Perceptions of professional autonomy among rural nurses
by Pamela Joan Swendseid

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Nursing
Montana State University
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Abstract:
The purpose of this study was to measure perceived nursing autonomy of nurses working in a rural setting and to explore the impact of several demographic and work-related variables on the autonomy score. A cross-sectional survey research design was used.

The convenience sample consisted of registered nurses working in seven Montana hospitals. The Pankratz and Pankratz Measure of Nursing Autonomy and Patients' Rights (1974) was distributed to the nurses in an indirect manner by the nursing directors. A total of 219 questionnaires were returned for a response rate of 32%.

The results determined that the rural nurses scored higher on the Nursing Autonomy and the Patients' Rights subscales than the original study in 1974. The score on the Rejection of Traditional Role subscale was lower than the 1974 study. Nurses who worked in a combination of clinical areas, such as in small rural hospitals, scored significantly higher on the Patients' Rights subscale as compared with other clinical areas of nursing. Education was a significant influence on Nursing Autonomy scores, with the bachelor's and master's degree nurses scoring higher than the associate degree and diploma nurses..

Results of this study indicate that rural nurses as a whole perceive themselves to be autonomous and patient advocates.

PERCEPTIONS OF PROFESSIONAL AUTONOMY AMONG RURAL NURSES

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Pamela Joan Swendseid

A thesis submitted in partial fulfillment
of the requirements for the degree

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APPROVAL

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Pamela Joan Swendseid

This thesis has been read by each member of the thesis committee and has been found to be satisfactory regarding content, English usage, format, citations, bibliographic style, and consistency, and is ready for submission to the College of Graduate Studies.

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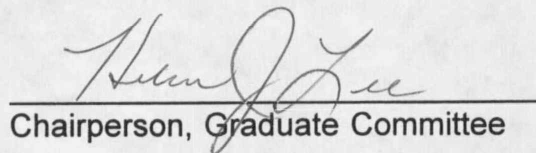
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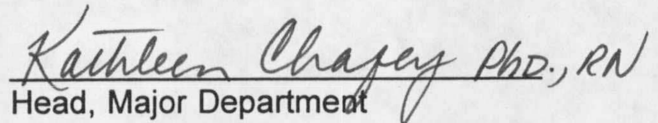
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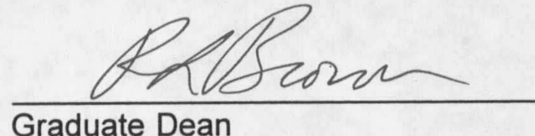
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ABSTRACT

The purpose of this study was to measure perceived nursing autonomy of nurses working in a rural setting and to explore the impact of several demographic and work-related variables on the autonomy score. A cross-sectional survey research design was used.

The convenience sample consisted of registered nurses working in seven Montana hospitals. The Pankratz and Pankratz Measure of Nursing Autonomy and Patients' Rights (1974) was distributed to the nurses in an indirect manner by the nursing directors. A total of 219 questionnaires were returned for a response rate of 32%.

The results determined that the rural nurses scored higher on the Nursing Autonomy and the Patients' Rights subscales than the original study in 1974. The score on the Rejection of Traditional Role subscale was lower than the 1974 study. Nurses who worked in a combination of clinical areas, such as in small rural hospitals, scored significantly higher on the Patients' Rights subscale as compared with other clinical areas of nursing. Education was a significant influence on Nursing Autonomy scores, with the bachelor's and master's degree nurses scoring higher than the associate degree and diploma nurses..

Results of this study indicate that rural nurses as a whole perceive themselves to be autonomous and patient advocates.

CHAPTER 1

INTRODUCTION

Background and Significance of Study

A large number of general hospitals in the western United States are small rural hospitals. The percentage of small hospitals varies from state to state. For example, in the northwest, 73 percent of the hospitals in the state of Montana have fewer than 50 beds. In contrast, Idaho has 60 percent and Washington has 33 percent of their hospitals classified as less than 50 beds (American Hospital Association, 1991).

Nurses employed in small rural hospitals are considered to be working in the realm of rural nursing. Limited literature is available concerning rural nursing practice and the role of the rural nurse. However, the role of the rural nurse in general is very diverse and unique (Scharff, 1987). Competency in several areas of nursing including medical-surgical, obstetrics, pediatrics, psychiatric, intensive care, and emergency care is necessary because the clinical area in which a rural nurse works may change on a daily or even hourly basis. She or he may also be the only nurse in the hospital. In addition, ancillary or support staff are not available on site 24 hours a day, as is common in large urban hospitals. Since the doctors are usually on call and 10 to 30 minutes away, the rural nurse is

frequently in a position to make autonomous decisions concerning patient care. Therefore, the nurse must be able to function independently without the immediate benefit of collaboration with other health care providers.

The relationship between the nurse and the physician in a rural setting has been described as having a high degree of familiarity (Surratt & Swendseid, 1991). Because the nurse and physician live and work together in close proximity in the rural community, the nurse may know what the doctor would want done in a certain situation, and initiate treatment before notifying the physician. Rural nurses may initiate interventions during the evening or night and ask the physician to write an order for these interventions when she or he comes in the next day (Scharff, 1987).

Autonomous practice, which is based on expert knowledge, is considered by many nurses to be the differentiating factor between professionals and nonprofessionals (Mundinger, 1980). Autonomy, a concept that is evolving in nursing, is defined as the freedom to make discretionary and binding decisions consistent with one's scope of practice and the freedom to act on those decisions (Lewis & Batey, 1982). Thus, autonomy is viewed by nurses as power to determine what needs to be done in providing patient care, to act on their assessments, and to accept accountability for those decisions. The nurse must be a competent practitioner of nursing, be capable of independent clinical decision-making regarding nursing care, utilize professional standards to guide nursing

practice, and act within the scope of nursing. Examples of autonomous behavior include initiating teaching and discharge plans, modifying diet and activity orders, individualizing pain control regimes, and making home care referrals when needed. The multiple roles, isolation in practice, and close physician-nurse relationship may be characteristics of rural nursing that may support or promote a high level of autonomy in rural nurses.

Purpose

Knowledge about rural nursing is currently in the early stages of development. Autonomy is a concept that has not been studied in a rural nursing population. Several characteristics of rural nursing, such as the isolation in which the nurses practice, the multiple roles they perform, and the close nurse-physician relationship (Scharff, 1987; Surratt & Swendseid, 1991), may influence the nurse's perceived autonomy. Therefore, the overall purpose of this study is to measure perceived nursing autonomy of nurses working in a rural area and to explore the impact of several demographic and work related variables on the autonomy score.

Research Questions

Research questions related to the purpose of the study include:

1. What is the influence of nursing education on perceived autonomy scores?

2. What is the influence of clinical area of nursing on perceived autonomy scores?

3. What is the influence of size of hospital on perceived autonomy scores?

4. What is the influence of being the only RN in the hospital on perceived autonomy scores?

5. What is the influence of availability of physicians on perceived autonomy scores?

6. What is the influence of shift worked on perceived autonomy scores?

7. What is the influence of type of nursing care delivery system on perceived autonomy scores?

8. What is the influence of age on perceived autonomy scores?

9. What is the influence of number of years in nursing on perceived autonomy scores?

Definitions

For the purpose of this study, the following terms were used.

Nursing Autonomy: The freedom to make discretionary and binding decisions consistent with one's scope of practice and the freedom to act on those decisions (Lewis & Batey, 1982).

Rural: Incorporated or census-designated places of 2500 or more

inhabitants are designated as urban (U.S. Bureau of the Census, 1987). All other places are considered rural. Using this definition, 75.6% of Montana's population is classified rural. For the purpose of this study, the entire state of Montana is considered to be rural.

Nursing Education: Highest level of nursing education achieved.

Clinical Area of Nursing: In larger hospitals, area of nursing in which the respondent works, such as medical-surgical, intensive care, emergency room, obstetrics, pediatrics, and psychiatric.

Size of Hospital: A small rural hospital is defined as one with a capacity of 50 acute care beds or less. A moderate size rural hospital is defined as one with a capacity of 50 to 100 acute care beds. A large rural hospital is defined as one with a capacity of over 100 acute care beds.

Only RN in Hospital: In small rural hospitals, nurses may be the only RN in the building.

Availability of Physicians: Physicians are either available in the building or are on call.

Shift Worked: Classified as primarily days, primarily afternoons, primarily nights, or a rotation of all shifts.

Type of Nursing Delivery System: The type of nursing delivery system is identified as an all RN staff, a combination of RNs and LPNs, or a mixture of RNs, LPNs, and aides.

Number of Years in Nursing: Number of years worked in the

nursing field since completion of basic nursing education.

Assumptions

1. Perceived nursing autonomy can be measured in rural registered professional nurses.
2. The nurses will respond openly and honestly to items on a questionnaire.

CHAPTER 2

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

The literature review focuses on two main topics, the rural nurse and nursing autonomy. In addition, selected pertinent resources from the educational and sociological literature that related to rural autonomy are included.

Rural Nurse

While a few articles about rural nurses are available, little research has been conducted with rural nurses. Most of these studies are qualitative or theoretical in nature.

Weinert and Long (1991) discussed several key concepts for rural nursing theory. These included a lack of anonymity, outsider/insider, and old-timer/newcomer. From a qualitative data base, Weinert and Long derived some relational statements regarding rural nursing. They stated that nurses in rural areas face much greater role diffusion than counterparts in urban settings, and rural nursing is significantly affected by a lack of anonymity. Rural nurses frequently are under pressure to assume the roles of others, such as practicing medicine when a physician is absent.

Scharff (1987) conducted ethnographic interviews with rural nurses in the northwest in order to delineate distinctive characteristics of rural hospital nursing. Scharff found that rural nursing practice frequently intersected with other health care disciplines, most notably, respiratory therapy, pharmacy, and medicine. Also, rural nurses identified that they were often the only RN on duty in the hospital, and they made decisions and acted on these decisions in emergencies and at other times when the physician was not available.

Bunde (1981) also used an ethnographic approach to study rural nurses' perceptions of job stress and coping methods. Six of the 24 nurses interviewed identified as a job stressor their frustration at having been taught to make nursing judgments and then not being allowed to practice the skill. Specific barriers to making nursing judgments were not identified. The rural nurses also identified the isolation in which they practice.

Ballantyne (1988) explored determinants of intended job turnover in rural nurses. While the concept of autonomy was not specifically identified for study, all of the nurses in the study (N=116) stated that decision making was an important job characteristic to them. However, decision making was not clearly defined in the study, nor was it measured in any way.

Nursing Autonomy

Some theoretical articles and editorials have been written about factors that promote nursing autonomy and the positive results of a high level of autonomy. In addition, research articles concerning autonomy in nursing students, faculty, and working nurses have been published that explore the impact of various demographic and work related factors on autonomy.

The impact of the type of nursing delivery system on autonomy has been explored. The prevailing argument is that primary nursing is supportive of and enhances nursing autonomy (Mundinger, 1980; Johns, 1990). The primary nurse is solely responsible for making nursing decisions in relation to patients. Advice from others may or may not be solicited. The primary nurse is ultimately accountable for the patient's care. Johns (1990) states that primary nursing leads to more patient-centered care and also holds the nurse accountable to the patients, the organization, and the profession. A clear job description and support groups for the primary nurse help to foster autonomy.

Hylka and Shugrue (1991) tried to increase staff nurse autonomy by changing the nursing role to one with more accountability. Staff RNs were to accept their own patient/physician orders and collaborate individually with the physician instead of communicating through the charge nurse. This

approach claimed success through improved communication and education. However, no quantitative measurement of autonomy was done.

Roberts (1990) stated that nurses can achieve professional autonomy through the use of nursing diagnosis and nursing DRGs. When admitted to a hospital, a patient is assigned an appropriate nursing diagnosis by the nurse. The nurse, in collaboration with the physician, then manages the patient's stay and decides which diagnoses remain on the active list or are no longer acceptable. Eventually, charges to the patient should be based on nursing diagnosis. As nurses become respected and valued for their unique contributions to patient care, professional autonomy will be enhanced.

Cassidy and Oddi (1989) conducted a study to determine differences in perceptions of ethical dilemmas and attitudes toward autonomy among four groups of nursing students (associate degree, generic baccalaureate, degree completion, and master's study). While no significant differences were found on perceptions of idealistic and realistic moral behavior, significant differences were found among groups on autonomy, patient rights, and rejection of traditional role limitations. Surprisingly, the associate degree and generic baccalaureate students scored significantly higher on the autonomy scale than the degree completion and master's students. When the effects of additional factors on autonomy were examined, it was found that younger nurses scored higher on autonomy

than older nurses, and registered nurses scored higher than non-registered nurses on autonomy. However, the instrument used to measure autonomy in this study (JAND--Judgments About Nursing Decisions and NAPRS--Nursing Autonomy and Patient's Rights Scale) was altered and certain items were deleted. This may have compromised the validity of the instrument.

Cassidy and Oddi (1991) replicated the above study; age and autonomy was again significantly correlated. In contrast to the original study, masters students scored significantly higher on autonomy than the other three groups. Also, registered nurses scored significantly lower than non-registered nurses on autonomy; this finding was in direct opposition to the original study. No conclusions on the effects of these variables can be drawn on the basis of these findings. The proportion of students representing the subgroups in the sample differed from the original sample due to a low response rate, and the possibility of bias exists.

Senior nursing students in diploma, associate degree, and baccalaureate nursing programs were the focus of a study on autonomy by Murray and Morris (1982). The nursing autonomy tool developed by Pankratz and Pankratz (1974) was administered to 224 nursing students from the three programs; the tool measured three variables of professional autonomy: nursing autonomy, promotion of patient's rights, and rejection of traditional role. The baccalaureate students scored higher on the Nursing

Autonomy and the Patients' Rights subscales than the other two groups. No significant difference was noted between groups on the Rejection of Traditional Role Limitations subscale.

Grandjean, Aiken, and Bonjean (1976) explored the professional autonomy and work satisfaction of nursing educators at four major state universities. Teaching, supportive colleagues, keeping clinical knowledge current, and faculty autonomy were seen as the most important aspects of the job. Salary, fringe benefits, and other extrinsic rewards ranked substantially lower in importance. Satisfaction with the more important conditions was generally low; lack of faculty participation in decision making was a particularly noteworthy source of dissatisfaction. The researchers suggested that increased professional autonomy would benefit faculty morale, recruitment, retention, and overall effectiveness in nursing education.

A study by Katzman (1989) compared perceptions of 163 nurses and physicians on the current and ideal status of the decision-making authority of professional nurses. The areas with the highest difference between physicians and nurses currently concerned patient care; nurses felt they should have more autonomy than the physicians thought nurses should exercise. Examples of differences were initiating physical assessments, answering patient's questions about medical treatment, changing inappropriate diets, deciding frequency of vital signs, and deciding what to

teach patients. One area that showed a major difference between the groups, currently and ideally, was the notion, held by physicians but not by nurses, that the nurse was primarily the physician's assistant.

Carmel, Yakubovich, Zwanger, and Zaltcman (1988) studied the relationship between nursing autonomy and job satisfaction in Israel. Due to a physician's strike, nurses delivered primary health care services for a period of three months. Job satisfaction and perceived autonomy were significantly higher during the strike period. Many nurses took an autonomous role and developed new programs. However, when the strike was over, the nurses did not attempt to retain any of their new roles. The authors concluded that in Israel, the nurses were able to take on the challenge of autonomy, but were not willing to publicly struggle to maintain it. Cultural differences regarding the traditional role of women in society could have had an effect on this study.

A descriptive study was done by Collins and Henderson (1991) to determine how autonomous registered nurses working in a hospital perceived themselves, and to assess the relationship of certain demographic variables to their perceived autonomy. The Pankratz and Pankratz Nursing Autonomy and Patients' Rights Questionnaire (1974) was used. Age and experience were not significantly related to autonomy scores. Based on this sample, the nurse scoring highest on autonomy was female, held a master's degree, and had an administrative role in the

clinical area of emergency nursing. Psychiatric nurses and critical care nurses closely followed the emergency nurses in scores on the rejection of traditional role limitations. It was hypothesized by the authors that these nurses are often expected to take the initiative with patients. The physicians and nurses are well-known to one another, work closely in treatment situations, and develop mutual trust and respect for each other's capabilities. These characteristics are also present in small rural hospitals, and may have a positive influence on rural autonomy scores.

In 1986, Wood, Tiedje, and Abraham conducted a study with a sample that included community health nurses with baccalaureate nursing degrees, senior-level generic nursing students, and registered nurses in a baccalaureate nursing program. A total of forty-five subjects were compared on age, years of employment in nursing, and professional autonomy. The community health nurses received higher mean scores on the nurses' rights and responsibilities dimension of autonomy than the generic nursing students and the registered nurses. A significant negative correlation was observed between the community health nurses' ages and their autonomy scores, meaning younger nurses perceived higher autonomy levels. Also, a significant correlation was observed between registered nurses with more years of employment and the nursing autonomy scores. The autonomy scale in the study was altered to render the tool appropriate for nurses working outside of the hospital. No reliability or validity data was

given for the altered tool. Because the sample in this study was convenient and small, the results must be viewed with caution.

Perry (1986) published an article discussing a research project about autonomy and self concept in a random sample of nurses (N=106) from the midwestern United States; however, no actual statistical data was given. The autonomy scale by Pankratz and Pankratz (1974) and the Tennessee Self Concept Scale were used. No significant relationship was found between self-concept and autonomy. However, a significant relationship between self-concept and client advocacy was found. Client advocacy was measured by the promotion of patient's rights dimension on the autonomy scale. This was interpreted to mean that the nurses were more inclined to be client advocates if they felt good about themselves. A positive correlation was found between autonomy and highest degree held, and a negative correlation between autonomy and years active in nursing. Again, no statistical data was presented to indicate the strength of these correlations.

The interaction of autonomy and social integration (relationships with co-workers) on job contentment was the focus of a longitudinal study by McCloskey (1990). Nurses with high autonomy and high social integration had more job satisfaction, were more committed to the organization, had more job motivation, and indicated more intent to stay on the job than those nurses with low autonomy and low social integration. The nurses with low

autonomy and low social integration were older, had more nursing education, tended to work on medical units, and used functional or team nursing. Highly autonomous nurses tended to work in intensive care units and use primary nursing.

Autonomy in Rural Areas

The need for expanding nurse autonomy in small rural hospitals was addressed by Wiens (1990). She identified the limitations placed on rural nurses by physicians, and the frustration experienced by the nurses when lack of autonomy prevents immediate response to patient needs due to no immediate availability of medical staff. Weins suggests clinical ladders and/or modified shared governance models of nursing to enhance autonomy in rural areas.

Autonomy in Rural Education

This search for literature has failed to produce any studies that examine or measure autonomy in the rural setting. However, the concept of autonomy in rural areas has been explored in educational literature. Haughey and Murphy (1983a, 1983b) conducted a study to determine the extent to which rural teachers in small remote schools in British Columbia were satisfied with the quality of their work life. Factor analysis derived seven categories that related to job satisfaction. Professional autonomy

was one of these categories. Autonomy was defined as the freedom to select subject matter, and the freedom to select teaching methods and materials. The professional autonomy associated with teaching generated the greatest amount of satisfaction in the respondents, with 70% of the sample being moderately or highly satisfied with their autonomy. Major contributors to the high turnover rate of rural teachers were identified as lack of privacy, geographic isolation, and lack of professional contacts. These concepts are remarkably similiar to the professional isolation and lack of anonymity reported for rural nursing by Weinert & Long, (1991).

Rural school psychologists were asked to describe the advantages of working in rural school settings in California, Georgia, Indiana, and Iowa (Huebner, McLeskey, & Cummings, 1984). Three main clusters of responses emerged; they included close contact and good working relationships with teachers, administrators, and parents, role diversity and autonomy, and positive environmental context. A "very high" and "high" job satisfaction was reported by 59% of the respondents. The school psychologists indicated a considerable degree of diversity and autonomy in their role functions and they reported practicing as generalists. The environmental context cluster included several rural concepts including high visibility, the initial mistrust, and the complexities of coping with multiple relationships with a single client. However, the most rural school included in the study had a mean population of 376 students and was in an outlying

area of a metropolitan area of 50,000 people. Applying these results to small remote rural areas must be done with caution.

The perceived problems of beginning secondary teachers was compared on the basis of location (inner-city, outer-city, suburban, and rural) by Kennedy, Cruickshank, and Myers (1976) in Ohio. Professional autonomy was defined as wanting greater control over what one can and cannot do as a teacher, and being able to make decisions that affect teaching. Inner-city teachers reported a significantly greater frequency of problems associated with professional autonomy than the other three groups. These problems included avoiding duties inappropriate to the professional role and changing school policies and regulations. Of the four groups, the suburban teachers reported the least frequency of problems with professional autonomy. Stratified samples were used but not clearly defined in this study; the respondents were asked to select the term they felt best described their school. The resulting rural sample is not described in relation to population or size, therefore generalizability is limited.

<u>Autonomy in Rural Families</u>

A survey of sociological and psychiatric literature revealed several articles and research relating to autonomy and rural areas. Rural adolescents' views of life possibilities and perceptions of autonomy and family decision making were studied by Sundberg, Tyler, and Poole (1984).

High school ninth-graders were given identical questionnaires in 1967 and 1979 relating to perceived future events, leisure activities, occupations, autonomy, and decision making. The later group showed significant increases in possibilities for occupations and leisure activities. The range of life possibilites broadened considerably over the time span; adolescents in the 1970s were aware of many more things that they might do. The girls listed more traditionally masculine occupations, such as truck drivers. However, the boys did not list traditionally female occupations, such as nursing. Changes in school curriculums and influences of the mass media were suggested as possible reasons for the increase. As compared to their 1967 counterparts, the boys in 1979 perceived less family cohesiveness and girls more autonomy.

The attitudes of junior high girls' toward the rights and roles of women were explored by Hertsgaard and Light (1984). The sample consisted of girls who lived on a farm, in a town of under 10,000, or in a city of over 10,000. Overall, the sample held a moderate view toward women's rights and roles. Moderate was defined as somewhere between the traditional conservative attitude and the liberal pro-feminist attitude. The more rural farm girls tended to be more conservative in their attitudes than their small-town and urban counterparts.

Jurich, Schumm, and Bollman (1987) collected data from mothers, fathers, and adolescents in rural and urban areas on the degree of family

orientation. A ten-item questionnaire was created to assess family versus individual orientation, the adolescent's involvement in the family, and the parents' contribution to the family. No reliability or validity of the instrument was discussed. The data were analyzed for rural-urban differences. Adolescent samples from both environments favored more family autonomy than did their parents; they felt that mothers and fathers should be more family oriented and did not favor physical punishment. However, the rural adolescents agreed more with their parents and were more family oriented than their urban counterparts. Rural parents were more family oriented than the urban parents. The authors speculated that because the rural community is centered around family participation, the rural family members seem to have less of an individualistic philosophy and there is more consensus among family members.

Family and job influences on role satisfaction of employed rural mothers was the focus of a study by McHenry, Hamdorf, Walters, and Murray (1985). One hundred fifty rural employed mothers were surveyed using established tools to determine family and job predictors of satisfaction with the dual-work role. Contrary to the original hypotheses, the job satisfaction variables of performance, progress, duties, and benefits proved to be more predictive of satisfaction with the dual-work role than family or psychosocial variables. The only significant family variable was children's support. The women in this study were in their forties and their children

were in adolescence; they may have seen their work as more central in their lives since household responsibilities and child care had greatly diminished at this stage in the life cycle.

Conceptual Framework

The major concept in this study is nursing autonomy. Professional autonomy means that practitioners are self-regulating and have control over their functions in the work situation. The authority to make and act on decisions is derived from the expert knowledge of the nurse. Accountability for the decision rests with the nurse (Nazarey, 1985). The autonomous nurse has the freedom to define her or his own tasks or projects, the methods or procedures used to accomplish those tasks, how problems or exceptions will be handled, and what criteria will be used to evaluate performance (Edwards, 1988).

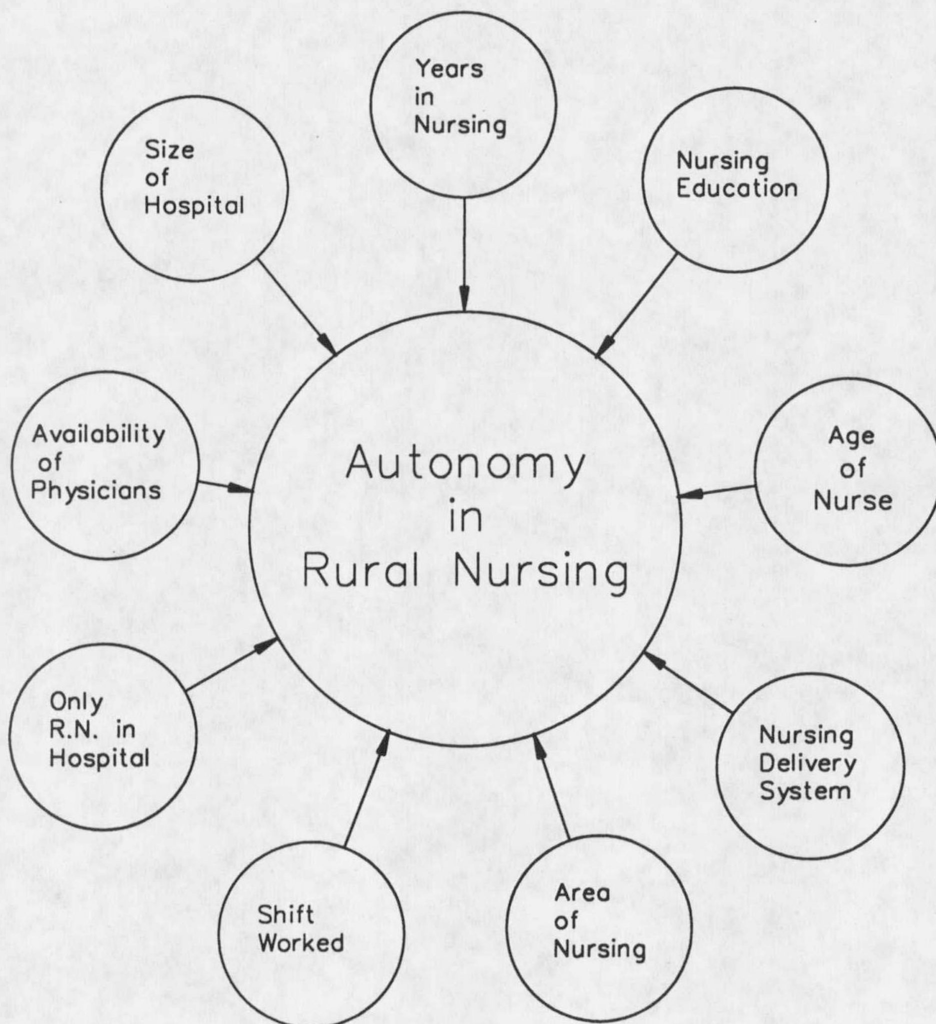
Nurses in small rural hospitals have been observed acting in an autonomous way, more so than their counterparts in larger hospitals. It is possible that the rural environment fosters autonomy through the multiple roles, isolation of practice, and close nurse-physician relationship. Two variables, size of hospital and availability of physicians, were identified to explore this observation.

The number of years in nursing, nursing education, age, area of nursing, and type of nursing delivery system have been explored in other

studies relating to autonomy (Cassidy & Oddi, 1989; Collins & Henderson, 1991; Murray & Morris, 1992; Perry, 1986; Wood, Tiedje, & Abraham, 1986). These preceding variables were thought to be appropriate and selected for this study also.

The "shift worked" variable was developed by the researcher after observing that nurses who worked the night shifts appeared to act more autonomously than those who worked day shifts. Availability of physicians and being the only RN in the hospital at night could have an impact on this observation. These variables were added to explore their impact on autonomy.

The model developed for the study has autonomy in rural nursing at the center (See Figure 1). The nine variables are shown as having some impact on the autonomy. The study will explore the impact, if any, of these nine demographic and work-related variables.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CHAPTER 3

METHODOLOGY

Design

Since the purpose of this study was to measure autonomy in rural nurses and look at the impact of the identified demographic and work-related variables at one specific point in time, an exploratory cross-sectional survey research design was chosen. This survey method was chosen because there was an established pencil and paper test available to measure the concept of autonomy. In addition, this method allowed an appropriate number of nurses to be included in the sample. The cost and time associated with administering the instrument was also manageable.

Population and Sample

The population selected for this study was registered nurses working in Montana hospitals with acute care beds. By limiting the sample to one state, any differences in each state's Nurse Practice Act that could influence the delivery of care was avoided. The state of Montana was chosen because it is a rural state and it is the researcher's place of origin. Montana also has a relatively non-restrictive Nurse Practice Act.

A convenience sample was chosen for this study. This method of

sampling was chosen over a random sampling of all registered nurses to ensure that the small and larger hospitals would be equally represented. To be included in the study, a hospital had to be listed in the American Hospital Association's 1991 directory and had to categorize services as general medical-surgical. Psychiatric, drug and alcohol, and rehabilitation hospitals were excluded. An additional selection criteria was that hospital ownership had to be community-based. This excluded veteran, military, and public health service Indian hospitals. The organizational structure and advancement policies of these institutions were thought to be different from the general rural community or church owned hospitals, and could possibly have an impact on the perceived autonomy scores of nurses. A large number of rural hospitals have nursing home beds included in the total bed count. These hospitals were included as long as acute care services were also available. Acute care was considered to be services where the average length of stay for patients is less than 30 days (American Hospital Association, 1991).

The study sample of nurses was drawn from five hospitals that were a part of the Montana Consortium for Excellence in Patient Care and two Montana hospitals not in the Consortium. The Consortium includes three hospitals with greater than 150 beds and four hospitals with less than 75 beds. Two Consortium hospitals declined to participate. To ensure an adequate sample size of nurses from small rural hospitals, two hospitals

with less than 50 beds in western Montana that were not in the Consortium were included to complete the hospital sample. The seven hospitals represent all areas of Montana.

Nursing directors or nurses who spend 75-100% of their time in administrative capacities were excluded from the study. This was to ensure that the sample's homogeneity was maintained. Nurses who had just graduated from their basic nursing education within the past year were also excluded for the same reason. In the hospitals with 51 beds or more, the nurses who worked on medical/surgical, intensive care, emergency care, and obstetric areas were included.

A total of 686 questionnaires were distributed to nurses in the seven hospitals and 219 usuable questionnaires were returned to the researcher. This represents a return rate of 32%.

Procedures for Data Collection

The Consortium coordinators or nursing directors from the seven hospitals were sent an introductory letter briefly describing the study (Appendix A). Approximately one week later, the researcher telephoned the coordinator or director and again described the study (Appendix B). It was stressed that participation by the hospital and nurses was voluntary. If the coordinator or director indicated willingness to participate, she or he was asked the number of nurses that met the sample criteria and the

appropriate number of questionnaires were sent to them. They were asked to distribute the questionnaires in an indirect manner to avoid coercion and to protect the potential participants' anonymity (Appendix C). A cover letter (Appendix D) was included with each questionnaire that explained the study. Participants were asked to complete the questionnaire and mail it in the enclosed prepaid envelope within one week of receiving it. Data collection ended two months after the original mailing to the nursing directors.

Instrument

The instrument used for this study was the Nursing Autonomy and Patients' Rights Questionnaire developed by Pankratz and Pankratz (1974) (Appendix E). Permission to use the instrument was obtained from the authors. It is a 47-item self-administered instrument that is answered using a five point Likert-type scale (1=strongly agree, 5=strongly disagree). The instrument contains three dimensions derived by factor analysis: nurses' autonomy, patients' rights, and nurses' rejection of traditional role limitations.

The nursing autonomy dimension measures nurses' perception of their rights, taking initiative, and assuming responsibility. Representative items include, "I would feel free to try new approaches to patient care without the permission of an administrative nurse" and "I do not answer too

many of the patient's questions because the doctor may have another plan in mind." The second dimension, patients' rights, refers to the nurse-patient relationship and focuses on how much latitude patients have or are allowed in knowing about and participating in their own care and treatment. The scale measures nurses' feelings concerning how much freedom they allow for the patient. Examples include "I feel the patient has a right to refuse care" and "I feel I should suggest to patients, family, and doctors any community resources I know are available." The last dimension, rejection of traditional role limitations, measures nurses' willingness to become involved with patients' personal matters and their relationship with other health professionals, particularly physicians. Representative items include "I have fulfilled my responsibility when I report a condition to a doctor" and "If I requested a psychiatric consultation for a patient, I would feel out of bounds."

The original instrument was administered to 702 subjects. Data were factor analyzed independently using a method known as the BC TRY System Cluster and Factor Analysis (Pankratz & Pankratz, 1974). Four clusters were retained by this method; the fourth cluster contained only three items and was dropped from further study (Pankratz & Pankratz, 1974). Reliability coefficients were as follows: Cluster #1 nursing autonomy .93, Cluster #2 patients' rights .81, and Cluster #3 nurses' rejection of traditional role limitations .81.

The data were also independently analyzed using the Pinneau method of factor analysis. The three factors derived had remarkable resemblance to the three clusters derived by the BC TRY system (Pankratz & Pankratz, 1974).

Content and face validity were established (Wood, et al, 1986). The questionnaire included a reasonable representative sampling of the domain of conflicts in nursing autonomy and the three dimensions which embody the major facets of autonomy. The three dimensions of autonomy in the instrument (nursing autonomy, patient's rights, and rejection of traditional role limitations) are congruent with the definition of autonomy as is used in this study.

Several demographic and work-related items were added to the questionnaire following the instrument (Appendix F). The questions related to the respondent's age, educational background, years in nursing, size of hospital, area of nursing, shift worked, type of nursing care delivery system, and availability of physicians.

Human Subjects

There were no identified risks to the participants in this study. There were also no direct benefits to be gained by the participants. Data obtained from participants in the study will add to the knowledge base about rural nursing. Exploration of possible indicators of autonomy will help nursing

define characteristics of autonomy.

Following approval by the Montana State University College of Nursing Human Rights Committee, the researcher made initial contact with the Consortium coordinators and nursing directors by an introductory letter. Approximately one week later, they were contacted by telephone and a brief description of the study was given. If verbal consent was given, packets were mailed to the directors. These individual packets contained four items. The first item was a cover letter to the coordinators and directors that listed guidelines for distributing the packets to the registered nurses. The second was a consent form for the coordinators and directors to sign and return to the researcher. An additional copy was included for the hospital's records. The third item was a cover letter to the registered nurses that stressed that participation was strictly voluntary and all responses would remain anonymous. The data was analyzed as group data only. The participants were not required to sign the letters and they could keep them. Consent was implied by the returned questionnaire. The fourth item was the 47 item questionnaire with the demographic questions included at the end.

In order to protect the anonymity of the participants, they were instructed not to make any identifying marks on the questionnaire. The completed questionnaires were kept in a locked file cabinet at the researcher's place of residence and destroyed once the study was

completed. The researcher's name, address, and telephone number were included in the cover letter, so the participants could call or write if questions arose. A short summary of the results was sent to the coordinators and directors upon completion of the study, and they were asked to share this information with the nurses.

Statistical Analysis

The data collection period ended two months after the packets had been mailed to the nursing directors. All statistical tests were computed using the StatPac Gold Statistical Analysis Package by Research Information Specialists in Mesa, Arizona. Guidelines developed by Pankratz and Pankratz (1974) (Appendix G) were used to score and interpret the autonomy questionnaire responses. A mean score was computed for each of the three dimensions of autonomy (nursing autonomy, patients' rights, and rejection of traditional role). This gave a perceived measurement of autonomy in rural nurses.

Descriptive statistics (mean, standard deviation, and range) were applied to all demographics and the three subscales of the instrument. The reliability of the autonomy instrument's subscales was computed using Cronbach's alpha.

To explore the relationship of some demographic and work related variables on the three dimensions of autonomy, an analysis of variance was

used. A Pearson's correlation was used to determine relationships between the age of nurses and number of years in nursing for each of the three dimensions of autonomy. A $p<0.05$ level of significance was utilized throughout the study.

CHAPTER 4

RESULTS

The purpose of this study was to measure perceived autonomy of nurses working in a rural area and to explore the impact of several demographic and work related variables on the autonomy scores. The results are presented in the following order: (1) description of the sample, (2) autonomy scores, and (3) impact of the demographic and work related variables on the autonomy scores.

Description of Sample

A total of seven hospitals in Montana consented to participate in the study. Three of the hospitals have 100 beds or more and four of the hospitals have 50 beds or less. A total of 686 questionnaires were distributed to the nurses by the nursing coordinators or directors in an indirect manner. All registered nurses working in the small hospitals were given the opportunity to participate, while medical-surgical, intensive care/critical care, emergency, and obstetric registered nurses in the larger hospitals were invited to participate. A total of 219 questionnaires were returned. This represents a return rate of 32%.

Autonomy Scores

The returned questionnaires were scored according to guidelines developed by Pankratz and Pankratz (1974). Cronbach's alpha levels for the Nursing Autonomy and Patients' Rights Questionnaire were as follows: Nursing Autonomy .71, Patient Rights .88, and Rejection of Traditional Role .82. Table 1 illustrates the means computed for each of the three subscales as compared with the means from the original study by Pankratz and Pankratz (1974). The mean scores for nursing autonomy and patients' rights are greater than the original study, while the mean score for rejection of traditional role is lower.

Table 1

Subscale Means and Range for Current and Original Study

	Swendseid 1994 (N=219)			Pankratz & Pankratz 1974 (N=702)		
Subscale	Mean	SD	Range	Mean	SD	Range
Nursing Autonomy	91.8	10.1	60-122	84.6	16.6	74-102
Patients' Rights	59.2	6.7	18-70	56.6	6.1	54-61
Rejection of Traditional Role	46.9	5.9	20-59	50.2	7.3	46-56

Collins and Henderson (1991) conducted a similar study using the Pankratz and Pankratz Nursing Autonomy and Patients' Rights Questionnaire in a sample of acute care nurses. The mean scores for the three subscales as compared with the current study are in Table 2. The range of scores for the Collins and Henderson study were not available. The sample in the current study scored higher on the Nursing Autonomy subscale and almost the same on the Patients' Rights subscale. The Rejection of Traditional Role subscale score is lower in the current study that the 1991 study.

Table 2

Subscale Means for Current and 1991 Study

	Swendseid 1994 (N=219)		Collins and Henderson 1991 (N=208)	
Subscale	Mean	SD	Mean	SD
Nursing Autonomy	91.76	10.08	86.88	9.56
Patients' Rights	59.18	6.73	59.82	4.99
Rejection of Traditional Role	46.91	5.89	50.88	5.20

Impact of Demographic and Work-Related Variables

What is the influence of the selected demographic and work related variables on perceived autonomy scores? The selected variables included nursing education, clinical area of nursing, size of hospital, availability of physicians, shift worked, type of nursing care delivery system, age, and years in nursing. The results are presented in the following discussion.

Nursing Education

The distribution of the registered nurses in relation to nursing education is illustrated in Table 3. Over half of the respondents (54%) had bachelors degrees and one third (33%) had associate degrees. The remaining respondents, had a nursing diploma (11%) and a masters degree (2%).

Table 3

Nursing Education (N=214)

Nursing Education	n	%
Associate Degree	70	33
Diploma	24	11
Bachelors Degree	115	54
Masters Degree	5	2

The bachelors and masters degree groups were combined for further analysis. The associate degree and diploma groups were also combined. An analysis of variance showed a difference between the two groups on the Nursing Autonomy subscale. The level of significance is .08, which is close to the .05 standard. No significant differences were noted between the Patients' Rights and Rejection of Traditional Role subscale and nursing education (Table 4).

The mean score for the bachelor's and master's degree nurse group was 92.84. The associate degree and diploma nurse group's mean score was 90.41.

Table 4

Results of Analysis of Variance: Nursing Education

Subscale	DF	ss	ms	F	Significance
Nursing Autonomy	1	302.40	302.40	2.96	.08
Patients' Rights	1	83.48	41.74	.91	.40
Rejection of Trad. Role	1	14.66	7.32	.21	.81

Clinical Area of Nursing

The respondents were asked to indicate the clinical area of nursing they worked 50% or more of the time (Table 5). One third (37%) reported working in the medical-surgical area and nearly one third (30%) reported working in the intensive care and critical care areas. Ten respondents (5%) chose the combination response; those respondents all worked in hospitals with 25 or less acute care beds. Twenty-three respondents (11%) indicated working in other areas, which included telemetry, dialysis, geriatric, neurology, orthopedics, and oncology.

Table 5

Clinical Area of Nursing (N=220)

Area of Nursing Work 50% or more	n	%
Medical-Surgical	81	37
Pediatrics	14	6
Obstetrics	14	6
Intensive Care or Critical Care	65	30
Emergency	10	5
Combination of All Above	10	5
Other	23	11

For further analysis, the pediatric and obstetric groups were combined and the intensive care/critical care and emergency groups also were combined. An analysis of variance showed the sample differed significantly on the Patients' Rights subscale ($F = 2.58$; $p<.05$). The nurses who chose the combination response had the highest mean score of 64.0. In descending order respectively, the mean scores for the other groups are: pediatric/obstetric M = 60.75, "other" M = 59.36, medical-surgical M = 59.36, and intensive care/critical care/emergency M = 57.74. The ten nurses who indicated they worked a combination of clinical areas worked in hospitals with less than 25 beds. Post hoc comparisons using the Tukey test indicated a significant difference ($p<.05$) between the combination nurses and the intensive care/critical care/emergency nurses. Results of the analysis for the Nursing Autonomy and Rejection of Traditional Role subscales revealed no significant differences between the groups. Table 6 illustrates the analysis for clinical area of nursing.

Table 6

Results of Analysis of Variance: Clinical Area of Nursing

Subscale	DF	ss	ms	F	Significance
Nursing Autonomy	4	262.41	65.60	.63	.64
Patients' Rights	4	457.32	114.33	2.56	.04*
Rejection of Trad. Role	4	93.52	23.38	.66	.62

<u>Size of Hospital</u>

The majority of respondents (64%) reported working in a hospital with 101 or more acute care beds. Thirty-nine respondents (18%) reported working in a hospital with 26-50 beds and 23 respondents (11%) reported working in a hospital of 25 beds or less. Table 7 illustrates the responses for size of hospital.

Table 7

Size of Hospital (N=220)

Size of Hospital	n	%
1-25 Beds	23	11
26-50 Beds	39	18
51-100 Beds	18	8
101+ Beds	140	64

The 51-100 bed group was collapsed with the 101+ group for further analysis. Also the 1-25 bed group and 26-50 bed group were combined. The mean scores for small rural hospitals (<50 acute care beds) and large rural hospitals (51> acute care beds) are respectively: Nursing Autonomy 91.8 and 91.7, Patients' Rights 60.1 and 58.8, and Rejection of Traditional Role 46.8 and 46.9. No significant findings were revealed by an analysis of variance (Table 8).

Table 8

Results of Analysis of Variance: Size of Hospital

Subscale	DF	ss	ms	F	Significance
Nursing Autonomy	1	.41	.41	.004	.95
Patients' Rights	1	78.98	78.98	1.74	.19
Rejection of Trad. Role	1	.14	.14	.004	.95

Only RN in Hospital

The respondents were asked if they were ever the only registered nurse in the hospital. The results are illustrated in Table 9. Eleven respondents (5%) reported yes and 53 respondents (24%) reported no. The remaining respondents (71%) worked in a large hospital and chose the

"not applicable" response.

Table 9

Only RN in Hospital (N=217)

Only RN in Hospital	n	%
Yes	11	5
No	53	24
Not Applicable	153	71

No significant findings were revealed by an analysis of variance on the "only RN in the hospital" variable. Table 10 illustrates the data.

Table 10

Results of Analysis of Variance: Only RN in Hospital

Subscale	DF	ss	ms	F	Significance
Nursing Autonomy	1	21.38	21.38	.21	.65
Patients' Rights	1	52.68	52.68	1.76	.19
Rejection of Trad. Role	1	7.49	7.49	.26	.61

Physician Availability

Physician availability was categorized as physicians being available in the building or on call at their home or clinic. More than half of the respondents (58%) indicated the physician was in the building and 42% indicated the physician was on call. The results are summarized in Table 11.

Table 11

Availability of Physicians (N=216)

Physician Availability	n	%
In Building	126	58
On Call	90	42

Table 12 illustrates the results of an analysis of variance with the variable availability of physicians. No significant differences between groups were revealed.

Table 12

Results of Analysis of Variance: Physician Availability

Subscale	DF	ss	ms	F	Significance
Nursing Autonomy	1	.43	.43	.004	.95
Patients' Rights	1	3.40	3.40	.07	.79
Rejection of Trad. Role	1	3.16	3.16	.09	.76

Shift Worked

Table 13 presents the distribution of the shift worked 50% or more of the time by the respondents. Almost half of the respondents (45%) worked day shift and one quarter (25%) worked night shift. Thirty-seven respondents (17%) indicated they rotated shifts. Responses under the "other" category (4%) included rotating day and night shift and 12 hour weekend shifts.

Days and afternoons were collapsed into one group for further analysis. An analysis of variance for the variable shift worked and the three autonomy subscales revealed no significant differences between groups. The results are in Table 14.

Table 13

Shift Worked (N=216)

Shift Worked	n	%
Days	98	45
Afternoons	18	8
Nights	54	25
Rotate Shifts	37	17
Other	9	4

Table 14

Results of Analysis of Variance: Shift Worked

Subscale	DF	ss	ms	F	Significance
Nursing Autonomy	3	295.35	98.45	.96	.41
Patients' Rights	3	35.65	11.88	.27	.86
Rejection of Trad. Role	3	40.43	13.48	.38	.76

Nursing Care Delivery System

Table 15 illustrates the distribution of responses to type of nursing care delivery system. A large majority (69%) indicated mixed caregivers, which included RNs, LPNs, and aides. Thirty-five respondents (16%) reported a mixture of RNs and LPNs, and 30 respondents (14%) reported

an all RN Staff.

Table 15

Nursing Care Delivery System (N=218)

Staffing Mixture	n	%
All RN Staff	30	14
Mixture RN & LPN	35	16
Mixture RN, LPN, & Aides	151	69
Other	2	1

For further analysis, the "other" category was deleted. No significant differences between groups were noted on an analysis of variance between nursing care delivery system and the three nursing autonomy subscales (Table 16).

Table 16

Results of Analysis of Variance: Nursing Care Delivery System

Subscale	DF	ss	ms	F	Significance
Nursing Autonomy	2	63.77	31.88	.31	.73
Patients' Rights	2	99.77	49.89	1.10	.34
Rejection of Trad. Role	2	117.22	58.61	1.68	.19

<u>Age</u>

The age distribution of the registered nurses is illustrated in Table 17. Nearly half of the respondents (47%) were in the 30-39 year age group. Sixty four respondents (30%) were in the 40-49 year age group and 28 (13%) were in the 20-29 year age group. The remaining 22 respondents (10%) were 50 years or older.

Table 17

Age of Registered Nurses (N=216)

Age	n	%
20-29	28	13
30-39	102	47
40-49	64	30
50-59	17	8
60-69	5	2

To determine if there was a relationship between age and the three autonomy subscales, a Pearson product correlation was calculated on the data. The correlation coefficient for the Nursing Autonomy, Patients' Rights, and Rejection of Traditional Role subscales are respectively r=.06, r=.08, and r=-.0003. No significant correlations were noted.

Years in Nursing

Table 18 presents the distribution of total number of years in nursing. A large number (52%) of the respondents reported working 1-10 years, with 57 working 1-5 years (28%) and 49 working 6-10 years (24%). Over one third of the respondents (37%) reported working 11-20 years in nursing, and the remaining 33 (16%) reported working 21 years or more in nursing.

Table 18

Number of Years in Nursing (N=217)

Years in Nursing	n	%
1-5	57	28
6-10	49	24
11-15	38	18
16-20	40	19
21-25	18	9
26-30	10	5
31+	5	2

A correlation was done on the data to determine if there was a relationship between years in nursing and the three nursing autonomy subscales. The correlation coefficients were Nursing Autonomy, $r = .08$, Patients' Rights, $r = .05$, and Rejection of Traditional Role, $r = .05$. No significant correlations were noted.

<u>Comments</u>

The nurses were asked to write their comments concerning rural nursing and autonomy. Several responses were noted. The main theme related to the nurse-physician relationship. For example, "must have good working relationship with physicians--feel free to suggest, agree, or disagree," "autonomy depends on the situation and who the attending physician is," and "some of my answers depend on communication RN has with physician--if rapport is good."

One nurse compared her experiences working in small and large rural hospitals. She wrote the following:

> I have worked in rural hospitals for all my career--from 16 beds to 280 beds in North Dakota, Montana, Washington, and California. I found the smaller the facility the more autonomy I had--without physicians in house it was necessary to make decisions in a crisis. I now, in the 280 bed facility, don't make these as often. However, in this facility I have better back up for physician problems and more resources if I feel the doctor is being neglectful or not receptive to pertinent information regarding the patient.

CHAPTER 5

DISCUSSION

The purpose of this study was to measure perceived autonomy in a sample of rural nurses and examine the impact of several demographic and work related variables on the autonomy scores. Nursing autonomy has been studied in urban areas in large hospitals, however no studies have been done in small hospitals in rural areas.

Autonomy

The rural nurses as a whole scored higher on the Nursing Autonomy and Patients' Rights subscales than the nurses in the original study by Pankratz and Pankratz (1974). While the increase in scores may be attributed to the rural environment, it must be acknowledged that the instrument and original scores are twenty years old. Nursing as a profession may possess a higher level of autonomy across the nation than when the autonomy tool was first developed and tested.

Collins and Henderson (1991) studied autonomy in a sample of hospital nurses using the Pankratz and Pankratz questionnaire. The scores for all three subscales were higher in their sample than the original data. When the scores by Collins and Henderson are compared with the current study, the Nursing Autonomy subscale mean score is still higher in the rural sample (M=86.88 and M=91.8, respectively). It appears the rural nurses in

this study perceived themselves as having a higher level of autonomy than in two previous studies using the same instrument.

While the nurses working in a rural area scored higher on the Patients' Rights subscale (M = 59.2) than the 1974 study (M = 56.6), the scores are almost identical to the Collins and Henderson (1991) study (M = 59.8). A possible explanation could be that over the years since the original study, nursing as a profession has become more autonomous in supporting patients' rights. This may be indicative of nursing nationwide and not unique to a rural setting.

The data relating to the rejection of traditional role is puzzling. The rural nurses scored lower (M = 46.9) than the nurses in the 1974 study (M = 50.2) and lower than the nurses in the 1991 study (M = 50.8). While it may be theorized that rural areas are more conservative and traditional than urban areas, no definitive explanation for this finding exists.

Demographic and Work-Related Variables

Nursing education was found to have an influence on nursing autonomy in this study. This finding is in agreement with previous studies. Collins and Henderson (1991), Murray and Morris (1982), Pankratz and Pankratz (1974), Pinch (1985), and Woods, et al (1986) all found a positive relationship between increased autonomy and increased education. The fact that over 50% of the sample in this study possessed a bachelor's or

master's degree may have had an influence on the results.

A significant relationship found in this study was between clinical area of nursing and the patients' rights subscale. The ten nurses who worked a combination of clinical areas obtained the highest mean score. Those ten nurses also worked in hospitals with 50 acute care beds or less. It may be that these nurses were familiar with the patients and physicians in their rural setting, and were comfortable with the role of patient advocate. After the nurses who worked a combination of areas, pediatric and obstetric nurses scored the next highest on patients' rights. In descending order respectively the groups are other (which included telemetry and dialysis), medical-surgical, and intensive care/critical care/emergency care.

Emergency room nurses scored significantly higher on the Rejection of Traditional Role subscale, followed by psychiatric nurses and critical care nurses in a 1991 study by Collins and Henderson. It was suggested that these nurses are often expected to take the initiative with patients with acute or urgent needs. The physicians and nurses are well-known to one another, work closely in treatment situations, and develop mutual trust and respect for each other's capabilities. The concept of nurse-physician familiarity has been noted in small rural settings and has been found to influence the health-seeking behaviors of rural nurses (Surratt and Swendseid, 1991). This relationship may influence nursing decisions also, and may be part of the reason why the combination nurses scored the

highest on the Patients' Rights subscale.

It is interesting that the size of hospital did not have a significant influence on the autonomy subscale scores. The premise that small rural hospitals would score higher than the large rural hospitals was not supported by the findings of this study. The sample as a whole scored higher on the Nursing Autonomy and Patients' Rights subscales than the 1974 study (Pankratz & Pankratz), however, the sample was too homogenous for any differences with the analysis of variance. This variable warrants further study.

The variables, physician availability, shift worked, and nursing care delivery system, were not found to be significantly related to any of the autonomy subscales. These variables were not studied in previous research. One explanation for the lack of significance with the variable physician availability was that some confusion was apparent in the returned questionnaires. The intent was to determine if any physician was available in the hospital building for consultation and emergencies. Nurses in large hospitals with over 100 acute care beds and fully staffed emergency rooms would answer no physician was available. A better measure of this variable is warranted.

The nurses worked a variety of shifts: rotating weekends, 12 hour shifts, 10 hour shifts, and rotating days and evenings. It was difficult to categorize this variable for analysis. Further study is warranted.

Nursing care delivery systems are generally undergoing major changes in the clinical setting. The role and responsibilities of the registered nurse are becoming more diffuse and varied. New and innovative nursing care delivery systems are being developed and implemented every year. This variable would also benefit from further study using a more precise measurement to differentiate if primary nursing, team nursing, case management, or other new nursing care delivery systems have an impact on autonomy scores.

Age and number of years in nursing were not significantly related to autonomy scores. These results are in agreement with the findings of Collins and Henderson (1991) and Pankratz and Pankratz (1974). Woods, et al. (1986) found a negative correlation between age and Patients' Rights scores and a positive correlation between years of employment and Patients' Rights scores. However, her sample (N=45) included community health nurses and nursing students. The roles and responsibilites of community health nurses are different from the acute care setting, and comparison of the two should be viewed cautiously.

Limitations

1. The instrument measured perceived behavior and not actual behavior.

2. Each hospital may have had a varied organizational structure and

job description for the staff nurses that may have influenced the autonomy scores.

3. Life styles and attitudes of nurses vary and could have had an impact on responses to questions.

Recommendations

Empirical information exists that autonomy is a major component of job satisfaction for nurses (Stamps & Slavitt, 1978). The promotion of autonomy within nursing could assist in meeting the nursing shortage and could promote job retention in the healthcare system. Characteristics that foster autonomy need to be identified and supported in the clinical area to empower the nurse to practice autonomously.

Rural nurses in this study perceived themselves as autonomous in the Nursing Autonomy and Patients' Rights subscales of the Nursing Autonomy and Patients' Rights Questionnaire (Pankratz & Pankratz, 1974). Further study is needed to determine if there are any factors within the rural environment that foster autonomy. It is also recommended that this study be replicated in different rural settings. Different sampling techniques and different measurements of the work-related variables are advisable.

Based on the comments written by the nurses, it would appear that the nurse-physician relationship may influence nursing autonomy. Further study regarding this variable is definitely warranted. A qualitative study of

the nurse-physician relationship and its influence on the nurse's autonomy is recommended. Also recommended is a study of rural physicians and their perceptions of nursing autonomy.

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APPENDICES

APPENDIX A

INTRODUCTORY LETTER

PO Box 1216
Morenci, Arizona 85540
September 28, 1993

Nursing Director
Address

Dear Nursing Director:

I am a registered nurse and a graduate student at Montana State University working on a master's degree in rural nursing. As part of the requirements for a master's degree, I am conducting a research project or thesis concerning autonomy in rural nurses. I am specifically measuring the degree of autonomy in rural nurses and looking at the impact of some selected demographic and work related variables, such as nursing education and shift worked.

Your hospital has been selected from a convenience sample of hospitals in Montana that belong to the Montana Consortium for Excellence in Health Care. The RNs from your hospital will be asked to complete a questionnaire that should take about 15 minutes. I am asking your help in accessing the RNs at your hospital.

All of the data will be reported as group data and there will be no way to identify a specific hospital from the returned questionnaire. All the staff nurses in the hospital must be given the opportunity to participate. I would like the questionnaires to be distributed in an informal manner, such as enclosed with their paychecks. This would prevent any perceived possibility of coercion by the nurses.

Participation by your hospital and the nurses is strictly voluntary. The RNs will receive a letter describing the study and if they choose to participate, they will mail the questionnaires directly to me, thus assuring confidentiality. No names or identifying marks will be made on the questionnaires, so they will remain anonymous also. I will send a consent form to you granting your hospital's permission for the study.

I will be contacting you in the next week by the telephone to discuss your participation in the study. If you consent to participate, it would be helpful if you knew the total number of registered nurses you have working in the hospital. I look forward to talking with you next week. Please call me if you have any questions or concerns. Thank you.

Sincerely.

Pam Swendseid, RN
(602) 865-2305

APPENDIX B

GUIDELINE FOR INITIAL TELEPHONE CONTACT BETWEEN RESEARCHER AND NURSING DIRECTORS

Guideline for Initial Telephone Contact Between Researcher and Nursing Directors

Hello. My name is Pam Swendseid. I am a registered nurse and am a graduate student at Montana State University working on a master's degree in rural nursing. As part of the requirements for a master's degree, I am conducting a research project or thesis concerning autonomy in rural nurses. I am specifically measuring the degree of autonomy in rural nurses and looking at the impact of some selected demographic and work related variables, such as nursing education and shift worked.

Your hospital has been selected from a convenience sample of hospitals in Montana that belong to the Montana Consortium for Excellence in Care. The RNs in your hospital (from your medical/surgical, intensive care, emergency care, and obstetric floors) will be asked to complete a questionnaire that should take about 15 minutes. I am asking your help in accessing the RNs at your hospital.

All of the data will be reported as group data and there will be no way to identify a specific hospital from the returned questionnaire. Would you be willing to distribute the questionnaires to the RNs working at your hospital? All the staff nurses in your hospital (on the medical/surgical, intensive care, emergency care, and obstetric floors) must be given the opportunity to participate. I would like the questionnaires to be distributed in an informal manner, such as enclosed with their paychecks. This would prevent any perceived possibility of coercion by the nurses.

Participation by your hospital and the nurses is strictly voluntary. It will be necessary for you to sign and return to me a consent form that I will send to you with the questionnaires. This consent form grants your hospital's permission for the study to be conducted with your staff nurses. The RNs will receive a letter describing the study, and if they choose to participate, they will mail the questionnaires directly to me, thus assuring confidentiality. No names or identifying marks will be made on the questionnaires, so they will remain anonymous also. How many staff RNs do you have working in your hospital (on your medical/surgical, intensive care, emergency care, and obstetric floors)?

I will mail the questionnaires directly to you along with some guidelines for distribution. I will also enclose my phone number, so you can contact me for any questions. I'll mail a short summary of the results to you upon completion of the study. Thank you very much for your cooperation and assistance. Goodbye.

APPENDIX C

LETTER TO NURSING DIRECTORS AND CONSENT FORM

Letter to Nursing Directors

Dear______________:

As per our telephone conversation, I am sending you the questionnaires for your staff RNs.

Guidelines for distribution of the questionnaires:

Please distribute the questionnaires in an informal manner such as in each nurse's pay envelope. In order to avoid any threat of coercion, it is important not to distribute them personally, such as at a staff meeting. All staff RNs who work at your hospital (on your medical/surgical, intensive care, emergency care, and obstetric floors) should be given the opportunity to participate. Management or administrative nurses are not included in the sample. Nurses who have graduated from their basic nursing program within the last 12 months are also not included.

A cover letter is included with each questionnaire and describes the study and consent. These letters provide information that ensures confidentiality and anonymity. These forms do not need to be signed; imformed consent will be implied by return of the questionnaires. Each RN is instructed to complete the form and mail it directly to me in the enclosed envelope within 5 days.

Two consent forms are enclosed for you. Please sign both to indicate your consent for your hospital's participation. Send one copy to me in the enclosed addressed and stamped envelope. The other copy is for your records. Thank you in advance for your help. I greatly appreciate it. I'll send you a summary of the results when the study is completed. Please contact me if you have any questions.

Sincerely,

Pam Swendseid, RN
PO Box 1216
Morenci, Arizona 85540
(602)865-2305

CONSENT FORM

Title of Study: A Measurement of Autonomy in Rural Nurses

Researcher: Pam Swendseid, RN
Graduate Student
College of Nursing
Montana State University
Home Address:
PO Box 1216
Morenci, Arizona 85540
(602) 865-2305

I acknowledge the receipt of these questionnaires and give my permission as an official representative of this hospital to allow all registered nurses (working on the medical-surgical, intensive care, emergency care, and obstetric floors) employed by the hospital to participate in this project. I acknowledge that I and/or the registered nurses may contact the researcher for any questions or concerns.

____
Signature of Nursing Director

____
Date

____
Name of Hospital

Montana State University

APPENDIX D

LETTER OF CONSENT FOR PARTICIPATION

Letter of Consent for Participation
Title of Study: A Measurement of Autonomy in Rural Nurses
Date: October 22, 1993

Dear Participant:
You are being invited to participate in a study that will explore the concept of autonomy in nurses working in rural areas. I am a graduate student at Montana State University's College of Nursing and currently live in Morenci, Arizona. I am conducting this study as part of the requirements for a master's degree in nursing.

You were selected to participate in the study because you work as a registered nurse in a rural Montana hospital. The entire state of Montana is classified as rural. Your hospital or floor has been selected as part of a sample from all the Montana hospitals that belong to the Montana Consortium of Health Care. Your nursing director has agreed to distribute questionnaires to the RNs working in the hospital.

Please understand that participation is strictly voluntary. Participation, or non-participation, will not adversely affect you or your job in any way. If you wish to participate, please fill out the enclosed questionnaire. It should take approximately 15 minutes to complete. Your individual replies will be kept anonymous. You will note that the questionnaire is not coded in any way. Please do not write your name or any identifying marks on the questionnaires. You may withdraw from this study at any time; this decision will not affect your work relationship with the hospital.

Participation in the study does not represent a risk for you. Completing the questionnaires will not benefit you personally. However, registered nurses may benefit from increased knowledge and understanding about autonomy in a rural setting.

Please contact the researcher if you have any questions. You may keep this letter explaining the nature of your participation. Your return of the questionnaire implies assumed consent. Results of the study will be available at the Montana State University College of Nursing's library. In addition, a short summary of the results will be sent to the nursing director of your hospital. When you have completed the questionnaire, put it in the addressed and stamped envelope that is enclosed and mail it directly to me.

Thank you in advance for taking the time and effort to complete this questionnaire.

Sincerely,

Pam Swendseid, RN
PO Box 1216
Morenci, Arizona 85540
(602)865-2305

APPENDIX E

INSTRUMENT

For each opinion statement, circle the number of the response that comes closest to how you feel. There are no right or wrong answers. Pleaseanswer <u>every</u> question.

1 STRONGLY AGREE
2 AGREE
3 UNDECIDED
4 DISAGREE
5 STRONGLY DISAGREE

1. I feel that patients should plan their own activities.

1 2 3 4 5

2. I have fulfilled my responsibility when I report a condition to a physician.

1 2 3 4 5

3. I would feel free to try new approaches to patient care without the "permission" of an administrative nurse.

1 2 3 4 5

4. I feel free to recommend non-prescription medication.

1 2 3 4 5

5. If I requested a psychiatric consult for a patient, I would feel out of bounds.

1 2 3 4 5

6. I believe a patient has a right to have all his questions answered for him.

1 2 3 4 5

7. If I am not satisfied with the doctor's action, I would pursue the issue.

1 2 3 4 5

1 STRONGLY AGREE
2 AGREE
3 UNDECIDED
4 DISAGREE
5 STRONGLY DISAGREE

8. I am the best person in the hospital to be the patient's advocate if he disagrees with the doctor.

1 2 3 4 5

9. If a patient is allowed to keep a lot of personal items, it becomes more trouble than it is worth.

1 2 3 4 5

10. I don't answer too many questions of the patient because the doctor may have another plan in mind.

1 2 3 4 5

11. I feel the doctor is far better trained to make decisions than I.

1 2 3 4 5

12. I would never call a patient's family after discharge.

1 2 3 4 5

13. Patients should not have any responsibility in a hospital.

1 2 3 4 5

14. Patients should be permitted to go off their unit and elsewhere in the hospital.

1 2 3 4 5

1 STRONGLY AGREE
2 AGREE
3 UNDECIDED
4 DISAGREE
5 STRONGLY DISAGREE

15. If a patient asks why his medication is changed, I would refer him to his doctor

1 2 3 4 5

16. If a policy change effects patient care, I want to understand why the change is necessary.

1 2 3 4 5

17. Patients should be encouraged to show their feelings.

1 2 3 4 5

18. I should be able to go into private practice like a doctor if I wish.

1 2 3 4 5

19. I feel patients should be told the medications they are taking.

1 2 3 4 5

20. I should have a right to know why a change is necessary before it is accepted.

1 2 3 4 5

21. Patients should be told their diagnosis.

1 2 3 4 5

22. If I make conversation with the patient, there is no need to explain procedures and treatments before they are started.

1 2 3 4 5

1 STRONGLY AGREE
2 AGREE
3 UNDECIDED
4 DISAGREE
5 STRONGLY DISAGREE

23. I generally know more about the patient than the doctor.

1 2 3 4 5

24. Patients in a hospital have a right to select the type of treatments or care they wish.

1 2 3 4 5

25. If I disagree with the doctor, I keep it to myself.

1 2 3 4 5

26. I feel the patient has the right to expect me, as a nurse,to effectively utilize my time in improving my skills by taking advantage of educational opportunities offered.

1 2 3 4 5

27. I would feel comfortable in authorizing a patient to leave the unit to go to another part of the hospital.

1 2 3 4 5

28. The patient has a right to expect me to regard his personal need to have priority over mine.

1 2 3 4 5

29. I feel the patient has a right to refuse care.

1 2 3 4 5

30. It should be the doctor who decides if the patient can administer his own drugs.

1 2 3 4 5

1 STRONGLY AGREE
2 AGREE
3 UNDECIDED
4 DISAGREE
5 STRONGLY DISAGREE

31. I would never refuse to carry out a doctor's order.

1 2 3 4 5

32. I feel that patients should be informed as to what constitutes quality health care.

1 2 3 4 5

33. The patient has a right to expect me to accept his social cultural code and to consider its influence on his way of life.

1 2 3 4 5

34. Patients should be permitted to wear what they want.

1 2 3 4 5

35. I would never interact with a patient on a first name basis.

1 2 3 4 5

36. I rarely give in to patient pressure.

1 2 3 4 5

37. Nurses should be held solely legally responsible for their own actions and not expect to come under the umbrella of the doctor or hospital in a malpractice suit.

1 2 3 4 5

38. Doctors must decide what nurses can and cannot do in the delivery of health care.

1 2 3 4 5

1 STRONGLY AGREE
2 AGREE
3 UNDECIDED
4 DISAGREE
5 STRONGLY DISAGREE

39. It is the prerogative of the nurse to decide whether or not to wear a uniform.

1 2 3 4 5

40. I would give the patient his diagnosis if he asks.

1 2 3 4 5

41. It should be the nurse's decision when to talk to the terminal patient about his condition.

1 2 3 4 5

42. I think it is my responsibility to initiate public health referrals on patients.

1 2 3 4 5

43. I feel that I should suggest to patients, family, and doctor any community resources that I know are available.

1 2 3 4 5

44. Patients can expect me to speak up for them.

1 2 3 4 5

45. I would never ask a patient about his or her sexual life.

1 2 3 4 5

46. I would talk very little to patients about their past.

1 2 3 4 5

1 STRONGLY AGREE
2 AGREE
3 UNDECIDED
4 DISAGREE
5 STRONGLY DISAGREE

47. I rarely ask a patient a personal question.

1 2 3 4 5

Please turn to the next page.

APPENDIX F

ADDITIONAL QUESTIONS

Now here are some questions about you and your job. Make a check mark next to your answer or write in your answer in the blank.

In what year were you born?

_________________Year of birth

What is the highest level of nursing education you have successfully completed? Check one.

_____ 1 ASSOCIATE DEGREE
_____ 2 DIPLOMA
_____ 3 BACHELORS DEGREE
_____ 4 MASTERS DEGREE
_____ 5 DOCTORAL DEGREE

How many years have you worked as a nurse? (Round up to the nearest year, if necessary).

_________________Years

What is the capacity of acute care beds in the hospital in which you work? Check one.

_____ 1 25 OR LESS ACUTE CARE BEDS
_____ 2 26-50 ACUTE CARE BEDS
_____ 3 51-100 ACUTE CARE BEDS
_____ 4 101 OR MORE ACUTE CARE BEDS

In what area of nursing do you work 50% or more of the time? Check one.

_____ 1 MEDICAL-SURGICAL
_____ 2 PEDIATRICS
_____ 3 OBSTETRICS
_____ 4 PSYCHIATRIC
_____ 5 INTENSIVE CARE/CRITICAL CARE
_____ 6 EMERGENCY CARE
_____ 7 COMBINATION OF ALL ABOVE
_____ 8 OTHER
please specify_________________

If you work in a small rural hospital, are you ever the only RN in the hospital? Check one.

_____ 1 YES
_____ 2 NO
_____ 3 NOT APPLICABLE, DON'T WORK IN SMALL HOSPITAL

Concerning the availability of physicians in your hospital, are there physicians (check one)

_____ 1 AVAILABLE IN THE BUILDING
_____ 2 ON CALL AT THEIR HOME OR CLINIC

What shift do you work 50% or more of the time? Check one.

_____ 1 PRIMARILY DAYS
_____ 2 PRIMARILY AFTERNOONS
_____ 3 PRIMARILY NIGHTS
_____ 4 ROTATE ALL SHIFTS
_____ 5 OTHER
please specify_________________________

What type of staffing is practiced on your unit/ hospital? Check one.

_____ 1 ALL RN STAFFPRIMARY NURSING
_____ 2 MIXTURE OF RNS AND LPNS
_____ 3 MIXED CAREGIVERS (RNS, LPNS, AND AIDES)
_____ 4 OTHER
please specify_____________________

Thank you for your time and effort. You may use the space below and on the back to write any comments about rural nursing or autonomy.

APPENDIX G

SCORING GUIDELINES

Scoring Instructions

Nursing Autonomy Subscale

Add the scores from questions 1, 3, 4, 8, 14, 18, 23, 24, 27, 34, 37, 39, 40, 41, and 42.
Subtract the total from 90.
Then add the remainder to the total of questions 5, 9, 10, 11, 12, 16, 30, 36, 38, 45, and 46.

Patients' Rights Subscale

Add the scores from questions 6, 16, 17, 19, 20, 21, 26, 28, 29, 32, 33, 34, 43, and 44.
Subtract the total from 84.

Rejection of Traditional Role

Subtract score of 7 from 6.
Add the remainder to the total of questions 2, 4, 10, 11, 13, 22, 25, 31, 35, 45, 46, 47.

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