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Research Article

Nursing Decision-Making in the Absence of Clear Medical Orders

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Abstract:

Nursing decision-making in the absence of clear medical orders is a critical and inherent component of professional practice, demanding the synthesis of clinical expertise, ethical reasoning, and autonomous judgment. When faced with ambiguous situations—whether due to sudden patient deterioration, vague directives, or gaps in provider availability—nurses must rely on theoretical frameworks like clinical judgment models and ethical principles to guide immediate, patient-centered actions. This process is not undertaken in isolation but operates within legal standards of care and is ultimately integrated back into the healthcare team through structured communication and collaboration. The capacity for such decision-making underscores the nurse's role as a primary safeguard for patient safety, highlighting the necessity of targeted education and systemic support to cultivate the confidence and competence required for these high-stakes judgments.

1. Introduction

The contemporary healthcare landscape is characterized by its dynamic complexity, where patient conditions can evolve with rapid unpredictability and clinical scenarios frequently present themselves outside the boundaries of standardized protocols or explicit physician directives. Within this intricate environment, the registered nurse operates not merely as a technical executor of prescribed medical orders, but as an autonomous professional whose clinical judgments and decisions are often the linchpin of patient safety, quality of care, and clinical outcomes. The cornerstone of this professional practice is nursing clinical judgment—a sophisticated, iterative process of noticing, interpreting, responding, and reflecting [1]. While the ideal clinical pathway involves collaborative decision-making within a multidisciplinary team guided by clear medical plans, nurses routinely encounter situations where such clarity is absent. It is in these moments of ambiguity and uncertainty that the depth of nursing knowledge, the strength of ethical reasoning, and the capacity for prudent action are most critically tested. The ability of a nurse to make sound, independent decisions in the absence of clear medical orders is, therefore, not an exceptional skill but a fundamental and daily requirement of the role, representing a significant point where professional accountability and patient welfare directly intersect.

The historical trajectory of nursing has been marked by a gradual but definitive shift from a role of dependent, task-oriented care to one of independent, judgment-based practice. This evolution is rooted in the expansion of nursing science, the formalization of advanced education, and the recognition of nursing as a distinct discipline with its own body of knowledge and theoretical frameworks [2]. This professional maturation has been accompanied and necessitated by the increasing acuity of patients in hospital settings, the expansion of care into community and primary health realms, and the technological advancements that allow for more complex interventions at the bedside. Consequently, the nurse's role has expanded to include significant assessment, diagnosis (in the nursing sense), intervention, and evaluation responsibilities that are often initiated independently. Regulatory bodies and professional organizations worldwide have codified this expectation. For instance, the American Nurses Association, in its *Nursing: Scope and Standards of Practice*, explicitly identifies clinical judgment as a central standard of professional performance, requiring nurses to use critical thinking and the best available evidence to make decisions and take actions [3]. Similarly, the International Council of Nurses emphasizes the nurse's responsibility to exercise professional judgment in providing care and to take appropriate action when patient safety is compromised [4].

The absence of clear medical orders can arise from a multitude of intersecting factors, each presenting its own set of challenges. Some situations emerge from sheer clinical urgency, such as a sudden patient deterioration—a precipitous drop in blood pressure, a catastrophic hemorrhage, or a cardiac arrest—where immediate action is imperative and there is no time to locate a physician or await a new order. In these acute crises, standardized emergency protocols (e.g., Advanced Cardiac Life Support) provide a framework, but nurses must still rapidly interpret the situation, apply the protocol, and make immediate decisions about medication administration, defibrillation, or other interventions [5]. A more common, yet equally critical, scenario unfolds during the silent gaps of healthcare delivery: the night shift, weekends, or in remote locations where immediate physician presence or telecommunication is limited. Here, a patient's condition may change subtly but significantly—developing new-onset confusion, escalating pain unrelieved by existing medication, or showing signs of a nascent infection. The nurse, as the constant presence at the bedside, must detect these changes,

assess their severity, and decide whether to intervene within existing standing orders, utilize prescribed PRN (as-needed) medications judiciously, or initiate the chain of command to contact the on-call provider, a decision that itself requires nuanced judgment about urgency and appropriateness [6].

Furthermore, ambiguity often resides in the orders themselves. Vague, contradictory, or potentially erroneous orders place the nurse in a precarious position. An order for a fluid bolus in a patient with signs of both hypovolemia and heart failure, or an analgesic dose that seems excessive for the patient's age and renal function, forces the nurse into a decision-making loop that balances the legal imperative to follow a licensed provider's order with the ethical and professional mandate to prevent harm. This is the domain of the "right to question" and the "duty to clarify," which are essential components of safe practice [7]. Finally, there are domains of holistic patient care where medical orders are intentionally sparse or non-existent, leaving the nurse to operate from a foundation of nursing knowledge. Managing a family's acute grief, addressing a patient's spiritual distress, implementing non-pharmacological comfort measures for anxiety, or providing nuanced education for a complex chronic illness are all areas where nursing decisions are paramount and often made autonomously based on therapeutic relationships and psychosocial theories [8].

2. Theoretical Foundations and Models of Clinical Judgment

Nursing decision-making in ambiguous situations is not an ad-hoc reaction but a cognitive process grounded in well-established theoretical models. Understanding these frameworks is crucial for deconstructing how expert nurses navigate uncertainty. One of the most influential models is Patricia Benner's *From Novice to Expert*, which describes how nurses progress through five stages of skill acquisition: novice, advanced beginner, competent, proficient, and expert [9]. This progression is characterized by a shift from reliance on abstract rules and context-free protocols to an intuitive, situational grasp of clinical realities. A novice or advanced beginner, when faced with a missing order, may rigidly seek rule-based solutions or become paralyzed by uncertainty. In contrast, the expert nurse, drawing upon a deep repository of past clinical experiences, can recognize patterns, perceive the salient issues in a complex situation, and make nuanced judgments without conscious deliberation on every step. This model explains why two nurses confronting the same clinical puzzle may arrive at different decisions; their level of experiential knowledge fundamentally shapes their perception and response.

Complementing Benner's work is the Clinical Judgment Model developed by Christine Tanner, which provides a more detailed, cyclical representation of the thinking process. Tanner's model outlines four key aspects: *Noticing, Interpreting, Responding, and Reflecting* [1]. *Noticing* involves a perceptual grasp of the situation—what data is relevant? A nurse might notice a slight change in a patient's respiratory pattern or a subtle shift in their affect. This is influenced by the nurse's knowledge, experience, and relationship with the patient. In the absence of a specific order to "monitor for respiratory decline," the expert nurse's skilled noticing triggers the decision-making process. *Interpreting* follows, where the nurse makes sense of the noticed data, developing explanations or hypotheses. Is the shortness of breath due to pulmonary edema, anxiety, or a pulmonary embolism? This stage relies heavily on critical thinking and clinical reasoning to weigh possibilities. *Responding* is the decision and action phase. The nurse decides on a course of action, which could range from elevating the head of the bed and applying oxygen per protocol, to calling a rapid response team, to administering a PRN diuretic if standing orders allow. Finally, *Reflecting* involves evaluating the outcomes of the action, both in-the-moment (reflection-on-action) and afterwards (reflection-on-action), which further refines clinical knowledge for future situations [1]. This model emphasizes that decision-making is not a single event but a recursive process where reflection feeds back into sharper noticing and interpreting in the future.

Another critical lens is provided by the concept of *Mindfulness* adapted to clinical practice. Mindful practitioners, as described by Epstein, engage in "present-moment awareness" and "cognitive openness" [10]. In practice, this means the nurse consciously avoids automatic, heuristic-driven responses when faced with ambiguity. Instead, they actively cultivate curiosity, observe without immediate judgment, and acknowledge the complexity and uncertainty of the situation. A mindful approach guards against cognitive errors such as confirmation bias (seeking only data that supports a premature conclusion) or anchoring (fixating on an initial impression). For example, when a post-operative patient has unexplained tachycardia, a mindful nurse would resist immediately attributing it to pain, and would systematically consider and assess for other causes

like hemorrhage, infection, or pulmonary embolism before deciding on an intervention. This deliberate, open-minded stance is a cognitive discipline that enhances the quality of decisions made under pressure.

These theoretical models collectively illustrate that effective decision-making without clear orders is a high-level cognitive activity. It integrates pattern recognition from experience (Benner), a structured reasoning process (Tanner), and a disciplined, open cognitive stance (Mindfulness). This integration allows the nurse to fill the gaps left by absent or unclear medical directives with informed, patient-specific clinical reasoning rather than guesswork or fearful inaction.

3. Ethical Frameworks and Moral Agency in Autonomous Decision-Making

When medical orders are absent or unclear, nursing decisions swiftly transition from the purely clinical to the deeply ethical. The nurse becomes a moral agent, required to navigate competing principles and values to determine the right course of action. Several core ethical principles provide the foundation for this deliberation. *Beneficence* (the duty to do good) and *Non-maleficence* (the duty to do no harm) are the most immediate guides [11]. A nurse must weigh the potential benefits of an independent action against its potential risks. Administering a narcotic reversal agent to a sedated patient with depressed respiration, even in the absence of a new order, is justified by the paramount duty to prevent imminent harm (non-maleficence) and to restore physiological stability (beneficence). *Autonomy*, respect for the patient's right to self-determination, also plays a key role. This involves ensuring that actions, even those taken independently in an emergency, align as closely as possible with the patient's known values and preferences, often documented in advance directives or gleaned from previous conversations [12].

Justice, the fair distribution of resources and care, can also be a factor, particularly in resource-constrained environments or when triaging care during a crisis. The principle of *Fidelity*(faithfulness) encompasses loyalty to the patient, the profession, and the collaborative team, creating potential tension when a nurse feels a physician's order (or lack thereof) is not in the patient's best interest [11]. To resolve these tensions, nurses employ ethical decision-making models. These models typically involve steps such as identifying the ethical problem, gathering relevant data, considering the stakeholders, exploring options, applying ethical principles, choosing an action, and evaluating the outcome [13]. For instance, a nurse caring for a terminally ill patient in severe pain may face an ethical dilemma when the prescribed PRN analgesia is insufficient and the covering physician is hesitant to increase the dose. The nurse must balance the duty to relieve suffering (beneficence) with the duty to follow the chain of command and avoid inappropriate medication administration. Applying an ethical model, the nurse might decide to use detailed clinical documentation of the patient's suffering, invoke hospital pain management policies, and escalate the concern to a nursing supervisor or palliative care team—an autonomous decision to advocate through proper channels.

This advocacy role is a direct manifestation of the nurse's ethical responsibility. Patient advocacy means acting as a safeguard, speaking up when the system fails to meet a patient's needs, especially when the patient is vulnerable or unable to speak for themselves [14]. In the context of missing orders, advocacy is not merely a suggestion but a professional obligation. It involves the nurse using their voice and agency to bridge the gap between patient need and medical response. This could manifest as a persistent yet respectful phone call to an on-call provider, a formalized clinical escalation using a tool like SBAR (Situation, Background, Assessment, Recommendation), or, in extreme cases, invoking institutional policies for chain of command or "doctor-issue" protocols to bypass a non-responsive physician. The moral courage required for such advocacy should not be underestimated, as it often involves challenging hierarchy and confronting potential conflict. Ultimately, ethical decision-making in the absence of clear orders is the practical application of nursing's moral compass, ensuring that patient welfare remains the unwavering center of all actions, even when those actions must be taken independently.

4. Legal and Regulatory Dimensions: Scope, Standards, and Liability

The autonomous decision-making of nurses operates within a clearly defined, though sometimes tension-filled, legal and regulatory landscape. The authority to make independent judgments is granted and bounded by two primary sources: the Nurse Practice Act (NPA) of the state or jurisdiction in which the nurse is licensed, and the established standards of care as defined by professional organizations and institutional policy. Every NPA defines the scope of nursing practice, outlining the activities that a licensed nurse is legally permitted to perform. Crucially, these acts often include

language that recognizes and protects nursing judgment. They authorize actions such as assessment, nursing diagnosis, care planning, health counseling, and the execution of medical regimens, but also increasingly acknowledge the independent initiation of certain interventions in specific circumstances or under protocols [15]. Understanding the specific provisions of one's own NPA is the first legal imperative for a nurse contemplating action without a direct order.

The concept of the *Standard of Care* is the legal benchmark against which a nurse's decisions and actions will be measured, especially if an adverse outcome leads to litigation. The standard of care is defined as what a reasonably prudent nurse, with similar training and experience, would do in the same or similar circumstances [16]. This is a powerful concept because it is context-dependent and allows for professional judgment. In a courtroom, expert witnesses would testify not about whether a physician's order was present, but about whether the nurse's actions—from assessment to intervention—met the standard of care for that clinical situation. For example, if a patient falls and hits their head, the standard of care would expect a nurse to perform a neurological assessment, monitor vital signs, and notify a physician. If the nurse failed to do these things simply because there was no order to "assess after a fall," they would likely be found negligent for failing to meet the professional standard, not for disobeying an order.

This directly leads to the critical distinction between *protocols*, *standing orders*, and *individual physician orders*. Protocols and standing orders are pre-approved, written directives that authorize nurses to perform specific actions under defined conditions without having to contact a provider for each instance. Common examples include hypoglycemia protocols, chest pain algorithms, or standing orders for postoperative care [17]. When a nurse acts under a valid protocol, they are legally and professionally protected because they are following an established, institutionally sanctioned pathway. The decision-making involves recognizing that the patient meets the protocol criteria and then executing the steps. Acting outside of protocols or standing orders, however, enters a grayer area. Here, the nurse's legal protection hinges on proving that their action was: 1) Necessary to prevent imminent harm or suffering, 2) Consistent with the standard of care, and 3) Followed by prompt notification of the responsible provider and thorough documentation of the clinical rationale [18]. The legal doctrine of *necessity* can provide a defense for actions taken in true emergencies to preserve life or prevent serious injury.Documentation, in this context, is not merely an administrative task but a legal and professional imperative. The medical record must provide a clear, contemporaneous narrative that justifies the independent action. It should detail the clinical assessment data that signaled a problem, the reasoning process that led to the decision, the specific actions taken, the patient's response, and the communication with the physician or supervisor [19]. Poor or absent documentation creates a vacuum in which a nurse's prudent judgment can be misconstrued as recklessness or negligence. Therefore, the legal environment, while imposing boundaries, also provides the framework that enables and legitimizes autonomous nursing action when it is exercised prudently, within scope, according to standards, and with meticulous documentation.

5. The Role of Communication and Interprofessional Collaboration

While this essay focuses on nursing decision-making in the *absence* of clear orders, it is essential to recognize that such decisions are almost always embedded within, and ultimately accountable to, a system of interprofessional collaboration. Effective decision-making is not about nurses working in isolation but about knowing how to navigate the collaborative ecosystem to fill information gaps and secure patient safety. The goal of an independent nursing action in an ambiguous situation is typically to stabilize the patient and/or to initiate the process of obtaining definitive medical direction. Thus, communication is the bridge that links autonomous judgment back to collaborative care.

Structured communication tools are vital for this linkage. The SBAR (Situation, Background, Assessment, Recommendation) technique is the most widely advocated framework for concise, effective clinician-to-clinician communication, especially during handoffs or when calling a physician with a concern [20]. When a nurse makes an initial decision—for instance, to administer oxygen for declining saturation—the subsequent SBAR call to the physician is where judgment is communicated and validated. The nurse presents the *Situation* ("I'm calling about Mr. Smith in room 402 who is having increased shortness of breath"), the *Background* (his admission diagnosis, relevant history), the *Assessment* (vital sign trends, lung sounds, the nursing diagnosis), and a clear *Recommendation* ("I've started him on 2L oxygen via nasal cannula and his sats are improving to 94%. I recommend he be assessed for a possible diuretic and a chest x-ray"). This format demonstrates professional judgment, provides a

rationale for actions already taken, and directs the conversation toward collaborative problem-solving.

The concept of the *Chain of Command* (or Chain of Communication) is an institutional safety mechanism designed precisely for situations where a nurse's clinical concern is not adequately addressed by the primary provider. If a nurse believes a patient's condition warrants a medical intervention that the covering resident or attending physician is refusing or failing to provide, the nurse has a professional duty to escalate the concern. This involves moving up the hierarchy—from the primary physician, to a fellow or senior resident, to the attending physician, to the nursing supervisor, and potentially to hospital administration or a medical director [21]. Utilizing the chain of command is not an act of disloyalty but a formalized process of advocacy and error prevention. It protects the nurse from allegations of practicing medicine without a license by ensuring that persistent concerns are heard by progressively higher levels of clinical authority until they are resolved.

Furthermore, collaborative models like Interprofessional Collaborative Practice (IPCP) emphasize shared goals, mutual respect, and distributed accountability [22]. In a truly collaborative culture, the boundaries between professions become more permeable, and decision-making becomes more fluid. A nurse's call to a physician might begin with, "I'm concerned about X, and I was thinking Y might be needed. What are your thoughts?" This reflects a partnership. Conversely, physicians in collaborative environments learn to trust and rely on nursing judgment, often giving broader parameters for PRN orders or supportive care. This symbiotic relationship reduces the frequency and stress of "absolute absence" of guidance, as it creates an environment where nursing assessments and recommendations are valued inputs into the medical plan. Therefore, while a nurse must be prepared to decide and act alone, the quality of that decision and its integration into the patient's overall care is profoundly influenced by the effectiveness of communication and the strength of interprofessional relationships.

6. Educational Imperatives and Strategies for Development

The capacity for expert clinical judgment and autonomous decision-making is not an innate trait but a competency that must be deliberately cultivated through education and experiential learning. Nursing curricula, from pre-licensure programs through continuing professional development, must move beyond teaching rote memorization of diseases and tasks to fostering the complex cognitive and affective skills required for judgment under uncertainty. A foundational shift involves integrating *Clinical Reasoning* as an explicit thread throughout coursework. This means teaching students *how* to think, not just *what* to think. Pedagogical strategies such as case-based learning, high-fidelity simulation, and reflective writing assignments are critical. Simulation, in particular, provides a safe, controlled environment for students and practicing nurses to encounter ambiguous clinical scenarios—a deteriorating patient with no clear diagnosis, a family conflict, a vague or conflicting order—and practice the processes of noticing, interpreting, responding, and reflecting without risk to actual patients [23]. Debriefing sessions following simulation are where the deepest learning occurs, as facilitators help learners unpack their thought processes, consider alternatives, and connect actions to theoretical principles.

The teaching and application of *Ethics* must also be contextual and practical. Rather than abstract lectures on principles, education should utilize realistic ethical dilemmas that nurses face daily. Students should practice using ethical decision-making models to work through cases involving pain management at end-of-life, resource allocation, or disagreements with providers [24]. This prepares them to frame their autonomous actions within an ethical framework, understanding that their decisions have moral weight. Similarly, legal education should transcend simple memorization of laws to focus on application: analyzing case studies to determine if a standard of care was met, practicing documentation of independent interventions, and role-playing chain-of-command conversations.

Perhaps the most potent educational tool is the intentional fostering of *Clinical Preceptorship* and *Mentorship*. Benner's model highlights that expertise is gained through experiential learning under guidance [9]. Novice nurses transitioning to practice require the support of proficient and expert nurse preceptors who can model clinical judgment in real-time. A skilled preceptor does not simply provide answers but uses questioning—"What are you noticing?" "What do you think is happening?" "What options do we have?"—to guide the novice through their own reasoning process. This "thinking out loud" mentorship helps novices internalize the cognitive patterns of experts. Furthermore, institutions must create cultures that support reflective practice. This can be encouraged through structured activities like clinical rounds, journal clubs focused on difficult

cases, or peer-review discussions where nurses present challenging situations and collectively analyze the decision-making involved [25]. Such forums destigmatize uncertainty and create collective wisdom, reinforcing that prudent independent action is a valued and discussed aspect of professional practice.

Ultimately, education must aim to develop what has been termed "*tolerance for ambiguity*"—the ability to remain effective and composed when situations are unclear, paths are not prescribed, and outcomes are uncertain [26]. This is an affective skill as much as a cognitive one, involving emotional regulation, resilience, and confidence. By combining robust theoretical grounding in clinical reasoning, ethics, and law with immersive, reflective practical experiences and strong mentorship, nursing education can systematically prepare practitioners to navigate the inevitable gaps in medical orders with competence, confidence, and a steadfast commitment to patient-centered care.

7. Conclusion

Nursing decision-making in the absence of clear medical orders represents one of the most demanding and definitive aspects of professional practice. It is a complex synthesis that resides at the intersection of deep clinical knowledge, patterned experiential wisdom, structured ethical reasoning, and a clear understanding of legal boundaries. As this analysis has demonstrated, such decision-making is not a discretionary or extraordinary function but an intrinsic, daily requirement of the nurse's role as the primary, constant caregiver at the patient's bedside. The theoretical models of Benner and Tanner provide a framework for understanding the cognitive journey from novice rule-following to expert intuitive judgment, while ethical principles offer the moral compass to guide actions when directives are absent. The legal and regulatory environment, far from being a mere constraint, establishes the scope and standards that both empower and hold accountable the nurse's autonomous actions, provided they are executed prudently and documented meticulously.

Critically, effective autonomous practice does not occur in a vacuum. It is inextricably linked to robust communication skills and a culture of genuine interprofessional collaboration. The use of tools like SBAR and the conscientious application of the chain of command are mechanisms that integrate independent nursing judgment back into the collaborative patient care plan, ensuring safety and continuity. Furthermore, the development of this high-level competency is an educational imperative, requiring curricula and professional development programs that prioritize clinical reasoning, ethical deliberation, and reflective practice over rote task-completion.

In the final analysis, the ability to make sound decisions amidst ambiguity is a hallmark of nursing expertise and a cornerstone of patient safety. Healthcare systems are inherently imperfect, characterized by shift changes, human error, communication gaps, and the unpredictable nature of human illness. It is the nurse, armed with professional judgment, moral agency, and the courage to act, who often serves as the final safeguard in these gaps. Cultivating, supporting, and valuing this aspect of nursing practice is therefore not just a professional concern but a fundamental necessity for the delivery of safe, effective, and compassionate healthcare. The nurse who can confidently and competently navigate the absence of clear orders is, ultimately, the nurse who fulfills the profession's most sacred promise: to be a vigilant protector and advocate for the patient entrusted to their care.

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