business including hardware and software that continuously monitors patient vital signs, integrates this data with the electronic health record (EHR), and provides data analytics. Michelle worked closely with these companies to ensure that
monitoring systems had appropriate alerts and alarms. Although it was nurses who were responsible for monitoring this information, at her hospital, they continued to rely on physician orders to set the parameters for patient alarms, frequently resulting in the phenomenon of “alarm fatigue” where nurses found themselves responding to multiple alarms during the course of a shift, many of which were not clinically meaningful. She expressed the sentiment that if nurses could work around these orders and directly interact with the companies who made the products, that

The relationship between industry and the nurses could be a lot more straightforward if the nurses could more outwardly express the things that they need at the bedside and the things that really should be within their control. And then the vendors would be tasked with responding to that.

Because this was not institutionally recognized as primarily the domain of nursing, Michelle felt silenced; in contrast, sales representatives were experienced as responsive, attuned to her needs, and could address clinical problems through better product design. Relationships with sales representatives thus functioned as a workaround to structural constraints. Although a patient safety issue like alarm fatigue is complex and has multiple root causes, for Michelle, working with industry on product solutions was the most straightforward way to address the problem, in contrast with the “tricky” structural concerns referenced by the paid speaker from GE Healthcare such as adjusting the scope of nursing practice, working with physicians, or addressing staff shortages and burn-out.

**Responses to the “as-if” myth**

The effects of the “as-if” world of nursing in the context of interactions between nurses and industry played out in a range of ways. For some, the experience of marketing was benign
and devoid of risk as the rejection of the identity of “decision maker” meant that there was simply no possibility for undue influence, as in Lorraine’s case. For others, marketing was particularly seductive as it was one of the few places that their expertise and authority as “just a nurse” were explicitly recognized. Others, however, actively challenged the “as-if” myth in asserting their power and influence and took a highly vigilant stance toward monitoring interactions with industry in clinical spaces in order to protect patients.

The seductiveness of recognition

For some participants, the experience of marketing was validating and created opportunities in their practice. Most notably, industry gave nurses the sense that their knowledge, judgment, and practices mattered, elevating their perceived status as clinicians, especially compared with physician colleagues. Marketing spaces were one of the few places where nurses’ power and the value of their work were explicitly recognized. Including nurses at a pharmaceutical industry-sponsored dinner, amongst their physician colleagues, conveyed the sense that nurses were valuable and crucial members of the clinical team. Morgaine, an ICU staff nurse, described attending a recent pharmaceutical company-sponsored dinner:

The presenters were very open to questions from doctors and nurses . . . They understand that the nurses, the intensity of the care is as it is and you’re the one that’s constantly there at the bedside, so, they want your buy-in.

For nurses trying to reconcile a discourse of constrained influence with the realities of their skilled, knowledgeable, and discretionary practice, this experience was refreshing.

The experience of interacting with industry where one was treated as a respected, knowledgeable professional contrasted with nurses’ day-to-day experiences where they devised clever workarounds to surmount medico-legal and bureaucratic obstacles that preserved
physician authority and bureaucratic surveillance. Marketing representatives were clearly
cognizant of the power dynamics within healthcare. The marketing materials we collected that
were targeted at nurses contained messages that would be seemingly out of place – and
considered to be greatly overstepping one’s ‘place’ – were they to be directed at physicians: for
example, the messages “Empowering Heroes to Heal” and “Let’s Work Together.” These
materials acknowledged implicitly that many nurses are disempowered in their practice and
frequently lack control over resources needed to affect these practices. Nurses’ lack of
recognition from physicians, administrators and policymakers as autonomous professionals
makes them particularly susceptible to industry’s overtures. Industry offers access to resources
and recognition that few nurses receive from employers or medical colleagues.

However, there was a risk to this form of validation as nurses’ attention and influence
could be had quite cheaply. Cynically, John, a nurse manager, noted that although

Nurses are very valuable, the sad thing is, we earn a huge amount of money, and why
would you be impressed with a rep that brings you food from the local Chinese
restaurant? . . . I think it’s because outside the money, [nurses] don’t get much, or they
perceive they don’t get much. So anything like that is kind of like a bonus.

John suggested that nurses’ experiences of being undervalued or having their work go
unrecognized made them particularly susceptible to marketing initiatives that sought to convey
appreciation, such as being treated to lunch. John realized that for nurses, it is rarely about the
money or personal gain. Rather, industry has tapped into a more intangible form of appreciation
that resonates deeply with nurses. Further, industry is increasingly a workaround to constraints
within the healthcare system offering resources that nurses can channel directly back into patient
care, perhaps nurses’ greatest source of validation.
Safeguarding decision making

A minority of participants actively challenged the “as-if” myth that nurses are not decision makers. Consequently, they approached interactions with industry with vigilance and conscious boundaries in order to safeguard their decisions from marketing influence. Cassie, an operating room (OR) nurse educator, answered the question of whether nurses had an impact on treatment or purchasing decisions,

Absolutely. A lot of products we buy, doctors have nothing to do with it. It’s really the nurses. The nurses know what the doctors want. The nurses will try things. The nurses will suggest things to the doctors. A lot of products we use are actually not physician-driven, are nurse or healthcare driven: gowns, gloves, some pieces of equipment.

This kind of influence, to Cassie, justified having strict policies around interactions with industry representatives. She explained, “They cannot give us pens, pencils, hats, sticky papers [per institutional policy]. They cannot bring in donuts. There’s no food. They’re not supposed to in any way have the ability to quote, unquote, ‘sway’ individuals.”

For Cassie, not only did nurses make decisions that would impact purchasing, they were patient advocates and their last line of defense, which could be compromised by unsafe marketing practices, with serious safety consequences. For example, sales representatives in the OR sometimes introduced to the surgeon a new device that the hospital had not yet evaluated or approved. It was the nurse who would advocate for the patient and ensure that only products vetted by the hospital were used on the patient. In other cases, the nurse protected the patient’s privacy, both physically and in terms of sensitive health information, or the integrity of the sterile field. Cassie explained,
The reason nurses are here is to really protect the patient. Unlike all the areas of the hospital, there are no family visitors in here. There’s no one who can come, and there’s no one who can make sure that these people are okay. And the vendors aren’t worried about the patients. The vendors are worried about selling the product . . . And the doctors are worried about doing a good case, making sure the patient’s doing okay. The vendor is there to support them in doing that.

Cassie clearly articulated how high the stakes can be in the case of conflicts of interest in nursing practice, even when they do not prescribe. She understood that close relationships with sales representatives, developed over time and bolstered by gifts and friendship, could alter the allegiances in an OR, potentially putting patients’ privacy, safety and quality of care in jeopardy when boundaries were crossed.

**Discussion**

Nurses in this study had internalized, come up against, and sometimes actively challenged the “as-if” world of nursing practice in exploring their identity as “decision makers” and the kinds of power they could claim in their practice. The omission of nurses from conflict of interest policy speaks to the assumed unimportance of nursing influence; nurses have not addressed this omission, as many appear to have internalized the perception that they do not actually make decisions of consequence, or even make decisions at all.

Certainly sexism, the undervaluing of caring practices and the historic, strategic subordination of the nursing profession by the medical profession and hospitals\textsuperscript{10,34,35} all contribute to discourses around the kinds of power a nurse can exercise. The “as-if” phenomenon is reminiscent of “medical etiquette” from the nursing profession’s early history where nurses’ comportment and work routines were structured to give the perception of physician dominance.\textsuperscript{34}
In this study, nurses’ accounts of decisions they made in the course of practice revealed that the physician “order” in many cases is more a product of collective decision-making. For example, the nurses on Michelle’s unit acquiring ‘blanket’ orders on every patient, which they could execute at their discretion.

The nursing profession in the United States, through the recent revision of the Code of Ethics for Nurses, asserts the reality that nurses are decision makers. Whereas the 2001 Code of Ethics stated, “The nurse is responsible and accountable for individual nursing practice and determines the appropriate delegation of tasks consistent with the nurse’s obligation to provide optimum patient care,” suggesting that a nurse’s authority was relegated to the limits of nursing practice or to delegating to those with lesser power or authority, the newly revised 2015 Code explicitly asserts a conception of nurses’ power that includes autonomous decision making and characterizes nurses as leaders: “The nurse has authority, accountability, and responsibility for nursing practice; makes decisions; and takes action consistent with the obligation to promote health and provide optimal care”.

But the rhetoric contained in the newly revised US Code of Ethics for Nurses, as well as discourses around multi-disciplinary models of healthcare, remain mismatched with the “as-if” world of many nurses. Rather than emulating physicians and striving for hierarchical and often oppressive “autonomy,” nurses need to deconstruct the notion that prescribers are the only “decision makers” in clinical practice. The “prescription” and the “order” are collective, participatory processes, and the contributions of all participants need to be made visible and validated institutionally.

Nurses and their labor continue to be perceived by healthcare institutions principally as a cost and some suggest that the invisibility of nursing work is a consequence of an economic
climate that has no way to quantify the “value” of nurses’ work. There is another fiction here: that nurses’ role and professional culture are truly valued. The reality is that professionals who are genuinely valued have control over the circumstances under which they practice and the ways in which they communicate with one another. Hospitals provide recognition for nurses only – if at all – in the form of cheap trinkets on “Nurse Appreciation Day.” These pale in comparison to the experiences and resources that industry can provide, and thus nurses are in a particularly susceptible position when it comes to negotiating interactions with industry or confronting marketing practices. In a study of senior staff nurses in New Zealand, many reported receiving gifts and payments from industry and justifying it in terms of perceived equity, explaining, “But doctors do it” and noting that nurses rarely had access to non-industry resources for professional education and work tools.

Re-thinking conflict of interest in the context of nursing practice

The concept of conflict of interest differs according to profession and must take into context the nature of professional work. Professional work is organized around the idea of openly serving a moral ideal and people rely upon professionals because their decisions are guided by this ideal rather than self-interest. But the nature of the service in terms of the roles a professional must fulfil and the nature of the conflicts, both internal and external to the primary role, differ considerably among professions, and so must the ways that conflicts of interest are understood and managed. RNs are situated differently than physicians within the healthcare system – both in the way their employment is structured and in their relationship to patients. For example, they typically are paid by the institutions in which they work, rather than by insurance or direct billing, and they do not have economic interests that may be at risk with adoption of new technologies, as might be the case for a physician in a clinic. Nursing has long been defined
by the practice of balancing multiple, conflicting interests, characterized as “working in-
between.” Freidson in his sociological study of the medical profession, characterized the
nurse as “the intense focus of conflicting perspectives” because the work of the nurse requires
balancing individual patient needs and individual physician orders with the aggregate needs of
the unit population and the resources he or she has available. Thus, industry is but one of the
multiple interests that nurses must balance and their practice may be also affected by the
conflicts of others, including the institutions in which they work.

Given the collective and processual nature of decision making in nursing practice and in
healthcare more generally, nurses will be collectively conflicted if the profession fails to engage
industry deliberately and ethically. Similarly, the consequences of conflicts of interest in nursing
practice are likely to permeate healthcare from patient care to hospital administration, and
include both safety and economic issues. For example, as seen with physicians and
pharmaceutical marketing, marketing to nurses may result in the use of high-cost, brand name
products and equipment that may be backed up by little evidence of safety or efficacy in routine
patient care. Instead, nurses can collectively maintain the public’s trust as a profession if the
issue of conflict of interest is taken up consciously and reflexively. This will require a total
deconstruction of the “as-if” myths around nursing practice and full recognition of the scope and
importance of nurses’ power and influence around treatment, purchasing and administrative
decision making. Clinical practice will always entail the balancing of multiple conflicting
interests in the sense that health care takes place within institutions in the context of limited
resources. But in managing conflicts of interest, nursing is advantaged by the privileged position
of being the most trusted profession and having the ethical and practical skill set in managing
conflicting interests that is essential in nursing work.
Limitations

This exploratory, qualitative study with a purposive sample of non-prescribing, hospital-based nurses, industry representatives, and administrators is not representative. The study was conducted in the western United States, thus scope of practice regulations may differ from state to state and country to country. Similarly, the nature of nurse-industry interactions may vary as regulations related to receipt and disclosure of gifts to health professionals from industry differ state to state. This purposive sample is drawn from acute care settings and specialties with a high rate of technology adoption, and thus, nurses in this study interacted mostly with the medical device industry. Nurses’ interactions with other industries, such as infant formula, health information technology, and food and beverage, and in settings outside of acute care require further exploration. Although we attempted to articulate the range of experiences around interacting with industry, these data are not exhaustive of nurses’ experiences with industry and we may have missed some important perspectives. Nevertheless, this study explores in depth the little-discussed phenomenon of the “as-if” world of nursing practice that may resonate with nurses across practice settings and countries, and sheds light on how these myths are perpetuated even in an era of advances in multi-disciplinary care.

Introducing structural change

If nurses are serious about addressing the dangers of conflicts of interest in healthcare, they must advocate for and institute real structural changes. Formal preparation for interactions with industry should be included in nursing curricula, particularly for advanced practice nurses taking on management or leadership roles. Engaging bedside nurses as expert colleagues in policy discussions at the hospital, state, and national levels around conflicts of interest and interactions with industry would ensure that policies are inclusive of nurses and relevant to
nursing practice. Physicians, administrators and nursing leaders should acknowledge what nurses actually do, understanding that healthcare teams, not just individuals, are susceptible to marketing influence. Recognizing on the policy level what nurses really are doing, as opposed to what they are socially authorized to do, could help ensure that nursing expertise contributes to the development of better healthcare products and services in an ethical manner. This could occur through reimbursement reform, the formation of nursing practice groups that are independent contractors of hospitals, or the revision of scope of practice to include at least the activities that nurses already perform.

**Conclusion**

Many nurses in this study struggled with the mismatch between a complex and autonomous practice and a medico-legal culture that made their power and authority invisible. In the context of interacting with industry, the “as-if” myth that nurses do not make decisions of consequence puts nurses at risk for conflicts of interest, because interacting with industry was perceived as ethically benign or a validating experience. As patient advocates, nurses need to be conscious of and vigilant about marketing in clinical spaces, yet assert their leadership and expertise in interacting ethically with industry.

**References**


3. Lakeman R. Mental health nursing is not for sale: Rethinking nursing's relationship with the pharmaceutical industry. *J of Psych and Mental Health Nurs.* 2010;17(2):172-177.


Table 1. Characteristics of sampled institutions

<table>
<thead>
<tr>
<th>Site</th>
<th>Funding</th>
<th># of beds</th>
<th># of patients/yr</th>
<th>Magnet status</th>
<th>Revenue</th>
<th>Specialties</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td>Publicly owned and operated</td>
<td>&gt;400</td>
<td>600,000</td>
<td>No</td>
<td>Safety net hospital; 75% uninsured or Medicaid</td>
<td>Level 1 trauma center</td>
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<td>#2</td>
<td>Not-for-profit Public university-affiliated</td>
<td>650</td>
<td>1,000,000</td>
<td>Yes</td>
<td>$1.5 billion/year</td>
<td>Ranked nationally for specialty services</td>
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<td>#3</td>
<td>Not-for-profit Private university-affiliated</td>
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<td>$2.5 billion/year</td>
<td>Ranked nationally for specialty services</td>
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<td>#4</td>
<td>Private, for-profit Hospital Corporation of America affiliate</td>
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<td>150,000</td>
<td>No</td>
<td>Not disclosed</td>
<td>Accredited specialty center</td>
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Table 2. Summary of sample characteristics
<table>
<thead>
<tr>
<th>Sample characteristic</th>
<th>n (%RN)</th>
</tr>
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<tbody>
<tr>
<td><strong>Total sample (n=72)</strong></td>
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</tr>
<tr>
<td><strong>Job title</strong></td>
<td></td>
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<tr>
<td>Staff nurse</td>
<td>26 (100%)</td>
</tr>
<tr>
<td>Advanced practice nurse*</td>
<td>20 (100%)</td>
</tr>
<tr>
<td>Industry professional</td>
<td>14 (36%)</td>
</tr>
<tr>
<td>Administrator**</td>
<td>6 (67%)</td>
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<tr>
<td>Supply chain professional</td>
<td>5 (20%)</td>
</tr>
<tr>
<td>Physician</td>
<td>1 (0%)</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td>72 (78%)</td>
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</table>

| **RN sample (n=56)**   |         |
| **Clinical specialty** |         |
| Critical care          | 14      |
| Medical-surgical       | 9       |
| Other *****            | 9       |
| Perioperative           | 6       |
| Industry-employed      | 5       |
| Cardiovascular          | 4       |
| Interventional cardiology | 3     |
| Oncology                | 3       |
| Pediatrics and neonatology | 3     |
| **TOTAL**              | 56      |

* Advanced practice nurses have a masters degree and worked as nurse managers, nurse educators, and Clinical Nurse Specialists

** Administrators were participants at the director and executive level within the hospital and included registered nurses and non-nurses

**** Other specialties included outpatient and ambulatory care, psychiatry, infection control, emergency, and dialysis

Table 3. Summary of data sources by site
<table>
<thead>
<tr>
<th></th>
<th>Site #1</th>
<th>Site #2</th>
<th>Site #3</th>
<th>Site #4</th>
<th>Conference</th>
<th>Other*</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>Interviews</td>
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<td>11</td>
<td>5</td>
<td>4</td>
<td>13</td>
<td>8</td>
<td>51</td>
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<tr>
<td>Focus groups</td>
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<td>2 (n=8; n=5)</td>
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<td>1 (n=4)</td>
<td>0</td>
<td>0</td>
<td>4</td>
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<tr>
<td>Fieldwork (hrs)</td>
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<td>Policies</td>
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<td>1</td>
<td>1</td>
<td>3</td>
<td>12</td>
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<td>0</td>
<td>0</td>
<td>60</td>
<td>0</td>
<td>65</td>
</tr>
</tbody>
</table>

* Data collected outside of the 5 sites included pilot interviews, interviews at professional conferences, and documents from trade and professional associations