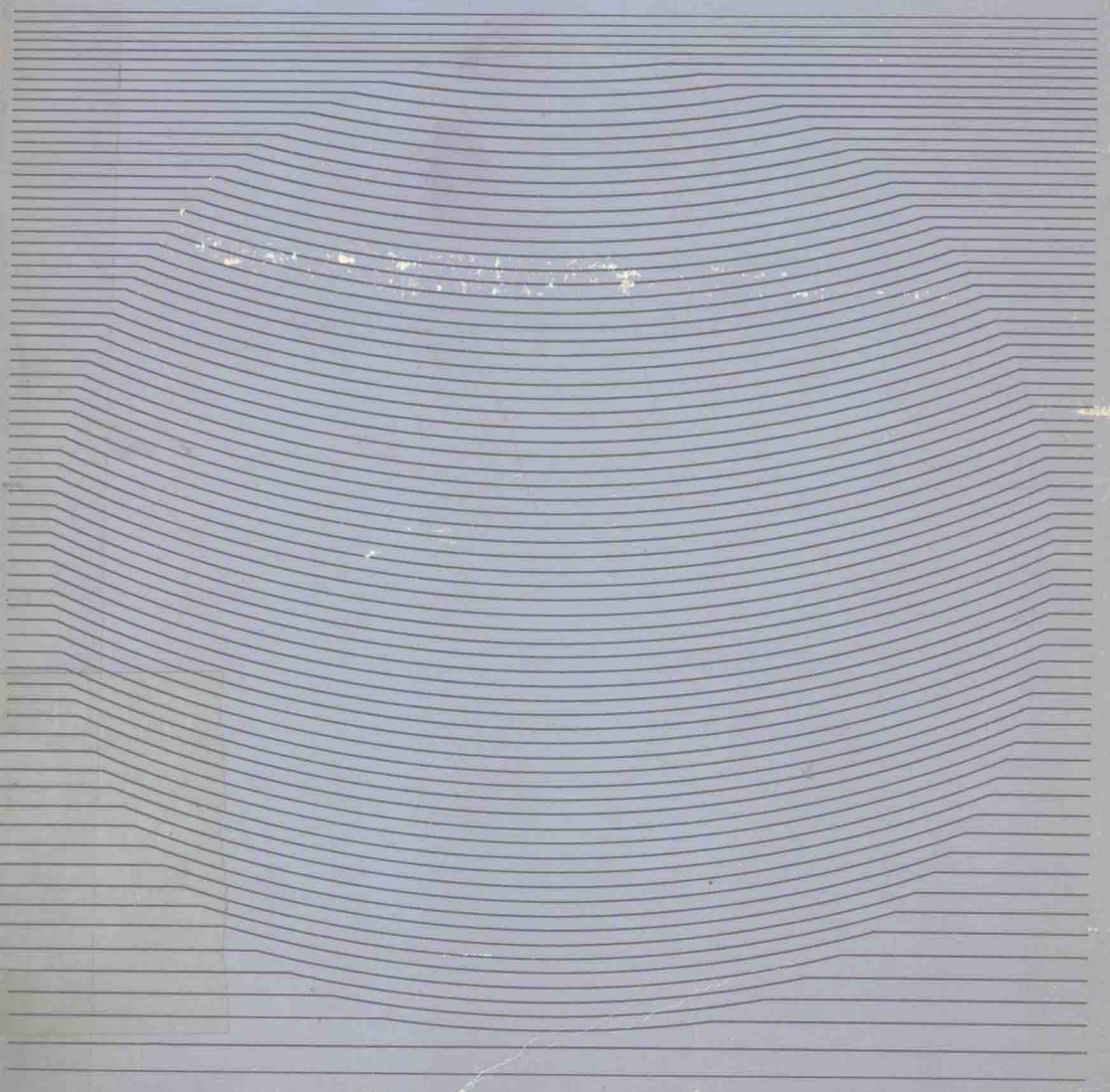
Edited by
Josephine M. Sana, R.N., M.A.
and
Richard D. Judge, M.D.

Physical Appraisal Methods in Nursing Practice



Physical Appraisal Methods in Nursing Practice

Edited by
Josephine M. Sana, R.N., M.A.
Professor of Nursing, University of Michigan
School of Nursing, Ann Arbor

Richard D. Judge, M.D.
Clinical Professor of Postgraduate Medicine
The University of Michigan Medical School, Ann Arbor

Little, Brown and Company
Boston

First Edition

Second Printing

Library of Congress catalog card No. 74-20224

ISBN 0-316-76995-9 (C)
ISBN 0-316-76996-7 (P)

Printed in the United States of America

PHYSICAL APPRAISAL METHODS IN NURSING PRACTICE

Dedicated to students preparing for the practice of nursing
and
nurses committed to the continued expansion
of their knowledge and clinical competence

PREFACE

Societal attitudes and expectations regarding health and health care delivery have changed greatly during the last decade. Problems of adequate access to needed services, their availability, and rising costs are continuing public and professional concerns. These concerns, coupled with the demands of a rapidly expanding science and technology, press the health professions to examine and modify their independent and partnership patterns of practice. Responsive to these forces for change, nursing continues to seek more efficient and effective ways of providing nursing care. From these efforts, new and varied roles and responsibilities for nurses have emerged, generating the need for new and varied knowledge and skills.

Increasingly, nurses find they must employ more precise physical appraisal methods in the clinical assessment of patients. Students preparing for the practice of nursing are expected to develop and use these skills as an integral part of the nursing process. Nurses unprepared or inexperienced in this aspect of clinical practice will need to develop or improve these competencies. The preparation of this book was motivated by this need and designed to provide a useful resource for students and practicing nurses alike.

The book is intended to provide a broad reference base, and the content is organized in three sections to facilitate its use. The chapters in Section I present four distinct and significant perspectives for the reader's consideration of the physical appraisal process. Combined, these chapters provide an introductory contextual framework for Sections II and III. Section II includes the chapters dealing with the specific approaches and methods utilized by the nurse in assessing the adult. Considerations unique and important to the physical appraisal of the very young, the adolescent, and the aged are presented in the chapters in Section III.

No attempt was made to cover extensively the knowledge base underlying normal or abnormal findings, nor was nursing intervention elaborated. For some readers, the content may be too detailed. It is our hope that the organization of the book will facilitate its selective use. For readers desiring more information, the references and suggested readings at the end of each chapter should be helpful guides. Editorial decisions were made in an effort to preserve the focus primarily upon the physical appraisal aspects of the assessment process. Consequently, the reader will need to utilize other resources for guidance in the planning and management aspects of nursing care.

The assistance and encouragement of the contributing authors is acknowledged with deep appreciation. Without their commitment and effort this book would not have been possible. We wish to thank the Director of the Medical and Biological Illustration Unit of the University of Michigan, Professor Gerald P.

Hodge, and staff artists Judith K. Simon and Nick G. H. Tan for the illustrations they prepared for the book. We are grateful for the secretarial assistance of Ms. Bernice E. Gittens, and Ms. Kathryn Richards. Acknowledgments would be incomplete without expressing special thanks to Christopher R. Campbell, Editor, Little, Brown and Company, for his ready help and counsel.

J. M. S.
R. D. J.

CONTRIBUTING AUTHORS

CANDACE M. BURNS, R.N., M.S.
Assistant Professor of Nursing (Co-ordinator Undergraduate Medical-Surgical), University of Michigan School of Nursing, Ann Arbor

PATRICIA MITCHELL BUTLER, R.N., M.S.
Assistant Professor of Medical-Surgical Nursing, University of Michigan School of Nursing, Ann Arbor

JOYCE CRANE, R.N., M.S.N.
Associate Professor of Nursing, University of Michigan School of Nursing, Ann Arbor

JO WAYLAN DENTON, R.N., M.S.
Assistant Professor of Medical-Surgical Nursing, University of Michigan School of Nursing, Ann Arbor

ELISA A. DIEHL, R.N., M.S.
Assistant Professor of Nursing and Acting Director, Continuing Education Service for Nurses, University of Michigan School of Nursing, Ann Arbor

CAROL GILBERT, R.N., M.S.N.
Assistant Professor of Medical-Surgical Nursing, University of Michigan School of Nursing, Ann Arbor

MARJORIE M. JACKSON, R.N., M.S.
Associate Professor of Nursing, University of Michigan School of Nursing, and Clinical Director, Surgical Nursing, University Hospital, Ann Arbor

JUDY M. JUDD, R.N., M.A.
Professor of Parent-Child Nursing, University of Michigan School of Nursing, Ann Arbor

ALICE MARSDEN, R.N., M.A.
Associate Professor of Psychiatric Nursing, University of Michigan School of Nursing, Ann Arbor

PHYLLIS COINDREAU PATTERSON, R.N., M.S.
Clinical Nursing Specialist, Hematology, University Hospital, The University of Michigan, Ann Arbor

SUSAN MENGEL PINNEY, R.N., M.S.
Assistant Professor of Nursing, University of Cincinnati College of Nursing and Health, Cincinnati

BARBARA A. SACHS, R.N., M.S.N.
Assistant Professor of Nursing and Co-director, Pediatric Nurse Practioner Program, University of Michigan School of Nursing, Ann Arbor

JOSEPHINE M. SANA, R.N., M.A.
Professor of Nursing, University of Michigan School of Nursing, Ann Arbor

SAMUEL SCHULTZ II, Ph.D.
Professor and Chairman of Research Area, University of Michigan School of Nursing, Ann Arbor

ANNE L. SHARPE, R.N., M.N. Ed.
Clinical Specialist, Pediatric Nursing, C. S. Mott Children's Hospital and University Hospital, The University of Michigan, Ann Arbor

CAROLYN P. STOLL, R.N., M.N. Ed.
Assistant Professor of Nursing, University of Michigan School of Nursing, and Clinical Director, Pediatric Nursing, C. S. Mott Children's Hospital and University Hospital, Ann Arbor

LINDA TANNER STRODTMAN, R.N., M.S.
Clinical Nursing Specialist, Endocrinology and Metabolism, University Hospital, The University of Michigan, Ann Arbor

MARGIE J. VAN METER, R.N., M.S.
Assistant Professor of Nursing, University of Michigan School of Nursing, and Clinical Nursing Specialist, University Hospital, Ann Arbor

CONTENTS

PHYSICAL APPRAISAL PERSPECTIVES

I

EXPANDED NURSING PRACTICE 1

Marjorie M. Jackson

A popular phrase in nursing parlance today is the "expanded role of the nurse." Ever so quickly, like a burst of Chinese firecrackers, the phrase has caught the fancy of the nursing profession. In haste, it has been rejected or endorsed in its embryonic stage without being seriously studied, completely understood, and fully tested in practice. *Expanded role* is a term that means whatever the user wishes it to mean. It is used interchangeably with "extended role" or to characterize a variety of new nursing roles: nurse practitioner, nurse clinician, or clinical nurse specialist. A selective use of the term emphasizes changing role and function; a wider and richer perspective focuses on changing nursing practice. The position presented here is that true expansion of nursing practice will be achieved when nurses assume greater responsibility and accountability for patient cure and restoration in acute, chronic, and preventive health care settings.

Expanded role has had its roots in the management concept of job enlargement, which grew out of an orientation toward and concern for the development of human resources in organizations. The enlargement concept includes a triad: (1) variety of knowledge and skills in doing a job; (2) a better utilization of the worker's total skills and abilities; and (3) responsibility and freedom in the performances of the job. True job enlargement is not the addition of the same kinds of tasks but an expansion of job content with a wider variety of tasks and an increased freedom of methods.

EXTENDED ROLE VERSUS EXPANDED ROLE

Murphy [7] provides an important conceptual distinction between the job enlargement of the nurse who is a role extender and the nurse who is a role expander. She describes role extension as a unilateral lengthening, an additive process, and role expansion as a spreading out, a process of diffusion. With expansion, by definition, there is a richer mix both in the variety of tasks and in the new relationships among the tasks. The very nature of nursing practice is dynamically changed. With extension, by definition, there is continued addition of similar tasks and techniques, so that the nature of nursing practice is essentially unchanged. Nurses have always been in an extended role for, like it or not, a substantial portion of clinical nursing practice has and continues primarily to be inherited medical practice. Many of the major clinical functions in nursing are predominantly medical orders translated into action. This is strikingly evident in hospitals, which constitute the professional center of the health care

world. Historically, nurses have been the physicians' assistants, implementing medical regimens and applying medical technology. The current controversy about roles and role alignments was ignited by the advent of a new breed, the physician's assistant, and is significantly influenced by the women's liberation movement's emphasis on equity and autonomy. This controversy revolves around the scope of nursing practice as distinct from medical practice.

THE NATURE OF NURSING PRACTICE

Definitions of nursing abound, and while there is no consensus, there is consistent recognition of its nature as human service and assistance. The primary goal of nursing is to assist persons to attain and maintain optimal physical, psychological, and social functioning. The assistance ranges along the entire health-illness continuum from birth to death and is offered in a variety of health care settings, including the home. This helping role of nursing encompasses both instrumental and expressive functions. These evolve from the needs of patients and from the needs of medical practice and of the medical practitioner. The persistent dilemma of nursing is the proper marriage of instrumental and expressive functions, and this conflict is intensified by the acceleration in the technology of therapy and the escalating demand for health care.

To care and comfort is said to be the special province of the nurse. To cure and restore is said to be the special province of the physician. Murphy has superimposed the extender-expander role concepts on this cure-care model in terms of physician-nurse responsibilities. When viewed in Murphy's juxtaposition, the nurse who takes on primarily the cure functions of medicine becomes an extender of cure, while the nurse who undertakes the care function becomes an expander of care. Yet does it not distort the reality of the bedside, neighborhood clinic, or of the family the public health nurse assists to distinguish care and comfort from treatment and cure? To say that cure is a secondary function of the nurse is to ignore the paradoxes that often occur at times when nurses find it impossible to secure patient comfort and preserve personal integrity because they are responsible for the very procedures that produce the discomfort or demean the patient's personal dignity.

Compounding these dilemmas is the growing complexity in the delivery of health services. Kelly [6] contends that the nurse's clinical role is shrinking and dwindling to coordinator and traffic director as more and more of the tasks central to patient care are reallocated to others: the clinical pharmacist, the inhalation therapist, the IV team. She comments that "The role is shrinking because the nurse is incapable of controlling the care situation or exerting instrumental influence over her work."

Not only is the content of nursing practice changing daily, but the emphasis and the context of practice are also rapidly shifting. Social forces and education are orienting the modern nurse to health rather than illness, to prevention rather

than crises, to a holistic rather than a technical approach, to the community rather than the hospital. The National Commission for the Study of Nursing and Nursing Education [8] and the Department of Health, Education, and Welfare [3] document the urgent need for a refocusing and redefinition of roles and practice. Both their reports underline the complementary roles of physician and nurse in a new professional realignment in the vast area of primary health care and in acute and chronic health care settings. It is beyond the province of this chapter to consider the urgent issues of role and function raised by these reports, but the reports are commended as essential resources.

The development of congruent roles of the physician and the nurse can resolve many current functional and jurisdictional disputes in scope of practice. Only through mutual understanding and agreement will a synthesis occur in the two divergent perceptions about nurses' roles, i.e., the nurse as a caretaker or the nurse as an assistant to the overburdened physician.

CLINICAL DECISION-MAKING

Basic to the expansion of practice and central to the complementary roles of nurse and physician is clinical decision-making. Cleland [1] has defined the role extender and role expander in terms of decision-making and has identified the number and quality of cues each uses in clinical judgment. On the basis of the range of cues brought to bear in clinical judgments, Cleland has postulated that critical distinctions can be made between levels of practice and among roles. She states:

> At the first level of nursing there are general nurses and nurse practitioners, at the second level there are nurse specialists and nurse clinicians. General nurses and nurse specialists work in structured and defined settings, and with narrow ranges of cues involved in the decision-making and with the dimension of time extending through the patient's current hospitalization, and often extending only through the current 8 hour day. Nurse practitioners and nurse clinicians utilize data gathered from many sources to plan a broad program of patient care with a space focus which also involves the family, and a time dimension which includes the entire course of the illness [1].

Within Cleland's important framework, the crucial question is no longer whether or not the best direction in which to expand the practice of nursing is toward the assumption of more of the tasks of medicine. Rather, the crucial question is how the nurse and physician may become a decision-making team in the diagnostic and therapeutic problems of clinical care. Despite the performance of the nurse as a diagnostician and therapist in the past decade of coronary care and, more recently, in respiratory care, physicians and some nurses have been reluctant to see the nurse as a diagnostician. My use of *team* and *diagnosis* here recognizes that insofar as accuracy and validity of clinical observations and scope and continuity of management are relevant to diagnosis and treatment, and

insofar as the nurse accurately validates observations and adds scope and continuity in management, the nurse and physician are interdependent, responsible, and authoritative. They are both clinicians in assessing the clinical variables at the bedside, in the clinic, or in the home and in making clinical judgments about the therapeutic management of patient care. Imperative in the concept of role expansion based on clinical decision-making is the acknowledgment that the nurse in expanded practice prescribes nursing care as independently as the medical clinician prescribes medical therapy. The fundamental strategies for this expansion must be derived from direct clinical experience with patients and from enhanced competencies in the methods and techniques of precise and objective clinical appraisal.

Defining expanding nursing practice as expansion in the scope and methodologies of clinical decision-making turns our attention to the complexities of clinical judgments. How does the nurse acquire the clinical evidence to support her clinical judgments? One of the reasons for the selective ignorance practiced by nurses in restricting their clinical judgments has been the failure to distinguish between the different types of observational data and to understand the rigor of the reasoning processes that characterize the total diagnostic procedure. Feinstein [4] has examined the nature of clinical judgments and has identified the kinds of clinical data and relationships among them that constitute the intellectual technology of decision-making. There are data that describe disease in impersonal terms (morphologic, clinical, microbiologic, and physiologic), data that describe the host in whom disease occurs, and data that describe the interaction between the disease and its host. Feinstein has proposed that the first be referred to as the evaluation of the disease, the second as evaluation of the patient as a person, and the last, as the evaluation of illness, i.e., the consequences of pathological processes in the patient.

Nurses tend to make gestalt observations and inferences and also to couch their observations and judgments in guarded and tentative language. "A good day," "usual night," "seems anxious" typify the all too familiar subjective and unsubstantiated documentation of patient response. The ability to make objective and measurable observations and to process them through systematic reasoning will distinguish the nurse in expanded practice. In processing clinical information and in making clinical decisions, important distinctions must be made between pure description, designation, and diagnosis. Feinstein [4] defines description as an account of an observed sensation, substance, or phenomenon. In designation, a name or classification is given to the observed entity. In diagnosis, the anatomic or other abnormality that is responsible for the observed entity is indicated.

The Nature of Clinical Judgment

Within Feinstein's perspective, the clinician makes two types of decisions: explanatory decisions and management decisions. Explanatory decisions are the