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

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.

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Signature Pamela J. Swendseid

Date May 5, 1994

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ABSTRACT

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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..

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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.

Autonomy in Rural Families

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.