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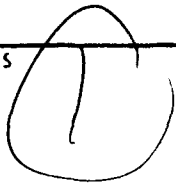


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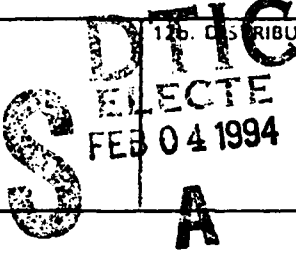
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MATERNAL-NEWBORN AND SURGICAL NURSES' PERCEPTIONS OF
PROFESSIONAL AUTONOMY DURING THE DEVELOPMENT OF
SHARED GOVERNANCE

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

By

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B.S.N., University of Wisconsin - Eau Claire, 1977

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October 26, 1993

I HEREBY RECOMMEND THAT THE THESIS PREPARED UNDER MY SUPERVISION BY Denise Ann Moore ENTITLED Maternal-Newborn and Surgical Nurses' Perceptions of Autonomy During Development of Shared Governance BE ACCEPTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF Master of Science.

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ABSTRACT

Moore, Denise A., M.S. Wright State University-Miami Valley School of Nursing, Wright State University, 1993. Maternal-Newborn and Surgical Nurses' Perceptions of Professional Autonomy During Development of Shared Governance.

Defined by Schutzenhofer (1987) as "the practice of one's occupation in accordance with one's education, with members of that occupation governing, defining, and controlling their own practice in the absence of external controls" (p. 278), professional autonomy has eluded nurses. Autonomy is the hallmark of professionalism (Mundinger, 1980). Because nurses are predominantly female, the limited autonomy in nursing practice is primarily rooted in female socialization norms which do not encourage women to be autonomous. Nursing education traditionally has also restricted the development of professional autonomy. Professional autonomy is further influenced by the work environment and differences in nursing practice models. Autonomy, in turn, is an important factor in job satisfaction for nurses (Rowland & Rowland, 1992) and has been shown to influence professional practice and patient outcomes (Baggs, Ryan, Phelps, Richeson, & Johnson, 1992; Maas & Jacox, 1977; Mundinger, 1980; Singlelton & Nail, 1984).

A descriptive-comparative study was designed to investigate differences in perceived autonomy between maternal-newborn nurses and surgical nurses and whether these perceptions changed during the development of shared governance at a 700-plus-bed, midwestern, not-for-profit, university-affiliated hospital. Secondary analysis of data from a larger, ongoing study of Organizational Dimensions of Hospital Nursing Practice (Martin, et al., 1991) was completed to test the following hypotheses:

- 1) The autonomy perceived by maternal-newborn nurses will be greater than that perceived by surgical nurses.
- 2) Both maternal-newborn and surgical nurses' perceptions of autonomy will improve during development of shared governance.

Professional autonomy was measured using the Schutzenhofer Nursing Activity Scale (NAS) (Schutzenhofer, 1988a). A two-way ANOVA was used to examine professional autonomy differences between the groups over time.

Shared governance was instituted in the setting in 1988 in the form of a hospital-wide Nursing Council, which continues to the present. The Nursing Council consists of 26 nurse members of which at least 13 must be staff nurses; the remaining positions are filled by clinical nurse specialists, nurse educators and administrative nurses. There is also a nurse liaison from the affiliated university school of nursing on the Nursing Council. All nominations

for council membership are selected by lottery from nurses who volunteer. There is no individual unit representation, a reflection of the core belief that nurses in every specialty face the same basic issues. The Nursing Council addresses all issues related to the nursing practice; in this setting, there are no separate subcommittees to deal with practice, education, and research issues.

In the primary study, data were available from December, 1990 (n = 125); May, 1991 (n = 164); November, 1991 (n = 194); and September, 1992 (n = 148). For this thesis, data from the December, 1990; November, 1991; and September, 1992 collection sessions was analyzed as these represented approximately annual measurements of the concepts of study.

The study findings indicated that although the mean autonomy score for maternal-newborn nurses was consistently higher, there were no significant differences between maternal-newborn and surgical nurses' perceptions of professional autonomy ($F = 2.81$, $DF = 1$, $p = 0.0970$). Additional analysis showed there were no significant changes in perceptions of professional autonomy over the two year time period studied.

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I. INTRODUCTION

In the quest for the establishment of nursing as a profession, nurses' inability to exercise professional autonomy has been a major drawback for a variety of reasons. Schutzenhofer (1988a) cited female socialization norms as the primary barriers to the development of personal autonomy in women. These barriers have contributed greatly to nurses' perception of very limited professional autonomy in their practice in comparison to the autonomous practice of other professionals. That perception has been compounded by the historical suppression of women and the power over nursing exerted by those outside the profession. Research on male nurses, who make up a small percentage of nurses, is very limited. Aldag and Christiansen (1967) found the personality profile of male nursing students to be more similar to their female counterparts than other male college students were to their counterpart female group. But once into the workplace, male nurses tend to seek the more autonomous roles. Dassen, Nijhuis, and Philipson's (1992) study of male and female intensive care nurses in the Netherlands found that the percentage of male nurses working in intensive care units was twice that found on other units of the hospital. Critical care nurses have been found to

have significantly higher perceptions of autonomy than nurses working in other areas (Alexander et al., 1982; Jordan, 1993).

Statement of the Problem

There are numerous articles noting the importance of autonomy to the nursing profession, but there is very little published research about changes in nurses' perception of autonomy as shared governance develops within an institution.

Significance and Justification

Professional autonomy is the key to validating the discipline of nursing's claim as a profession of equal stature to those in other disciplines. According to Mundinger (1980), autonomy is the hallmark of professionalism. Traditional nursing practice models restrict the exercise of autonomy (Pinch 1981). A study by Katzman (1989) indicated nurses and physicians disagreed on nurses' authority to determine nursing care, decide on standards of nursing care, or even decide the frequency of taking vital signs. In all areas examined, the nurses in the sample desired more authority than physicians ascribed to them.

Several authors have indicated that the restriction of professional autonomy is frequently given as a reason nurses leave the nursing profession (Kelly, 1992; Maas & Jacox, 1977; Wandelt, Pierce, & Widdowson, 1981). In small-group interviews with staff nurses and nurse supervisors, Wandelt

et al. (1981) found that the nurses felt the inability to exercise control over their clinical practice produced feelings of career stagnation. As professionals, they felt they should have discretion and choice in work methods. The researchers concluded that nurses who leave nursing do so because of work conditions which interfere with the practice of nursing. The status of most nurses as employees in bureaucratic organizations where nursing is a department in the institutional hierarchy imposes a major constraint on nursing autonomy and professionalism. Traditionally, most decision making occurs at the top of the hierarchy and the goals of the organization prevail. If the goals of the organization run counter to the nurse's professional goals in the care of patients, this places the nurse in a dilemma which may result in the nurse leaving the job or leaving the nursing profession all together (Kelly, 1992; Maas & Jacox, 1977).

The United States is currently experiencing a nurse shortage. Recently released data from the American Hospital Association (AHA) for the year 1991 reported an average full-time equivalent (FTE) vacancy rate of 8.7% for hospital-employed RNs (AHA, 1993). Vacancy rates varied from 12.2% to 3% by geographic area. For the state concerned in this thesis, the vacancy rate was reported as 5.6% (AHA, 1993). Although the national figure represents an improvement from the 11% vacancy rate reported for 1990, there was also 3.4% increase in the number of budgeted RN

FTEs and a 5.6 % increase in the number of RN FTEs employed, indicating an increase in the demand for RNs (AHA, 1993). Due to the diversification of patient care settings, technological advancements, and the progressive increase in both the age and acuity of patients, even more RNs will be needed in the future, particularly those with baccalaureate or higher degrees. The National League for Nursing (cited in Jackson, Mcfalda, & McManus, 1990) has predicted that by the year 2000, the demand for RNs will outweigh the supply by 600,000 and that the demand for baccalaureate-prepared nurses will be particularly critical at twice the available supply. Between 1983 and 1987, enrollment in all categories of RN education programs dropped more than 20% (McKibbin & Boston, 1990); the 61,660 new RN graduates in 1989 were the lowest number since 1973 (NLN, 1991). Although the number of students enrolled in all types of basic RN programs has increased each year since 1988, the largest enrollment increases have been in two-year associate degree programs. Between 1985 and 1989, the proportion of new RNs graduating from associate degree programs increased from 55.1% in 1985 to 61.4% while the proportion graduating from baccalaureate degree programs remained constant at approximately 30% (NLN, 1991). If this trend continues, many RNs in the coming years will be poorly prepared to function in new expanded nursing roles. These facts indicate that not only is there a current nursing shortage, but the shortage will most likely intensify in the future.

Given the high cost of recruiting and orienting nursing personnel, hospital executives must be concerned with not only attracting nurses to their facilities, but retaining nurses as well. Autonomy in nurses' work situations influences job satisfaction (Alexander, Weisman, & Chase, 1982; Carmel, Yakubovich, Zwanger, & Zalctman, 1988). In fact, the AHA reported that nurses perceive autonomy as the strongest predictor of job satisfaction (Rowland & Rowland, 1992, p. 515). Hospital executives will need to design organizations which support autonomous nursing practice to effectively compete for scarce nursing resources. As more nurses move out into alternative health care sites in the next century, nurses must be comfortable with exercising their professional autonomy. In the future, the acute care hospital will be only one small box on the health care organizational chart (Michaels, 1989). By the year 2000, it is anticipated that hospitals will become exclusively critical care centers. Other services, such as surgery and maternity care, will be provided at free-standing locales and patients will be discharged directly to home care (Jackson et al., 1989). The nursing profession will need both highly specialized individuals to provide complex, technology-saturated care to patients and those prepared in a broader sense to care for nonacute patients in other settings where the nursing role will be quite different. In both settings, nurses will be required to exercise much more autonomy than nurses in today's environment and will be held

fully accountable for the practice of their profession. It is imperative that nurses demand and exercise professional autonomy now if the nursing profession is to meet the challenges of tomorrow.

While autonomy has been identified as the hallmark of a profession, collaboration, the act of working together with one another, is an essential characteristic of professional interactions (Mundinger, 1980). Mundinger (1980) noted that members of a profession do not take direction from peers in how to carry out their activities; each member is recognized as an autonomous individual. In a true profession, supervision of another's work is unacceptable, yet many nurses work in environments in which their work is closely supervised and scrutinized by other nurses as well as physicians. Professional practice emphasizes lateral communications and relationships which cross positional boundaries; in doing so, collaboration results in more than the collaborators could accomplish alone (Mundinger, 1980). Assuring the full use of professional nursing expertise, collaboration is necessary for the provision of quality nursing care (Porter-O'Grady & Finnigan, 1984). In the final analysis, Mundinger (1980) predicted that collaboration with other professionals, clients, and, most importantly, nurse colleagues, may be the most effective means of providing nursing's unique, yet subtle service. If nursing is to survive and flourish as a profession, nurses

must recognize the need for autonomy as the basis for professional collaboration.

The quality of patient care is also influenced by nurses' perceptions of autonomy. Settings in which nurses perceive themselves as autonomous motivate them to initiate more nursing activities (Carmel et al., 1988) and feel responsible for patient outcomes. If differences in perceived autonomy in particular specialty areas could be identified, factors which contribute positively to that difference could then be identified. The identified factors that contribute to autonomy could ultimately become a focus for management in increasing job satisfaction.

One strategy for addressing the need for autonomy and independence in professional nursing practice has been the development of shared governance, an organizational model based on participative management principles. In this model, decision making is the right and responsibility of those closest to the issues. Nurses make decisions regarding clinical nursing practice, patient care quality, continuing nursing education, and nursing research (Porter-O'Grady & Finnigan, 1984). Through the action of a nursing council composed of both administrative and clinical nurse representatives, shared governance is designed to involve nurses from all levels in the institution in making decisions regarding the practice of nursing in that particular facility. Nurses make decisions regarding clinical nursing practice, patient care quality, continuing

nursing education, and nursing research (Porter-O'Grady & Finnigan, 1984). When nurses from all areas work together within a shared governance structure, an environment for effective communication and professional collaboration results. In their study of nurses at an institution where shared governance had been instituted, Ludemann and Brown's (1989) findings provided preliminary evidence that shared governance creates an environment in which nurses perceive they have greater influence, autonomy, and freedom to innovate.

Statement of Purpose

The purpose of this thesis is to study the professional autonomy perceived by maternal-newborn and surgical nurses during the development of shared governance in a large hospital organization. This will entail looking at the organization at three approximately equidistant points in time two (1990), three (1991), and four (1992) years after the institution of shared governance at the study site.

Hypotheses

- (1) The autonomy perceived by maternal-newborn nurses will be greater than perceived by surgical nurses.
- (2) Both maternal-newborn and surgical nurses' perceptions of autonomy will improve significantly during the development of shared governance.

Operational Definitions

- (1) Autonomy: Professional autonomy is "the practice of one's occupation in accordance with one's education, with

members of that occupation governing, defining, and controlling their own activities in the absence of external controls" (Schutzenhofer, 1987, p. 278). In this study, autonomy will be measured by the Schutzenhofer Nursing Activity Scale. This 35-item scale using Likert type responses is more fully discussed in Chapter III.

(2) Nurse: Any individual currently licensed as a registered nurse (RN) in the setting state. In this study, RNs were identified from a list generated by the hospital personnel department and only RNs were invited to participate in the study.

(3) Maternal-newborn nurse: An RN who cares for pregnant/postpartum women, well newborn infants, or critically ill newborn infants. Clinical practice areas under this category included Birthing Center 1 (postpartum care and normal newborn nursery), Birthing Center 2 (labor and delivery), Neonatal Intensive Care Unit, and Birth & Family Education. In the original study, identification of maternal-newborn nurses was accomplished both by a list generated by the hospital personnel department used to invite the potential subjects and by self-report on the study instrument.

(4) Surgical nurse: An RN who cares for patients before, during or after surgical procedures. Clinical practice areas under this category included Inpatient Operating Room (OR), Post-Anesthesia Care Unit (PACU), Pre-Op, Outpatient OR, Same Day Surgery, Pre-Admission

Testing, and Endoscopy. In the original study, surgical services nurses were identified both by a list generated from the hospital personnel department used to invite potential subjects and by self-report on the study instrument.

(5) Shared governance: A decentralized organizational model in which responsibility for all aspects of nursing are shared between caregivers, nurse administrators, and the chief nurse executive. Shared governance enables nurses from all levels to influence decisions which affect nursing practice, the work environment, professional development and personal fulfillment (Rowland & Rowland, 1992). Shared governance was established at the study hospital in 1988.

Assumptions

The following statements are assumptions of this study:

- (1) Participants in the study will complete the instrument honestly.
- (2) Professional autonomy is important to registered nurses.
- (3) Professional autonomy is an important contributor to quality care.
- (4) Professional autonomy is important to job satisfaction and retention.

Limitations

The limitations of this study are:

(1) Generalizability of study results is limited due to the use of a convenience sample and collection of data from a single site.

(2) Data gathering tools were grouped into a rather lengthy booklet which took approximately 45 minutes to complete. The fact that the NAS was the last instrument completed may have affected how participants responded to it.

(3) The composition of the group participating in the study was partially different at each data collection session. The inability to match responses between study times dictated that each group of respondents be treated as an independent group for statistical analysis, even though some individuals participated in more than one data collection session. This may affect the results of the data analysis.

Summary

The lack of perceived autonomy in the nursing profession is a critical area of concern for nurses today. Recognition of the concern is evident in current nursing literature; however, relatively little research has been done regarding professional autonomy in the context of shared governance. As nurses take on the expanded roles anticipated in the future, the exercise of professional autonomy will become even more important. This study was

intended to provide background information regarding maternal-newborn and surgical nurses' perceptions of professional autonomy and changes in those perceptions that may occur during development of shared governance.

The rest of this thesis traces the course of the research project. In Chapter II, the relevant literature will be reviewed and the theoretical framework for the study will be described. The methodology of the research project will be described in Chapter III. In Chapter IV, the results of the data analysis will be detailed. Chapter V will include conclusions drawn from the study as well as implications for further research.

II. REVIEW OF LITERATURE

The autonomy of nurses in the practice of their profession has been a subject of study for a number of authors. The source of much of the difficulty surrounding professional nurses' autonomy lies in the legacy of women's traditional socialization into society and the historical control of nursing by groups outside the nursing profession. Professional autonomy has been researched in relation to a number of variables including characteristics of nursing students, job satisfaction, and clinical specialty areas to determine correlates and predictors of autonomy. Measurement of professional autonomy has been a challenge for researchers. Some of the tools used to measure autonomy are imprecise at best, measuring other variables in addition to autonomy.

This chapter will first examine major social and historical forces influencing the personal and professional autonomy of nurses. Next, research concerning autonomy and associated variables will be reviewed. The chapter will conclude with a description of the conceptual framework developed for this thesis.

Non-Empirical Literature

Social and Historical Influences on Women's Autonomy

Schutzenhofer's (1988b) article provides insight into the forces affecting the personal as well as professional autonomy of women. Much of the nursing profession's difficulties in claiming and capturing professional autonomy equal to nurses' responsibilities and education lies in the fact that nursing is predominantly a female profession. Ashley (1976) observed that the role of nursing in the health field is descriptive of women's role in American society. Traditional nursing roles evolved from 19th century images of women as submissive, dependent, and deferent beings--hardly characteristics associated with autonomy. Despite the emergence of the feminist movement, these stereotypes persist in the contemporary discipline of nursing and continue to thwart nurses' quest for professional autonomy.

Part of the problem in understanding the limited professional autonomy in nurses, who are predominantly female, stems from the lack of a solid body of research on the adult development of women in general (Schutzenhofer, 1988b). Pinch (1981) and Gilligan (1979) noted that most developmental theorists have studied male development and tried to make women fit into these models; however, these models fail to consider the unique developmental experiences of females. The result is a dichotomy which views men as "normally" autonomous and "normal" women as the

opposite--submissive and passive. Aggressive, autonomous women are viewed as deviant (Gilligan, 1979).

Weitzman (1988) has noted that from infancy, males and females are socialized differently. Females frequently receive overt and covert messages from societal institutions not to be too intelligent or seek too much success. Family, school, and church combine forces to encourage feminine passivity and the resulting under-achievement as desirable feminine attributes (Weitzman, 1988). This socialization process may direct some women, perhaps those in female professions like nursing, to seek value as individuals from outside sources. These experiences combined with an internalization of society's devaluation of women's roles may be what causes some females to describe themselves as "just a (wife, mother, daughter, or nurse)".

Another result of female socialization is described as "other-centeredness" or putting others before oneself. While a certain amount of other-centeredness may be desirable, it can lead to women equating personal desires with selfishness and indulging those desires as wrong. As a natural extension of this line of thought, self-sacrifice becomes a measure of goodness (Gilligan, 1977, 1979). Self-sacrifice may be what drives some nurses to exhaust themselves trying to meet all of their patients' needs without consideration for their own personal requirements. Other-centeredness may also explain why women, especially those in traditional female roles, feel such strong

responsibility in their relationships with others and experience guilt feelings even for events outside their control (Schutzenhofer, 1988b).

Just as developmental theory has focused on males, models of identity formation are also male-oriented. Erikson (1963) suggested that identification with an occupational role helps define personal identity and integrate previous developmental stages. Men find identity through their work, while a woman's identity is defined by relationships (Gilligan, 1977), since, until recently, most women have not had occupational roles. Even though Erikson's model does not stand well from a feminist perspective, many women define themselves and are defined by others in terms of their external relationships as someone's wife, mother, daughter, or sister. External relationship definitions may make it difficult for a woman to function independently.

A most powerful socialization force impacting on the development of women's autonomy is the legal system. Throughout most of the early history of this country, women were considered a husband's property and denied rights guaranteed to men. Though today many laws have been changed to grant women equal rights, Pinch (1981) noted that the restrictive attitudes reflected in those early laws persist to some extent. Given the history of the legal controls on women, it is easy to realize why nursing must struggle

against legal efforts by groups outside the profession to determine nurses' education and practice.

Socialization affects the decision-making skills essential for autonomy; women in traditional roles have little opportunity for decision-making. Gilligan's (1977) study of women and moral decision making indicated that the women in her study felt excluded from decisions made outside their own personal world. These women also felt subject to decisions of the significant man in their lives. This may explain why some nurses feel unprepared to make the autonomous decisions that a professional must make.

Stereotyping is another facet of socialization that has impacted development of women's autonomy. Ashley (1976), posited that "nursing, perhaps more than any other profession, has been influenced by social conceptions regarding the nature of women" (p. 75). Although stereotyping is a fact for both sexes, stereotypes associated with women portray society's devaluation of women and female roles. Much of female stereotyping is predicated on the need to become a wife and mother to reach full development as a woman. This kind of stereotyping limits women's development and exercise of autonomy and limits women's awareness of life choices beyond traditional roles. The relationship of medicine and nursing within the health care system strongly echoes stereotypical male-female relationships. In Victorian times, physicians invested much energy in efforts to control nurses' education and practice

to prevent nursing from becoming an profession independent of medicine, which reflected the Victorian attitude that women were "less independent, less capable of initiative, and less creative than men, and [thus] in need of masculine guidance" (Ashley, 1976, p. 76). The stereotypical male-female relationship continues to this day in the form of nurse practice acts which mandate physician supervision of nursing activities even though the physician is rarely present when nursing care is performed, providing an effective method of restricting nurses' professional autonomy.

Although female socialization norms are largely responsible for the lack of autonomy in nurses, nurses also contribute to their own situation. Historically, nurse educators promoted the concept of nursing as preparation for marriage and motherhood. Showcasing nursing as the key to marriage, preferably to a physician, the public press readily promoted the idea. This kind of promotion has also contributed to lack of career commitment, as women, until recent years, have been socialized to retire from the workforce after marriage (Hughes, 1988). Lack of commitment to the profession affects nurses' professional autonomy. Muff (1988) noted that as long as nurses are depicted as subservient, rigid, and non-autonomous, the nursing profession will attract individuals possessing those traits and for whom self-actualization and responsibility are threatening prospects. To the extent that nursing is

portrayed as a stopgap to marriage, it will attract women who lack career aspiration and lifelong professional commitment.

Nursing education is also responsible for limiting the development and exercise of professional autonomy. As a result of strictly regimented learning processes and control of even some aspects of their personal lives (Ashley, 1976), some nurses never develop professional autonomy. These individuals then spend their working years practicing nursing in a rigid, mechanical manner without realizing a key ingredient is missing (Kalisch & Kalisch, 1988). By the same token, it seems possible that emphasis on professional socialization of students into nursing by nurse educators could neutralize these negative aspects.

The work environment may also restrict professional autonomy. Ashley's (1976) review the role of the nurse and relationships between nurses, hospital administrators, and physicians highlighted the tremendous lack of control nurses have historically had over nursing practice and education, particularly in the hospital setting. The hierarchal structure of the typical hospital department of nursing, which places nurses in supervisory positions over their peers, discourages professional autonomy and collaboration between nurses. It has been the author's experience that nurses are frequently not represented at hospital committee meetings in which decisions affecting nursing practice are made. Hospital policies that constrain nursing practice,

dismissal of nurses' ideas and needs by administrators, and poor staffing all limit the development of professional autonomy and are frequently cited as reasons why nurses leave nursing (Maas & Jacox, 1977; Wandelt et al., 1981). Such factors in the workplace may interact to produce an evolutionary effect on nurses' perceptions of professional autonomy over time.

Empirical Literature

Nursing Students and Autonomy

To discover the nature of students attracted to the nursing profession, Boughn (1988) conducted a study to determine whether or not female nursing students are as autonomous as female students in both traditional female occupations and non-traditional occupations. A convenience sample of 1,046 female freshman through senior students enrolled in baccalaureate programs in the schools of: nursing (n = 366), education (n = 354), business (n = 166), and arts/sciences (n = 157) participated in the study. Deans and chairs of the four schools involved identified the appropriate faculty to obtain proportioned numbers of class levels. The chosen faculty administered the questionnaire within a two-week period at the beginning of the fall semester.

Data were collected using three instruments: a demographics sheet, Kurtines' autonomy scale, and Bem's Sex-Role Inventory of masculine and feminine attributes. Kurtines' autonomy scale consists of 25 true/false items.

In reviewing the development of Kurtines' tool, Boughn (1988) reported internal reliability of the instrument at .61 and reported face validity. Item analysis was done and correlations were in the expected directions related to achievement orientation, interpersonal aggressiveness, and masculinity (statistics were not reported).

Autonomy scores differed, but not significantly, among all four schools ($F = 2.51$, $p = .0566$, no df reported). Nursing students had the lowest mean for autonomy, while the highest mean came from students in the school of arts/sciences. The inability to detect differences was thought to be due to disproportionate group sizes because the arts/sciences and business group sizes were smaller than nursing and education. An additional ANOVA comparing nursing ($n = 366$) with education ($n = 354$) and arts/sciences combined with business ($n = 510$) revealed no significant difference between nursing and education ($\text{PrGTF} = .9838$); however, there was a significant difference ($\text{PrGTF} = .0161$) between nursing and the combined non-traditional female occupations in the schools of arts/sciences and business.

Autonomy and masculinity scores were significantly correlated using data from all four schools ($r = .449$, $p = .0001$, no df reported). The highest mean scores for both autonomy and masculinity were in arts/sciences. The lowest mean scores were in nursing, although it should be noted that the mean autonomy scores of nursing and education were 11.44 and 11.45, respectively and differed by only .01.

There was no significant relationship between autonomy and the demographic variables of parents' occupation, GPA, and MSAT/VSAT scores. The results of this study support the idea in the theoretical literature that the nursing profession does not attract naturally autonomous females. Are there ways to stimulate the development of professional autonomy in nursing students with relatively low levels of perceived autonomy in their personal lives?

In another study involving nursing students, Cassidy and Oddi (1988) examined four groups of nursing students to determine differences in perception of ethical dilemmas and attitudes toward autonomy. The sample consisted of 130 randomly selected female students enrolled in four different types of nursing programs: associate degree (n = 23), generic baccalaureate (n = 29), baccalaureate completion (n = 33), and masters (n = 45). Associate degree (AD) students were in their last semester of study, generic and completion baccalaureate (BSN) students had completed at least 90 credit hours, and masters (MSN) students had completed at least 15 credit hours of a 36 credit hour program. Possible similarities between some these groups should be noted. AD students in their last semester and BSN completion students who had completed 90 credit hours could conceivably be very similar. Also, MSN students and BSN completion students were similar in that they were both licensed and practicing. Data collection was via questionnaires mailed to a total of 236 nursing students

with a return of usable responses rate of 57.7% (n = 130). Demographic data collected included type of program, age, education in ethics, and licensure as an RN.

The Judgement About Nursing Decisions (JAND) tool, was used to measure ethical dilemmas in nursing practice. The JAND is a self-administered 39-item instrument, consisting of six stories involving nurses in ethical dilemmas. Each story is followed by five to seven nursing responses to the situation. Each item requires two responses in yes/no format; Column A indicates whether to nurse should or should not engage in the action (idealistic) and Column B indicates whether the nurse in that situation would be likely or not to engage in the action (realistic). Content validity, face validity and evidence of discriminate validity of the JAND had been reported by the developer. Empirical validity for the JAND was based on correlation of sub-scores with the "principled morality score" (p score) of the Defining Issues Test (DIT), a measure of moral development used in the developer's original study. The correlation of the DIT and the JAND for Column A is reported as .28 ($p < .01$) and .19 ($p < .05$) for Column B; while significant, these are not strong correlations, so the tools are obviously measuring something different. Reported reliability for Column B, using Cronbach's alpha, ranges from .70 to .73 with different groups of nurses, but the developer reported Column A lacks internal consistency and is not being used as a separate scale to test hypotheses.

It seems odd that despite this lack of consistency, the researchers still decided to use the JAND. A reliability of 0.80 is considered the lowest acceptable alpha for a well-developed measurement tool (Burns & Grove, 1987).

The Nursing Autonomy and Patients' Rights Scale (NAPRS) was used to measure the variables of autonomy and advocacy, patients' rights, and rejection of traditional role limitations. The NAPRS, developed by Pankratz and Pankratz in 1974, is a 47-item, self-report instrument comprised of three sub-scales. Agreement or disagreement with each statement is indicated with a five-point Likert scale. Items on the NAPRS were developed from a questionnaire on nurse attitudes towards their professional roles and patients' rights, comments from nurse respondents to the questionnaire, and issues identified by selected nursing leaders. An initial pool of 69 items was administered to several groups of practicing nurses ($n = 702$). Factor analysis tentatively indicated the presence of the variables and that the NAPRS has potential for providing information on the three variables it claims to measure (no specifics reported). Cassidy and Oddi (1988) simplified instrument scoring by basing it on a simple sum of actual responses. Items were reversed and scores adjusted to reflect a total score for the scale and each sub-scale equal to the sum of the responses to the items.

Reliability analyses (Cronbach's alpha) of the JAND and the NAPRS and their respective sub-scales indicated a number

of unreliable items, particularly in autonomy and idealistic behavior, with alphas of only .216 and .199 respectively (Cassidy & Oddi, 1988). After unreliable items were eliminated, reliability analyses were recalculated. As a result, the autonomy sub-scale was reduced from 26 to 17 items and the idealistic behavior sub-scale was reduced from 39 to 25 items. The alpha of the autonomy scale was improved to a respectable .746 while the alpha of the idealistic scale improved only to a still very poor .400 (Cassidy & Oddi, 1988).

Demographics of the respondents showed a mean age of 31 years, 38.4% (n = 50) had completed an ethics course, and 49.2% (n = 64) had completed an ethics seminar. Significant differences among the four educational groups were noted on autonomy ($F = 20.93, p < .000$), patients' rights ($F = 3.14, p = .027$), and rejection of traditional role limitations ($F = 5.51, p < .001$). Post hoc tests using Scheffe's procedure indicated autonomy scores of AD and generic BSN groups were significantly higher than BSN completion and MSN groups ($p = .06$). There were no significant ($p > .05$) differences between groups on patients' rights. On rejection of traditional role limitations, AD students scored significantly higher than MSN students ($F = 5.51, p = .001, \text{no df reported}$).

Additional independent variables were examined for their effects on the sub-scales:

- (1) Age - The sample was divided into two groups by mean age. Younger students scored significantly higher on autonomy ($F = 34.14, p = .000$), and rejection of traditional role limitations ($F = 4.98, p = .02$). Younger students also scored higher, though not significantly, on patients' rights ($F = 3.81, p = .053$) (Cassidy & Oddi, 1988). No df values were reported.
- (2) RN status - Students who were RNs scored significantly higher on autonomy ($F = 59.38, p < .000$), while non-RN students scored higher on patients' rights ($F = 5.51, p = .02$) and rejection of traditional role limitations ($F = 10.25, p < .001$) (Cassidy & Oddi, 1988). No df values were reported.
- (3) Ethics education - Students who had taken an ethics course scored significantly higher on autonomy ($F = 6.89, p = .009$) and rejection of traditional role limitations ($F = 10.25, p < .001$) (Cassidy & Oddi, 1988). No df values were reported.

Surprisingly, students who had not taken an ethics seminar scored significantly higher on autonomy ($F = 19.38, p < .000$, no df reported) than those who had attended an ethics seminar (Cassidy & Oddi, 1988). The researchers suggested that the superficial discussion of ethics in the short time frame of seminar may generate more confusion than clarification.

Between all groups and all variables there were no significant differences found on perceptions of idealistic and realistic moral behavior. Cassidy and Oddi (1988) noted that the removal of the unreliable items from both the JAND and the NAPRS may have compromised instrument content validity. In addition, the unreliability of the JAND with this sample and the failure of its subscores to correlate significantly with any other variables may partially explain the lack of differences found among the four groups of nurses in perceptions of ethical dilemmas. Both the JAND and the NAPRS require further psychometric evaluation.

It is interesting to note here that when Cassidy and Oddi (1991) replicated their study, many of their 1988 findings were contradicted. In the 1991 study, the sample consisted of 147 students (a 40% response rate) who responded to a mailed questionnaire (number of questionnaires mailed was not reported). The final sample included 23 associate degree (AD), 11 generic baccalaureate (BSN), 52 degree-completion, and 60 master's degree (MSN) students. This sample was different from the original sample in that there were less generic BSN students and more degree-completion and master's students. The mean age of this sample was 32.3 years. In regard to ethics education, 41% (n = 60) had completed an ethics course and 50% (n = 73) had attended an ethics workshop or seminar. Cassidy and Oddi (1991) again reported problems with unreliable items on both the JAND and the NAPRS. Both instruments were modified

in essentially the same fashion as before. The alpha for the NAPRS was reported to exceed .75 for all three subscales. Even with elimination of unreliable items, the idealistic subscale of the JAND was only .54, while the realistic behavior subscale produced an alpha of .70. Nunnally (1978) recommends that tools in early stages of development, such as the JAND, should have a reliability of at least .70; the unacceptable reliability of the idealistic subscale decreases the reliability of the JAND as a whole.

In examining the results by program, the only consistent finding for both studies was that AD students scored significantly higher on rejection of traditional role limitations than MSN students ($F = 7.69, p < .0001$). In 1991, the generic BSN students also scored significantly higher than the MSN students. On autonomy, MSN students were significantly higher than the other three groups ($F = 7.69, p < .0000,$). In the original study, AD and generic BSN students scored significantly higher on autonomy.

The effects of age were the same for both studies, except that in Cassidy and Oddi (1988), younger students had scored higher on patients' rights. Younger students scored higher on autonomy ($F = 5.55, p = .0199$) and rejection of traditional role limitations ($F = 5.01, p = .0268$) than older students in both studies.

The findings related to RN status were reported as opposite of those in the original study. RNs scored

significantly lower than non-RNs on autonomy ($F = 42.17, p = .0000$), patients' rights ($F = 6.51, p = .0118$), and rejection of traditional role limitations ($F = 24.36, p = .0000$). RNs scored significantly lower than non-RNs (Cassidy & Oddi, 1991). It is interesting to note that MSN students (who were licensed RNs and were the largest group in the sample) scored significantly higher on autonomy than the other three groups, yet RNs scored significantly lower than non-RNs on autonomy. Is this an error on the researchers' part or could the degree completion group have scored so low on autonomy as to offset the autonomy scores of the MSN students? Conversely, in the original study, non-RNs scored higher on patient rights and rejection of role limitations only and RNs scored higher in autonomy. Data regarding ethics education showed that students who had a formal ethics course scored significantly higher on autonomy ($F = 4.42, p = .0373$) and perceptions of realistic moral behavior ($F = 4.12, p = .0443$); there were no significant differences for groups who had or did have an ethics course on patients' rights, rejection of traditional role limitations, or perceptions of idealistic moral behavior (Cassidy & Oddi, 1991). In the original study, ethics course students scored significantly higher on autonomy ($F = 6.89, p = .009$) and rejection of traditional role limitations ($F = 10.25, p = .001$); there were no significant differences by ethics course on perceptions of idealistic or realistic moral behavior (Cassidy & Oddi,

1988). By ethics seminar attendance, those students who had not attended an ethics seminar scored higher on autonomy ($F = 4.92, p = .0238$) and rejection of traditional role limitations ($F = 9.75, p = .0023$) than those who did attend an ethics seminar (Cassidy & Oddi 1991). These results are similar to those from the original study, with the exception of the effect on rejection of traditional role limitations.

In summary, Cassidy and Oddi (1991) suggested that the inconsistent findings between the replication and the original study may have been due to proportional differences between the student subgroups. Age in both studies exerted a significant effect on autonomy and rejection of traditional role limitations. Another consistent finding was that formal ethics education positively influenced attitudes on autonomy while continuing education on ethics negatively influenced attitudes on autonomy. The lack of reliability of the moral behavior subscale of the JAND in this study indicates this tool may not be appropriate for use in research until it is refined further.

Autonomy and the Work Environment

The relationship of personal characteristics, job-related characteristics and the perception of autonomy were examined by Alexander, Weisman, and Chase (1982). In a descriptive study designed to analyze autonomy as perceived by nurses working in different clinical contexts in a large university-affiliated hospital, the study sample ($n = 789$) represented 97.7% of the staff nurses employed full time at

the study facility. Subdivided by clinical context, the sample consisted of 134 nurses working on medical units, 178 nurses on surgical units, 108 nurses on special care units, and 117 nurses on pediatric and obstetrical units. In educational level, the sample was divided fairly evenly between baccalaureate (40%), diploma (30%), and associate degree (32%). The majority of the sample nurses (61%) were in their first nursing position and had worked in the study hospital for less than three years, worked on primary nursing units (57%), and rotated shifts (62%). Measurement tools for the study included a structured 30-minute personal interview with each nurse by a trained professional interviewer and a questionnaire developed from several other instruments. Instruments included: a) Five items from Rotter's (1966) Locus of Control Scale, a 29-item tool to measure personal efficacy (no psychometric values reported); b) the Head Nurse Scale, a 5-item scale developed for the study to measure the staff nurse's attitudes toward her head nurses' leadership style and responsiveness ($\alpha = .89$); four items from the Quality of Employment Surveys, which measure workers' perception of their decision-making power relative to the conduct of the jobs ($\alpha = .75$); and the Physician Task Delegation Scale, which measures the nurse's perception of frequency of delegation of inappropriate tasks by physicians. Other information collected included nursing education, length of employment, unit workload, position level, and method of nursing care on units surveyed.

Data were analyzed by zero-order Pearson Product Moment correlations and multiple regression techniques. Pearson Product moment correlations at $p < .05$ indicated autonomy was positively related to internal locus of control ($r = .20$), primary nursing ($r = .11$), and the head nurse scale ($r = .34$). Baccalaureate education was negatively associated with autonomy ($r = -.13$, $p < .05$) for the total sample; this was a significant finding with surgical nurses ($r = -.13$, $p < .05$). For special care nurses, those in their first position ($r = .20$, $p < .05$) and those with low workloads ($r = .18$, $p < .05$) were associated with high perceived autonomy. The finding of higher autonomy in a first position would seem to reinforce Cassidy & Oddi's (1988, 1991) results linking higher autonomy with younger age. Alexander et al. (1982) suggested that intensive care units, by virtue of their lower workloads and sensitivity to staffing, may instill a greater sense of autonomy in nurses who work there. Parent-child nurses with longer employment times viewed themselves as having greater control over their work than their counterparts in other areas (Alexander et al., 1982).

Multiple regression analysis to distinguish the influence of each independent variable on the nurses' perceptions of autonomy from the affects of all other variables yielded nearly the same results as for the correlational analysis. Baccalaureate education ($r = -.15$), internal control ($r = .18$), primary nursing

($r = .13$), the head nurse scale ($r = .34$), and the adequacy of professional time ($r = -.15$) were found to significantly predict perceived autonomy across all clinical areas ($F = 9.34$, $df = 11;691$, $p < .05$). For surgical ($r = .18$, $F = 3.94$, $df = 11;166$, $p < .05$) and special care unit nurses ($r = .14$, $F = 4.93$, $df = 11;96$, $p < .05$), workload had a significant effect on perceived autonomy. The parent-child nurses who felt they had both inadequate time for professional development ($r = -.20$) and thought physicians delegated inappropriate tasks to them ($r = -.23$) had significantly lower levels of perceived autonomy ($F = 4.70$, $df = 11;105$, $p < .05$). Clearly, there are a number of factors in the work environment which exert an effect on nurses' perceptions of autonomy.

Autonomy and Shared Governance

One of the few published works which examined shared governance was Ludemann and Brown's (1989) study of staff perceptions of shared governance approximately two years after the structure was initiated at Rose Medical Center in Denver, Colorado. The shared governance body at this institution was a nursing congress with bylaws that gave each employee in the nursing division an equal vote. Nursing staff were elected to decision-making councils and committees. The purpose of the study was to evaluate the effectiveness of the shared governance structure through the measurement of staff perceptions before and after the

structural change in the organization. Staff perceptions before shared governance were based on staff recollection.

Data was collected using two exploratory, descriptive, correlational surveys completed at two different points in time. The first survey was distributed to the total nursing division (n = 630) about one and one-half years after the institution of shared governance and the response rate was 28% (n = 178). A second survey was distributed six months later to a randomly selected sample of 200 nursing division staff; 74 survey were returned for a 37% response rate (Ludemann & Brown, 1989). The researchers justified administration of the second survey by noting that there was an unanticipated layoff of personnel due to low patient census during the week that the first survey was administered, which they felt may have affected those results. In addition, the researchers were concerned with the low response rate of the first survey and believed a second survey might assist them in determining the reliability of the findings; however, there were very few differences found between the first and second surveys and the second survey results were not included in the researchers' final report.

Following a review of the literature and examination of existing instruments, Ludemann and Brown (1989) designed a four-part instrument for the study which included a 15-item organizational commitment scale, a 24-item commitment to the nursing congress scale (developed by the researchers), and a

42-item attitudinal scale that measured toward the work environment (specifically, perceptions of autonomy and power and climate for change and innovation), staff influence within the organization, and a 14-item scale that measured job satisfaction. The attitudinal scale was adapted from a work environment scale by Welsch (Ludemann & Brown, 1989).

Validity and reliability of the instrument were assessed using factor analysis and Cronbach's alpha. Through factor analysis (oblique rotation), three subscales related to work environment were identified: 1) personal power and autonomy, 2) workload, and 3) climate for innovation. Three subscales related to job satisfaction were also identified: 1) intrinsic rewards, 2) extrinsic rewards, and 3) opportunities for growth. Based on the factor analysis, a shortened version of the instrument was developed which included only those items with factor loadings above .5000. The long version of the tool was used with the first distribution of the survey and the short version of the tool was used with the second distribution of the survey. Ludemann and Brown (1989) reported the alphas for all scales and subscales as $\geq .85$, except for workload (.78), climate for innovation (.72), and extrinsic rewards (.78) in the shortened version of the instrument.

Due to the low response rate for both data collection sessions, the two samples were compared with the total population at the time of the second survey by age, position, and work status. While the mean age of both

sample groups was seven years older than the population, the distribution patterns of both the samples and the population were very similar. By position, the groups were proportionally represented in both samples, except for unit secretaries and licensed practical nurses (LPN), who were underrepresented by no more than three percentage points. By work status, the two samples were very similar; the first sample had a full-time/part-time ratio of 69.8%/30.2% while the ratio for the second sample was 72.9%/27.1%. Work status information for the population was not available (Ludemann & Brown, 1989).

Findings indicated perception of the work environment was more positive after shared governance. By paired t-test, there was a mean change of .12 ($t = 2.97$, $SD = .44$, $p = .004$) in attitudes toward the work environment, with the greatest differences in the subscales of personal power and autonomy (mean change = .27, $t = 5.20$, $SD = .55$, $p = .000$) and climate for innovation (mean change = .21, $SD = .59$, $t = 3.84$, $p = .000$). The greatest mean change was on the influence scale, scored from 1 to 5/low to high (mean change = .56, $t = 7.82$, $SD = .76$, $p = .000$), indicating a significant increase in the staff's perception of ability to influence decision making in the organization. Results also indicated increased job satisfaction. Overall job satisfaction increased by .19 ($t = 4.84$, $SD = .42$, $p = .000$), with extrinsic rewards (salary and benefits) increasing by .22 ($t = 4.52$, $SD = .52$, $p = .000$) and

intrinsic rewards (self-respect and prestige) by .16 ($t = 3.73$, $SD = .47$, $p = .000$). Workload, as anticipated, did not change significantly (mean change = .07, $t = 1.64$, $SD = .44$, $p = .100$). Repeated Measures Analysis of Variance failed to find any interaction effects among demographic variables and the various scales and subscales discussed above (Ludemann & Brown, 1989).

Commitment to the organization and the nursing congress were examined next. With a possible high score of 7, the mean organizational commitment score was 5.08 and the mean nursing congress commitment score was 4.62, both indicating a mild degree of commitment. Relationships between demographic variables and commitment were examined using ANOVA. Commitment to the both the organization and the nursing congress increased with age, years employed at the study hospital, and a higher position within the nursing division. The researchers also found that nursing staff who worked full-time and had more education were more likely to be committed to the nursing congress, though not to the organization.

In critique, the author questions the accuracy with which the staff was able to recall their perceptions from nearly two years prior, a concern acknowledged by the researchers. The researchers could have done factor analysis and reliability testing on the instrument with a test sample before the first administration, rather than using one version of the tool with one sample and another

version with the second sample. It was also difficult to understand the data analysis associated with commitment, as the researchers discussed "staff" demographic characteristics, but included demographic variables related only to nurses (ie, basic RN education, highest nursing degree, and years in nursing).

Other Studies Utilizing the NAS

The primary study, which produced the data for this thesis, is a descriptive, correlational, longitudinal study undertaken to build a data base in relation to nurses' perceptions of several organizational dimensions and to allow evaluation of organizational changes in relation to those dimensions. Six dimensions were examined, including organizational climate, professional practice climate, work satisfaction, power orientation, centralization power, and professional nursing autonomy (using the NAS). Results from the December, 1990 and May 1991 data collection sessions were reported by Martin et al. (1991). Autonomy scores for the entire sample indicated that participant nurses in December 1990 (n = 125), and May 1991 (n = 164) perceived either a high level (69% and 55% respectively) or a mid level (32% and 45% respectively) of professional autonomy. The mean autonomy score was 190 in December, 1990 and 186 in May, 1991. There were no significant differences in the means between the two sessions ($F = 1.14$; $df = 159, 123$; $p = .45$) (Martin, et al., 1991). With the December, 1990 data, demographics were determined to explain 41% of the

variance in perceived autonomy. In both sessions, higher perceived autonomy was associated with higher final degree, higher professional affiliation scores, and fewer years licensed (Martin, et al., 1991).

Schutzenhofer's (in press) most recent work with her NAS focused on nurse characteristics and professional autonomy. From a random sample of 2000 RNs in four states, Idaho, Missouri, Florida, and Maryland, 542 (27.1%) responded to a mailed package including a demographic questionnaire and two research instruments. One instrument was the Personal Attributes Questionnaire (PAQ) developed by Spence, Helmreich, and Stapp (1974), which measures masculine-feminine traits, and the other was the NAS. The typical respondent was female (95.4%), married (74.4%), currently employed in nursing (88.9%), and based at a community/teaching hospital (95%). Only 5% of the respondents reported their work setting as in public health. The respondents' mean age was 42.3 years (range = 23-80 years). They had worked an average of 14.9 years (range = 0-59 years) in nursing since graduation, an average of 17.3 years (range = 1-59 years) ago. By basic education, the sample was 40% diploma, 35% AD, and 25% BSN. Two respondents were graduates of generic MSN programs. In addition to basic nursing education, highest degree attained was also measured; 29.3% reported the diploma as the highest degree, 24.2% the AD, 28.9% the BSN, 5% the MSN, and

2.2% the doctorate in nursing. The remaining 10.4% reported various non-nursing degrees.

Schutzenhofer (in press) noted significant relationships between professional autonomy and six variables. Mean NAS scores of respondents with an MSN (NAS = 207.44) were significantly higher ($p = .05$) than those with a diploma (NAS = 192.72), AD (NAS = 191.32), or BSN (NAS = 192.52). Public health nurses had a significantly higher mean NAS score than the hospital-based nurses ($t = 2.79, p = 0.01$). Among the hospital-based nurses, psychiatric nurses scored highest, even higher than critical care nurses. Across all groups, the clinical specialty was a significant factor to consider when evaluating a respondent's NAS score ($F = 2.32, p = 0.04$). There were no significant differences in the NAS score between primary, team or functional nursing care models. When compared to staff nurses, nurse managers had significantly higher NAS scores ($t = 5.09, p = 0.00$); however, respondents who reported their primary position as a clinical nurse specialist or nurse practitioner had a significantly higher mean NAS score than either nurse managers or staff nurses ($F = 33.48, p = 0.00$). While only 41.5% of the respondents reported membership in any professional nursing organization, those who did report professional affiliation had significantly higher NAS scores ($t = 5.62, p = 0.00$). Pearson product correlations of the PAQ and the NAS indicated masculine traits explained 13% ($r = .36$), feminine

traits explained 6% ($r = .24$), and masculine-feminine traits explained 2% ($r = .15$) of the variance in the NAS scores. There were no relationships noted between either age or years of experience and professional autonomy. Details of the statistics, such as degrees of freedom, were not provided in the Schutzenhofer (in press) study.

Schutzenhofer's (in press) results support the positive relationship found by Martin et al. (1991) between highest final degree, professional affiliation, and professional autonomy. The positive association between fewer years licensed and higher autonomy scores found by Martin et al. (1991) are not supported. Results also indicate that stereotyped feminine characteristics are related to lower perceived autonomy while stereotyped masculine characteristics are related to higher perceived autonomy.

Conceptual Framework

The conceptual framework of this thesis is that perceptions of professional autonomy in nursing are based on personal characteristics, socialization as a female, and nursing education. Work environment, nursing practice model, and shared governance further influence nurses' perceptions of professional autonomy. Perceptions of autonomy ultimately influence job satisfaction, professional practice and patient/client outcomes. A schematic model of the framework can be found in Figure 1. In this thesis, autonomy was examined within the context of work environment (practice area) and the development of shared governance.

Summary

Boughn's (1988) work indicated that baccalaureate nursing students are less autonomous than similar students enrolled in baccalaureate programs in non-traditional occupations, and Schutzenhofer (in press) found stereotyped feminine characteristics associated with lower perceived autonomy, findings which reinforce the theoretical literature regarding characteristics of women in predominantly female professions. Cassidy and Oddi's (1988, 1991) finding that attitudes on autonomy are positively associated with younger age and formal ethics education provides some strength for Alexander et al.'s (1982) finding of high perceived autonomy in association with nurses in their first position on special care units, and is also reinforced by Martin et al.'s (1991) result associating higher autonomy with fewer years licensed. By contrast, Ludemann and Brown (1989) found no relationships between demographic characteristics and perceptions of personal power and autonomy before and after the institution of shared governance. Primary nursing has also been found to be positively associated with perceptions of autonomy (Alexander et al., 1982). Autonomy may be influenced by education, experience in the workplace, nursing practice models and shared governance. When considered together, these findings may have implications for nursing educators as well as health care institutions considering implementing

different models of practice or management structures which demand increased autonomous behavior from nurses.

The conceptual framework developed for this thesis contends that professional autonomy is a product of personal characteristics, female socialization, and nursing education, which is further influenced by the work environment, nursing practice models, and shared governance. Autonomy ultimately affects job satisfaction, professional practice, and patient/client outcomes.

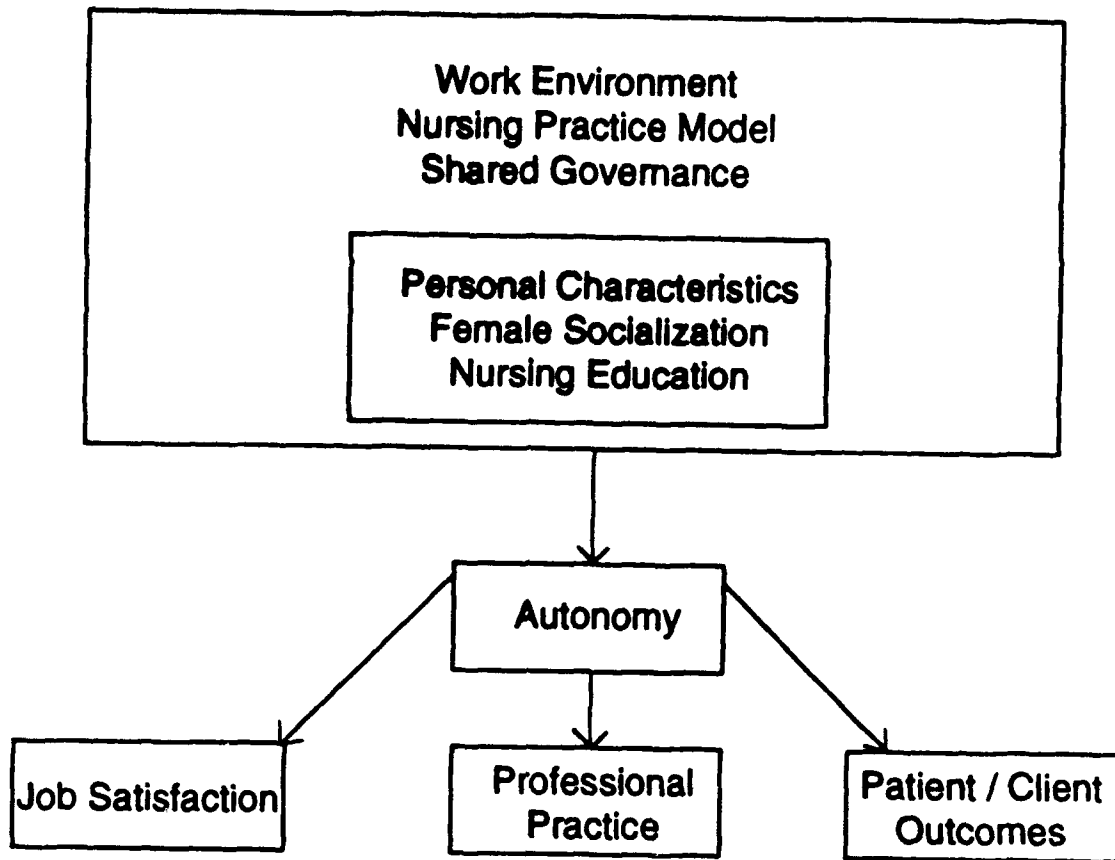


Figure 1. Conceptual framework of autonomy

III. METHODOLOGY

The purpose of this thesis is to study the professional autonomy perceived by maternal-newborn and surgical nurses during the development of shared governance in a large hospital organization. In this chapter, the methods of the research will be discussed. A description of the research design and the instrument to be used will be followed by a discussion of the sampling plan and human rights protection techniques. The data analysis plan for testing the research hypotheses will also be presented.

Research Design

A comparative-descriptive research design was used to examine the differences between maternal-newborn and surgical nurses' perceptions of professional autonomy and changes in those groups' perceptions during the development of shared governance. A secondary analysis of data collected as part of Martin et al's (1991) larger ongoing study of Organizational Dimensions of Hospital Nursing Practice was performed. All data were collected from one site. Data were not matched for the participants. For this study, the measures of maternal-newborn and surgical nurses' perceptions of professional autonomy from three different points in time were examined and compared.

Setting

The setting for the study was a large midwestern teaching hospital. Accredited by the Joint Commission of Accreditation of Health Care Organizations, the hospital was an urban, not-for-profit institution with an average daily census of approximately 500 patients and is designated as a Level III Perinatal Center and a Level I Trauma Center. The hospital employed approximately 1200 RNs. Through a collaborative agreement between the division of nursing and the local university school of nursing, the hospital had been a primary site for several nursing studies. For the purposes of the original study, hospital clinical practice areas were classified as medical-surgical, maternal-newborn, critical care, behavioral sciences, surgical services, and ambulatory services.

Shared governance was instituted at the study hospital in 1988. The shared governance structure consists of a 26-member hospital-based Nursing Council. Members of the Nursing Council include staff nurses, clinical nurse specialists, nurse educators, administrative nurses, and a liaison from the affiliated university. Thirteen (50%) of the Nursing Council members must be staff nurses to give them proportional representation. Individual unit representation was not an issue as the nurses agreed from the beginning on the basic belief that all nurses face the same problems. There are no subcouncils. Council membership is voluntary. Members are chosen by lottery each

year in autumn and one-quarter of the members are rotated every six months. Some of the units have unit councils to address individual unit issues and decisions and the chairpersons from the unit councils come to Nursing Council meetings. Forms are available on each nursing unit for nurses to use to provide input on issues. According to one of the clinical nurse specialists who has been involved in the shared governance model since its inception, the first issues brought before the council tended to be unit-based problems and complaints about other departments. To develop a comfort level in the nurses in collaborating with other departments, the Nursing Council initially handled these types of problems. As time has passed, staff nurses now resolve interdepartmental issues independently. The issues coming before the Nursing Council now involve issues which affect all nurses. For example, when a computer-assisted medication dispensing system was instituted, the Council focused on what impact the system would have on nursing practice and the educational needs of the nursing staff. Another benefit from shared governance has been improved communication and relationships between administrative and clinical nurses.

It was the observation of the chief nurse executive of the facility and one of the clinical nurse specialists that participation by the surgical services nurses in shared governance initially was less than other nurses in the hospital, primarily due to the fact the nursing management

of that department was less supportive of the shared governance concept. One reason for this is that surgical services does not fall under the nursing department in the hierarchy of the hospital and tend to feel separated from the department of nursing. Another reason may be that the surgical areas are geographically separate from the rest of the units, which may cause nurses who work in these areas to feel isolated.

Population

The population for this study included all registered nurses employed by the hospital who were working in either the maternal-newborn or surgical services clinical practice areas. Units included under the maternal-newborn area were labor and delivery, postpartum, normal newborn nursery, the neonatal intensive care unit, and birth/family education. Units included under surgical services included operating room, post-anesthesia care unit, pre-operative care, outpatient operating room, pre-admission testing, and endoscopy. The total number of nurses employed in the maternal-newborn areas was 368 and the total number of nurses employed surgical services was 192.

Sample

The study sample was a convenience sample consisting of nurses from the maternal-newborn and surgical areas who participated in the primary study on organizational dimensions in hospital nursing practice. All RNs were invited to each data collection session except for the first

session, in which a stratified random sample of 127 were invited. In the primary study, 125 (total) nurses participated in the first data collection session, 194 in the second, and 148 in the third. Information regarding the extent of participation in shared governance was not sought from the respondents in the original study.

Human Subject/Ethical Considerations

Human subject protection was addressed during data collection for the primary study. Respondents participated voluntarily and there was no penalty for not participating. Food was provided as an incentive as nurses participated in the study during a break, meal time, or adjacent to a shift worked. Participants' identities were not coded to responses to assure anonymity of responses; however, detailed demographics could be used to identify participants. For this reason, the data was coded by a graduate assistant at the university and no individual data were reported. Starting with the September, 1992 data collection session, participants were asked to voluntarily place their social security number in a place provided on the demographics collection tool (Appendix A) for the purpose of determining whether the same individuals were participating in the primary study each time data were collected and to improve data analyses by matching responses over time. This activity was optional and subjects were briefed as such; 122 of the 164 participants responded.

Subjects were informed of the purpose of the study and

the fact that data gathered may be used in other research studies in a cover letter at the beginning of the questionnaire (Appendix B). Once collected, data were placed in locked storage in the office of the primary investigator conducting the primary study. Permission to conduct this study was obtained from the university Institutional Review Board (IRB) (Appendix C) as well as the Nursing Research Committee, IRB, and Senior Vice President for Hospital Operations at the institution involved (Appendix D). Results of this thesis will be shared with the primary research team and will be offered to both the study site and Dr. Schutzenhofer.

Methods/Procedures

In the primary study, nurses were chosen via stratified random selection with replacement for the first data collection in December 1990. Unfortunately, a poor response rate from the critical care nurses and subsequent replacement resulted in all of the nurses from the critical care specialty being invited and only a portion of the nurses in the other specialties being invited (Martin et al., 1991). For the second (November, 1991) and third (September, 1992) data collection sessions, all nurses were invited by individual letters (Appendix B) delivered to them through hospital mail. Participants were able to choose to attend any one of four data collection sessions held over the course of one day.

In the primary study, data on nurses' perceptions of professional nursing autonomy were collected using the Schutzenhofer Nursing Activity Scale, formerly known as the Professional Nursing Autonomy Scale, (Appendix A) which was part of a larger questionnaire containing five other tools. For this thesis, the existing data was used to examine and compare the perceptions of professional nursing autonomy held by maternal-newborn and surgical nurses.

Measurements/Instruments

The Schutzenhofer Nursing Activity Scale (NAS) is a self-report instrument consisting of 35 items. Only 30 items are scored; the other five items are included as experimental items to be compared with scale items as an additional measure of reliability (Schutzenhofer, 1988a). A 4-point Likert scale is used to rate each item, with 1 representing very unlikely for the respondent to act in this manner and 4 representing very likely for the respondent to act in this manner. Some of the items are reversed and items are also then weighted with a value of 1, 2, or 3 for scoring purposes, depending on whether they represent a high or low level of autonomy. After modifying the original tool to address scaling difficulties encountered in pilot testing of the NAS autonomy, Schutzenhofer (1988a) reported Cronbach's alpha at .92 for internal consistency on the modified tool, which divided possible autonomy scores into five categories, ranging from very low to very high levels of autonomy. Data analysis and comments from RN

participants in the testing of the modified tool revealed that few items rated in the first two categories; also 40 respondents wrote comments after completing the tool indicating that a rating of three was what any RN would do. To rectify this problem, the one, two, and three (very low, low, and mid level) ratings were grouped together in a new rating of one (low) with the original ratings of four (high) and five (very high) becoming two (mid level) and three (high), respectively. The present tool, revised as described above, has a Cronbach's alpha of .91. Content validity was addressed through the use of current nursing literature for examples of autonomous behavior and ideas from nursing leaders in the development of the tool. The items developed from these sources were then submitted to a panel of doctorally prepared nurses for review and ranking. For the primary study, the NAS alphas for the entire sample were .88, .88 and .89 for the first, second and third data collection sessions, respectively.

The scores on the NAS were used to determine perceived levels of autonomy. Scores can range from 60 to 240, with scores of 60-120, 121-180, and 181-240 representing lower, middle, and higher levels of professional autonomy, respectively (Schluzenhofer, 1988a); scoring is accomplished by multiplying the numerical value of each item response by the weight assigned to each item. Items representing a lower level of autonomy are assigned a value of 1; items representing a middle level of autonomy are

assigned a value of 2; and items representing a higher level of autonomy are assigned a value of 3. The NAS has been used in a number of unpublished master's theses and doctoral dissertations, but the only published literature using the NAS has been conducted by Dr. Schutzenhofer. Permission to use the NAS has been obtained from Dr. Schutzenhofer (Appendix E). The research team in the primary study has granted permission for this researcher to use the existing autonomy data for this study (Appendix F).

Data Analysis

Data analyses were performed to address the two research hypotheses:

- 1) The autonomy perceived by maternal-newborn nurses will be greater than that perceived by surgical nurses.
- 2) Both the maternal-newborn and surgical nurses' perceptions of autonomy will improve significantly during the development of shared governance.

Descriptive statistics (frequency and percentages) were calculated from the existing data to describe the sample. The dependent variable is autonomy and the independent variables are clinical practice area (maternal-newborn or surgical) and time of data collection. A two-way analysis of variance (ANOVA) was used to examine the difference of perceptions of professional autonomy within and between the two groups of nurses in relation to practice area and time. The level of significance was set at .05.

Summary

A comparative-descriptive study was designed to guide the examination of maternal-newborn and surgical nurses' perceptions of professional autonomy during the development of shared governance. A secondary analysis of data collected in a larger study with the NAS was planned using a two-way ANOVA and descriptive statistics.

IV. ANALYSIS OF DATA

This thesis addressed the problem that while there are numerous articles noting the importance of autonomy to the nursing profession, there is very little published research about changes in nurses' perception of autonomy as shared governance develops within an institution. This chapter contains a report the findings of the thesis. In addition to a description of the sample, a report of the results of the data analyses for each research hypothesis will be presented.

Demographic Profile

The sample was composed of RNs employed in maternal-newborn (MN) or surgical services (SS) practice areas who participated in the December, 1990; November, 1991; and September, 1992 data collection sessions of the ongoing primary study and completed the Schutzenhofer Nursing Activity Scale (NAS). One nurse from each of the first two sessions and four nurses from the last session were excluded from the study due to missing data on the NAS resulting in a total sample of 105 nurses. In the first session, 20 MN nurses and 11 SS nurses participated. In the second session, 14 MN nurses and 22 SS nurses participated.

Fourteen MN nurses and 24 SS nurses participated in the third session.

The first demographic characteristic examined was age. For the total sample, nurses between 30 and 39 were the largest group (n = 44, 42%) and the next largest group (n = 32, 30.4%) were nurses between 40 and 49. The sample's age distribution by frequency as well as percentages can be found in Table 1. The MN and SS nurses differed by age. The largest portion of the MN nurses was age 40-49 in the second (36%) and third (50%) sessions, but in the first session, the largest portion (35%) was between 30 and 39 years of age. The SS nurses were slightly younger, with nurses aged 30-39 comprising the largest portion in all three sessions. With the MN nurses, the third largest group were those 50 and over, while with the SS nurses, the group aged 20-29 made up the third largest group.

Educational demographics, including basic nursing education and highest degree attained, were examined next. The diploma degree (n = 43) and the Bachelor of Science in Nursing (BSN) (n = 41) were the most frequently reported levels of basic nursing education comprising 41% and 39% of the sample, respectively. Twenty nurses reported the associate degree (AD) as their basic nursing education. The MN and SS nurses differed in their basic education in that the MN nurses were more likely to have a BSN. In the first and second sessions, 60% and 64%, respectively, of the MN nurses entered nursing with a BSN; in the third session,

BSN and diploma nurses each comprised 36% of the MN nurses. By contrast, the majority of the SS nurses had a diploma degree in all three sessions.

The highest degree attained for the sample showed 39 (37%) nurses with a diploma degree, 38 (36%) nurses with a BSN, 18 (17%) nurses with an AD, and 9 (9%) nurses with a Master of Science in Nursing (MSN). Again, only one nurse (1%) reported "other" as the highest degree; specifics were requested in the primary study, but not included in the computer-generated statistical report. The MN nurses also differed from the SS nurses by highest degree attained. The largest number of MN nurses reported a BSN as the highest degree attained, except for the third session, in which a diploma degree was reported as the highest degree attained. As with basic education, the largest percentage of SS nurses for all three sessions reported a diploma as the highest degree attained. These results indicate that while some of the MN nurses have pursued education beyond their basic nursing education, most of the SS nurses have not. Educational frequency and percentage distributions are presented in Table 2.

Table 1

Age Distribution of Sample at Three Survey Times

AREA	MATERNAL-NEWBORN			SURGICAL		
	1	2	3	1	2	3
TIME	<u>n</u> (%)	<u>n</u> (%)	<u>n</u> (%)	<u>n</u> (%)	<u>n</u> (%)	<u>n</u> (%)
AGE						
20-29	3 (15)	2 (14)	1 (7)	2 (18)	3 (14)	2 (8)
30-39	7 (35)	4 (29)	3 (21)	5 (46)	10 (46)	15 (63)
40-49	6 (30)	5 (36)	7 (50)	3 (27)	7 (32)	4 (17)
50 +	4 (20)	3 (21)	3 (21)	1 (9)	2 (9)	3 (12)

* Due to rounding, percentages may not total to 100%

Table 2

Education Distribution of Sample for Three Survey Times

AREA	MATERNAL-NEWBORN			SURGICAL		
	1	2	3	1	2	3
TIME	<u>n</u> (%)	<u>n</u> (%)	<u>n</u> (%)	<u>n</u> (%)	<u>n</u> (%)	<u>n</u> (%)
BASIC EDUCATION						
AD	4 (20)	2 (14)	4 (29)	3 (27)	3 (14)	4 (17)
Diploma	4 (20)	3 (21)	5 (36)	6 (56)	14 (64)	11 (46)
BSN	12 (60)	9 (64)	5 (36)	2 (18)	5 (23)	8 (33)
Other	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	1 (4)
HIGHEST DEGREE ATTAINED						
AD	4 (20)	1 (7)	4 (29)	2 (18)	3 (14)	4 (17)
Diploma	4 (20)	2 (14)	5 (36)	5 (46)	13 (59)	10 (42)
BSN	10 (50)	8 (57)	3 (21)	3 (27)	5 (23)	9 (38)
MS	2 (10)	3 (21)	2 (14)	1 (9)	0 (0)	1 (4)
Other	0 (0)	0 (0)	0 (0)	0 (0)	1 (5)	0 (0)

* Due to rounding percentages may not total to 100%

Examination of length of employment demographics revealed that over 50% of the nurses had long tenures at the current hospital; 22 MN nurses and 36 SS nurses had been employed at the current hospital for more than ten years. The next largest employment category was five to ten years with 9 MN nurses and 7 SS nurses. While greater than 10 years was the largest category for both groups of nurses at all three survey times, the percentage of SS nurses in the category was more than 60% each time compared to 40-50% for the MN nurses. See Table 3 for length of employment frequencies and percentages.

Table 3

Length of Employment Distribution of Sample at Three Survey Times

AREA	MATERNAL-NEWBORN			SURGICAL		
	1	2	3	1	2	3
TIME	<u>n</u> (%)	<u>n</u> (%)	<u>n</u> (%)	<u>n</u> (%)	<u>n</u> (%)	<u>n</u> (%)
LENGTH OF EMPLOYMENT						
<6 mos	1 (5)	0 (0)	0 (0)	0 (0)	3 (14)	1 (4)
6 mos-1 yr	1 (5)	1 (7)	0 (0)	0 (0)	1 (5)	0 (0)
>1 yr-3 yrs	5 (25)	2 (14)	3 (21)	2 (18)	1 (5)	1 (4)
>3 yrs-5 yrs	1 (5)	1 (7)	2 (14)	0 (0)	1 (5)	4 (17)
>5 yrs-10 yrs	3 (15)	3 (21)	3 (21)	2 (18)	2 (9)	3 (13)
>10 yrs	9 (45)	7 (50)	6 (43)	7 (67)	14 (67)	15 (63)

* Due to rounding, percentages may not total to 100%

Frequency and percentages were also calculated for job status of the sample. Eighty-two percent (n = 86) of the nurses were a Primary Nurse (PN) I, including 35 MN nurses

and 51 SS nurses. The next most frequent participants were a PN IV/Clinical Nurse Specialist (n = 10) of which 7 were MN nurses and 3 were SS nurses. While Primary Nurse I was the largest category for both groups of nurses at all three survey times, the percentage of SS nurses in this category was greater (80-90%) than MN nurses (70-80%). See Table 4 for the frequency distributions for job status.

Table 4

Job Status Distribution

AREA	MATERNAL-NEWBORN			SURGICAL		
	1	2	3	1	2	3
TIME	n(%)	n(%)	n(%)	n(%)	n(%)	n(%)
JOB STATUS						
PN I	15 (75)	10 (71)	10 (71)	9 (82)	20 (91)	22 (92)
PN II	0 (0)	0 (0)	2 (14)	1 (9)	0 (0)	0 (0)
PN III	2 (10)	1 (7)	0 (0)	0 (0)	0 (0)	0 (0)
PN IV/Clin Spec	2 (10)	3 (21)	2 (14)	0 (0)	1 (5)	2 (8)
Shift Resource	0 (0)	0 (0)	0 (0)	0 (0)	1 (5)	0 (0)
Nurse Manager	0 (0)	0 (0)	0 (0)	1 (9)	0 (0)	0 (0)
Other	1 (5)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)

* Due to rounding, percentages may not total to 100%

The last sample parameter examined was professional affiliation: membership in professional organizations, number of offices held in professional organizations, and professional presentations (See Table 5 for details of professional affiliation). Of the total sample for each clinical area, 50% (n = 24) of the MN nurses and 61% (n = 35) of the SS nurses reported membership in a professional

organization. For each survey time, a greater percentage of SS nurses reported membership in a professional organization than did MN nurses. An examination of the number of offices held revealed that 86% (n = 90) of the nurses in the sample had never held an office in a professional organization and 71% (n = 75) had never made a professional presentation.

Table 5

Professional Affiliation of Sample for Three Survey Times

AREA	MATERNAL-NEWBORN			SURGICAL		
	1	2	3	1	2	3
TIME	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
MEMBERSHIP IN PROFESSIONAL ORGANIZATION						
Yes	11 (55)	8 (57)	5 (36)	8 (73)	14 (64)	13 (54)
No	9 (45)	6 (43)	9 (64)	3 (27)	8 (36)	11 (46)
NUMBER OF OFFICES HELD						
		**		**	**	
None	19 (95)	11 (79)	14 (100)	8 (73)	17 (77)	21 (88)
One Office	0 (0)	2 (14)	0 (0)	3 (27)	2 (9)	0 (0)
Two Offices	0 (0)	0 (0)	0 (0)	0 (0)	1 (5)	2 (8)
Three Offices	1 (5)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
PRESENTATIONS						
		**		**		
None	15 (75)	9 (64)	9 (64)	8 (73)	13 (59)	21 (88)
Some	5 (25)	4 (29)	5 (36)	3 (27)	8 (36)	3 (13)

* Due to rounding, percentages may not total to 100%

** Denotes locations of missing frequencies

Descriptive Statistics for
the Variable of Autonomy

Secondary analysis of the autonomy data originally collected with Schutzenhofer's (1988) Nursing Activity Scale

(NAS) in the primary study was performed by the Statistical Consulting Center at Wright State University using SAS, version 6.07. The NAS was completed by 20 MN nurses and 11 SS nurses in the December, 1990 session, 14 MN nurses and 22 SS nurses in the November, 1991 session, and 14 MN nurses and 24 SS nurses in the September, 1992 session. As indicated in Chapter III, a score of 60-120 represents a low level of autonomy, a score of 121-180 represents a mid level of autonomy, and a score of 181-240 represents a high level of autonomy (Schutzenhofer, 1988a). In the first session, the mean autonomy score of the MN nurses was 190.5 (SD = 26.24, range = 142-235, median = 187.5) and for the SS nurses the mean autonomy score was 185.09 (SD = 16.29, range = 164-212, median = 184), a difference of 5.41 points. In the second session, the mean autonomy score of the MN nurses was 189.43 (SD = 25.54, range = 153-234, median = 188.5) and the mean autonomy score of the SS nurses was 179.96 (SD = 13.61, range = 158-210, median = 178), a difference of 9.47 points. In the third session, the mean autonomy score of the MN nurses was 186.21 (SD = 21.34, range = 140-212, median = 190) and the mean autonomy score of the SS nurses was 179.08 (SD = 22.89, range = 146-219, median = 178.5), a difference of 7.13 points. From the first session to the third session, the MN nurses' overall mean autonomy score dropped by 4.286 points while the SS nurses' overall mean autonomy score dropped 6.007 points. According to the NAS scoring guidelines, the MN nurses' mean score indicated a

high level of professional autonomy for all survey times. The SS nurses' mean score for the first session was in the high range, but for the last two sessions their mean scores were in the high end of the mid range scale. See Table 6 for descriptive statistics on MN and SS nurses' perception of autonomy mean scores for each survey time and Table 7 for perception of autonomy overall mean scores.

Table 6

Perception of Autonomy Mean Scores by Survey Time

TIME	AREA	n	AUTONOMY*	
			MEAN	SD
12/90	Maternal/Newborn	20	190.500	26.244
	Surgical	11	185.090	16.288
11/91	Maternal/Newborn	14	189.428	25.539
	Surgical	22	179.954	13.605
12/92	Maternal/Newborn	14	186.214	21.344
	Surgical	24	179.083	22.893

* Low level = 60-120; mid level = 121-180; high level = 181-240

Table 7

Perception of Autonomy Overall Mean Scores

AREA	n	AUTONOMY	
		MEAN	SD
Maternal-Newborn	48	188.938	24.253
Surgical	57	180.579	18.361

Hypothesis One

The first research hypothesis was that **the perception of professional autonomy held by maternal-newborn nurses will be greater than that held by surgical services nurses.** To examine both the differences in perceptions of professional autonomy held by MN nurses and SS nurses and whether those perceptions changed over time, the analysis was approached by a two-way Analysis of Variance (ANOVA) that considered both research hypotheses. The dependent variable was the overall autonomy score and the independent variables were area (maternal-newborn or surgical) and time (1990, 1991, 1992). Although MN nurses consistently had higher autonomy scores than SS nurses, the difference was not significant at the 0.05 level. In view of the small sample sizes, the F-ratios for the components of the model (See Table 8) show the main effect for "area of clinical practice" ($F = 2.81$, $df = 1$, $p = 0.0970$) to be worthy of further study with a larger sample.

Table 8

Summary Table of 2-Way ANOVA for Perceptions of Autonomy by Survey Time and Area

SOURCE	df	Mean Square	F	p
Survey Time	2	209.25	0.45	0.6392
Area	1	1306.65	2.81	0.0970
Survey Time*Area	2	32.75	0.07	0.9321

Hypothesis Two

The second research hypothesis of this thesis was that **both maternal-newborn and surgical nurses' perceptions of autonomy will improve during development of shared governance.** The same data analysis was used to examine the changes in perception of autonomy over time; there was no significant difference for the main effect of survey time ($F = 0.45$, $df = 2$, $p = 0.6392$). It should be noted that the autonomy scores of both groups were relatively high to start with, so there was not much room for improvement. The interaction effect of time by area also was not significant with $F = 0.07$, $df = 2$, and $p = 0.9321$ (See Table 8).

Summary

In this chapter, a demographic description of the sample nurses and the results of data analysis were presented. By age, MN nurses tended to be slightly older. By education, MN nurses tended to have baccalaureate degrees while SS nurses tended to be diploma graduates. By job status and length of employment the MN nurses and SS nurses were similar with the largest number of nurses in both practice areas most likely to be a Primary Nurse I with a length of employment of 10 years or more. A two-way ANOVA found neither practice area ($p = 0.0970$) or survey time ($p = 0.6392$) to exert a significant effect on the perceptions of professional autonomy held by the nurses. Practice area and survey time also had no significant interaction effect ($p =$

.9321). Although the MN nurses consistently had higher autonomy scores than the SS nurses, the differences were not significant ($F = 2.81$, $df = 1$, $p = .0970$).

V. CONCLUSIONS, DISCUSSION, IMPLICATIONS AND RECOMMENDATIONS

This final chapter contains conclusions drawn from data analysis followed by a discussion of those results of data analysis in relation to the previous review of literature and the theoretical framework. Implications of the thesis for nursing practice, nursing administration, nursing education, nursing research, and recommendations for further research will then follow.

Conclusions

The purpose of this thesis was to examine the differences between the autonomy perceived by maternal-newborn nurses and that perceived by surgical services nurses and changes in those perceptions during the development of shared governance at a large, urban, university-affiliated hospital in the Midwest. Secondary analysis of data collected in an ongoing study of organizational dimensions of hospital nursing practice was performed. Autonomy data from three data collection sessions approximately one year apart were selected for analysis by two-way ANOVA.

The first hypothesis was that maternal-newborn nurses' perception of professional autonomy will be greater than

perceived by surgical nurses. The findings indicated that although the mean autonomy score for maternal-newborn nurses was consistently higher, there were no significant differences between maternal-newborn and surgical nurses' perceptions of professional autonomy ($F = 2.81$, $df = 1$, $p = 0.0970$). For the total sample, the perception of autonomy mean score on the NAS for maternal-newborn nurses was 188.938 while for surgical nurses it was 180.579. The score for maternal-newborn nurses represents a high level of perceived autonomy and for surgical nurses a mid level, but the surgical nurses' mean score is only .421 points from a score of 181, which is classified as a high level of perceived autonomy; therefore, both groups of nurses (if means are rounded to the nearest whole number) can be said to have high levels of perceived autonomy. Alexander et al. (1982) found that parent-child nurses with longer employment times tended to veil themselves as having more control over their work, a variable associated with higher autonomy scores in that study. Alexander et al.'s (1982) finding is supported by this thesis. Although locus of control was not examined, in this thesis, many nurses displayed the associated characteristic of higher autonomy scores.

Maternal-newborn nurses in this sample had an average length of employment of over 10 years. Alexander et al. (1982) also noted that institutions in which nurses have a high level of perceived autonomy also had lower turnover rates, which is supported by the data in this thesis. For

both groups, the majority of the nurses had been at the current institution for more than 10 years and the next largest group was the 5-10 year group.

The findings of non-significant differences between maternal-newborn and surgical nurses may be related to the small sample size; of the 348 nurses employed in maternal-newborn areas, participation rates for each session ranged from 3.1% to 5.7%. Another possible explanation may be that only the more autonomous nurses participated in the survey.

The second research hypothesis was that both maternal-newborn and surgical nurses' perceptions of autonomy will improve during development of shared governance. Autonomy scores for both groups declined over the timeframe of the thesis, but the changes were not significant at the .05 level ($F = 0.07$, $df = 2$, $p = .9321$). With the levels high at the beginning, there was less room for improvement.

If autonomy has eluded nurses, as indicated in the literature, why were the mean autonomy scores in this thesis so high? Jordan's (1993) thesis, which also involved secondary analysis of data from the same primary study, focused on perceptions of professional autonomy among critical care nurses and medical-surgical nurses. Jordan's (1993) data indicated a high level of autonomy among those nurses as well. Other dimensions environment in which the nurses at the hospital studied function may provide some justification.

The hospital has always been known in the community as a center of nursing excellence. Nursing is not viewed by upper management as a dependent activity, which has produced a nursing culture which is different than that in other area hospitals. Primary nursing, a nursing care model which has been associated with higher autonomy, has been in place since the 1970s. Nurses pursuing higher education are supported through a combination of flexible scheduling and tuition assistance programs. Currently plans are in progress for institution of clinical ladder program for nurses interested in attaining recognition for clinical expertise.

The organization has a flat structure. The chief nurse executive (CNE), senior vice-president for hospital operations, has responsibilities which include all services related to patient care other than physician care. The CNE is a voting member of the Executive Board and a member of the Medical Staff Committee. She also is a part of Hospital Policy Committee, composed of only four members, which makes all major hospital operational and financial decisions. Through the CNE, nurses have a powerful voice at the top of the organization. The CNE has been crucial in establishing organizational support for shared governance and empowering the nurses to fully participate in decisions concerning nursing issues within the institution. The hospital's philosophy of nursing (Miami Valley Hospital, 1993), one of

the first documents produced by the Nursing Council, reflects the attitudes among the nurses at this institution:

Nurses at Miami Valley Hospital consistently strive for quality individualized care. Quality is enhanced by the commitment of each professional nurse. Every nurse has the right and responsibility to participate in decision-making processes that influence nursing practice.

Effective communication is the cornerstone of collaboration, collegiality, and professionalism; it is encouraged and facilitated, thereby creating a dynamic environment which promotes professional growth (p. 3).

The philosophy indicates the nurses believe in many of the concepts associated with autonomy and it seems plausible that nurses working in this particular environment may very well demonstrate higher autonomy than might be expected.

Discussion

Professional autonomy is "the practice of one's occupation in accordance with one's education, with members of that occupation governing, defining, and controlling their own activities in the absence of external controls" (Schutzenhofer, 1987, p. 278). Professional autonomy has been found to be source of job satisfaction for nurses (Rowland & Rowland, 1992); constraint of professional autonomy by hospital bureaucracy is frequently cited the

reason nurses leave nursing (Maas & Jacox, 1977; Wandelt, et al., 1981).

Autonomy, the hallmark of a profession (Mundinger, 1980), has thus far eluded nurses. A review of the theoretical literature revealed the part of the reason for the lack of autonomy in nurses lies in the fact that most nurses are women and female socialization norms do not encourage women to be autonomous beings. Family, school, and church forces combine to encourage feminine passivity and underachievement as desirable feminine attributes (Weitzman, 1988) and limit opportunities for decision-making (Gilligan, 1977). Nursing education, with its regimented learning processes and control of even some aspects of students' personal lives, also limits the development and exercise of professional autonomy to the point that some nurses never possess it. Nursing schools also have historically promoted the concept of nursing as preparation for marriage and motherhood, thus stifling career commitment and attracting those who do not seek autonomy (Hughes, 1988).

Ashley's (1976) work cited the persistence of male-female stereotyping from Victorian times as partially responsible for the limitation of autonomy and the control that physicians and hospital administrators to this day exert over nurses. Within the legal system, even though many laws have been changed to give women equal rights, Pinch (1981) noted that restrictive attitudes still exist to

some extent and nurses must struggle with groups outside of the nursing profession for legal control of nursing education and practice.

The empirical literature supported the theoretical literature. In Boughn's (1988) study of female students in baccalaureate degree programs, nursing students had lower autonomy scores than other female students in nontraditional programs, supporting that women attracted to the nursing profession may be naturally less autonomous. Alexander et al. (1988) found that nursing management had an effect on nurses perceptions of autonomy.

Theoretical and empirical literature were combined to develop the conceptual framework for this thesis, which indicates that professional autonomy is dependent on personal characteristics, socialization as a female, and nursing education. The work environment, nursing practice model, and shared governance further influence nurses' perceptions of autonomy, which influences job satisfaction professional practice, and patient/client outcomes.

Although a non-significant difference, maternal-newborn nurses tended to have higher autonomy scores than surgical nurses in this thesis. Maternal-newborn nurses included nurses from the neonatal intensive care unit as well as the labor and delivery unit, both of which utilize high-technology equipment and procedures and in that respect are similar to adult intensive care units. Although the differences in this sample were not significant, the higher

autonomy perceived by maternal-newborn nurses is similar to Alexander et al.'s (1982) and Jordan's (1993) finding of higher autonomy scores in critical care nurses.

The maternal-newborn sample also had a higher percentage of BSN nurses. Alexander et al. (1982) found BSN education negatively associated with autonomy, a result which is not supported by this thesis. In addition, autonomy scores did not change significantly over time during development of shared governance for either group, a finding which is not consistent with Ludemann and Brown's (1989) finding of increased personal power and autonomy after the institution of shared governance. One reason for inconsistent findings may be that shared governance had already been in existence for two years prior to any measurements of autonomy being conducted, whereas Ludemann and Brown (1989) were measuring staff perceptions of shared governance before and after it was instituted.

The lack of consistency within the literature on autonomy may be due to the different measures of autonomy. It is very possible that the various researchers measured something different. Professional autonomy is a difficult concept to define in concrete, measurable terms and, as a result, research findings differ.

Nurses in the primary study, in Jordan's (1993) work, and in this thesis had high scores on a tool which measures perceptions of nursing autonomy. Nurses' perceptions of autonomy may not be on the same scale as lawyers' or

physicians' perceptions of autonomy. If different groups of professionals' perceptions of professional autonomy were measured, where would nurses rank? The finding of high autonomy scores in this thesis and the idea that nurses as professionals have limited autonomy are not as incongruous as one might think.

Implications

Nursing Practice

Nursing practice can be improved by elevating nurses' perceptions of professional autonomy. If nurses perceive themselves as independently able to effect positive patient outcomes through the professional practice of nursing, not only will they initiate more nursing activities, but they will tend to collaborate with other nurses to solve nursing care problems. Professional autonomy indicates recognition of nurses' uniquely important contribution to patient care; autonomous nurses will be more likely to collaborate with other professionals as equals.

Nursing Administration

Nursing administrators are in a key position to foster nurses' perceptions of autonomy; a nurse manager's management style has been found to be strongly associated with staff nurse autonomy (Alexander, et al., 1982). Through the use of participative management structures, such as shared governance, all members of the nursing staff have an opportunity to be involved in all decisions affecting nursing practice and nursing standards in their institution.

Nursing management representation on all major hospital committees is crucial for assuring that nursing practice is not ultimately controlled by persons outside the nursing profession.

Nursing Education

The review of literature done for this study indicated that the nursing profession attracts individuals whose perceptions of autonomy are lower than those attracted to other professions (Boughn, 1988). Knowing this, nursing educators must strive to create educational situations which support and build professional autonomy to prepare students for the roles RNs will have in the future. Nursing educators can also play an important role by providing students opportunities for professional collaborations amongst each other; such activities would enlighten the students' awareness of the varied and special expertise their peers possess. It is the author's personal belief that nurse educators should work to combine some nursing courses with similar courses in other health profession programs, particularly medical students. Such a move would stimulate recognition of autonomous nursing practice, build respect between professionals for their unique talents, and improve the possibilities for true interdisciplinary collaborations in the future.

Nursing Research

This thesis also has implications for nursing research. Further investigation into the concept of professional

nursing autonomy and patient outcomes associated with autonomy may give further credence to nursing as a true profession. The kinds of organizations which foster professional autonomy is another area for further study implicated by this thesis. Even with the high reliability of the NAS in measuring autonomy, the NAS may only measure one aspect of a broader concept encompassing a number of other variables. Much more work is needed to further develop the measurement of autonomy and discover the context in which it can be most accurately measured. Professional autonomy is important to nurse researchers themselves. The existence of professional autonomy is the force behind their work which drives them to investigate problems, devise solutions, and collaborate with others to further the practice of nursing.

Recommendations for Research

1. This study should be replicated with participation by a larger portion of the maternal-newborn and surgical nurses employed at the subject hospital.
2. It would be interesting to compare the autonomy perceived by hospital nurses compared to nurses employed in other settings, such as nursing homes, home health care, and public health, in the same geographical area.
3. This study should be replicated in other institutions with similar characteristics to see if similar results are obtained.

4. More research on the specific effects of shared governance on perceptions of autonomy would be valuable.
5. Individual and organizational factors which influence perceptions of autonomy should be investigated further. Investigation of autonomy should be conducted in conjunction with other organizational dimensions in an effort to explain this site's differences from others described in the literature.
6. More definitive work on the relationship between gender and perceptions of autonomy is needed.

Summary

In this thesis, maternal-newborn and surgical nurses' perceptions of professional autonomy were not found to be significantly different and did not change during development of shared governance. Additional information was gathered about the functioning of the shared governance structure. Professional autonomy is critical for the advancement of the nursing profession. Nurses' professional autonomy has not been extensively researched and there is a need for further research into the relationship between autonomy and nursing education as well factors in the workplace associated with autonomy.

APPENDIX A

Data Collection Instruments

Directions and Formatting of Instrument
in Actual Survey Booklet

SCHLITZENHOFFER PROFESSIONAL NURSING ACTIVITY SCALE (Waltz & Strickland, 1988)

The following items describe situations in which a nurse must take some action that requires the exercise of professional nursing judgment. You are asked to respond to each item according to how likely you would be to carry out the action in each item. Please respond to each item even if you have encountered such a situation before. Use the following scale in responding to the items.

a = Very unlikely of me to act in this manner	c = Likely of me to act in this manner
b = Unlikely of me to act in this manner	d = Very likely of me to act in this manner

Circle the letter after each situation that best describes how you would act as a nurse. There are no right or wrong answers.

SITUATION	RESPONSES			
	Very Unlikely	Unlikely	Likely	Very Likely
221. Develop a career plan for myself and regularly review it for achievement.	a	b	c	d
222. Consider entry into independent nursing practice with the appropriate education and experience.	a	b	c	d
223. Voice opposition to any medical order to discharge a patient without an opportunity for nursing follow-up if my teaching plan for the patient is not completed.	a	b	c	d

Schutzenhofer Nursing Activity Scale Items

1. Develop a career plan for myself and regularly review it for achievement of steps in the plan.
2. Consider entry into independent nursing practice with the appropriate education and experience.
3. Voice opposition to any medical order to discharge a patient without an opportunity for nursing follow-up if my teaching plan is not completed.
4. Initiate clinical research to investigate a recurrent nursing problem.
5. Refuse to administer a contraindicated drug despite the physician's insistence that the drug be given.
6. Consult with the patient's physician if the patient is not responding to the treatment plan.
7. Depend upon the profession of nursing and not on physicians for the ultimate determination of what I do as a nurse.
8. Evaluate the hospitalized patient's need for home nursing care and determine the need for such a referral with a medical order.
9. Accept a temporary assignment to a unit even if I lack the education and experience to work in that unit.
10. Propose changes in my job description to my supervisor in order to develop the position further.
11. Answer the patient's questions about a new medication or a change in medication before administering a drug, whether or not this has been done previously by the physician.
12. Institute nursing rounds.
13. Withhold a medicine that is contraindicated for a patient despite pressure from nursing peers to carry out the medical order.
14. Consult with other nurses when a patient is not responding to the plan of nursing care.
15. Routinely implement innovations in patient care identified in the current nursing literature.

16. Initiate a request for a psychiatric consult with the patient's physician if my assessment of the patient indicates such a need.
17. Promote innovative nursing activities, like follow-up phone calls to recently discharged patients, to evaluate the effectiveness of patient teaching.
18. Assess the patient's level of understanding concerning a diagnostic procedure and its risks before consulting with patient's physician if a patient has questions about the risks of the procedure.
19. Assume complete responsibility for my own professional actions without expectation to be protected by physician or hospital in the case of a malpractice suit.
20. Develop effective communication channels in my employing institution for nurses' input regarding the policies that affect patient care.
21. Make appropriate in-house referrals to social service and dietary only after obtaining a medical order.
22. Develop and refine assessment tools appropriate to my area of clinical practice.
23. Record in the chart the data from my physical assessment of the patient to use in planning and implementing nursing care.
24. Initiate discharge planning concerning the nursing care of the patient, even in the absence of medical discharge planning.
25. Report incidents of physician harassment to the appropriate manager or administrator.
26. Offer input to administrators concerning the design of a new nursing unit or the purchase of new equipment to be used by nurses.
27. Complete a psychosocial assessment on each patient and use this data in formulating nursing care.
28. Adapt assessment tools from other disciplines to use in my clinical area.
29. Carry out patient care procedures utilizing my professional judgement to meet the individual patient's needs even when this means deviating from the

"cookbook" description in the hospital procedure manual.

30. Decline a temporary reassignment to a specialty unit when I lack the education and experience to carry out the demands of the assignment.
31. Initiate referrals to social service and dietary at the patient's request.
32. Assess needs of patient for home nursing care only under order of physician.
33. Write nursing orders to increase the frequency of vital signs of a patient whose condition is deteriorating even in the absence of a medical order to increase the frequency of such monitoring.
34. Administer a medication to which a patient reports an allergy if the physician will assume responsibility for my actions.
35. Assume all blame for any conflicts or problems I have with physicians.

This is as it appeared in the actual survey book

DEMOGRAPHIC DATA

Please circle the letter that most closely describes you and/or fill in the blank as indicated.

256. Age:

- a. 20-29
- b. 30-39
- c. 40-49
- d. 50 and over

257. Basic education:

- a. AD
- b. Diploma
- c. BSN
- d. Other (specify) _____

258. Highest degree attained:

- a. AD
- b. Diploma
- c. BSN
- d. Master's Degree
- e. Doctorate Degree (DNS, EdD, PhD)
- f. Other (specify) _____

259. Length of employment in current hospital:

- a. Less than 6 months
- b. 6 months - 1 year
- c. Over 1 year - 3 years
- d. Over 3 years - 5 years
- e. Over 5 years - 10 years
- f. Over 10 years

260. Job status:

- a. Primary Nurse I
- b. Primary Nurse II
- c. Primary Nurse III
- d. Primary Nurse IV/Clinical Nurse Specialist
- e. Clinical Nurse
- f. Shift Manager
- g. Nurse Manager
- h. Director/Asst. Director/Administrator
- i. Other

DEMOGRAPHIC DATA - Page 26

261. Employment status:

- a. Full-time
- b. Part-time
- c. Support

262. State what hours you normally work (e.g., Start 8am and end 9pm)? _____

263. In what year were you first licensed as an RN? _____

264. Clinical area of practice:

- a. Medical-Surgical (for example Renal, Orthopaedics, Oncology)
- b. Maternal-Newborn (for example Berry 1 or 2, Birth & Family Ed., NICU) -
- c. Critical Care - (for example Burn, ICU, CICU, Telem, Adv. Care, CareFlight, ER, Neuro)
- d. Behavioral (for example Turning Point, Mental Health, Day Therapy, Pain, Rehab)
- e. Surgical Service (for example OR, PACU, Pre-op, outpatient OR, SDS, PAT, Endoscopy)
- f. Ambulatory (for example out-patient clinics, perinatal clinic, AKU, IVF)
- g. Support Nurse Registry
- h. Other (UM, Dischg Planning, Ed. Coord., Adm, Mgmt, Shift Manager, IV Therapy)

PROFESSIONAL AFFILIATION

265. To what professional organizations do you currently belong?

- a. None
- b. Some, as follows ("X" all that apply):

_____ ANA

_____ NLN

Other (list)

266. Identify the number of offices you have held in these professional organizations.

- a. None
- b. One office
- c. Two offices
- d. Three or more offices

267. Identify the presentations you have made at professional meetings.

- a. None
 - b. Some, as following ("X" all that apply):
- _____ Poster(s)
- _____ Paper(s)
- _____ Keynote/invited presentation(s)

DEMOGRAPHIC DATA - Page 27

288. *Social Security number _____ (optional).

289. Are the Practice Model (PACE 2000) changes in effect on your unit?
(Circle one) YES or NO or Not Applicable

310. *My work unit is _____ (optional).

If there are any comments you wish to make about any of the questions or just generally, please do so.

This completes the questionnaire. Thank you for your cooperation.

*Including your social security number and/or unit is voluntary. However, if you choose to include your SSN#, we will not connect it to your name or use it for any purpose, other than to track the number of people who previously participated in this research project. The number will be used for statistical purposes only by the coder and statistician.

Your unit will be used to give unit results only if 20 RNs and at least 50% of the RNs on the work unit respond.

APPENDIX B

Original Study's Consent and Cover Letters

I will participate in the study entitled:

"Organizational Dimensions in Hospital Nursing Practice"

on Wednesday, June 2, 1993 in CHE Room 1813.

Choose one:

- 8 a.m. - 9 a.m.**
- 11 a.m. - 12 noon**
- 12:30 p.m. - 1:30 p.m.**
- 2 p.m. - 3 p.m.**
- 3:45 p.m. - 4:45 p.m.**

Area of practice _____

Signature _____

**Sign and return to: Jean Corron or Gayle Jordan
Nursing Office 1st Floor
By Friday, May 21, 1992**

APPENDIX C

University IRB Form

RESEARCH INVOLVING HUMAN SUBJECTS

SC# 1333
Original Review X
Continuing Review _____
Amendment No. _____

ACTION OF THE WRIGHT STATE UNIVERSITY
INSTITUTIONAL REVIEW BOARD
Assurance Number: M-1021-01

Title: Medical-Nurses And Surgical Nurses' Perceptions Of Professional Autonomy During
Development Of School Curriculum

Contract No.

Principal Investigator: Doris A. Moore, P.I. Student
Patricia A. Martin, Ph.D., Faculty Advisor
Department: School of Nursing

The Institutional Review Board named above has taken the following action with regard to
the use of human subjects on this proposed project:

X Approved
_____ Approved pending receipt of the items listed **
_____ Disapproved
_____ Deferred

The restrictions, if any, are attached and are signed by the Committee Chair. If disapproved,
the reasons are attached and are signed by the Committee Chair and by other consultants, if
any.

This retrospective record review is recommended for Expedited Review. P.I. for original data (P
Martin) is Faculty Advisor for this study.

Eugene P. Herr
Signed _____ Acting Chair

Date: July 20, 1993

APPENDIX D

Agency Permissions

Wright State University-Miami Valley
School of Nursing

AGENCY PERMISSION FOR CONDUCTING STUDY

THE Miami Valley Hospital, 1 Wyoming Street, Dayton, OH 45409

GRANTS TO Danise A. Moore, RN, BSN

A student enrolled in a program of nursing leading to a Master's degree at Wright State University, the privilege of using its facilities in order to study the following problem: **ANALYSIS OF INTENSIVE-CARE AND SURGICAL NURSES' PERCEPTIONS OF PROFESSIONAL AUTONOMY DURING THE DEVELOPMENT OF SHARED GOVERNANCE.**

The conditions mutually agreed upon are as follows:

1. The agency (may) (may not) be identified in the final report.
2. The names of consultative or administrative personnel in the agency (may) (may not) be identified in the final report.
3. The agency (wants) (does not want) a conference with the student when the report is completed.
4. The agency is (willing) (unwilling) to allow the completed report to be circulated through interlibrary loan.
5. Other: _____

Date: 5/20/93

Danise A. Moore
Signature of Student

Patricia A. Martin, RN, PhD
Signature of Agency Personnel/Title
Patricia A. Martin, RN, PhD
Signature of Faculty Member

MVH Miami Valley Hospital

One Wyoming Street
Dayton Ohio 45409-2793
Telephone 513-223-6192

90

September 3, 1993

Danise A. Moore
2457 Christales Drive
Beavercreek, OH 45434

Dear Ms. Moore:

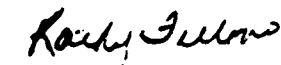
Your Wright State University thesis proposal entitled "Maternal Newborn and Surgical Nurses' Perceptions of Professional Autonomy During Development of Shared Governance" was recommended for approval by the Nursing Research Committee at its August 1993 meeting.

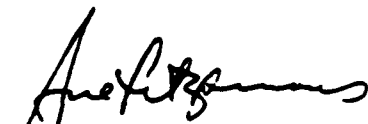
Please forward your proposal with a cover letter asking for IRB expedited review to Dr. James Funkhouser, Chairman of MVH IRB. Send copies of MVH IRB and WSU IRB approval to me before data collection begins. Please notify the interim chair of the Nursing Research Committee when data collection begins and ends. A report of your completed research (copy of thesis) is to be sent to the interim chair of the Nursing Research Committee within two months after data collection ends.

Best wishes with your study. We look forward to your report.

Sincerely,


Jean Branner, RN
Interim NRC Chair


Kathy Fellows, RN, MSN
Interim NRC Chair
Ext. 3389


Sue Fitzsimons, RN, PhD
Senior Vice President
Hospital Operations

cc: James Funkhouser, IRB Chair
David Uddin, Director of Clinical Research
Jean Corron, Adm. RIG Committee

MVH Miami Valley Hospital

October 6, 1993

Denise Moore, RN, BSN
Graduate Student, Wright State University
2457 Christaloe Drive
Beavercreek, OH 45434

Dear Ms. Moore:

Your project entitled, "Maternal-Newborn and Surgical Nurses' Perceptions of Professional Autonomy During Development of Shared Governance" which does not involve any treatment or intervention with patients, is approved by the expedited method of the Institutional Review Board (IRB) of Miami Valley Hospital.

This approval requires:

1. The use of the Miami Valley Hospital Consent Form.
2. That any adverse effects of this procedure be reported immediately to this Committee.
3. That this approval is for one year and if it extends beyond this period a request for an extension is required.
4. That any publication, report, thesis, etc. resulting from this study must be reviewed by the Committee prior to publication or release.
5. That a progress report must be submitted before an extension of the approved one-year period can be granted.
6. That any change in the protocol or informed consent form must be approved by the IRB; otherwise, approval is terminated.

Sincerely,


James W. Funkhouser, M.D.
Chairman
Institutional Review Board (IRB)

(moore)dd

cc: Clinical Research Center
Miami Valley Hospital

APPENDIX E

Permission to Use Instrument

St. Louis Children's Hospital



One Children's Place
St. Louis, Missouri 63110-1077
314-454-6096 Fax: 314-454-2741

Center of
Nursing Excellence

May 12, 1993

Denise A. Moore, BSN, RN
2457 Christaloe Drive
Beavercreek, OH 45434

Dear Denise,

Thank you for your interest in my autonomy scale. I am most happy to send you a copy of the revised autonomy instrument and an information packet. The scoring instructions are attached. Information about the original study is reported in both the book chapter and the *Journal of Professional Nursing* article. My only request of researchers who use the scale is that I receive a summary of the outcomes and that you also inform me of any publications or papers that result from your study. The scale is now called the Nursing Activity Scale (NAS). The title change, as reported in the original publications, is an effort to reduce respondent bias.

I have included a list of my publications on autonomy. You will also find a handout from a presentation, a list of those who have reported completed studies using the NAS and the abstract and summary of a study I recently completed which was funded by Sigma Theta Tau, International. The report of this study was recently accepted for publication by *Image*. An excerpt from the summary of the study is already published in *Reflections*, fall of 1992, Sigma Theta Tau's newsletter.

I am familiar with Pat Martin's work. I look forward to reading your study. Please say hello to Dr. Martin for me. Don't hesitate to call if you have any further questions once you've looked over the NAS and the attached materials. Good luck with your study!

Sincerely,

Karen Kelly Schutzenhofer, EdD, RN, CNAA
Director, Center of Nursing Excellence

APPENDIX F

Research Team Permission



**Wright State
University**

Wright State University-
Miami Valley
School of Nursing
Dayton, Ohio 45435
513/673-3131

July 27, 1993

Denise A. Moore, RN, BSN
2457 Christae Drive
Beavercreek, OH 45434-7040

Dear Ms. Moore,

This is a follow-up to our earlier correspondence to do secondary analysis from the ongoing study Organizational Dimensions of Hospital Nursing. Thank you for your assistance with data collection in June 1993. Now that your research questions are formalized and the time frame identified, this is to formalize the verbal permission given by Jean Corron for you to use the OB and Surgical Services nurses' responses on demographics and autonomy for December, 1990; November, 1991; and September, 1992. You now need MVH Nursing Research Committee approval and WSU IRB approval. WSU Statistical Consulting Center will provide the analysis; however, they will not provide you with the raw data.

We look forward to your final thesis report.

Sincerely,

Patricia A. Martin

Patricia A. Martin, RN, PhD
Principle Investigator for
Organizational Dimensions
of Hospital Nursing

cc:	J. Corron	G. Jordan	M. Reinhart
	L. Cox	T. Lupo	P. Risner
	T. Gustin	D. Mals	M. L. Chen

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