Recent statistics indicate approximately 27% of nurses work in medical-surgical areas; this is the highest percentage of any practice grouping (Australia Institute of Health and Welfare, 2010; Louisiana State Board of Nursing, 2011). In many countries, such as Australia and New Zealand, nurses working in either a medical or surgical acute setting are not seen by the profession or themselves as specialist nurses. Over the last 20 years, the author contends medical-surgical nursing has changed and should now be considered an international nursing specialty. Two issues should be addressed: lack of professional recognition and career development. The professional status of medical-surgical nurses is not described clearly in the literature. A search of major nursing literature databases (1990-2011) found 4,499 citations on specialty (specialism, specialist) practice in nursing, and only 74 on medical and/or surgical nursing specifically; none discussed medical-surgical nursing as a specialty. Consequently, in this article a view of the subject based on Australian practice that may be translated culturally is presented. A conceptual model for medical-surgical nursing is proposed as a beginning point toward recognizing this clinical area as an internationally accepted specialty.

Medical-surgical nurses in Australia do not consider themselves part of a specialty. Many times, when they are asked about their area of nursing practice, the phrase “just med-surg” is used. Equally, the term general nurse denies this group an identity within nursing practice and consequent recognition as practitioners in a specialty. Hunt (1999) traced the history of the development of the nurse specialists; however, the results were inconclusive and conflicting, with some agreement that in the late 1980s the term was in use internationally.

As medical-surgical nursing is not yet a formal specialty in many countries, how can the discussion move forward? Intrinsically linked with specialism is an expansion of the scope of practice to incorporate skills and knowledge unique to the specialty. An examination of how the scope of practice for medical-surgical nurses already is expanding and a conceptual framework can move this group into a specialty. The New South Wales Nurses Association (2009) indicated the context in which nurses practice, the client’s health needs, the education and qualification of nurses, and the institutional policies that define the scope of practice. The Queensland Nursing Council (2005) suggested the scope of practice will expand based on six principles:

1. Clients’ health needs are met and health outcomes are improved.
2. The specialty enhances existing aspects of professional practice.
3. The expansion is lawful and appropriate for the context.
4. Expansion of the scope of practice is based on appropriate consultation and planning.
5. The registered nurse/midwife expanding his or her practice (a) is already practicing at an advanced level, (b) has the appropriate education, (c) is assessed as competent, and (d) understands the degree of accountability.
6. A competent health professional has assessed the competence of the registered nurse or midwife who will incorporate the activity into practice.

To extend practice of a medical-surgical nurse to become either a specialist or an advanced practice nurse, addressing the above considerations provides a way forward. The use of a conceptual framework developed for medical-surgical nurses can provide the road map for advancing medical-surgical nursing as a specialty and/or an advanced practice medical-surgical nurse. A conceptual model also can be used to demonstrate how the six principles are met or can be met within the advanced practice framework.

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Determinants of Health

**Environmental**
- Physical
- Chemical
- Biological
- Social
- Economic
- Cultural
- Political

**Individual**
- Genetic contribution
- Attitudes and beliefs
- Lifestyle and behavior
- Biomedical factors

Outcomes

- Disease
- Impairments
- Symptoms
- Injuries
- Disability
- Functional limitations

Outcome Interventions

- Prevention and health promotion

Inputs Resources

- Research
- Evaluation
- Monitoring

Other Information

- Financial
- Material
- Human


The Context of Practice

Unique to medical-surgical nursing is a commitment to valuing and nurturing holistic patient care from pre-admission to organizing community care. Most patients spend some time in either a medical or surgical area; for example, following admission and stabilization in a critical care area, a patient may be transferred to a generalist area prior to discharge. Medical-surgical nurses are similar to critical care nurses in that they need an eclectic body of knowledge from each of the recognized subspecialties. Thus the questions that need to be asked include the following: What is so special about medical-surgical nursing? Is there a unique body of knowledge? Earlier research (Lyneham, 2004) identified four distinct areas of medical-surgical practice: clinical issues, discharge planning, clinical risk management, and patient education. These are seen in other clinical specialties, but they are practiced uniquely within medical-surgical nursing. These areas of practice can be organized into a conceptual framework.

A Conceptual Framework for Medical-Surgical Nursing

A conceptual framework has a number of benefits for medical-surgical nursing. In clinical practice, a conceptual framework will do the following:
- Provide a common language to describe the clinical situation under scrutiny and report findings about it (Mason & Waywood, 1996).
- Develop a set of guiding principles against which judgments and predictions might be made.
- Act as a series of reference points to locate clinical questions within contemporary practice.
- Provide a structure to organize the content of practice and frame conclusions within the context (Minichiello, Axford, Greenwood, & Sullivan, 1999).

Nursing's conceptual frameworks do not exist in a vacuum; they must be an aligned component of a broader system. A conceptual framework of the Australian health system was presented in Australia's Health 2000. Figure 1 illustrates the relationships among components of the health system and how these are aligned. Most developed countries operate from a similar model.

The conceptual framework for medical-surgical nursing was developed from the above structure and contains four main elements that interact during provision of patient care. The elements have some commonality with other clinical areas. However, it is the model's implementation that ensures uniqueness (see Figure 2).

Education

In medical-surgical nursing practice, patient education can be divided into the three stages of a person's hospitalization: pre-admission, during admission, and discharge. Each stage has a different purpose. The aim of pre-admission education is to prepare clinically for the admission and to reduce the patient's stress and anxiety while improving adherence to treatment. During an admission, the focus of education is to keep the patient informed regarding the progress of his or her condition, and to introduce new information if the patient's care diverges from the expected. During this time, discharge planning education begins with the
A Conceptual Model for Medical-Surgical Nursing: Moving Toward an International Clinical Specialty

FIGURE 2. Conceptual Model for Medical Surgical Nursing

Education

Discharge Planning

Clinical Risk Management

Clinical Issues

- Pre-admission
- During hospitalization
- Discharge

- Education
- Clinical
- Social
- Economic

- Global perspective
- Forward looking
- Open communication
- Integrated management
- Continuous process
- Shared vision
- Teamwork

- Practice
- Theory
- Goals
- Inter-professional coordination

aim of maintaining health and wellness, reducing re-admission, and improving adherence to the rehabilitation plan (Commodore-Mensah, Dennison, & Himmelfarb, 2012).

Many nurses assume once a patient is given verbal information and printed educational materials, the patient understands. However, similar to any learning task, most people need to hear the information several times, especially when multiple facts or instructions are given. In addition, some information needs to be written (Hueckel, Mericle, Frush, Martin, & Champagne, 2012). In the next section, the three stages of education for a planned hospitalization are discussed. If the hospitalization is not planned, little or no time exists for pre-admission education.

Pre-admission. The quality of pre-admission education can impact the patient's hospital experience. Education at this stage can have a positive effect, including anxiety reduction, effective pain management, decreased complications, and reduced bed days (Ferguson & Pawlak, 2011; Larson et al., 2010). Education should start in the physician's office, when hospitalization is suggested as a health strategy. The next point of contact for surgical patients is a pre-admission clinic. Medical patients are more likely to be admitted directly or enter through an emergency department; consequently, medical patients are less likely to receive adequate pre-admission education. As patients have become more literate in searching for information on the Internet and from other sources, the amount of misinformation increases. This can be a challenge to the medical-surgical nurse as many web-based sources provide incorrect information. The nurse needs to navigate the information tactfully and provide the patient with correct information. A good model for pre-hospital education is found in the cardiac surgical area in preparation for open-heart surgery. Patients in this setting are given information on all aspects of their hospitalization, associated risks, and intensive care stays; visits from former patients may provide support as well. This is a good model to follow when considering pre-admission education (Goodman, 2009).

Education during hospitalization. Interestingly, most nurses educate their patients daily and do not even think about it. For example, if a patient is about to begin a regimen of antibiotics, the nurse giving the first dose of the medication often will make a comment such as, "The doctor has ordered some antibiotics for your chest infection. Are you allergic to anything (or name of drug)? It is best if you take this tablet with food." Education research has demonstrated clearly that stress and anxiety are impediments to learning (Pelchat, 2010; Shea, 2008). Current methods of patient education are at best ad hoc. Patients may not be prepared to receive information or be limited in their ability to understand it. These are not valid reasons to say education should not be done. On the contrary, it must be done. However, to be effective, teaching techniques should be based on the overall effects of the hospitalization. Literature suggests small amounts of information should be given in each session; visual aids such as diagrams, videos, and e-learning reinforce basic education measures (Wittmann-Price & Fisher, 2009). These tools are already used in many medical-surgical areas but are not recognized as a component of specialist practice.

Although the patient is the main focus of education, family and caregivers need information in preparation for and after discharge. The caution here is to ensure the patient consents to the involvement of others. Some patients deny a problem exists or do not want to learn about their illness. This group is a challenge and the skill gained through the nurse's mental health education may assist in these interactions (Garcia-Perez et al., 2011). Skilled medical-surgical nurses take their patients from unawareness to knowledge.

Mordiffi, Tan, and Wong (2003) examined the differences in percep-
tions in the pre-surgical situation and found 20% to more than 50% of patients did not receive adequate information on areas they thought to be important. If surgical nurses are to be considered specialists, this assumption must be addressed. It may be as simple as starting a patient education session by asking, "What would you like to know about your surgery/condition?"

Education in discharge planning. The nature of discharge planning depends on if the problem is an acute surgical procedure or an acute/chronic medical condition. Aruffo and Gardner (2001) and Tilus (2002) agreed discharge education is a collaborative effort among all health professionals. The nurse frequently assumes the role of coordinator to ensure the patient's needs are met. The issues that require education will be discussed later in this article.

Clinical Issues

Medical-surgical nurses approach patient care with precision and understanding. However, where is the nurse-generated evidence for their practice? Medical-surgical nurses often appear to borrow their evidence for practice from other nursing specialties and other disciplines. Medical-surgical nurses also no longer retain many of the aspects of care that were unique to their area, such as wound and pain management, leaving these aspects of care to others. The gradual erosion of care responsibilities diminishes the power of medical-surgical nurses to argue clinical uniqueness. However, this situation can be remedied by engagement and input in the clinical area. The focus of this engagement can be based on the conceptual framework through developing relevant research questions related to education, discharge planning, risk management, and clinical practice.

Medical-surgical nurses need to take responsibility for defining their practice and providing the needed evidence. The basis of medical-surgical practice is understanding the trajectory of care, the specific holistic goals each patient needs to achieve, the clinical skills required to manage the patient's condition, how each component of care makes a whole, and how that care impacts the long-term health of the patient and family. These concepts can form the basis of research conducted by medical-surgical nurses for medical-surgical practice. The lack of specific medical-surgical postgraduate courses (only three in Australia) should not deter the nurse; until there are more specific courses that lead to a master's degree, preparation in clinically non-specific areas can assist nurses in developing the necessary research skills. Nonetheless, more specific medical-surgical courses at the master's level are required.

Discharge Planning

The aim of discharge planning is for the patient to understand his or her condition and how to continue the management plan after discharge in order to return to optimal health or accept a new level of health. This can be achieved through care in relation to education, clinical management, and social and economic needs. The questions that need to be resolved are listed in Table 1.

Medical-surgical nurses are in a position to assume the coordinating role in discharge planning. The referral to appropriate agencies relies on the medical-surgical nurse's understanding of the patient as a person who needs to function outside the hospital environment. While discharge plans appear in the literature and are used in practice, their utility apparently has not been tested in the medical-surgical area except in cases of particular clinical interest, such as falls risk (Day, Ramos, & Hendrix, 2012). Given one of the unique aspects of medical-surgical nursing is that patients receive care from the pre-admission period to discharge planning, discharge as a component of specialist practice needs further development and research.

Clinical Risk Management

Clinical risk management (CRM) is critical for the safety of all patients in all clinical areas. There is a plethora of risk evaluation forms; however, the holistic notion of CRM is not well understood in medical-surgical nursing. What are the overall risks to patients and how can care be manip-

### Table 1. Questions Related to Discharge Planning

<table>
<thead>
<tr>
<th>Clinical</th>
<th>Social</th>
<th>Economic</th>
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<tr>
<td>• What are the outstanding clinical issues?</td>
<td>• Is the patient able to provide self-care?</td>
<td>• What is the economic impact of this admission on the patient and family?</td>
</tr>
<tr>
<td>• Is any continuing nursing care required?</td>
<td>• Does the patient have support at home?</td>
<td>• Are the required services affordable?</td>
</tr>
<tr>
<td>• Is there a need to refer for other services?</td>
<td>• How capable is that support?</td>
<td>• Who will pay?</td>
</tr>
<tr>
<td></td>
<td>• Do the patient and support system need education? If so, by whom?</td>
<td>• Are the required services affordable?</td>
</tr>
<tr>
<td></td>
<td>• What does the patient need to know?</td>
<td>• Can the patient return to work? If so, when?</td>
</tr>
<tr>
<td></td>
<td>• What behaviors are expected?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- What is the timeframe for the behaviors to be demonstrated?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- What are the levels of required behavior?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Is the behavior achievable in the time frame?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Which agency is best placed to provide care?</td>
<td></td>
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<tr>
<td></td>
<td>• Can the activities of daily living be met?</td>
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A Conceptual Model for Medical-Surgical Nursing: Moving Toward an International Clinical Specialty

ulated to reduce these risks? The elements of CRM need to be understood for what they are, not for what they seem to be. Some nurses believe CRM is a collection of risk assessment forms (e.g., falls, pressure ulcers), but these are just one small aspect of CRM. A global perspective is needed to determine what it means to deliver safe medical-surgical patient care. Risk management is a discipline for living with the possibility that future events may cause adverse effects. For a risk to be understandable, it must be expressed clearly. Such a statement must include two elements: a description of the current conditions that may lead to the loss, and a description of the potential loss. CRM ensures accountability for actions that are in the best interest of the patient (Chubb Health Care, 2004).

The term risk management is applied in a number of diverse disciplines. It is addressed by persons in the fields of statistics, economics, psychology, social sciences, medicine, biology, engineering, toxicology, systems analysis, operations research, and decision theory, among others (Chubb Health Care, 2004). To many social analysts, politicians, and academics, risk management is the management of environmental and nuclear risks, those technology-generated macro-risks that appear to threaten existence. To bankers and financial officers, it is the sophisticated use of such techniques as currency hedging and interest rate swaps. To hospital administrators, one aspect of concern is the reduction of adverse patient outcomes (Department of Health, Victoria, Australia, 2012).

The history of risk management comes from the world of commerce and finance. Although well developed in health, it is often cogent to return to the roots of management theory so medical-surgical nurses can develop their own strategies for CRM. Frigo and Anderson (2009) suggested a business model that if the word clinical replaces strategic, it may help medical-surgical nurses develop a CRM strategy for their units:

1. Achieve a deep understanding of the strategy of the organization.
2. Gather views and data on clinical risks.
3. Prepare a preliminary clinical risk profile.
4. Validate and finalize the clinical risk profile.
5. Develop a clinical risk management action plan.
6. Communicate the clinical risk profile and strategic risk management action plan.
7. Implement the clinical risk management action plan.

Achieving a deep understanding of the strategy of the organization requires an understanding of the supporting policy and procedures that support clinical care. Once this understanding is achieved, the medical-surgical nurse is able to begin the task of developing CRM suitable for his or her area which takes into account the culture of the organization, a profile of the typical patient, an understanding of evidence-based risks and best practice, and a commitment to outcomes that minimize the potential for adverse outcomes. The next steps are critical to achieving this goal.

Medical-surgical nurses need to gather views and data on known clinical risks, which may include research data or even a new research project. It should not be assumed the CRM processes developed for other clinical areas are appropriate for every clinical area. This project may be used to prepare a preliminary clinical risk profile and then validate and finalize the clinical risk profile.

The final three stages start with the development of a clinical risk management action plan. In Australia, RiskMan is used; however, no research data appear to be available to support its clinical value. The plan needs to include process, actions, and required documentation. Currently validated risk assessment tools can be integrated into the plan only if they have been validated appropriately. A necessary component of this stage is the development of supporting policy and procedures to direct staff in implementing the process. The next stage is crucial; without adequate communication, the profile and action plan will remain a document gathering dusk in the corner of someone's office.

Communication of the plan should start with education to help staff understand the purpose and rationale of the CRM plan. Communication can take many forms, including written, verbal, and web-based. The CRM plan needs an introductory period in which communication can occur, a start date for implementation, and a timeframe for process evaluation of the CRM plan to begin (Biegen et al., 2010).

The application of the proposed conceptual framework can guide medical-surgical practice into a recognized specialty. Evidence for the six requirements has increased so that the scope of practice will be recognizable first by medical-surgical nurses and then by other nursing groups. Application of the conceptual framework has the potential to improve patient outcomes and nurse satisfaction is likely to follow. The literature is very clear that CRM and education positively affect the patient (Finlayson, Peterson, & Cho, 2009; O'Brien et al., 2010; Williams, 2008). Improving care and outcomes is likely to reduce the cost of health care.

Medical-surgical nurses are already pushing the boundaries of care; however, they are not always looking for or creating the evidence required to support the extension of boundaries. Published research on medical-surgical nursing is minimal compared to other specialties. A change in attitude toward research and practice development is required to move the debate forward. This change will support enhanced/advanced practice and be appropriate in the medical-surgical context. While many medical-surgical nurses practice at an advanced level and have sought further education, very few post-graduate courses are available for the specialty. The outcomes for nurses would be a defined career pathway; there is evidence this would improve work satisfaction and nurse retention (Ellenbecker, 2010).
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Objectives

This continuing nursing educational (CNE) activity is designed for nurses and other health care professionals who are interested in a conceptual model for medical-surgical nursing. After studying the information presented in this article, the nurse will be able to:

1. Discuss the status of medical-surgical nursing as a specialty from an international perspective.
2. Describe a conceptual framework for medical-surgical nursing.
3. Explain how a conceptual framework can guide medical-surgical practice into a recognized specialty.

Note: The author, editor, and education director reported no actual or potential conflict of interest in relation to this continuing nursing education article.

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REFERENCES


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Signal-to-Noise Ratio: Filtering Out Ineffective Communication

- Tells the recipient what cannot be done...
- Has a subtle tone of blame...
- Includes words like can’t, won’t, unable to, which tell the recipient what the sender cannot do...
- Does not stress positive actions that would be appropriate, or positive consequences. (Bacal, 2013, p. 2)

Positive phrasing and language have the following qualities:
- Tells the recipient what can be done...
- Suggests alternatives and choices available to the recipient...
- Sounds helpful and encouraging rather than bureaucratic...
- Stresses positive actions and positive consequences that can be anticipated. (Bacal, 2013, p. 2)

Filtering SNP

In today's health care environments, the art of listening and paying attention can be lost due to distractions from many sources. Effective nurse managers have the art and skill of dealing with SNR. They can identify a legitimate signal versus noise. They know the strength of the signal in the workplace in no way indicates the importance of the message being delivered. Some employees may speak softly or rarely, but have an important message. The SNR actually may be reversed, with the noise level far exceeding the softly delivered signal. Noise may be more apparent and noticed due to its intensity and/or frequency, but that does not mean soft signals should be discounted. They may be the most significant of all. The quiet, unassuming employee needs to be heard just as much as the loud staff member. Unfortunately, unlike electrical systems, loudness and frequency do not constitute legitimacy. Understanding and appropriately filtering SNR represent both an opportunity and a fundamental skill of the successful manager.

REFERENCES


Improved Hypoglycemia Management

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A Conceptual Model

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MEDSURG NURSING.  July-August 2013  •  Vol. 22/No. 4
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