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Autonomy: A Realistic Goal for the Practice of Hospital Nursing?

Autonomía: ¿una meta realista para la práctica hospitalaria de enfermería?

ABSTRACT

Autonomy can be defined as independence or freedom. When it is used to describe individual work, it refers to the ability to make decisions without undue influence from others. The purpose of this paper is to critique two models of autonomy, one developed from the discipline of occupational health, and one developed from the discipline of nursing. These models potentially provide insight to the work of nurses in hospitals. Additionally, this paper will explore the possibility of applying these traditional western models to cultures and countries other than the US, Europe, and Australia. The question of whether a hospital nurse can be autonomous is complicated by the structure of the society in which the work of the nurse exists and the barriers produced by those structures. In order for nurses and women to exercise more autonomy in work settings, powerful members of the society must acknowledge the reality of the under valued status of women and women's work and allow for a greater exercise of discretion by women.

KEY WORDS

Nurse, women, autonomy, hospital, work.

RESUMEN

La autonomía puede ser sinónimo de independencia o libertad. Cuando se utiliza para referirse al trabajo individual, se entiende como la habilidad para tomar decisiones sin injerencia de terceros. El propósito del presente artículo consiste en realizar una crítica a dos modelos de autonomía, uno desarrollado desde la disciplina de la salud ocupacional y el otro desde la disciplina de la enfermería. Estos modelos potencialmente suscitan una reflexión sobre el trabajo de la enfermería hospitalaria. Adicionalmente, en este documento se explorará la posibilidad de aplicar estos modelos tradicionales occidentales en culturas distintas a las de Estados Unidos, Europa y Australia. La pregunta acerca de si una enfermera hospitalaria puede ser autónoma es compleja debido a la estructura social en la que se desarrolla su trabajo y a las barreras que esas estructuras le imponen. Para que las enfermeras, y las mujeres, puedan ejercer su autonomía en los ambientes de trabajo, los miembros más poderosos de la sociedad deben reconocer la realidad del subvalorado estatus de la mujer y de su trabajo, y así considerar un mayor ejercicio de su discrecionalidad.

PALABRAS CLAVE

Enfermera, mujeres, autonomía, hospital, trabajo.

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utonomy can be simply defined as independence or freedom (1, 2). When it is used to describe individual work, it refers to the ability to make decisions without undue influence from others (3). Decisions are made independently and are based on education and experience of the individual worker. The decisions are generally considered immune from the arbitrary exercise of authority (4, 5). The concepts of autonomy and work have been discussed for several decades by scientists and theorists, particularly in relationship to the work of women and the professions and occupations that have traditionally been associated with women (2, 4-9). Nurse scientists and leaders have been among the people interested in the notion of autonomy for nurses. That interest now extends beyond the boundaries of traditional western cultures, and includes cultures and countries in Asia and South America. But how much autonomy do nurses actually have and how does the concept of autonomy, especially for women, fit into different cultures?

There are a number of scientists in occupational health, women and work, nursing organizations, and nursing work environment (10-15), who have studied autonomy, work, and nurses. The purpose of this paper is to critique two models of autonomy, one developed by Karasek (16-19), from the discipline of occupational health, and one developed by Kramer (20-24) with additions by Aiken (25, 26), from the discipline of nursing. These models potentially can provide insight to the work of nurses in hospitals. Additionally, this paper will explore the possibility of applying these traditional western models to cultures and countries other than the US, Europe, and Australia.

Interest in nurses and the work of nurses waxes and wanes depending on the various cycles of nurse shortage and surplus. Today, there is a nurse shortage that extends worldwide (27-29), so interest is intense. In order to help alleviate the shortage, wealthy countries, such as the US, UK, UAE, and Saudi Arabia, have had some success in recruiting nurses from poorer or less developed countries. These countries typically have fewer financial resources, lower nurse wages, and a more difficult nurse work environment (29-32). However, even with more resources committed to nurse immigration, nurse education, and nurse work environment, the US has a severe and, likely, sustained nurse shortage that has been predicted to extend well into the 21st century (33-37). Critical nurse shortage areas in the US include hospital bedside nurses and nursing faculty. Strategies that have been suggested to help alleviate the shortage include providing a more favorable work environment for nurses and increasing wages in the acute shortage areas. Nursing faculty shortages have occurred and are occurring for reasons different from bedside nurses and will not be discussed in this paper. Rather, this paper will focus on the shortage of hospital bedside nurses. There is evidence that simply increasing wages will not resolve the nursing shortage. Rather, it will be necessary to create and sustain a more favorable work environment that may encourage nurses to remain at work at the hospital bedside (25, 38-40).

Evidence suggest (41-43) that some nurses at the hospital bedside would be more satisfied with the work environment if they had increased workplace autonomy. Scientists have found that the ability to make decisions about patient care, about the organization of one's work, and about one's work schedule are associated with increased job satisfaction (44-46). This autonomy includes the freedom to work or not to work, the freedom to decide when and how to do the work, and, in the professional opinion of the nurse, the ability and

freedom to plan the work to provide the best outcome for the patient. This need for freedom seems obvious for any professional group, but has proven illusive for all nurses, especially hospital nurses. Nurses have sought freedom or autonomy in numerous ways but with minimal success. These strategies, such as by becoming advanced practice nurses, by moving to technologically advanced practiced areas, by moving away from practice areas dominated by physicians, by moving into management, or by achieving advanced credentials and educational degrees, have frequently taken them away from the hospital and bedside nursing (3, 15, 45, 47-49). But the autonomy sought by nurses has not been forthcoming, particularly work in hospitals and specifically at the direct care level. The question of why autonomy for nurses has been so illusive has not been answered. Critique of the following models related to autonomy may provide some clues to this contentious issue.

In the 1970s and 1980s, Karasek (16-18) developed a model to describe the work of various occupational groups and professionals, specifically to explain the interaction between the psychological demands of work and the decision latitude that exists in work. The model has been tested for several decades in various countries and in numerous occupational groups (8, 9, 16, 18, 19). Karask has hypothesized that occupational groups that experience high psychological demand and low decision latitude experience significant "job strain", which is defined as inability to work effectively and which produces discomfort for people in the work environment that is similar to job stress. Karasek and others (8, 18, 50, 51) have consistently found that professional nurses as an occupational group, when given the Karasek Job Content Questionnaire (18, 19), perceive they have a high level of decision latitude and a high level of psychological demand related to their work. In contrast, there is evidence that nurse assistants express a high level of psychological demand but a low level of decision latitude in their work. So, registered nurses, compared to nurse assistants and other select occupational groups, experience a more positive or "active" work environment, according to the Karasek model, as indicated by their expression of control over decisions related to their work. This decision latitude helps moderate the high psychological demand associated with the work.

This finding seems to contradict the extensive literature (48, 52-57) that describes job dissatisfaction among professional nurses. There is a literature of several decades describing job dissatisfaction and "burn out" particularly among hospital bedside nurses (25, 58-62). Several studies have evaluated the relationship between the Karasek model and job satisfaction, but those studies with nurse participants typically investigate the relationships between the job strain and physiological symptoms or diseases (9, 50, 51, 63-65).

One explanation for the contradictions found in the Karasek model testing literature and the nurse burnout and job dissatisfaction literature may be that the Karasek model is relational and the values are not absolute. So, professional nurses may appear to be in the active work or non-job strain quadrant of the model compared to other occupational groups, but still express dissatisfaction with aspects of the work over which they have little control and want more control. Another explanation might be that the respondents to the Karasak questionnaire may hold jobs in

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nursing where there is more decision control about the work. The psychological demand responses have tended to remain high but the decision latitude responses vary. Since the original Karasek model was developed, the author has added additional scales measuring additional aspects of work. Some of these additional measures might be useful in providing more context about the various types of nursing work and the responses to that work. The model might prove useful in guiding the study of autonomy in nurse work; but it requires more clarification of the potential mediating effects of the various scales, more specifics about the different types of autonomy, and more study of the relationship between job strain, nurse job dissatisfaction, and burnout.

Kramer (20, 21, 23, 66) developed a model of autonomy in the work of nurses as it related to the "magnet" hospital program. During1980s there was another nursing shortage and the magnet hospital program (21-23) was created to identify hospitals that were designated as good places for nurses to work. The hospitals were selected by nurse leaders but the selection criteria were vague and based primarily on opinion. More recently, Kramer and others have begun to empirically test the notion of autonomy in magnet hospitals (3, 44, 67-69). In the more recent magnet model, Kramer defines autonomy as "the person "who own(s)ed the problem, issue, and solution" and the "degree of effectiveness of control" as reflected in visibility, viability, and recognition of a formal structure allowing and encouraging nurses' control over practice" (3, 44). Kramer (70) developed a questionnaire to measure autonomy and has found that magnet hospital nurses do not always perceive they have autonomy in their clinical practice (3). Aiken (26) and others (25, 67, 71, 72) have used a version of the Kramer model and modified Karmer's question-naire. It is called the Nurse Work Index-Revised (NWI-R) and the scientists have found relationships between aspects of autonomy and positive patient outcomes. The specific areas of autonomy in the model that seem to be important are collaboration with physicians, control over practice, and decision-making.

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Scientists have also found relationships between increased collaboration with physicians, control over practice, and decision making to be related to improved job satisfaction (12, 25, 52, 73-76). This is consistent with work done in the 1990s by Shortell and others (77, 78) related to nurse work environment in the intensive care units. Aiken's early work tended to use nurse respondents from Pennsylvania, so selection bias may have been a problem in some of these studies. However, later work has included nurse respondents from other countries, primarily Canada and the UK, and the studies have produced similar results (79-82).

In summary, the body of literature testing the Karasek model indicates that nurses have more decision latitude about their work than other health workers, such as nurse assistants. But the model is not specific to health care environments and tends to find that all the professional workers fit into the non-job strain or active work quadrants of the model. Additionally, the model is designed to measure job strain, which is defined as an interaction between psychological demand and decision latitude, so the measures may not be sensitive enough to detect the specific issues of hospital nurses, particularly those nurses who provide direct bedside care.

The studies in the body of literature testing the Kramer/Aiken model provide

substantial evidence that nurse-physician collaboration, decision making ability, and control of practice in hospital bedside nurses is related to nurse job satisfaction and select positive patient outcomes (15, 83-85). If we accept the evidence in this literature; that is that nurse autonomy is related to nurse job satisfaction, that nurse job satisfaction is important to reduce nurse turnover (86-88); and that nurse autonomy is related to positive patient outcomes; why does the hospital work environment for bedside nurses continue to reflect a lack of autonomy related to the work of nurses?

To answer this question, some health care leaders would respond that the issue is cost (67, 88-92). In order to improve the work environment for bedside nurses, hospital organizations and the broader society must provide more nurses in the environment. Undoubtedly, increasing the number of nurses in the work environment allows for a more reasonable distribution of work and a higher level of job satisfaction for nurses (93-96). It also allows more time for nurses to perform activities for which they have been specifically trained; surveillance of the patient and vigilance in observation of the instability/stability of the patients' condition, interception of errors or disease complications and prevention of harm related to those errors or complications, management and/or maintenance of the patients' current health status, and the ability to provide comfort to the patient and family and improvement in the patients' health status; versus simply "following doctors' orders and doing as they are told". Because there is the economic assumption that resources are finite in any society, increasing the resources provided for one section of the society will, by definition, necessitate decreasing the resources in another section. Therefore, the cost of adding (recruiting, training, educating, providing salaries and benefits) additional professional nurses must be not be discounted and must be considered in light of the competing demands for health resources and other resources in a community, society, or country.

Another argument for maintaining the current hospital working conditions, and therefore lack of autonomy for nurses is that nurses do not have sufficient training or education to exercise the autonomy they desire (6, 15, 49, 97-99). This is the argument that only "doctors know best" about patient care. This argument perpetuates the notion that hospital bedside nurses are simply an extension of the physician and that their role is only that of conduit of information between the patient and physician, with no thinking or independent action needed or taken. But, all health care professionals, whether they acknowledge it or not, know that this limited role of the nurse is complete fantasy. This is the fantasy role of the nurse that is often displayed in the media and in literature. This is the fantasy role of the nurse that many hospital administrators, physicians, and other high-ranking officials want to believe is reality. But all these officials know that without the critically thinking, technologically skilled, and competent professional nurse, modern day hospitals would cease to exist. Nurses, like all other health professionals, vary in their talents and skills but, overall, hospital bedside nurses are completely capable, by virtue of education, training, and experience, of exercising autonomy in their work, specifically collaboration with physicians, control of practice, and decision making about patient care.

Therefore, I would argue that high cost and lack of education are not the only or even the most significant barriers in preventing hospital bedside nurses from

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exercising autonomy in the form of a more lateral collaboration with physicians, control of nursing practice, and decision making about patient care. To understand the resistance that exists toward nurses having autonomy, I would suggest the consideration of the theory of oppressed group behavior (100-103). There is a small feminist literature relating oppressed group behavior theory and the work of nurses. Roberts and others have argued for this concept for several decades (100-107). However, nurses and feminists have long had a contentious relationship and often discount the work and thoughts of each other (11, 108-110). Feminists have frequently characterized nurses as existing in the past in a profession that is virtually exclusively female and therefore less desirable than other professions or occupations. Feminist activism has tended to focus on forcing the inclusion of females in occupations and professions that have been more exclusively male-dominated. Nurses, on the other hand, have viewed feminist activism as extreme and have generally denied the oppression that exists for the nursing profession as a whole. It is very difficult for educated, capable, and proud women to acknowledge that they exist in a profession that is oppressed by men, organizations, and societies. Individual nurses who think about their status and the status of the nursing profession often feel disempowered and helpless if they acknowledge the oppression. So, they deny the oppression and attribute any weakness or perceived lack of knowledge or skill to the individual nurse.

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This, of course, is one of the hallmarks of oppressed group behavior. This rationalization can lead to "horizontal violence" or "blaming the victim" within the group, which is blaming any weaknesses on individual members of the group or on sub-groups other than those in which you are a member (111-115). For example, in a hospital intensive care or operating room nurses often view themselves as more independent, autonomous, and therefore, "better-than" medical-surgical nurses. They can align themselves with powerful (male) physicians and then distance themselves from those "others" (weaker female)-medical-surgical nurses who just cannot seem to do their jobs". This same rationalization can force nurse administrators and managers to take sides against bedside nurses. The nurse administrators or mangers align themselves with the hospital executives, another powerful male group, and can then distance themselves from those "emotional (weaker female) nurses at the bedside who just cannot seem to or refuse to understand money matters".

Applying the concepts of oppressed group behavior to the nursing profession requires a suspension of the denial that most nurses express about nurses as victims. It requires that nurses accept that all nurses are members of an oppressed group (116, 117). Accepting this notion does not mean that individual nurses are weak or bad or helpless. It does mean that persons other than nurses make many of the decisions that are critical to the work of nurses and that nurses often have little or no voice when those decisions are made. It means that many of the decisions associated with the ability of many nurses to perform their jobs adequately are out of the control of those nurses. It means that blaming groups of nurses for a perceived inadequacy or injustice or incompetence, is often unrealistic and damaging. The "blame" and responsibility for many of the organizational or societal conditions lie with the powerful (male) groups in the hospital or in

the society, the physicians and the hospital executives. These powerful groups are dominated by men or by male-oriented reasoning and thinking. Nurses, that is females, are often discounted for using reasoning or thinking that is different from this "male standard". Even nurse executives, frequently have very limited control over allocation of resources for nurses and have limited autonomy in decision making about support services and other resources that are necessary for nurses to do work adequately.

This oppression of traditionally female occupations and professions has not changed significantly in most societies. Some of these occupations and professions have benefited in status and wages by the addition of males to their ranks but this is not universally the case. Many societies still place little value, as demonstrated by relative status and wages, on elementary or secondary school teachers, childcare or elder care workers, secretaries, flight attendants, or dental assistants, all traditionally female professions. In the US, female professors continue to be under represented in the higher paid and higher status professorial and tenured ranks in universities (118). The women tend to be relegated to the lower paid and lower status ranks of instructor, lecturer, or non-tenured faculty ranks (119-121). In the US, females are consistently penalized for taking time away from work in business or industry for childbearing, child rearing, or providing elder care (121, 122).

So, is it is possible for hospital bedside nurses, or any nurses, to achieve autonomy in the workplace? The question is complicated by the structure of the society in which the work of the nurse exists. The ability of the nurse to attain a measure of autonomy in work will depend on the ability of the society to re-evaluate and re-value the traditional work of women. The societal structures that produce barriers to this autonomy run very deep and are very strong. In order for nurses to exercise more autonomy in hospitals, powerful people in the hospital and members of the society at large must acknowledge the reality of the under valued status of women and women's work in that society. Only then would it be possible to orchestrate a societal and/or organizational change in the value placed on the traditional work of women and permit women to exercise autonomy in work.

People who become nurses are raised and nurtured in the same societal structure in which all people in the society are raised. People who become nurses have been taught the same biases and prejudices as those people in the general society about the lack of worth of the traditional work of women, work such as caring for the sick, the weak, the young, and elderly. So, people who become nurses may, and often do, bring with them the societal notion of devaluing the work of nurses. Just because you are a nurses does not mean that you do not have biases and prejudices toward nurses. Nurses and others, often characterize these feelings in the individual nurse as poor self-worth, poor self-esteem, poor self-image, and even self-loathing. This is also characterized as the poor public "image of the nurse" and the nursing profession has sought to change this image by expending much effort and expense toward advertising and marketing. But attempting to change the image is treating the symptom, not affecting a cure. In order for a "cure" to be achieved, the people in the society must value the work of the nurse and demonstrate this perception of value by awarding higher status and higher wages to nurses.

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