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May 2015

Lived Experiences of Nursing Autonomy: a Phenomenological Exploration

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LIVED EXPERIENCES OF NURSING AUTONOMY: A

PHENOMENOLOGICAL EXPLORATION

by

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A Dissertation Submitted in

Partial Fulfillment of the

Requirements for the Degree of

Doctor of Philosophy

In Nursing

at

University of Wisconsin - Milwaukee

May 2015

ABSTRACT
LIVED EXPERIENCES OF NURSING AUTONOMY: A PHENOMENOLOGICAL
EXPLORATION

by

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The University of Wisconsin - Milwaukee, 2015
Under the Supervision of Professor Mary Jo Baisch

The purpose of this phenomenological study was to explore the meaning that acute

care, bedside nurses' assign to their autonomous actions. A feminist critique of the

nursing work environment was applied using standpoint theory. This was balanced and

supplemented by a post-modern critique using Foucault's method of assessing power and

knowledge in relation to the discipline of a profession. This study was designed to

explore how issues of gender, knowledge, and power affected participants' interpretations

of their autonomous actions.

This study used a qualitative, phenomenological approach with an emergent

design. Purposive sampling was used to find registered nurses currently working in acute

care settings and whose only form of practice was the provision of direct patient care. 10

Participants were recruited by email and snowball sampling and were from a wide variety

of specialty areas. Data were collected using three semi-structured interviews. Each

participant was interviewed three times, which allowed for an in-depth exploration of the

issues of autonomy, gender, and power. The interviews were audio-recorded and then

transcribed verbatim. The transcribed interviews were analyzed using DEDOOSE™, a

web-based qualitative data management software program designed to facilitate analysis of qualitative data.

Participants revealed that the context in which they acted was crucial to their autonomy. Poor nurse-physician relationships and fear created a negative context in which autonomy was inhibited while trust and respect created an environment in which autonomy could flourish. For these participants autonomy meant that they were able to do the right thing for their patients and it led to positive patient outcomes. Participants felt that gender issues negatively impacted their relationships with physicians which in turn negatively impacted their autonomy. While most participants discussed the positive benefits of nurse empowerment they had largely negative reactions to power in general.

The purpose of this study was to understand the impact of gender and power on the autonomous decisions and practice of bedside nurses. It is clear that gender issues impact nurses' work environments. Developing policies to improve nursing autonomy will require that we understand the social and political context in which these actions occur.

Dedication

To my daughter Jasmin

Thank you for your support and encouragement

as we moved through our school journeys together. Your always

sage advice of "Don't Panic!" helped me more than you know!

Table of Contents

Acknowledgements

This journey was made possible by many people who accompanied me as I made my way through. They say it takes a village to raise a child; I believe it takes a village to write a dissertation.

I would like to thank my Major Professor, Dr. Mary Jo Baisch, for her always kind approach and her encouragement along the way. I appreciate her insight and wisdom in guiding me through this process.

Dr. Karen Morin, my Initial Advisor, saw me through some difficult times. I will be forever grateful for her kindness, her encouragement, and her belief that I could do this.

I would like to thank Dr. Decoteau Irby who taught me so much and challenged me to think more deeply. His insights as someone from outside the world of nursing were invaluable.

I am grateful to my readers, Dr. Peninnah Kako and Dr. Lucy Mkandawire-Valhmu, fellow kindred spirits in feminist research whose challenging and thoughtful questions greatly improved my work.

I would like to thank Terry Ortiz for her unshakeable faith in me. Her support enabled me to complete this journey.

Finally, I would like to thank my daughter Jasmin. She has been my greatest cheerleader.

List of Figures

List of Tables

Chapter 1: Introduction of the Study

Autonomy in nursing has been the subject of much research in the past 30 years. Researchers such as Kramer and Schmalenberg (2005), Lake (2002), Weston (2008), and Aiken and Patrician (2000) have all explored autonomy in the context of acute care settings. While a great deal of this research focuses on whether hospitals have in place the organizational structures that are believed to enhance nursing autonomy in the workplace, little consideration of nursing as a gendered profession – and the consequences of nursing's gendered nature – is offered. Researchers seeking to measure autonomy rarely consider the impact of gender, and medicine's historical domination of nursing's knowledge and power in their studies.

Considering issues of gender and power is important when discussing nursing autonomy because according to the United States Census Bureau, 92% of all nurses in the United States are female (Landivar, 2013). The fact that nurses are predominantly female leaves nurses at risk for oppression due to gender inequalities that are present in today's healthcare settings (Dubrosky, 2013; Roberts, Demarco, & Griffin, 2009). In addition, these gender issues contribute to nursing's relative lack of power in today's healthcare setting. When combined, gender oppression and nursing's lack of power serve to suppress and conceal nursing knowledge behind the veil of medical discourse. Therefore, matters of gender, knowledge and power must be considered in order to develop a more complete picture of nursing autonomy. This study was designed to explore professional autonomy and the meaning of autonomous actions taken by nurses within the context of gender, knowledge, and power.

Hermeneutic phenomenology is the research method of choice when the researcher seeks to understand the meaning of a phenomenon as it is understood by those who are experiencing the phenomenon (Cohen, Kahn, & Steeves, 2000). It is an especially useful method when a fresh perspective is needed on a topic (Cohen et al., 2000). Hermeneutic phenomenology is distinguished from other types of phenomenology in that the researcher not only documents the experiences of the subjects but also interprets those experiences through the lenses of the research questions (Creswell, 2007). This method was useful in this case because I sought to understand the meaning nurses assign to their autonomous actions as well as to understand how the socio-political context influenced nurses' interpretations of their actions.

The hermeneutic method encourages the researcher to study how people interpret their lives and make meaning of what they experience (Cohen et al., 2000). The process begins when a researcher is interested in learning more about the experiences a specific population has with a certain phenomenon. Often the researcher has some experience or knowledge about the phenomenon and wishes to develop a deeper understanding of the phenomenon and its context (Earle, 2010). The researcher begins by doing a literature review in order to discover what is already known about the phenomenon. Immersing him- or herself in the literature, the researcher then develops questions and pinpoints gaps in the knowledge about the phenomenon and identifies a population who experiences the phenomenon (Galletta, 2013). Those experiencing the phenomenon are invited to share their stories with the researcher (Van der Zalm & Bergum, 2000). Then the narratives are read and reread by the researcher who searches for common themes in the words and

within the interconnected lifeworld of the participants. Finally, the researcher offers an interpretation of the findings that offer a deeper explanation and understanding of the phenomenon (Annells, 1996). This type of inductive research is a good starting point for theory development.

Understanding Oppression and Autonomy

Several nurse theorists have explored the idea that nurses are an oppressed group who would benefit from emancipatory methods of research (David, 2000; Dubrosky, 2013; Farrell, 2001; Fletcher, 2006; Roberts et al., 2009). The common theme among them is that nurses are capable of overcoming their oppression but they must first acknowledge the deleterious effect gender roles have had, and continue to have, on nursing practice – especially when it comes to autonomy. Standpoint theory and intersectionality, as they relate to feminism, offer cogent methods for considering issues of gender and power. Foucault's theory about power/knowledge also provides a powerful tool for understanding power and its relationship with knowledge. Both feminist theorists and Foucauldian theorists argue that power/knowledge has a particular point-of-view and that the more points-of-view that are included, the more complete the picture of a society can be. In addition, both perspectives inform the context of women in society and in the workplace.

Standpoint theory and oppression.

The fundamental assertion of Standpoint Theory is that those who are oppressed have a perspective about the world that is unique and more complete than that of those who are not oppressed and that this unique point-of-view may be used to dismantle

structures that serve to support and reinforce oppression (Harding, 2008). Standpoint

theory works well with phenomenological research methods because, in part, they both

focus on the experiences of individuals as members of a group and because they seek to

develop a fuller understanding of the lifeworld of those individuals. Like hermeneutic

phenomenology, standpoint theorists argue "… that knowledge is situated and

perspectival" and that a particular standpoint is co-created by the researcher and the

participant (Hekman, 1997, p. 342). Standpoint Theory is especially useful in research

with oppressed groups because it acknowledges that oppressed participants may hide

knowledge due to fear, shame, anger, or hermeneutical injustice (Rolin, 2009). Using

Standpoint Theory as a framework to understand nurses' interpretations of autonomy

allows the researcher to discover the meaning nurses ascribe meaning to their

autonomous actions. It helps the researcher identify issues of gender and power while

analyzing the narratives.

Standpoint Theory is also useful as a framework when the investigator aims to

explore issues of emancipation from oppression. Understanding the meaning nurses give

their autonomous actions will be useful only if the goal of such understanding is to free

nurses from the structures that serve to keep nursing knowledge and practice undervalued

and under-recognized. Standpoint theorists' argue that reality is socially constructed and

that the structure of that reality is best understood from the bottom up rather then from

the top down (Hekman, 1997). This perspective is useful because nursing often finds

itself at the bottom of the hierarchy that is present in so many of today's healthcare

settings (Roberts et al., 2009). The emancipatory objective of Standpoint Theory guides

nurses' insights as they assess their own oppression. This process sheds light on the structures that keep nursing knowledge and practice on the margins.

Intersectionality.

Any examination of power structures would be incomplete without an examination of the multiples ways in which privilege and oppression intersect. Intersectionality theorists argue that gender, race, class, sexuality, and culture all intersect and that one cannot simply consider issues of gender in isolation from issues of race, class, sexuality, and culture (Samuels & Ross-Sheriff, 2008; Van Herk, Smith, & Andrew, 2011). It is especially important to consider issues of race and class when examining gender issues in nursing because nurses from minority groups have historically been and continue to be under-represented in the nursing workforce (American Association of Colleges of Nursing, 2014; Van Herk et al., 2011). Van Herk, Smith, and Andrew (2011) note that the dominance of the white middle class perspective in today's healthcare environment affects not only nursing practice but also who is recognized as a nurse. Intersectionality theory can help bring to light the multiple ways in which privilege and oppression are shaped in the practice environment.

Foucault and knowledge/power.

Like standpoint theorists, Foucault and others argue that power must be examined from the bottom up (Bradbury-Jones, Sambrook, & Irvine, 2008). However, Foucault maintains that power can be productive as well as oppressive and that it creates new ways of seeing reality in order to produce the "truth" in a certain society (Bradbury-Jones et al.,

2008). It is this view of productive power that provides a counter-balance to standpoint theory's assertion that power is oppressive and destructive (Hekman, 1997).

Standpoint theorists' assertion that the view of the oppressed is more complete, more true, than that of the oppressor is balanced by Foucault's theory about power/ knowledge. While Foucault argues that power is better understood from the bottom, he does not privilege the knowledge of the oppressed as somehow more complete. Instead he argues that all points-of-view are partial because knowledge is only possible in the context of a particular perspective (Hekman, 1997). In fact, it is these contexts that are of particular interest to Foucault. He maintains that power/knowledge is best understood by analyzing the way in which power is present even in its minutest forms (Bradbury-Jones et al., 2008).

Standpoint of the Researcher.

In both feminist research and in phenomenological research it is important for the researcher to develop an understanding of how his or her personal experience impacts the research. My decision to explore the professional autonomy of acute care, bedside nurses through a feminist lens was influenced by a myriad of factors. My work as a bedside nurse specializing in critical care made me acutely aware of the challenges to my professional autonomy. In the critical care environment I was often expected to act in the best interest of my patient, even if this meant stepping outside my legal scope of practice to act first and obtain orders later. That this practice was ubiquitous was shocking to me. The realization that this practice created a situation in which nursing knowledge and

practice remained hidden drove me into graduate school with a desire to better understand the phenomenon called professional autonomy.

My desire to use a feminist lens reflects my own background. My experiences growing up poor in a working class neighborhood in the southern United States and being raised in a fundamentalist Christian church in which women were to be seen and not heard influenced my views of class, race, and gender roles. In college my consciousness was raised when I was introduced to feminism and came to understand the multiple ways in which oppression and privilege had shaped my life. These insights informed my worldview when I entered the nursing workforce and served as the impetus for using phenomenology and feminism as frameworks for my research.

Nursing Practice.

Nursing is a global profession that has a wide variation in how it is practiced from country to country. According the World Health Organization (W.H.O.) varying levels of education required for entry to practice combined with large variations in scope of practice creates challenges for the professionalization of nurses throughout the world. (World Health Organization, 2009). In many countries, including the United States, there are multiple pathways to become a registered nurse. In the United States, for instance, one can become a nurse through a hospital based diploma program, a community college based associate's degree program, or through a university based bachelor's degree program; graduates from all of these programs take the same licensing exam and hold the same credentials (American Association of Colleges of Nursing, 2011). The W.H.O. recommends that a bachelor's degree be established as the minimum level of education

for entry into nursing practice however many countries do not have the resources or the faculty available to make this recommendation a reality (World Health Organization, 2009).

Nursing's scope of practice also varies widely depending upon the country. In many countries in the developing world there is a shortage of physicians and tasks normally reserved for a physician have been shifted onto nurses (McCarthy, 2012). However these changes are not always codified into the legal scope of nursing practice which hinders the professionalization in those countries (McCarthy, 2012). In Europe efforts to make a university degree the minimum education for entry into nursing practice have been under way since the Bologna Process began in 1999 (Davies, 2008). These efforts have been constrained by the cost of changing nursing education to the university level and by cultural mores in which nurses are viewed as technicians rather than as professionals with a unique knowledge base (Davies, 2008). Nursing practice in the United States is complicated by the fact that it is regulated by each individual state through the state's Nurse Practice Act (Djukic & Kovner, 2010). While the scope of practice laws are similar from state to state, they are not as uniform as they would be if they were legislated at the national level (Djukic & Kovner, 2010). Furthermore, the institutions in which nurses work institute policies and procedures that are designed to prevent malpractice suits and that often restrict nursing practice in the process (Djukic & Kovner, 2010).

Nursing autonomy.

Researchers have used a variety of quantitative methods to ask nurses whether they are autonomous practitioners, to search for predictors of autonomy, and to describe the outcomes of autonomy (Macdonald, 2002; Varjus, Leino-Kilpi, & Suominen, 2011). However, these studies have failed to adequately explore the phenomenon of nurses' experiences as autonomous practitioners. The researchers simply inquire whether or not nurses have autonomy without probing further to discover how nurses define autonomy and what having autonomy means to them. Researchers are especially likely to use magnet hospital researchers' definition of autonomy as well as to conduct their studies exclusively in Magnet designated hospitals. Magnet hospitals are hospitals that receive special accreditation because they have structures and processes in place that attract and retain nursing staff (Kramer & Schmalenberg, 2004c). The difficulty with focusing on Magnet hospitals is that they represent only 3 to 6% of all the hospitals in the United States, making the research results generalizable to a very small population of the country's nurses (ANCC, 2013). Noticeably lacking in the literature are qualitative studies that aim to understand and explore the context of nurses' experiences of autonomy (Varjus, Leino-Kilpi, & Suominen, 2011). If we fail to understand the context of nursing experiences of autonomy we will lack the understanding necessary to make lasting changes that improve nurses' practice environments.

Further complicating the issue are the multiple definitions of autonomy that are present in the literature (Varjus, Leino-Kilpi, & Suominen, 2010). Researchers are not always explicit about which of these various definitions they are using in their studies o.

This ambiguity leads to questionable operationalizations of the concept and to poorly designed instruments to measure it (Iliopoulou & While, 2010; M. M. Kramer et al., 2008).

Statement of the Problem

The nursing literature about autonomy falls primarily into two categories – definition of autonomy and factors affecting autonomy. Quantitative researchers like Kramer and Schmalenberg (2004a), Weston (2008), and Li et al. (2007) focus on defining and measuring nursing autonomy and the impact of autonomy on nursing's work environments. These researchers focus on discovering the organizational structures and processes that must be in place in order to improve nursing autonomy. With women comprising 92% of the 2.8 million nurses that are practicing today, one can argue that gender plays a role in the constraints and limitations nurses face as they seek greater autonomy for themselves and their profession (Labor, 2008). However, research to date has not considered the issues of gender and power and the influence nurses have or do not have on the ability to create and properly execute organizational structures and processes that would enhance their autonomy.

The theoretical nursing literature about autonomy is primarily concerned with nursing's desire for professional status, as well as the impact of women's and nurses' socialization within the bureaucratic institutions in which they are employed (Varjus et al., 2010). No studies were found that sought to understand autonomy within the larger context of gender and power. Filling this gap is important because researchers who do not consider the impact of gender and power upon nursing's ability to achieve greater

autonomy may fail to develop policies that change the larger context in which nurses practice. Attempts to increase nursing autonomy without simultaneously changing the context of nursing practice are destined to fail because the underlying factors that limit nursing autonomy will remain unchanged.

Statement of Purpose

The purpose of this phenomenological study was to look at the professional autonomy of acute care bedside nurses and to explore the meaning that they assign to their autonomous actions. Many studies have used quantitative means to ask nurses whether or not they have autonomy (Aiken & Patrician, 2000; Kramer & Schmalenberg, 2004a, 2005; Vahey, Aiken, Sloane, Clarke, & Vargas, 2004). While these studies may identify occasions of autonomy, they fail to explore the deeper context in which autonomous actions occur. Understanding the meaning that nurses ascribe to their autonomous actions will help make clear why nurses take these actions, sometimes risking their licenses to do so. The negative impact of gender and hierarchical power relations upon nursing's quest for autonomy makes understanding the meaning nurses ascribe to their autonomous actions an important task. Developing policies to improve nursing autonomy will require that we understand the social and political context in which these actions occur. Now is the time for nurses to address these issues.

A part of the drive to better understand autonomy comes from outside of nursing. According to an Institute of Medicine (IOM) (2004) report, "The work environment of nurses, the largest segment of the nation's health care work force, needs to be substantially transformed to better protect patients from healthcare errors" (IOM 2004).

The IOM (2011) issued a challenge to nursing for it to transform its practice so that nursing practice reflects nursing education. In order to meet this challenge nursing must reflect upon its history as a gendered and oppressed profession. Nursing must also find ways to assess the reality of practice for nurses today (IOM, 2011). This study, with its emphasis on current practice, is positioned to help transform nursing by making clear issues that impede the profession's progress as a discipline.

The purpose of this phenomenological study was to explore the meaning that acute care, bedside nurses' assign to their autonomous actions. It was also designed to explore how the meaning they assigned to these experiences impacted their sense of empowerment and vice versa and how their sense of empowerment was influenced by their viewpoints as nurses working in a hierarchical and gendered profession. Because the vast majority of the literature about autonomy concerns nurses working in acute care settings, this will be the focus of this study, though it should be noted that further studies of nursing autonomy in non-acute care settings will help further our understanding of this phenomenon. The specific questions for this phenomenological study are:

1.   What are bedside nurses' experiences of autonomy as they practice nursing in acute care hospitals?

2.   What meaning do nurses assign to their autonomous actions?

3.   How does gender impact the meaning that nurses give to their autonomous actions?

4.   How does the meaning nurses assign to their autonomous actions contribute to nursing's lack of power in today's healthcare system?

Assumptions

For the purposes of the study, the following assumptions will be made:

1. Nurses participate in autonomous actions.

2. Nurses ascribe meaning to their autonomous actions.

3. Gender roles and expectations have an influence upon behavior.

4. Nurses are an oppressed group.

Definition of Terms

For the purposes of this study the following definitions will be used:

Autonomy – the ability to be self-governing (Macdonald, 2002); the ability to make decisions without supervision or interference (Donchin, 1995; Mundinger, 1980); the authority, freedom, and discretion to make decisions (Weston, 2008).

Bedside nurse – any nurse working in an acute care facility whose primary job is to care for patients at the bedside. For the purposes of this study the educational background of the bedside nurse, which may vary, will include only those nurses with a Bachelor's degree or less. Participants with a master's degree but working as a bedside nurse will be excluded because their advanced education may have an influence on their perspectives on autonomy that those with less education may not have and because this study is concerned with nurses who are not classified as advanced practice nurses or as clinical nurse leaders.

Oppressed group – a group of individuals who share a common experience (gender identity, race, profession), whose sense of history, affinity, and separateness are created, in part, by their affiliation with one another, who lack decision-making power,

and whose norms have been defined by a separate and dominant group (Roberts, 2000; Young, 1990).

Significance to Nursing Science

Developing a greater understanding of the meaning nurses give to their autonomous actions will influence nursing research, policies, and practice. Researchers who study autonomy will benefit from understanding the meaning that nurses give to their autonomous actions as well as from understanding the context of those actions. A clearer picture of the context of autonomous actions will enhance the perspective of researchers as they develop instruments designed to measure autonomy. This will facilitate theory development by helping to make clear what nurses perceive to be important factors in their ability to practice autonomously. Understanding the meaning nurses give to their autonomous actions will also help to elucidate how nursing's power has been affected by the hierarchical healthcare system. Nurses, with their focused and near continuous contact with patients, have a knowledge and skill set that is unique in the healthcare system. This unique knowledge, coupled with the fact that the overwhelming majority of nurses are women, gives nurses a distinctive point-of-view that provides a foundation for their knowledge. A better understanding of the connection between gender, power, and nursing knowledge will help researchers and policy-makers develop interventions and organizational strategies that take advantage of nursing's unique perspective. Finally, this study will help nurses by giving voice to their experiences of practicing autonomously in a healthcare system that routinely marginalizes nursing knowledge and power.

Chapter 2: Literature Review

Autonomy has been a key issue for nursing since the beginning of modern

nursing. Florence Nightingale considered autonomy as the key feature that distinguished

nurses in her time from lay persons who provided care to the sick and dying (Gagnon,

Bakker, Montgomery, & Palkovits, 2010). Yet nursing grew as a profession bounded by

bureaucracies that, due to nursing's gendered status, were difficult to influence in

nursing's favor (Gagnon et al., 2010). Furthermore, the structure of our modern day

healthcare system was entrenched before women in the United States even had the right

to vote. Physicians were able to lobby for legislation that ensured an autonomous practice

for themselves while creating a dependent practice for nursing (Ballou & Landreneau,

2010d; Shi & Singh, 2010). As a result, nursing was forced to develop and mature within

bureaucratic organizations that did not favor the autonomous practice of nurses (Kramer,

Maguire, & Schmalenberg, 2006). Since the advent of modern nursing in western health

care delivery systems, the phenomenon of nursing autonomy has been the subject of

much debate. A significant gap in the literature concerning our understanding of how

nurses understand and perceive the phenomenon of autonomy in their day-to-day work

environments. Also missing from the literature are studies whose purpose is to understand

professional autonomy in light of the significant gender issues that continue to plague

nursing.

Context of the Phenomenon

This chapter will include an exploration of autonomy from an historical

perspective. Then feminist perspectives of nursing as a gendered profession and gender's

influence on nursing's pursuit of professional autonomy will be considered. Finally, the phenomenological method and its usefulness to complete this study will be discussed.

The origins of the problem.

While autonomy in nursing has been discussed extensively in the past 30 years it is worthwhile to look back to the beginnings of modern medicine and nursing in order to explore the roots of the difficulties with understanding nursing autonomy today. A brief look at the dynamics of healthcare from the mid-19th century to the early 20th century will reveal how the building blocks of the modern healthcare system continue to influence so much of nursing practice in the 21st century.

Birth of the disease model and medical dominance.

American nurses, prior to the mid-19th century, enjoyed a period of relative autonomy in their patient care activities (Ashley, 1976; Kalisch & Kalisch, 1978; Reverby, 1987). Nursing care took place in the patient's home and nurses, unlike the doctors of the day, would care for their patients literally from birth, through illness, and beyond death (Ballou & Landreneau, 2010; Rafferty, 1995). They acted as mid-wife, health-care provider, and even assisted with the preparation of the body after nursing their patients through the process of dying (Rafferty, 1995). That nurses performed their duties so well was not lost on the physicians at the time. The physicians, who were busy founding hospitals and trying to change the locus of care to these hospitals, came to view these independent-minded women as competition that needed to be eliminated in order for their hospitals and their practices to succeed (Nelson & Gordon, 2004; Rafferty,

1995). As a result of the Flexner Report physicians banded together to push medical

education into medical schools and to lobby for and gain legislation that not only

specified exactly who could and could not practice medicine but also made nursing care

dependent upon a physician's plan of care (Ashley, 1976; Ballou & Landreneau, 2010;

Duffy, 2011; Reverby, 1987). This effectively closed the door on independent practice for

nursing practice (Ashley, 1976; Malka, 2007). As medical schools were established and

entrance requirements outlined, medicine became a closed and nearly all-male profession.

It came to dominate the healthcare industry based on physicians' monopolistic control of

knowledge and their ability to legislate who could and could not use this knowledge

(Ashley, 1976; Ballou & Landreneau, 2010; Malka, 2007; Reverby, 1987; Shi & Singh,

2010).

Nurse leaders play a part.

Even as physicians sought to hamper independent nursing practice, nursing

leaders pushed for reform that would enhance the image of nursing yet ensure that

women did not overstep the societal boundaries of their Victorian culture (Ashley, 1976;

Reverby, 1987). For example, Nightingale believed that health was achieved through

moral reform, cleanliness, clean air, and rest (Nelson & Gordon, 2004; Rafferty, 1995).

Indeed, Nightingale, and her American contemporaries were more concerned about the

moral character of nurses than about their clinical skills (Ashley, 1976; Reverby, 1987).

These early leaders focused more on reforming the nurse's character and improving the

morals of the working class than they did on the technical skills achieved by nurses;

furthermore, they actively campaigned to keep nurse training in the hospitals (Malka,

2007; Rafferty, 1995; Reverby, 1987; Weiss, 1995). It was widely believed that any woman, with proper moral guidance, could become a nurse and early reform efforts put much into changing the character of working class women to be more aligned with the ideals of the middle and upper class (Ashley, 1976; Reverby, 1987). Nurses were considered the ultimate mother figures and as such needed only the proper environment and experience to develop her natural capabilities as a woman (Reverby, 1987). Additionally, nurses were instilled with a fierce sense of duty and obligation to be loyal to physicians and hospital administrators who were helping to shape them into proper women (Ashley, 1976; Malka, 2007; Reverby, 1987).

American nursing was also strongly influenced by the large number of hospitals opened and operated by Catholic women living in religious orders dedicated to the care of the poor and the sick (Kalisch & Kalisch, 1978; Levin, 2011). The women running these hospitals were able to gain power and to earn the respect of male physicians because of their heavy emphasis on nursing as a religious calling and a sacred duty (Marshall & Wall, 1999). As medicine developed better treatments and anesthesia became available physicians recognized a need for hospitals to care for those recovering from their treatments; physicians began to ask religious communities to build the hospitals and to staff them (Levin, 2011). Religious communities emphasized the importance of duty, calling, and obedience to their nurses which helped them gain the trust of the physicians with whom they worked (Marshall & Wall, 1999).

With the heavy emphasis on duty and propriety in both secular and religious nursing it is no surprise that nursing leaders in both Europe and the United States quickly

fell in line with physicians who wanted training to take place in the hospital and to be

provided by physicians (Weiss, 1995). These nursing leaders were given power over the

nursing trainees which resulted in early nursing leaders siding more with the physicians

and the hospital administrators than with the trainees under their charge (Ballou &

Landreneau, 2010; Rafferty, 1995). Ballou and Landreneau (2010a), Malka (2007), and

Rafferty (1995) all note that physician and hospital administrators used their authoritative

and legislative power to keep student nurses in the hospitals by using these students to

staff the hospital, by preventing the students from having contacts outside the hospital,

and by limiting their ability to work independently (without physician supervision) once

they graduated. This arrangement saw physicians' and administrators' wealth increase

substantially (Ballou & Landreneau, 2010d).

However, even this amount of control was not sufficient. Physicians and hospital

administrators sought to further restrict nurses' control within the health care system by

actively lobbying to prevent nursing education from moving to the university (Ashley,

1976; Ballou & Landreneau, 2010). Physicians and hospital administrators argued

vehemently that university education of nurses would lead to disastrous and dangerous

outcomes because better educated nurses might perceive that they knew better than the

physician and this would lead to insubordination and medical errors (Ashley, 1976;

Malka, 2007). These actions were carried out before women had the right to vote in the

United States and they continue to influence nursing practice to this day (Weiss, 1995).

With nurses firmly ensconced near the bottom of the health care hierarchy, the autonomy

they once enjoyed as independent practitioners prior to the medicalization of the health

care system has yet to be fully recovered (Ballou & Landreneau, 2010; Rafferty, 1995; Weiss, 1995).

Autonomy in the 21st century.

Nurses' gains in the struggle for autonomy are interwoven with their fundamental role as patient advocates (Shirley, 2007). The consumers' rights movement in the 1970's encouraged patients to challenge the paternalism of the medical system (Malka, 2007; Reverby, 1987).This created an opportunity for nurses, acting as patient advocates, to challenge the power of the bureaucracies of the institutions in which they worked (Shirley, 2007). "In supporting the autonomous rights of patients, nursing also created the opportunity to challenge the institutions … on behalf of their own interests…" (Shirley, 2007, p. 18). The confluence of power shifting towards the consumer and the growth of the women's rights movement helped pave the way for nurses to advocate for greater recognition of their knowledge and more autonomy in their practice (Malka, 2007; Shirley, 2007).

As nurses gained greater control over their practice the areas of overlap between nursing practice and medical practice increased. For instance, both professions perform assessments, administer medications, and perform procedures on patients (Djukic & Kovner, 2010). While both professions engage in diagnosing, nursing diagnosis concerns a patient's response to illness where medical diagnosis concerns a patient's disease process. Medicine retains control over prescribing medications and treatments and in many state practice acts physician orders override or take precedence over a nursing

order (Djukic & Kovner, 2010). In this way medicine maintains its dominant stature in the healthcare system (Ballou & Landreneau, 2010a).

However, this is not to say that nurses have no options when confronted with an order they feel would harm their patient. Nurses learn in school that they are obligated to question any medical order that might bring harm to the patient. They learn that there is a specific chain of command to follow when questioning orders and that the ultimate responsibility for keeping the patient from harm lies with them because they perform the final check before a treatment or medication is administered. Nursing and medical practice acts require that every medical intervention, laboratory test, and medication needs a physician's order before it can be implemented no matter how critical the need. Even when nurses know what needs to be ordered they are legally obligated to wait for a physician to prescribe it.

Despite the fact that nursing autonomy has been highly valued over the past few decades, little improvement has been noted in the state of bedside nurses' autonomy and their level of practice (Kramer et al., 2006). While significant gains have been made for advanced practice nurses, entry-level nurses continue to struggle for professional autonomy. There are several factors that contribute to nursing's difficulty with achieving autonomy; these include nurse researchers' inability to come to an agreed upon definition of autonomy, a lack of proper instruments for measuring autonomy, the negative impact of socialization as women in a society that devalues women and women's work and an unclear delineation of nursing's scope of practice. These factors will be discussed in greater detail in the following sections.

Defining Autonomy

One limiting factor to nurses' gaining greater autonomy has been, and continues to be, the variety of definitions that exist in the literature about nursing autonomy (Varjus et al., 2011). A poor understanding of the phenomenon of autonomy makes it difficult to measure and track outcomes of autonomous practice. This is a direct result of the fact that each researcher appears to be using his or her own understanding of the concept of autonomy (see Table 2.1). This practice has generated many definitions of autonomy that are used inconsistently across studies (Kramer et al., 2007). Kramer and Schmalenberg (2008) explain that it is nearly impossible to accurately measure the phenomenon because the studies purporting to measure autonomy do not make explicit which of the already existing definitions of autonomy they are measuring. This viewpoint is also expressed by Iliopoulou and While (2010) who write that while autonomy's "…relationship with nursing practice and status has been addressed extensively, it has been poorly defined, operationalized, and measured" (p. 2521). The inconsistent and seemingly interchangeable uses and measurements of autonomy make it difficult to compare methods or results from different studies (Kramer et al., 2007). Unfortunately, there is very little consensus on a standardized, uniform, and operationalized definition of nursing autonomy (Gagnon et al., 2010). This lack of a standardized definition leads to confusion in interpreting the results of studies on autonomy.

As is demonstrated by the variety of definitions in Table 2.1, the concept of autonomy has many aspects. Berndt, Parsons, Paper, and Browne (2009), Macdonald (2002) and Weston (2008) note that autonomy includes having authority to act and to

make decisions based on nursing judgement. Mundinger (1980) and Kramer et al. (2007)

include the concept of overlapping spheres of practice in their definition. Overlapping

spheres occur when a patient presents with a problem for which there is both a medical

and a nursing intervention. In this case, according to Kramer et al. (2007) the nurse acts

in the best interest of the patient. Keys' (2009) definition for autonomy notes that an

autonomous nurse is independent and has the ability to act without undue supervision.

Table 2.1 Definitions of Autonomy

Researcher	Definition	Year
Mundinger	Autonomous nursing care is not a nurse's providing medical care without medical supervision; it is a nurse's providing nursing therapy that complements and often overlaps medical care	1980
Macdonald	The privilege of self-governance	2002
Kramer, Maguire, & Schmalenberg	Autonomy is the freedom to act on what you know, to make independent clinical decisions that exceed standard nursing practice, in the best interest of the patient	2007
Weston	Autonomy is the authority and freedom to make clinical nursing judgments related to patient care	2008
Berndt, Parsons, Paper, & Browne	Autonomy is the degree to which nurses have the authority, expectation, and opportunity to make decisions that affect their nursing practice	2009
Keys	The ability of an individual to independently carry out the responsibilities of the position without close supervision	2009

There are several difficulties with some of the most recent iterations of the

definition of autonomy. First, it remains unclear as to what exactly qualifies as the

overlapping sphere of practice – even Kramer et al. (2007) do not expand on what the

overlapping sphere of practice rightly contains. Second, if stepping outside of nursing's

scope of practice is to be considered autonomous practice, than what are the ethical and

legal ramifications of promoting this definition? While the definitions proposed by

Kramer et al. (2007) and by Weston (2008) appear to reflect nursing practice as it is

practiced, their definitions of autonomy raise questions about the place for and the

importance of autonomous practice that does not exceed nursing's scope of practice. The

definition proffered by Kramer et al. (2007) appears to make acting outside the scope of

practice a requirement for practicing autonomously; this viewpoint fails to acknowledge

the many actions that are within the scope of practice that can be practiced autonomously.

Finally, it is unclear in Keys' (2009) definition what is meant by close supervision of

independent nursing practice.

Measuring autonomy.

For the past 30 years researchers have been interested in nursing autonomy, both

in how to define it and in ways to measure it. Numerous studies link autonomy to job

satisfaction and retention of nurses; autonomy has been listed as the most important

contributing factor to nurses' job satisfaction (Hinno, Partanen, Vehvilainen-Julkunen, &

Aaviksoo, 2009; Zangaro & Soeken, 2007; Zurmehly, 2008). Weston (2008) writes that

autonomy is measured using instruments that are measuring work-related autonomy such

as freedom over work-scheduling, job processes, and methods. However she maintains

that these instruments are not measuring autonomy, which she defines as, "…the

authority and freedom to make clinical nursing judgments related to patient

care" (Weston, 2008, p. 91). M. Anthony (1997) states that the few instruments developed

to measure autonomy from a nursing perspective actually do not assess the true extent of

the actual behavior present in autonomous actions nor do they outline where in the

process the participation occurs. Instrument development studies failed to consider

nurses' perspective of autonomy; instead they measured traits that the researchers

consider important.

It is important to discover the meaning of autonomy from nurses who are

experiencing it in their everyday practice (Varjus et al., 2010). Berndt, Parsons, Paper,

and Browne (2009) report that while the importance of healthy work environments is not

argued, the problems lie in the variability of the terms used to describe such workplaces.

In their review of the literature on professional autonomy of nurses in hospital settings

Varjus et al. (2010) conclude that the concept of autonomy was incoherently defined and

measured. They found that the literature was primarily concerned with nursing's, "…

desire for professional status, the impact of women's and nurses' socialization and the

relationship of autonomy to job satisfaction within bureaucratic organizations" (Varjus et

al., 2010, p. 201).

The nursing work index – revised.

There are several instruments that have been used extensively to measure

autonomy. However, as can be seen in Table 2.2, there are significant gaps in the

usefulness of each of these instruments. For instance, in their assessment of the Nursing

Work Index – Revised (NWI-R), Kramer and Schmalenberg (Kramer & Schmalenberg,

2004k) found that items in the scale containing the word autonomy were vague and

lacked a definition that promoted understanding of the concept. Furthermore, even

though initial validation studies were not performed by Aiken and Patrician (2000), the

un-validated scales were used in multiple studies both in the United States and abroad

(Berndt et al., 2009). When psychometric studies were performed investigators

discovered that the reliability and validity of the NWI-R was questionable (Bonneterre,

Liaudy, Chantellier, Lang, & Gaudemaris, 2008; P. P. Slater & McCormack, 2006).

Additionally, invalid uses of the instrument, such as researchers altering the questions, or

selecting individual questions to use in their studies, have prevented the development,

communication, and synthesizing of nursing knowledge concerning the phenomenon of

autonomy (Weston, 2009).

Table 2.2 Instruments Measuring Autonomy

Researcher	Instrument	Gap
Aiken and Patrician (2000)	Nursing Work Index - Revised	Factor Structure does not support measurement of autonomy in any of the sub scales
Kramer and Schmalenberg (2004b)	Essentials of Magnetism	Subscales fail to describe autonomy and are better seen as identifying antecedents of autonomy
Berndt et al. (2009)	Healthy Workplace Inex	Based on PES-NEW which has problems with its factor structure and is based on an instrument with poor validity measurements

While the NWI-R is well-known for measuring the presence of important

characteristics of hospital-based nurses' work environment, some critics have questioned

whether it really measures all the traits that are significant in modern hospital settings.

Cummings, Hayduk, and Estabrooks (2006) write that because nursing environments are

very complex and contextually sensitive, using factor-analytic scales and sub-scales to

describe nursing environments assumes that nursing environments are unitary and

cohesive. These assumptions miscalculate the complexity, multi-faceted nature, and variability of nurses' practice environments (Cummings et al., 2006).

According to Kramer and Schmalenberg (2004a) the NWI-R is outdated and that, "What was useful, innovative and important to magnetism, job satisfaction, and productivity in 1984 is not necessarily the same in 2004" (p. 365). Slater, O'Halloran, Connolly, and McCormack (2010) note that because the factor structure fails to replicate statistically, significant concerns are raised about the validity of reported findings. This becomes an important issue when organizations use the results of these studies to apply their resources and energies into poorly validated results because the misdirected resources contribute to nursing staff dissatisfaction (Paul Paul Slater et al., 2010). In fact, Slater et al. (2010) caution that organizations would be better served if they focused on developing adequate staffing resources, improving the doctor-nurse relationship, and strengthening nurse management rather than devoting resources to increasing organizational support, increasing control over nurse practice, and improving autonomy. They urge researchers to develop studies that explore the complexity of the nursing work environment in order to better understand the factors that might predict the quality of those environments (Paul Paul Slater et al., 2010). A hermeneutic phenomenological study exploring nurses' perceptions of autonomy in their practice environments can help unpack the complexity of this phenomenon. A richer understanding of nursing practice will lead the way to the development of policies that better reflect nursing practice in the current healthcare system.

Essentials of Magnetism.

Several instruments were developed to evaluate magnet hospitals. Magnet hospitals earn their designation through a credentialing process which requires that a hospital dedicates itself to providing resources to nurses and to supporting their practice. The Essentials of Magnetism is a tool developed to measure the presence of eight characteristics that are present in a good work environment for nurses. Those eight elements are: 1. Control over Nursing Practice, 2. Good Nurse-Doctor Relationships, 3. Nurse Manager Support, 4. Support for Education, 5. Clinical Competence, 6. Cultural Values, 7. Adequacy of Staffing, and 8. Autonomy (Kramer & Schmalenberg, 2004a). Kramer and Schmalenberg (2004a) developed the Essentials of Magnetism instrument as a replacement for the outdated Nursing Work Index tool (Weston, 2009). According to Kramer and Schmalenberg (2004k) there is considerable evidence that the nearly 30-year-old NWI is no longer useful and is out of step with today's nursing practice (Kramer & Schmalenberg, 2004c). Their new scale was entitled Dimensions of Magnetism to describe the traits from the Nursing Work Index – Revised that they perceived were still relevant to nursing practice in the 21st century (Kramer & Schmalenberg, 2004c).

The first step in their instrument development process was to discover how nurses working in magnet hospitals defined the "essentials of magnetism". They engaged in a qualitative study to discover how nurses define three of the eight essentials: 1. Autonomy 2. Control over Nursing Practice and 3. Nurse – Physician relationships (Kramer & Schmalenberg, 2004a). This study led them to develop a theory of autonomy in which autonomy is "…the mental assembling, synthesizing, and integrating of the who, what,

why and where of nursing autonomy" (Kramer & Schmalenberg, 2004a, p. 367). They

then developed questions to measure each of the dimensions of the theory. Ultimately,

they defined autonomy as the, "…freedom to make independent decisions that exceed

standard nursing practice and are in the best interests of the patient" (Kramer &

Schmalenberg, 2004a, p. 368).

For Kramer and Schmalenberg (2004k) this definition does not mean that nurses

are practicing medicine without medical supervision, instead they write that it consists of

nurses practicing nursing in a sphere that overlaps with medical practice. This sphere

includes emergent situations, patient advocacy, and taking actions to prevent or treat a

life-threatening situation (Kramer & Schmalenberg, 2004k). Their instrument contains 65

items measuring autonomy and control over nursing practice; they weighted items based

on information from their qualitative study that revealed the factors that were important

to nurses (Weston, 2009). The new instrument was designed to measure the structure and

process elements that support or detract from autonomy and control over nursing

practice; this is in lieu of identifying participants' perceptions about the degree to which

autonomy and control over nursing practice exists in their work environments (Weston,

2009). Weston (2009) writes that, "Conceptually, the instrument is for measuring

elements that are essential to a productive and satisfying work environment for nurses

while the subscales may be indicating antecedents to, rather than attributes of, control

over nursing practice and autonomy" (Weston, 2009, p. 92).

It is noteworthy that Kramer and Schmalenberg (2004a) recognized the need for a

more contemporaneous instrument to measure and describe nursing's current work

environment. Their new instrument is designed to assess important aspects of the workplace such as autonomy, control over nursing practice, and nurse-physician relationships. While the new instrument assesses the structural elements of autonomy, gaps remain concerning how those structural elements are related to the experience of the actual presence of autonomy in nursing practice today (Weston, 2009). A study exploring nurses' experiences of autonomous actions and the consequences of those actions will help better elucidate how the structural elements of autonomy affect autonomous practice in today's healthcare system.

Healthy Workplace Index.

Another instrument designed to measure key concepts of the workplace, including autonomy, is the Healthy Workplace Index (HWPI) (Berndt et al., 2009). The HWPI was developed using Parsons' Healthy Workplace Intervention framework and includes the following key elements: empowerment, participatory change management and shared leadership. It was designed to evaluate the structure, processes and outcomes of healthy workplaces (Berndt et al., 2009). A unique characteristic of the HWPI is that it can be used across all members of a multi-disciplinary team.

The instrument consists of 37 items that measure nine conceptually defined domains, including adequate staffing, collegial/collaborative relationships, and control over nursing practice. The domains were assessed using exploratory factor analysis (Berndt et al., 2009). The instrument was developed by assessing the strength of relationships between the domain scores of the HWPI and the Practice Environment Scale of the Nursing Work Index (PES-NWI). The Clinical Autonomy Scale and the

Control Over Practice Scale from the Control over Nursing Practice instrument were used

to measure outcomes of a healthy work environment (Berndt et al., 2009). However care

must be taken because the validity of the instruments with which they were compared are

under scrutiny. Even the authors identify several areas for further development to the

results in which the resulting factor structure was so different from the factor structure

hypothesized (Berndt et al., 2009). A qualitative study focused on understanding the

components of autonomy will help further the development of measurement tools

designed to assess the components of autonomy that nurses find relevant and will help

unpack the complexity of the nursing work environment.

Feminist perspectives.

Nursing's understanding of the phenomenon of autonomy has been evolving as

nursing practice has evolved. However, despite extensive resources that have been

applied to defining and measuring autonomy, the concept remains poorly understood,

poorly operationalized, and poorly defined (Gagnon et al., 2010; Iliopoulou & While,

2010). The following section will explore the reasons that the phenomenon of autonomy

continues to be poorly understood.

Skar (2009) writes that the possible actions a professional may take are

determined by the amount of freedom that the professional has to make the choice; in this

case autonomy means that the professional has the freedom to choose between alternate

actions. In emergent situations nurses must often choose between acting before they have

a physician's order or taking actions that are within their scope of practice but that might

delay care to the patient (Kramer & Schmalenberg, 2004a). Nurses appear to define

autonomy as the choice between acting immediately in the patient's best interest or delaying care but acting within their scope of practice (Kramer et al., 2006). For example, if a patient were to have an anaphylactic reaction to a medication the nurse would have to choose between a) administering medication to treat the reaction before she had an order for the medication and b) paging the physician, waiting for a return phone, obtaining the order for the medication and finally giving the medication. Kramer et al. (2006) found that nurses choose the former when they have developed trusting relationships with physicians who support the practice.

Kramer and Schmalenberg (2004a) noted that 20 years ago autonomy was defined simply as the ability to carry out one's nursing duties without undue supervision. Kramer et al. (2007) found that the nurses in their study redefined their own practice boundaries based on the needs of the patients and the clinical situation and that the nurses acted first and obtained physician confirmation at a later time. According to Kramer and Schmalenberg (2008) this "do first and obtain confirmation later" practice is based on a history of mutual trust between physicians and nurses and is almost certainly the most frequently occurring autonomous action in the inpatient setting that occurs in the overlapping sphere of practice (Kramer & Schmalenberg, 2004k). However, this practice serves to maintain the dominance of medicine as it involves the freedom to act beyond the existing rules and structure without having an impact on changing those rules or structures (Weston, 2008).

The idea of flexible boundaries present in inter-professional collaboration presents a challenge to more traditional, hierarchical divisions that have defined physicians and

nurses and that have led to strictly defined roles for physicians and nurses. Occupations

such as nursing that are seeking autonomy and its related rewards struggle against the

constraints of traditional roles (Salhani & Coulter, 2009a). Furthermore, the healthcare

environment in which nursing is immersed remains deeply paternalistic and continues to

be organized primarily around the needs of the institutions and the medical professionals

– largely men (Macdonald, 2002). This leads to a continued power imbalance between

nurses and physicians in which nursing's scope of practice is constrained by tradition,

institutional rules, and policies rather than by the actual legal scope of practice (Shirley,

2007; Skar, 2009).

Relational autonomy.

With women comprising 92% of the 2.8 million nurses that are practicing today,

one can argue that gender plays a role in the constraints and limitations nurses face as

they seek greater autonomy for themselves and their profession (Labor, 2008). Scholars

argue that nurses are too constrained by their institutional environments to have truly

autonomous practice (Shirley, 2007). The nursing literature about autonomy is primarily

concerned with nursing's desire for professional status, as well as the impact of women's

and nurses' socialization within the bureaucratic institutions in which they are employed

(Varjus et al., 2010). In the same vein, giving nurses formal authority to make decisions

does not constitute, "… professional autonomy in any meaningful sense if the

institutional culture … is not supportive of their capacity for independent

judgment" (Macdonald, 2002, p. 195). Similarly, Shirley (2007), writes that nursing

practice is most properly understood as a practice that is interdependent with other

professionals rather then strictly autonomous from them. Macdonald (2002) notes that a

better understanding of autonomy will come when we view autonomy through the

complex web of personal and institutional relationships that support or negate autonomy

and the making of real choices in the workplace. "This relational understanding of

autonomy sees that persons are never fully independent and seeks instead to find ways to

facilitate meaningful self-direction within an overall context of

interdependency" (Macdonald, 2002, p. 198).

A relational understanding of autonomy can lead to resistance to the over-

valuation of traditional roles which has, "… contributed to the justification of the

enormous authority invested in the medical profession" (Donchin, 1995, p. 50). In this

view autonomy is socially constructed or is dependent on an individual's social

relationships and the power structures in which she or he finds him- or herself embedded

(Macdonald, 2002). Study of relational autonomy leads to a better understanding of the

relative lack of autonomy nurses have when compared to physicians. The relational

understanding of autonomy views all health care providers as never completely

independent and seeks to aid meaningful self-direction always within an overarching

concept of interdependency (Macdonald, 2002).

In order to recognize what we mean by autonomous actions we must uncover

what are voluntary actions. This requires that people acknowledge that their actions are

embedded within a social and gendered matrix and that these interrelations are woven

into people's daily lives (Donchin, 1995). The advanced skills nurses have achieved as

they embrace technology, expand their education, and care for sicker and sicker patients

have given nurses increased knowledge of mental and physical assessment, responses to health conditions such as sepsis and diabetes, and interventions in response to those conditions. The evolving science of the discipline supports nurses' claim as professionals with a specialized domain of knowledge (Shirley, 2007).

Nursing is often considered 'care work' (Dahl, 2010). Recognition of 'care work' demands that care and care-giving work is respected at the same level as other forms of paid work and is not subjected to institutionalized forms of disrespect (Dahl, 2010). It is in this lack of recognition for the importance of care work that nursing's knowledge is downplayed or even undermined. It is because nurses are doing this "care work" that we have been able to amass the knowledge we have and is the manner in which we have gained such an intimate understanding of our patients and their conditions.

However, if one understands nursing practice to be relational, indeed all of health care is conducted within a relational matrix, one must consider professionalization from a different perspective. Salhani and Coulter (2009e) write that the idea of flexible or permeable professional boundaries that is implied by inter-professional collaboration makes a unique challenge for traditional professional privileges. In their study of inter-professional work relations of a Canadian mental health team, they define nursing's professional project as the consolidation and expansion of it's professional jurisdiction (Salhani & Coulter, 2009a). They go on to say that medical dominance, gender, and the nature and scope of nursing are central to the discussions about nursing's professional project; "… it seems clear, but not without qualification, that the medical profession significantly limits the full realization of nursing's historical and modern professional

project" (Salhani & Coulter, 2009a, p. 1222). However, it is not just the medical profession that impacts nursing's autonomy. Nurses' themselves tend to downplay their knowledge and expertise in a given area, which certainly leads to a devaluing of the work that nurses do (Summers & Summers, 2009; Weston, 2010).

In order to overcome this, nurses must learn to communicate that their work involves a specific knowledge base and skill set that is different from and even unknown to physicians (Summers & Summers, 2009; Weston, 2010). Qualitative studies are needed to better help nurses articulate their knowledge base by allowing nurses to tell their stories and give voice to their experiences. A study that explores autonomy from a relational viewpoint recognizes the complex nature of the healthcare system and supports the hermeneutic phenomenological objective of finding deeper meaning in nurses' descriptions and experiences of autonomy.

Standpoint theory.

Standpoint theory provides both a political and a methodological perspective for developing knowledge that is for women and about them; as such it is an excellent method to explore nursing and nursing's relationship with autonomy (Harding, 2008). Standpoint theory allows the unique perspective of marginalized groups' voices to be heard, and one of the things they often say is that 'things look different from our point of view' (Harding, 2008). The development of this authentic voice is of utmost importance if the discipline of nursing is to address the political realities which surrounds it (Georges, 2005). Standpoint theory provides a framework in which a careful

understanding of the problem leads to the search for solutions to the problem (Kushner &

Morrow, 2003).

When we use standpoint theory to examine the phenomenon of autonomy we find

many factors – social, political, and gender – at play in a complex matrix of social

interaction that can best be understood from the standpoint of those enmeshed in its web

(Harding, 2008). Physicians and nurses have very different understandings of what

exactly constitutes nursing practice, with physicians often playing a dominating and

limiting role and nurses playing a resisting and limited role. Standpoint theory may help

nurses understand their practice because its focus on emancipation and self-reflection

uses scientific methods and personal politics to help everyone see the world from outside

the oppressors' institutionalized vision (Harding, 2008). Standpoint theory reduces

oppression in groups by raising the consciousness of the group itself (Harding, 2009).

She argues that the oppressed group must become its own group, for itself (Harding,

2008). Nurses, as the largest group in the health care system, could have tremendous

power if they had the time, resources, and leadership to find their collective voice.

Articulating autonomous practice as an aspect of nursing practice will forward the

discipline and its underlying practice.

Kushner and Morrow (2003) write that standpoint theory as a "…critical feminist

theory is a normative concern with the status of women, an empirical focus on the

conditions that have produced dominations in gender relations" (Kushner, K. 2003) and

on methods of inquiry that can assist in the transformation of those relations. When

exploring autonomy from this perspective we see that nurses are an oppressed group who

must somehow take on more professional roles while their ability to have professional and personal autonomy is so limited by physicians' lobbying groups and by the institutions in which nurses find themselves working (Kushner & Morrow, 2003). Hagell (1989) argues that nurses have a particular kind of knowledge, one that belongs solely to nurses, that is based on their situation as (mostly) women in a patriarchal society and in part by their participation in a gender-defined occupation – nursing. Standpoint theory may help nurses step outside this institutionalized vision of their work by clarifying the way nursing knowledge is constrained by assumptions of more empirical, positivist research paradigms that so often serve institutional and public policy (Harding, 2008). According to Harding's theory, (2008) recognition of nursing knowledge, whether it is considered scientific or not, will increase nursing's power because knowledge and power are inextricably linked. As nurses find their voice and own and disseminate their evolving knowledge they will build leverage to bargain for greater control and expansion of their scope practice.

Intersectionality.

Intersectionality is a way of thinking about oppression in which the researcher considers how gender, race, class, and sexuality intersect in a subject's life (Samuels & Ross-Sheriff, 2008). It was developed by African-American feminists in response to the white, middle-class values that were prevalent in feminist theory in the latter half of the last century (Van Herk et al., 2011). It is important for nurses to consider the intersection of gender, race, and class, "…because we experience our lives not solely as gendered persons, but as classed and radicalized persons…" as well (Van Herk et al., 2011, p. 30).

However, as Mattsson (2014) notes it is difficult to see, recognize, and acknowledge power relations related to gender, class, and race.

The history of race and class in the United States is reflected in the history of nursing. Early nursing leaders exerted a great deal of effort to portray nursing as an occupation for proper women; white, Victorian, middle class values dictated that a proper woman performed her duties - whether as wife or nurse - in an obedient, altruistic, and self-sacrificing manner (Ashley, 1976; Ballou & Landreneau, 2010a; Reverby, 1987). Furthermore, nursing, like the rest of the United States was racially segregated and African-American nurses were excluded from white nursing schools; while there were nursing schools for African-Americans, nurses who graduated from these schools were excluded from membership in nursing organizations and thus were not part of the effort to professionalize nursing (Andrews, 2003; Wheeler, Foster, & Hepburn, 2014).

Nursing today continues to be dominated by white, middle-class values and as a result whiteness is privileged as normal (Van Herk et al., 2011). This has a negative impact on patient care and on the recruitment and retention of minority nurses (Van Herk et al., 2011). In recent decades nursing leaders have made increasing the diversity of the nursing workforce a priority however nursing remains a profession composed of white, mostly middle-class women (American Association of Colleges of Nursing, 2014). Intersectionality theory, "… provides an opportunity for nurses to engage in critical dialog about their own oppression and privilege and the impact that this has on their ability to practice professionally" (Van Herk et al., 2011, p. 32).

Foucault's power/knowledge and autonomy.

French philosopher Michel Foucault had much to say about power and knowledge and their use in modern society. Foucault suggests that there is a dynamic relationship between social structures and individuals and that these may be observed in the way people fashion their existence (McNay, 1992c). According to Foucault's (1984) perspective there is a dynamic interaction set up between nurses and hospital administrators, physicians, and their governing bodies. Dynamic power shifts occur in each interaction a nurse has with physicians, her nurse manager, or a member of the administration. Using Foucault's perspective, power is not owned but exists to be used or resisted by people in a society. While power imbalances exist and may be irreversible, the normal state of power is unstable and dynamic, i.e. it is unfixed, fluid, and reversible (McNay, 1992c). Furthermore, Foucault's ideas concerning the micro-politics of everyday life are helpful when examining local power relations such as those between nurses and physicians (Manias & Street, 2000). Much like standpoint feminist theorists, Foucault (1984) argues that researchers should explore their own relationship with power, their personal position in the research process, and the way that their activities may support or undermine the flow of power in a given situation (Manias & Street, 2000).

Foucault's (1984) framework for studying power includes the term knowledge/ power which he uses to make explicit his view that power and knowledge are inter-related. Exploring autonomy through the lens of knowledge/power will open paths to further understanding of the dynamics involved in achieving greater autonomy for nursing because Foucault's theory states that power does not necessarily belong to any

one person or group and that it is possible to gain power through knowledge and by participating in acts of resistance to the traditional power holders. McNay (1992c) writes that Foucault's idea that people exert some degree of autonomy in shaping their present conditions of existence helps keep women from being passive non-actors in a patriarchal structure of domination. Rather than passively acquiesce to current power structures, women can participate in acts of resistance in which they tap into power to make a change in the situation.

When reviewing the interdependent and overlapping spheres of practice discussed by Kramer et al. (2006) a critical view must be taken of the practices they describe. The authors describe nurses making decisions to treat a patient independent of a physician's input, either because the status of the patient requires it or the nurse and physician have "an understanding" (Kramer et al., 2006). While these actions are proclaimed as autonomous actions by the nurses performing them and the researchers searching for a definition of autonomy, these actions do nothing to break down the barriers against diagnosis and prescription that nurses have struggled for decades to overcome. In order for these actions to be acts of resistance in the Foucauldian sense they should lead to an expansion of nursing practice. Instead it leads to a situation in which the actions serve to improve communication between the nurse and the physician without the physician having to give up any of his or her power in the exchange.

Traditional research frameworks such as positivism, which privileges the ideas of absolute truths, linear thinking, and the standardization of knowledge, have served to maintain the status quo for nursing knowledge discovery and its applications (Huntington

& Gilmour, 2001). As a result nurse researchers and theorists spent several decades

forming grand and middle range theories of nursing that are predictive and prescriptive;

this approach however does not do justice to the complex nature of nursing knowledge

and practice (Holmes & Gastaldo, 2002; Huntington & Gilmour, 2001). These positivist

perspectives perpetuate the impression of nursing as a powerless profession because they

privilege medical knowledge and ways of knowing over those of nursing (Huntington &

Gilmour, 2001). Thus the lack of autonomy for nurses is due, in part, to the fact that

nurses and others rely on traditional frameworks to analyze nursing practice (Holmes &

Gastaldo, 2002).

Developing a Foucauldian viewpoint and using a post-modernist feminist

perspective helps nursing move away from the dominance of medical discourse that

remains so prominent in nursing's representations of itself (Bradbury-Jones et al., 2008;

Huntington & Gilmour, 2001). Using the knowledge/power framework developed by

Foucault (1984) to examine nursing practice, it becomes evident that nurses do exert

some disciplinary power in the form of "autonomous" actions. When nurses "act first and

tell later" they use their knowledge of what their patients need – for example medication

to treat a life-threatening anaphylactic reaction – to tap into medical power so they can

act in order to meet the patient's immediate and critical needs. Foucault might label these

actions as resistance to the domination of medicine's power over nursing, and they would

be if the end result was a greater recognition of the knowledge and skills of nurses.

However, too often these actions are overlooked or are accepted as the status quo by both

the nursing and the medical staff. Then "autonomous" may be construed as another way

that nursing continues to allow medicine to dominate and control nursing practice. If nurses stood together with their acts of resistance and insisted on recognition of their autonomous and life-saving actions they could challenge the dominant medical paradigm and help nursing gain recognition for its knowledge and help loosen the grip that medicine has on nursing practice (Bradbury-Jones et al., 2008).

Into the Future

Optimizing efforts to increase autonomy begins by exploring autonomy as nurses experience it and uncovering how nurses understand autonomy. Once nurses successfully articulate their practice they will have a stronger footing for greater participation in nurse-positive policy-making and decision-making (Summers & Summers, 2009). Increasing nursing's participation in decision-making requires that nurses develop the skills, "…to manage meetings, gather and analyze existing evidence, explore alternatives, and make sound decisions…" (Weston, 2009, p. 9). Weston (2010) further asserts that nurses need to develop an understanding that both direct patient care and the management of the context of that care constitutes genuine nursing practice.

Increasing nurse autonomy requires a baseline autonomy-enabling management practice in which the management educates nurses about the concept of unique and overlapping spheres of nursing practice (Kramer et al., 2007). Negotiating nursing's scope of practice begins with recognition by everyone involved of the unique and overlapping spheres in which nursing and medical practice exist; this requires a tolerance for some degree of ambiguity (Kramer et al., 2007). Thus medical education and practice models that recognize a continuity of care between the staff nurse and the physician will

enhance staff nurse clinical autonomy (Kramer et al., 2007). Finally, recognizing autonomous practice can be accomplished by including autonomy-related concepts in the performance review criteria to be met by nurses as they advance in their knowledge and confidence (Kramer & Schmalenberg, 2008).

Phenomenology and the lived experience

As nurses have sought to articulate and make their knowledge base explicit they have increasingly relied on qualitative methods to achieve their goal (Caelli, 2000; Earle, 2010). Phenomenology has become the qualitative method of choice for researchers seeking to understand the lived experiences of their patients, yet this research method has rarely been applied to exploring the lived experiences of nurses in their work environment (Earle, 2010). This section will offer a brief history of phenomenology as well as explore the usefulness of phenomenology for discovering the lived experiences of nurses practicing autonomously.

Phenomenology - Laying the Foundation.

Phenomenology finds its roots in the philosophical works of Franz Brentano (1838-1917) and Carl Stumpf (1848-1936) (Smith, 2011). These philosophers laid the groundwork for Edmund Husserl (1859-1938) to develop a descriptive qualitative research method based on ideas present in both Brentano's and Stumpf's work (Dinkel, 2005; Smith, 2011). Husserl's student, Martin Heidegger (1889-1976), developed his own qualitative research method that differed from his teacher's in that it was interpretive and focused more on experience rather than knowledge (Smith, 2011; Spiegelberg, 1982).

Brentano and Stumpf were both philosophers and psychologists who used philosophical methods to provide answers to questions that religion was not able to supply (Dinkel, 2005). According to Huemer, (2010) Brentano was a philosopher who maintained that philosophy should be carried out according to methods that were as rigorous and exact as those in the natural sciences. He was the first philosopher to emphasize that knowledge should be based on direct experience and that the interpretation of the knowledge begins in relation to outside objects (Dinkel, 2005; Huemer, 2010). Brentano's assertion that every thought or mental act is related to some object, known as the principle of intentionality, led to the conclusion that all perceptions have meaning; this conclusion became the basis for Husserl's phenomenology (Converse, 2012).

Carl Stumpf was Brentano's first notable student and Brentano was Stumpf's main source of inspiration as he developed his philosophy of history. Like Brentano, Stumpf used the term phenomenology to describe the study of knowledge gained by direct experience (Fisette, 2009). For Stumpf, the field of phenomenology is limited to phenomena and their properties. He theorized that knowledge could be extracted from the empirical analysis of observed material that is experienced rather than from concepts that exist only in theory (Spiegelberg, 1982). For Stumpf there can be no knowledge without an object about which to have knowledge. It was his student, Edmund Husserl, who expanded the definition of phenomenology to include the transcendental phenomena that are used to form an "intentional consciousness" of a phenomenon. The intentional consciousness of a phenomenon arises from the intention the thinker had when

considering the phenomenon. This facilitates the formation of an unbiased justification of the researchers basic views towards the world and allows the researchers to use these views to discover the interconnectedness of the world in a rational and scientific manner (Dinkel, 2005; Fisette, 2009).

Husserl's phenomenology.

Husserl's work represents the emergence of a science of phenomenology as a scientific method; his work focused on establishing transcendental phenomenology in which phenomena were considered as a cognition of the essences of the phenomena rather than matters of fact (Annells, 1996). In fact Husserl defined phenomenology as "the science of pure consciousness" (Earle, 2010, p. 287). His method sought to set out the way in which the world is created and experienced through conscious acts (Annells, 1996; Earle, 2010). He believed that "subjective information should be important to scientists seeking to understand human motivation because human actions are influenced by what people perceive to be real" (Lopez & Willis, 2004, p. 727). Husserl further argued that people live their lives without much critical reflection on their experiences; he believed that a scientific approach to understanding peoples' experiences would bring out the underlying essences and serve to elicit the essential elements of the lived experiences that are specific to a group of people (Lopez & Willis, 2004). He called this method descriptive phenomenology because it is used to seek a reflective understanding of peoples' lived experiences in order identify the core essence of the their combined experiences (Spiegelberg, 1982).

Husserl's work contributed to the development of phenomenology by focusing on two main concepts that were important for his work in descriptive phenomenology. He first used the term "intentionality" to describe the human capacity to be aware of objects as well as their context; it is this ability that allows humans to come to some conclusion about objects in the world which makes it possible for humans to communicate with one another (Earle, 2010). He proposed that phenomena, because they cannot be separated from experiences, should be understood through descriptions of the experience of the phenomenon (Dinkel, 2005; Earle, 2010).

Husserl's second important contribution to phenomenology as a method of research is the idea of bracketing or eidetic reduction. Bracketing involves separating the researcher's 'natural attitude' about an object or phenomenon from the pure experience of an object; this process of bracketing facilitates the discovery process for the researcher (Dinkel, 2005). It serves to reduce personal prejudices, preconceptions, and biases and allows researchers to transcend their preconceptions and personal knowledge as they listen to and reflect on the participants' lived experiences (Dinkel, 2005; Earle, 2010; Lopez & Willis, 2004).

Although Husserl was primarily a philosopher, he sought to apply scientific principles, popular in his time, to his philosophical methodology. This is most apparent in Husserl's belief that "there are features to any lived experience that are common to all persons who have the experience" (Lopez & Willis, 2004, p. 728). According to this belief, the essences of each experience must be distilled until a generalized description is possible. This generated essence is meant to represent the one correct interpretation of the

experiences of the participants (Lopez & Willis, 2004). Husserl's belief that it was

possible and necessary for the researcher to bracket out all prior understanding of a

phenomenon before considering the contexts of those phenomenon reflects his attempt to

make his phenomenology more rigorous according to traditional scientific empiricism

(Lopez & Willis, 2004).

Heidegger's phenomenology.

Phenomenology continued to evolve through one of Husserl's students,

Heidegger. Heidegger, challenged some of his assumptions about phenomenological

inquiry, which ultimately led to a new twist on phenomenological research – interpretive

phenomenology (Lopez & Willis, 2004). While Husserl's focus was on bringing an

objective, scientific methodology to philosophy and phenomenological interpretation,

Heidegger was forming his own ideas and soon was the leader of his own school of

thought concerning the discovery and understanding of phenomena (Annells, 1996).

Heidegger's main point of departure from his mentor was the idea that people's view of

reality must include the context in which they live – he called this context the lifeworld to

demonstrate that people's realities are influenced by the world in which they live (Lopez

& Willis, 2004). Interpretive phenomenology is designed to ascertain the way in which

the lifeworld of a particular person in a group of participants contributes to the points of

agreement and the points of departure between their subjective experiences (Dinkel,

2005; Lopez & Willis, 2004). Closely related to this concept is Heidegger's idea of

freedom. He believed that the subjective experiences of people are inextricably rooted in

their social, cultural, and political contexts; a condition Heidegger referred to as situated

freedom (Lopez & Willis, 2004). Heidegger believed that people have the freedom to make choices; however their freedom is bound by the circumstances in which they find themselves (Loo, 2012).

Heidegger moved away from Husserl in several other important ways. First, he disagreed with Husserl that the researchers' experiences could and should be bracketed out of the inquiry phase and believed that understanding arises only through our preconceived notions (Earle, 2010). Heidegger's points of departure from Husserl were revolutionary at the time because they offered a radically new way to approach understanding humankind (Annells, 1996; Earle, 2010). He stepped away from the strictly empiricist viewpoint that objectivity must be continuously maintained. Instead, Heidegger's work embraced the subjective and declared that reality is co-created by the participants and the researcher (Van der Zalm & Bergum, 2000). He believed that the pre-conceptual understanding of the researcher – who would not have had the idea to choose an area of research without a pre-conceptual understanding of the research focus - could be used, with caution, to guide the research process (Inwood, 1997; Lopez & Willis, 2004). Heidegger believed that people have a pre-understanding of things just by the nature of their being in the world; furthermore he taught that this understanding cannot be eliminated through the process of reduction espoused by Husserl (Earle, 2010). Instead Heidegger re-introduced the idea of the hermeneutic circle which demonstrates the reciprocal relationship between pre-understanding and understanding (Earle, 2010).

Figure 2.1 The Hermeneutic Process

- Starting Point
- Meeting the Lifeworld of the Participant

Preunderstanding

Experience

Deep Understanding

Interpretation

- Becomes Basis for Pre-Understanding as Cycle Continues
- Co-Created Meaning
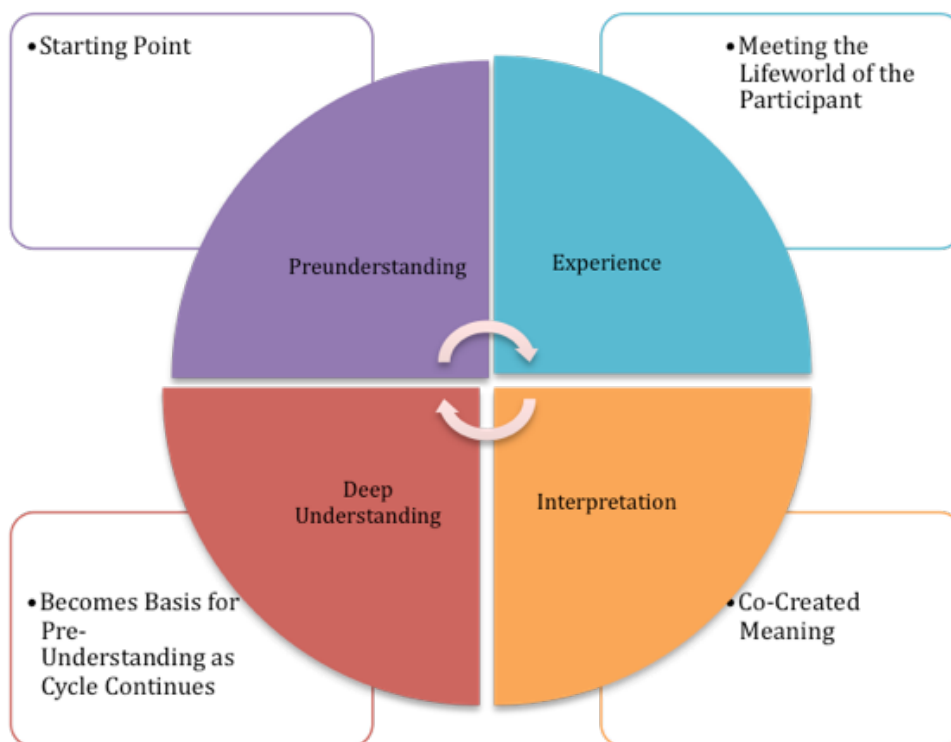
As the figure illustrates, pre-understanding is the first step in the hermeneutic

circle – it begins when a researcher knows something about a phenomenon but wishes to

develop a deeper understanding of the phenomenon as it occurs within the lifeworld of

those experiencing the phenomenon. As the researcher gains understanding by applying

hermeneutic phenomenology to the question new insights are gained. The researcher can

use these new insights to delve deeper into the phenomenon, with the new insights now

acting as the pre-understanding and the circle repeats itself again (Earle, 2010).

Heidegger's interpretive phenomenology uses this process to gain deeper and deeper

understanding of the phenomenon under study (Dinkel, 2005). This process of gaining

deeper understanding includes an interpretation of the descriptions offered by the

participants so that the researcher's findings are co-created by the researcher and the participants (Earle, 2010). These co-created findings would then be subjected to the interpretative process by the researcher who sought to discover new and unique ways of understanding the phenomenon (Annells, 1996).

Phenomenology and nursing autonomy.

Nurse researchers use hermeneutic phenomenology as a research method to help them gain greater insight into their patients' responses to illnesses as well as their responses to nursing interventions (Annells, 1996). They use this method because it offers a way to understand the complexities of their patient's life situation in order to make meaningful contributions to their patient's well-being while considering the entire context of their patient's life experience (Annells, 1996; Dinkel, 2005). Nursing as a profession exists in a complex matrix of stakeholders who may or may not support nursing autonomy. Using hermeneutic phenomenological research to understand autonomous nursing practice will increase our understanding of the complex interactions that take place within the context of providing professional nursing care to patients and their families.

Looking Forward

The Institute of Medicine's acknowledgement of the strong link between staff nurse autonomy and patient safety makes it vital that clinical autonomy be clearly articulated and defined (IOM, 2004; Kramer et al., 2006). Kramer et al. (2007) write that, "Increasingly, physicians and nurses have acknowledged that physicians are no longer solely responsible for 'everything that happens to the patient'" (Kramer et al., 2007, p.

51). This increased recognition takes place in an atmosphere which places the focus on accountability, quality of care, and patient outcomes; therefore it is important for nurses to work collaboratively and independently and to the full scope of their practice as respected members of the healthcare team (Gagnon et al., 2010). Macdonald (2002) suggests that going forward it will be crucial to understand the social and institutional factors that enable autonomy. As nurses move towards greater autonomy and collaboration with physicians these factors will be even more important in laying the foundation for mutual respect between the professions.

It is important to continue to explore the phenomenon of autonomy, as the professional literature reflects different definitions and opinions. What is being measured remains unclear when we ask nurses if they experience autonomy in the workplace, just as the definition of autonomy continues to be unclear in studies exploring the concept (Kramer et al., 2006; Weston, 2010). Furthermore, a more thorough exploration of the impact of nursing as a gendered profession is required to fulfill nursing's ongoing quest for professional autonomy. As a gendered profession nursing suffers under a system that penalizes nurses as nurses and as women (Skar, 2009). This has lead to a body of literature concerning nurses as an oppressed group. The nursing profession will not be able to achieve full autonomy until its oppression is brought to light and successful interventions have been developed to lift nurses out of oppression. Only then will nurses be able to join to together and stand as a unified and cohesive group and demand that they be recognized for their tremendous contributions to the health and well-being of the patients they serve (Summers & Summers, 2009).

Chapter 3: Methodology

This study used a qualitative, phenomenological method with an emergent design. This allowed me to make ongoing decisions about the study, especially questions for the second and third interviews, which reflected the information learned during the preparation phase and the first and second interviews (Seidman, 1991). An emergent design is used when the researcher wishes to have the inquiry based on the realities and viewpoints of the participants rather than those of the researcher (Polit & Beck, 2008).

Sample

Purposive sampling is the method of choice for qualitative researchers because it ensures that recruitment efforts will be directed towards finding those who have experienced the phenomenon of interest and who will be most beneficial to the study (Polit & Beck, 2008). In this case, purposive sampling was used in order seek out and find participants who have experienced the phenomenon of acting autonomously while working in an acute care inpatient setting. In order to avoid a conflict of interests or possible repercussions from employers, participants were not recruited through their places of employment. Rather, participants were recruited from a local university by inviting students enrolled in the university's bachelor of nursing completion program and bachelor of nursing (B.S.N.) to doctorate of nursing practice (D.N.P.) program with the goal of recruiting at least 10 participants from a wide variety of specialty areas. These efforts resulted in 12 nurses volunteering to participate with 10 nurses completing all 3 interviews. While sample size may be difficult to accurately predict in qualitative studies, data saturation, a phenomenon that occurs when no new information is being gleaned

from the data, can be an effective standard against which progress can be measured and will be used to decide the number of interviews needed (Polit & Beck, 2008). The initial goal of 10 participants reflects the recommendation of Kvale (1996) who notes that the recommended number of interviews in qualitative interview studies is 10 to 15 interviews. In addition to the recruitment emails, the snowball method of recruiting was used; each of the participants as well as colleagues of the researcher were asked to refer anyone to the researcher who they believed might be interested in the study.

The sample consisted of registered nurses currently working in acute care hospitals and whose only form of practice is the provision of direct patient care. Nurses who split their job duties between bedside care and administrative duties were excluded because these nurses may have an understanding and view of autonomy that is substantially different from nurses who do not have administrative privileges or responsibilities and because the goal was to understand the viewpoint of the bedside nurse. This resulted in no men being recruited into the study as the only men who responded to the emails were nurse managers. Also excluded from the study were nurses with a graduate degree in nursing because nurses with graduate degrees are considered advanced practice nurses and the purpose of this research study was to understand the professional autonomy of entry-level nurses. As a result several nurses with master's degrees who were working as bedside nurses were unable to participate in the study. Participants were required to speak and understand English fluently because that is the primary language of practice in the area and because it is the researcher's native language. This requirement might have had the unintended consequence of excluding

nurses whose first language is not English. All participants received a $30 gift card at the end of the third interview to thank them for their time and participation.

Protection of the participants.

IRB approval was obtained from the University of Wisconsin-Milwaukee. Pseudonyms were used for each participant in order to preserve the confidentiality of the participants and to prevent participants from feeling threatened with repercussions if they disclosed autonomous actions that exceeded their scope of practice. The names and contact information for each participant will be kept for three years in a locked file cabinet to which only the researcher will have access; after three years they will be destroyed. Confidentiality was maintained throughout the study and analysis process. Each participant signed a consent form after learning the purpose of the study, which served as an agreement that they were participating in the study of their own free will and ensuring that they understood the purpose and risks associated with participating in the study. During this process they were informed that they had a right to decline to answer any question and that they could stop the interviews at any point. They also had the right to withdraw from the study and to refuse to answer any question asked of them.

Methodology

Data were collected through the use of three semi-structured interviews each spaced between about one week apart. This timing is recommended by Seidman (1991) because it allows enough time for the participant to reflect upon the previous interview(s) but is soon enough that the sense of connection between the interviews does not get lost. During the first interview the participants were encouraged to tell their

stories (See Table 3.1). Questions at this stage in the interview process were the most

open-ended and were designed to generate the key story that became the focus for more

in-depth questioning later in the interview process (Galletta, 2013). This helped provide

a backdrop for deeper, more theoretically based questions that occurred in the later

interviews (DiCicco & Crabtree, 2006; Galletta, 2013).

Table 3.1 Questions for Interview 1

Research Questions	Interview Questions	Purpose
What are bedside nurses' experiences of autonomy as they practice nursing in acute care hospitals?	Tell me about why you chose to become a nurse.	Background/ Search for gendered reasoning
	Tell me about the units you have worked on as a nurse.	Background
	Tell me about autonomy on your favorite unit.	Looking for instances of autonomy
	Tell me about autonomy on your least favorite unit.	
	Tell me about the shifts you have worked.	
	Tell me about autonomy on your favorite shift.	
	Tell me about autonomy on your least favorite shift.	
	Was is it like working with physicians?	
	Tell me about autonomy and working with physicians.	
	Tell me about autonomy and working with other nurses?	

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The second interview focused on eliciting examples of autonomous behavior including the context, precipitating factors and the consequences of the behavior (See Table 3.2). The participants' responses from the first interview were reviewed and questions were tailored to the responses of each participant.

Table 3.2 Questions for Interview Two

Research Questions	Interview Questions	Purpose
What meaning do nurses assign to their autonomous actions?	Reflecting on (response from previous interview)	Search for meaning
	Tell me about a time when you acted autonomously and it went well.	
	Tell me about a time when you acted autonomously and it did not go well.	
	What kind of things makes it easier to be autonomous?	
	What kind of things makes it harder to be autonomous?	
	Tell me about how working with physicians impacts autonomy.	
	Tell me about how working with other nurses impacts autonomy.	

The third interview was designed to delve into the deeper meaning nurses ascribe to the autonomous actions they described in the previous interviews (See Table 3.3). As in the second interview, the participants responses from previous interviews were reviewed and the questions in the third interview reflected their responses in the previous

interviews.

Table 3.3 Questions for Interview 3

Research Questions	Interview Questions	Purpose
How does gender impact the meaning that nurses give to their autonomous actions?	Thinking back to your examples of acting autonomously - how do you think being a (woman/man) influenced your actions?	Connect to theoretical construct
	How do you think gender affects nursing's autonomy?	
How does the meaning nurses assign to their autonomous actions contribute to nursing's lack of power in today's healthcare system?	How are autonomy and power related when it comes to nursing practice?	
	When you think about power and nursing what does that bring up for you?	

Questions in the third interview required more self-reflection on the part of the participant and therefore were asked only after a strong rapport was established between the participant and myself (DiCicco & Crabtree, 2006; Galletta, 2013). (See Table 3.3). The one-week space between interviews was designed to offer several advantages to one longer interview. Dividing the interview into manageable sections helped prevent participant and interviewer fatigue (Galletta, 2013). Using a three-interview technique allowed for rapport to be established and built upon before participants are asked to delve into the deeper meaning associated with their actions – an action that might have provoked feelings of vulnerability (Galletta, 2013; Knox & Burkard, 2009).

Finally, the space between interviews allowed the participant and me time to reflect upon the research questions and to think more deeply about our interactions (Knox & Burkard, 2009). This opportunity for deeper thought allowed participants to create connections and understandings about the subject that would not have been made if the interview occurred as a single event and allowed both the me and the participant to clarify any areas of misunderstanding or confusion that may have arisen (Knox & Burkard, 2009). Each interview was about 45 to 75 minutes in length.

Procedures.

Participants were interviewed after signing an informed consent form for the study (Appendix A). The interviews took place at a place and a time that was convenient for the participant. The choice of locations and the time for the interview was determined at the participant's discretion. Allowing the participant to set the location for the interview helped ensure that the participant was comfortable in the setting and helped facilitate the establishment of a rapport between the me and the participant (DiCicco & Crabtree, 2006; Galletta, 2013; Polit & Beck, 2008). Semi-structured interviews offered me a way to explore a subject deeply while at the same time remaining true to the research question or questions that prompted the study (Galletta, 2013).

A semi-structured interview guide (see Tables 3.1-3.3) was used to conduct the interviews that lasted approximately 45 – 90 minutes. The interview guides were used to ensure that the questions I asked were clearly connected to the purpose of the research; additionally, careful consideration was given to the ordering of the questions to ensure that the order reflected a "…deliberate progression toward a fully in-depth exploration"

of the subject being considered (Galletta, 2013, p. 45). Only one researcher conducted the interviews in order to assure consistency across interviews. The interviews were audio-recorded using the digital voice recorder on the my iPhone. The interviews were transferred to my computer in a password protected folder. The recordings were deleted from the iPhone. I personally transcribed the interviews verbatim. Field notes were recorded at the end of each audio file and were transcribed with the interview. A biographical data sheet was used to collect participant information such as age, gender, highest nursing degree etc. (See Appendix B).

A reflexive field journal, in which I recorded initial impressions of the interview, themes that appeared within the interview, and impressions of the encounters was maintained in order to enhance the credibility and auditability of the findings (Galletta, 2013).The field journal was also used to maintain a record of key decisions in the research and interpretive process, to record musings and thought processes about the data, and to maintain an auditable record of the interpretive process (Galletta, 2013; Polit & Beck, 2008). Phenomenologists use reflexive journaling to make clear their the way in which their pre-understanding and their background with the subject influence the research process (Finlay, 2002). Reflexive journaling allows the researcher to "… examine the impact of the position, perspective, and presence of the researcher" on the research and on the interpretation of the data (Finlay, 2002, p. 532). This process helped me to understand the unique perspective my own life experience brought to the my understanding of the phenomenon. It also helped me process my own reactions to the participants stories.

Method of analysis.

As Creswell (2007) recommends, the analysis in this phenomenological study

began when I wrote a full description of my own experience with the phenomenon. This

process facilitated my attempt to bracket my preconceptions so that I could focus on the

participants' narratives (Creswell, 2007). Once I was clear about my pre-understanding of

the research question, I was able to explore the data by developing a list of significant

statements about how the participants were experiencing the research topic (Creswell,

2007). As Galletta (2013) endorses data analysis began immediately after each interview

and included reflections about the interview process, about interactions between me and

the participant, and about themes that appear to be emerging from the data. Each

interview was transcribed before the next interview took place. This allowed me to

review the interview and to develop probing questions that were based upon the stories

the participants told. This process allowed us to move more deeply into the subject. All

transcribed data were loaded into DEDOOSE, a web-based data management software

program designed for assisting with the management of qualitative data.

During the process of labeling, storing, and reviewing, certain themes emerged;

these themes "…represent a core level of meaning and are often referred to as

codes" (Galletta, 2013, p. 122). I began analysis using inductive coding by exploring the

data from a broad perspective that became more and more focused as I fully engaged the

data (Cohen et al., 2000). In this process patterns, categories and themes were identified

within individual interviews as well as across interviews. After the reading of the data six

broad themes were identified - autonomy, gender's impact, nurse-nurse relationship,

nurse-physician relationship, power, and solutions. Next I sought to understand the identified patterns, categories and themes by considering them separately and in terms of the global context of the data (Bernard & Ryan, 2010). I re-read the interviews focusing on each of the themes. Common patterns within the themes were noted and child codes were named as sub-themes became apparent. This led to the development of 60 codes that reflected common threads in the data (see Appendix C). Finally the data were analyzed theme by theme in order to create a narrative text that emerged from the analysis of the data. As the thematic analysis progressed some codes were combined and others abandoned as the data failed to support them. This left me five major themes and 24 sub-themes which most completely reflected the voices of the participants.

The data were also analyzed using a deductive approach. Deductive analysis begins with theories formed from the researchers experience with the phenomenon and the literature review. Hypotheses are formed from these sources and the data is explored for instances that either confirm or disconfirm the hypotheses (Bernard & Ryan, 2010). Standpoint theory formed the theoretical framework for this phase of analysis. The data were considered from a feminist perspective. I sought to discover whether issues of gender and power were relevant to the participants when considering questions of autonomy and if so, how these issues were relevant. The initial codes reflect in part, my own experience as a female acute care, bedside nurse. Concept maps were used to help me see connections between concepts that emerged as themes during the analysis (see Appendix D).

Ensuring Quality

An important question to be answered when pursuing a qualitative study is how one may balance the need for quality creative and interpretive work with the scientific community's demand for positive proof that the "right" answers have been attained (Polit & Beck, 2008). Qualitative researchers have a wide variety of opinions about this need for "proof" and about the process of how to go about achieving it – if that is what they believe is appropriate for their research (Polit & Beck, 2008; Whittemore, Chase, & Mandle, 2001). For this project the framework outlined by Whittemore et al. (2001) was used as a guideline for achieving and maintaining validity throughout the research project. The following sections will describe in greater depth the primary and secondary characteristics of their framework.

Validity: the primary concerns.

In their synthesis of validity criteria Whittemore et al. (2001) describe validity as the overarching goal of qualitative research. Validity is composed of both primary and secondary characteristics; the primary components – credibility, authenticity, criticality and integrity – apply to all qualitative research while the applicability of the secondary characteristics varies according to the type of research being pursued (Whittemore et al., 2001).

Meeting the primary concerns.

Polit and Beck (2008) describe credibility as confidence in the truth of the data as well as confidence in the interpretation of the data that is offered by the researcher.

Authenticity occurs when the portrayal of the research is reflective of the lived and perceived experiences of the participants (Whittemore et al., 2001). According to Polit and Beck (2008), criticality is achieved as the researcher critically appraises every decision made throughout the entire research project. On the other hand, integrity is achieved through continuous self-reflection and self-scrutiny which helps to ensure that the interpretations of the researcher are valid and are grounded in the data (Polit & Beck, 2008).

Credibility.

Meeting the requirement of credibility requires that the researcher have a solid foundation of data from which to draw conclusions (Charmaz, 2004). Charmaz (2004) recommends that one should consider the range, number, and depth of observations that are contained in the data as a way of increasing the thoroughness, and therefore the credibility of the study. I sought to meet the requirement of credibility by conducting three interviews with nurses from a wide variety of acute care nursing units, such as intensive care units, medical-surgical units, step-down units, and emergency departments. While a goal of 10 participants was set, participants were recruited until data saturation was achieved. Data saturation became apparent as the themes and categories that presented in the data became repetitive and redundant (Polit & Beck, 2008). Credibility was enhanced by audio-taping and then transcribing the interviews verbatim (Polit & Beck, 2008).

Authenticity.

Authenticity occurs when researchers ensure that the multiple voices and realities of the participants are well-represented in their analysis of the findings (Polit & Beck, 2008). Authenticity refers the ability of the researcher to make the participants' individual and distinctive voices clear (Creswell, 2007). It is evident when a text invites "readers into a vicarious experience of the lives being described and enables readers to develop a heightened sensitivity to the issues being depicted" (Polit & Beck, 2008, p. 540). S. Anthony and Jack (2009) write that a study is made credible by strong adherence to proper methodology which in turn leads to an authentic account of the phenomenon under investigation. Authenticity in this study was achieved by providing thick and vivid descriptions of the findings to draw readers into the stories of the participants and therein find connection with the participants' stories (Polit & Beck, 2008).

Criticality.

Whittemore et al. (2001) list criticality as a primary criterion for validity. It consists of critical appraisal by the researcher of every decision he or she makes throughout the research process (Polit & Beck, 2008). The use of a systematic research design needs to be clearly defined in order to demonstrate evidence of critical appraisal (Whittemore et al., 2001). This project used the following criteria, described by Polit and Beck (2008) in their discussion of quality enhancement strategies. First, I kept a careful and detailed documentation and decision trail. This enhanced audibility, which will allowed me to trace the decision process as well as to search for negative instances of the phenomenon and to examine potential bias (Polit & Beck, 2008; Whittemore et al.,

2001). Second, I developed a codebook with an audit trail for following the decision

making process in the analysis of the data. Finally, I used peer review and debriefing

sessions with a mentor who has expertise in qualitative methods in order to engage in

dialogue that helped the researcher follow the methodological process (Polit & Beck,

2008; Whittemore et al., 2001).

Integrity.

Closely related to criticality is integrity. Polit and Beck (2008) describe integrity

as the process of ongoing self-reflection and self-scrutiny throughout the research process

that is designed to ensure that interpretations are grounded in the data. Whittemore et al.

(2001) reflect that if the investigators are self-critical and if they seek integrity at every

phase of the inquiry they will be able to avoid dogma and uncritical verification of the

data. In order to achieve integrity during this project I engaged in several strategies as

recommended by Whittemore et al. (2001). In addition to the audit log, a reflexive journal

was maintained. According to Finlay (2002), reflexivity is defined as thoughtful,

conscious self-awareness. This reflexive analysis by the researcher consists of a continual

evaluation of subjective responses, the inter-subjective dynamics, and the research

process as a whole (Finlay, 2002). Reflexive journaling is especially important in

hermeneutic phenomenological research because the researcher brings his or her lived

experience, specific understanding, and historical background to the research process.

This pre-understanding of the phenomenon separates the researcher's interpretations of

the data from those of the participants' interpretations (Finlay, 2002). At the same time

the researcher's pre-understanding interacts with the understanding of the research

participant to create an understanding that is more than the sum of the experiences. According to Finlay (2002), the use of reflexivity allows the researcher to take the problem of subjectivity in research and transform it into an opportunity for deeper understanding of the dynamics at play.

Validity: the secondary concerns.

The secondary characteristics of validity - explicitness, vividness, creativity, thoroughness, congruence, and sensitivity - are listed by Whittemore et al. (2001) as additional guidelines that help to develop validity in qualitative research. Polit and Beck (2008) and Whittemore et al. (2001) write that these secondary concerns are supplementary benchmarks of validity and may not be relevant to every study; therefore it is up to the researcher to decide which of these characteristics are to be used. For the purposes of this study all six of the secondary characteristics will be applied.

Explicitness.

Whittemore et al. (2001) write that explicit presentation of the results of a study shows evidence and support for inferences, decisions, and conclusions reached by investigators throughout the study. Both Whittemore et al. (2001) and Polit and Beck (2008) note that explicitness is made possible by maintaining adequate records that account for methodological decisions, interpretative processes, and investigator biases. As with criticality and integrity, explicitness requires a careful documentation trail which is made possible when the researcher records the interviews and transcribes them verbatim (Polit & Beck, 2008). Polit and Beck (2008) also recommend that researchers document their backgrounds and credentials, their use of reflexive journals, and their

quality enhancement efforts. Using all of these tools enabled me to use thick and vivid descriptions in the presentation of the findings (Polit & Beck, 2008).

Vividness.

Vividness refers to the process of presenting rich, thick and faithful descriptions that highlight the noteworthy themes present in the research data (Polit & Beck, 2008; Pyett, 2003; Whittemore et al., 2001). The researcher must balance portraying the essence of the phenomenon with the need to avoid overwhelming the reader with excessive detail (Whittemore et al., 2001). The goal of the researcher is to present the data in such a way that it draws the readers into the findings so that they are able to personally experience and understand the phenomenon within the context of the participants' experiences (Polit & Beck, 2008; Whittemore et al., 2001). Whittemore et al. (2001) suggest that thick, intense descriptions using impactful and evocative writing would best fulfill the requirement of vividness. Vividness was achieved by presenting the research findings in the most compelling way by using comprehensive field notes and verbatim transcripts to create rich, concise descriptions of the results and by writing in a way that best describes the participants' experiences.

Creativity.

Polit and Beck (2008) and Sandelowski and Barroso (2003) write that creativity in qualitative research demonstrates challenges to traditional ways of thinking in order to allow the researcher use creative powers to generate insightful interpretations of the findings. Creativity leads to imaginative ways of organizing, analyzing, and presenting the data as well as challenging traditional ways of thinking about a phenomenon (Pyett,

2003; Whittemore et al., 2001). Creativity is demonstrated during the presentation of the findings and is demonstrated with vivid descriptions and evocative writing about the findings. I sought to use creative strategies along with feedback from another professional to look deeply and broadly at the data so that they might be presented in the most thought-provoking manner. I used concept maps to organize my thoughts about the data.

Thoroughness.

Qualitative researchers use the term thoroughness to describe solid sampling and data collection procedures that lead to the full development of ideas (Polit & Beck, 2008). Sandelowski and Barroso (2003) and Whittemore et al. (2001) identify thoroughness with completeness, consistency and saturation of the data. Thoroughness is evident when scrupulous attention has be applied to the connection between themes and the full development of ideas (Whittemore et al., 2001). Polit and Beck (2008) outline several measures that can be taken to ensure the thoroughness of the approach and analysis of the data in a study. These measures include triangulation, using comprehensive field notes, achieving saturation of the data, and documentation of quality enhancement efforts (Polit & Beck, 2008; Whittemore et al., 2001). This study used the space triangulation method in which the investigator collects data on the same phenomenon across multiple sites in order to address cross-site consistency. Cross-site consistency was achieved by questioning acute care nurses who work in a variety of units and in a variety of institutions. As previously noted, I interviewed 10 participants multiple times to enhance

the potential for data saturation to be achieved. Comprehensive field notes were used to achieve thoroughness as well as integrity and vividness.

Congruence.

Polit and Beck (2008) describe congruence as the interconnectedness between the research question and the method used to answer the question, between the current study and previously published studies, and between the findings and practice. In addition, Whittemore et al. (2001) write that there should be logical congruence of the study findings with the philosophical perspective stated by the researcher. Finally, Sandelowski and Barroso (2003) note that the findings of the study should fit into contexts outside the study situation. I used strategies described by Whittemore et al. (2001) to ensure the greatest possible congruence between the research question, method used, and study findings. They recommend reflexive journaling, triangulation of data, and thick, vivid descriptions of the data as ways of establishing congruence (Whittemore et al., 2001). While these strategies address other criteria, e.g. thoroughness, they are included here to explicate their importance for achieving congruence.

Sensitivity.

Polit and Beck (2008) and Whittemore et al. (2001) describe sensitivity as a validity criterion that ensures that research is implemented in ways that are conscious of the nature of human, cultural, and social contexts. The research should be accomplished in a manner that considers sensitivity to and concern for the people, groups, and communities being studied (Polit & Beck, 2008). This study required special attention be paid to the issue of sensitivity. The participants in this study shared actions that are not

yet legally recognized as appropriate actions for nurses to take. Dealing with this topic sensitively honored the nurses who were willing to share their stories and ensured that their stories were used to benefit the community of nurses with whom they work. In order to accomplish this, I used the methods outlined by Whittemore et al. (2001) to address sensitivity in this study. They recommend that multiple voices are articulated, heard and reported. This was accomplished by presenting multiple voices in the presentation of the data. In addition, sensitivity encompasses ethical considerations in the design and conduct of the research method (Polit & Beck, 2008; Whittemore et al., 2001). In order to meet ethical considerations the confidentiality of each participant was maintained. Pseudonyms were assigned during transcription and the data were de-identified prior to analysis.

Summary

This hermeneutic, phenomenological study explored the lived experiences of autonomy of acute care, bedside nurses. It will seek to capture the full context of these experiences with sensitivity to the participants who are willing to share their stories. Using a semi-structured interview guide and strict adherence to privacy protocols will help ensure that the data is collected consistently and sensitively. Disseminating the findings will help the nursing community by identifying autonomous actions, the contexts in which they occur, and the consequences that result from taking those actions. It is hoped that autonomy as it is currently practiced will be better understood and will lead to significantly greater recognition of nurses and nursing practice.

Chapter 4: Results

This phenomenological study of nursing autonomy was conducted using a series of 1 to 3 interviews with 12 nurses. In this chapter I will present a brief introduction to the participants followed by an in-depth discussion of the themes that emerged during the analysis of the interviews.

Profile of the Participants

All of the participants were female. While about half were ADN prepared nurses, only three of the participants listed an associate's degree as their highest degree; nine participants had either a bachelor's in nursing or bachelor's degree in another field. One participant listed a Masters of Business Administration as her highest degree. Most of the participants were enrolled in some form of degree program reflecting the fact that a university's student roster was used for recruiting purposes. Four participants were enrolled in a Bachelors degree completion program, two were enrolled in a Doctor of Nursing Practice (DNP) program, and two participants were pursuing their Doctor of Philosophy (PhD) in nursing. The years of nursing experience ranged from 3 months to 28 years though most of the participants had between 3 and 10 years of experience. Eleven of the participants identified their race as Caucasian; one participant identified herself as bi-racial of Caucasian and African-American descent. Attempts to recruit male participants were made using the snowball technique, however the only inquiries from potential male participants came from men who were working as nurse managers and thus ineligible to participate (see Table 4.1).

Table 4.1 Profile of Participants

Pseudonym	Age	Nursing Years	Highest Nursing Degree	Highest Degree	Type of Unit	Number of Interviews Completed
Anna	28	6.5	B.S.N.	Bachelors	ICU	3
Diane	35	7	A.D.N.	Associates	Emergency Department	3
Emma	32	10	B.S.N.	Bachelors	Emergency Department	3
Jill	56	28	B.S.N.	Masters	ICU	3
Kari	31	4	A.D.N.	Associates	Sexual Assault	3
Kisha	32	10	B.S.N.	Bachelors	ICU	3
Linda	46	18	B.S.N.	Bachelors	Sexual Assault	3
Lisa	26	1	A.D.N.	Bachelors	Surgical	3
Mary	37	5	B.S.N.	Bachelors	Mental Health	1
Sydney	27	3	B.S.N.	Bachelors	Medical	3
Terry	46	3	A.D.N.	Bachelors	Surgical	3
Zoey	23	0.25	A.D.N.	Associates	Oncology	1
Average	34.9	7.4				

Phenomenologists and standpoint theorists are interested in the lived experiences of their subjects. The research questions for this study were focused on the lived experiences of autonomy of bedside nurses and are therefore a good starting point when beginning to analyze the data. The following sections focus on the analysis of the context

of autonomy, the meaning of autonomy, the impact of gender on autonomy, and the

meaning of power and empowerment for study participants and address the stated

research questions: 1. What are nurses experiences of autonomy? 2. How does gender

impact the meaning that nurses ascribe to their autonomous actions? and 3. How does the

meaning nurses assign to their autonomous actions contribute to their lack of power in

today's healthcare system?

Themes and Sub-Themes

During the analysis several themes and sub-themes were apparent (see Table 4.2).

As participants share their stories of autonomous actions it became clear that the context

in which the actions occurred was vitally important to the participant's feelings of

autonomy. Furthermore the meaning participants ascribed to autonomy had an influence

upon their autonomous actions. It was evident from the narratives and the language used

by participants that gender influenced their ability to be autonomous. Finally, power was

discussed as an important element in their work environment.

Table 4.2 Themes and Sub-Themes

Themes	Sub-Themes
Context of Autonomy	
	Failed Autonomy
	Tasking
	Poor Nurse-Physician Relationships
	Fear of Negative Repercussions
	Assumed Autonomy
	Shift Dependent
	Autonomy and the Nursing Environment
	Earned Autonomy
	Experience
	Trust
	Respect
Meaning of Autonomy	
	Part of the Team
	Freedom of Practice
	Benefit of the Patient
	Nursing Concerns
	Doing What's Right
Gender's Influence	
	Personal Versus Global Influence
	Male Nurses
	The Doctor-Nurse Game
	Professional Relationships
	Knowing the Right Approach
Power	
	Physicians and Power
	Power as Negative
	Power as Positive

Context of Autonomy

The answers to the first research question - "What are nurses experiences of autonomy?" - developed along some common themes. The stories participants told about autonomy made it clear that the context in which autonomy occurred was vitally important. It became apparent from the participants' stories that the degree of autonomy the participants felt depended upon the context in which the autonomous actions happened or did not happen. After examining the contexts described by the participants several major themes emerged - failed autonomy, assumed autonomy, and earned autonomy. These will be explored further in the following sections.

Failed autonomy.

Failed autonomy describes a feeling by participants that there was an occasion to act autonomously but they were powerless to do so. The participants identified several causes for failed autonomy. Many of the participants described the effect workload had on their ability to be autonomous. They often used the word tasking to describe being so busy that they only had time to complete nursing tasks without time to think about the patients. Sometimes the participants discussed the impact of negative nurse-physician relationships on autonomy. Finally participants described situations in which they knew that an action needed to take place but in which they did not take that action for fear of negative repercussions. It is in all these occasions of failed autonomy that we can see the effect of oppression on nursing practice.

Tasking.

Having many tasks to accomplish was linked to decreased autonomy by eight of

the participants. They used words like tasking or taskmaster to describe the feeling of

working simply to get the job done. A lack of time to think was a common theme when

participants discussed tasking. Anna explained,

> On the floors you're so busy I feel like putting out little fires. You know,
> people have to go to the bathroom, people have to do this, people have to
> do that. It's just task, after task, after task. You're handing pills out.
> Sometimes you don't have enough time to think…

Terry described the situation on her surgical unit, where the surgeons were not always

supportive of nurses acting independently as "…more robotic and not really thinking."

Terry went on to explain that the physicians wanted nurses to simply follow their orders

and not really have an opinion about the care they were providing. Sydney explained how

the lack of time makes it harder to be autonomous,

> A lack of time because if you have no time and you're on a set schedule
> and you have to get these meds out, what opportunity do you have to be
> autonomous? How can you? It's just harder. You stay on that schedule.
> You don't have enough time to really look at the patient, care for the
> patient, see those little things that might tip you off that would change the
> way you do something.

Sydney's statement reveals the core of the problem - without time to think nurses miss

important cues that their patients need help. When administrators, managers, and

physicians demand that nurses follow a schedule created by someone other than then the

bedside nurse they are contributing to failed autonomy. Nurses have many tasks to

complete for each patient every day. They have assessments to complete, medications to

pass, and dressings to change. Participants felt that completing those tasks according to

someone else's deadline - either the physician's or their manager's timeline - impeded

their autonomy and had a negative influence on the care of the patient.

Another common theme that emerged as the participants discussed tasking was a

sense of depersonalization. Several participants discussed feeling detached from their

work. Diane described it like this, "It's not like I feel like I'm a valued part of the patient's

team. I'm more just the robot that goes in and does what I'm told." The feeling of being a

robot was also expressed by Terry when she talked about feeling robotic and not really

thinking. Sydney talked about how her hospital's schedule, "…made it seem more like a

factory, like a cog in a wheel. I didn't feel very autonomous." Kisha said,

> And your skill level, like what you knew, what your job on the floor was,
> it was just like you were another person. I don't know how to say that. I
> was just kind of like trivial or just another body on the floor - they need
> you but you're just there to pass meds, to do the skills, and these task
> things and that's it.

This sense of depersonalization and sense of removal from decision making process was

distressing for the participants.

Poor nurse-physician relationships.

The quality of the nurse-physician relationship was strongly related to the amount

of autonomy participants felt they had. While analyzing the participants' discussions of

the nurse-physician relationship several themes emerged. The nurses described

physicians who demanded unquestioning obedience to their orders, physicians who failed

to even acknowledge the participant's presence, and physicians that required special

treatment in order for the participants to obtain the orders they needed.

When asked what made it harder to be autonomous nearly all the participants

responded that a difficult nurse-physician relationship made it harder to act

autonomously. Jill talked about physicians who have difficulty working with nurses.

> They're not open to suggestions. It's their way or the highway. They're the
> doctor, we're just the nurse. They're definitely few and far between when
> there is someone who will work with you as opposed to those who have
> that attitude.

Many of the nurses talked about "doing as you are told" when it came to interacting with

the physicians. Diane said, "But there's some doctors they indeed want you to feel like

you go and you do what I told you to do. 'Oh, you have different ideas? Don't care!'"

Zoey described the negative consequences of doctors not listening. She felt,

> …more inclined to make suggestions to the doctors that I think are much
> nicer and are willing to work with the nurses as opposed to the doctors
> who just strictly just expect the nurses to do their basic duties and not
> really make suggestions to the doctors about patient complaints.

Terry talked about the negative consequences for "…climbing the chain of

command. Then they're mad at you that you didn't wait for them to call you. So some of

them don't want you to exercise autonomy. They want you to do as you're told and let the

worries to them." The influence of oppression can be seen in these examples. Nurses that

follow the chain of command by contacting higher levels of physicians when a patient

need is not addressed by the original physician face negative consequences from all

levels of physicians. Often the original physician will be angry that the nurse went above

his or her head and the supervising physician will be reluctant to make patient care decisions for another physician's patient. The participants felt unable to act autonomously in the face of a hospital culture that supports physician dominance and the superiority of the medical model.

Not being heard was a common complaint made by the participants. According to Terry, "…the ones that don't consider your judgment to be worthy of listening to by far is the biggest headache." Sometimes this poor working relationship had negative consequences for the patients as is evidenced by the story that Sydney tells of a resident who did not believe that her patient was as sick as Sydney believed her to be,

> I don't even remember what she came in for, some respiratory thing, some syndrome, she had post-polio syndrome. I called the doctor who was a resident at the time, you know first year and I told him and he just totally blew me off. I mean, didn't trust me at all. She ended up dying in the ICU a couple of days later. But yeah, he just didn't believe me and that's frustrating. Those are the frustrating experiences with doctors when they don't listen to you.

Sydney believed that her patient might not have died if the physician had listened to her when she first expressed her concerns. Jill also expressed frustration when talking about doctors not listening. She described how, "… they don't understand the ramifications or think about the ramifications for the patient." Diane described the negative impact poor working relationships have on patient care and on her ability to effectively advocate for her patient,

> I knew usually what I wanted but getting a doctor to give me what I wanted was extremely frustrating. "Please, this patient is in pain, can you please just write me a Vicodin. They need it." "No, no, no they can take

Tylenol." Tylenol's not working. So I felt like I really had to advocate for
my patients a lot. But a lot of the time I felt like I couldn't.

When physicians fail to listen to nursing concerns they are contributing the suppression

of nursing knowledge by ignoring nurses observations based on close and continuous

observations of their patients.

Fear of negative repercussions.

Fear was a common theme amongst the participants when they talked about

situations that made it difficult to be autonomous. The most common fear was that the

doctor would yell at the participant. In most cases participants described physicians being

angry at them for something they did according to their nursing judgment. Jill was yelled

at for failing to get a patient out of bed after open heart surgery. She relayed the following

incident,

> When I was doing agency [work] I took care of a heart patient at a local
> hospital and in the middle of the ICU (intensive care unit) I had a CT
> (cardiac) surgeon start yelling at me because I wouldn't get the patient out
> of bed. And I told him back that he has a femoral arterial line and he's on
> Nipride I'm not getting him out of bed. "I am the doctor and you get him
> out of bed!"

She continued to refuse to get the patient up because of fears for his safety. Ultimately

she was forced to switch patient assignments and the patient's new nurse got him out of

bed. This incident is typical of the ones described by participants. Even with her years of

experience as an intensive care nurse, Jill was not immune from direct attack. That she

was forced to switch assignments only serves to prove the systemic nature of the problem

as it was Jill who was punished rather than the physician.

Witnessing such events was enough to change the practice of several of the participants. Diane explained,

> I've never really been yelled at by a doctor but I don't plan on it either. I will try and avoid it at all costs because I don't like it. So I don't really know what my fear is about doctors. Because I've never personally been yelled at but just I've been scared vicariously through others.

It is easy to see how negative behavior on the part of the physician negatively impacts patient well-being. The nurses in the study were eager to avoid negative confrontations with physicians and they expressed that it was difficult to know when a physician would become upset with them. Anna expresses this dilemma perfectly,

> But I've seen nurses get screamed at for…It's one of those things where it could be the same thing. Let's just say for example, ordering a routine lab before something's supposed to be done. Some physicians will yell at the nurse for not putting that order in and some physicians will yell at the nurse for putting that order in and acting autonomously or not acting autonomously. It's very dependent on the culture of the unit, the culture of the physicians and the nurses. It's hard. It's really hard to know who wants what and when. And how much they want you to do it by yourself as the nurse or if they want you to come to them for every little thing that we need.

Emma also commented on the difficulty of knowing what the physicians expect and how that can decrease nursing autonomy. She describes the negative impact physicians can have on nursing autonomy,

> But I feel like your autonomy can be diminished if you're working with physicians who are retaliatory or anything like that. Once you've made a decision and they demean it then the next time you're like, "Oh, I'm not going to do that. I'm going to check first." Then they're like, "Why are you always asking me questions?" So it becomes very, almost adversarial versus working together.

All of the participants expressed the desire that these adversarial incidents not happen.

Assumed autonomy.

Assumed autonomy refers to situations in which nurses have or gain autonomy because of the situation in which they find themselves. For instance, most nurses in the study said they had more autonomy when they worked third shift. Sometimes autonomy increased or decreased depending upon the type of unit on which the participant was working. Finally, the patient's condition sometimes led to autonomous actions, especially when the physician was unavailable or unreachable.

Shift dependent.

Nearly all of the participants interviewed stated that autonomy was greatest on third shift and least on day shift. The increase in autonomy was often related to a lack of resources. Terry explained that, "Night shift is, as you know, very different from any other shift. You have less resources, you can have more problems." The lack of resource people like the physician, unit educator, the unit clinical nurse specialist, and the unit manager created a context for increased autonomy. Often they used the term skeleton crew to describe the situation. Emma explained it like this,

> I feel like autonomy on night shift is very different because you have usually a skeleton crew. Usually you don't have a physician standing right there by you. You usually have to call, even when someone is sick it's not like they're coming in unless there's a surgical emergency which doesn't happen super often. Since you're working with a skeleton crew of nurses you're also practicing much more independently I feel like.

Linda also talked about a skeleton crew, "Because I was a night shift, did I have a little bit more autonomy? Yeah, because you're a skeleton crew on nights so you've got two or three nurses and you're pretty much running the show." Rather than harming their

practice, the participants felt that the lack of resources created their autonomy. Anna also

commented on how working night shift changed her practice.

> When I was working third shift you were forced to be autonomous more
> or less. You had residents that didn't want to be bothered, they didn't want
> to come if they didn't have to. So you really had to develop that kind of
> sense of, well I'm going to have to do this by myself. I need to figure out
> everything that I can for this patient before calling the doctor. And that
> kind of developed a lot of autonomy, I feel. Because you really were kind
> of…. You were the only one there sometimes on third shift, so it kind of
> forced that development.

In contrast, participants who worked day shift felt that they had less autonomy because

there were so many people involved in the patient's care. The presence of so many people

meant that participants were so busy following orders that they were not able to think or

act autonomously. Lisa explained,

> I feel like on day shift I had less autonomy because there's more people
> around, there's more hands in the pot, there's social workers, and case
> managers, and physicians, and residents, and everybody is there and
> giving their two cents worth about what the plan should be. I feel like I
> still had choices and decisions but I didn't really ever feel like I had the
> final say about something.

Autonomy and the nursing environment.

The environmental influence on autonomy was even more evident when

participants discussed autonomy and the types of units on which they worked. Every

nurse that had worked in both the intensive care unit (ICU) as well as on the floor stated

that they their autonomy dramatically increased when they worked in the ICU. Kisha felt

that,

> …there's more autonomy in the unit and what I learned from experienced
> nurses leading by example. And seeing their interaction with the doctor
> and them saying that was appropriate, that was good. Next time call me or

do this, or not even. Next time hang this instead, or you did that great.
They give feedback pretty readily.

A common theme surrounding the increased autonomy was the amount of

leeway participants had in the ICU when caring for patients. Emma talked about how

she enjoyed the autonomy she experienced while working in the Cardiovascular ICU.

She, "… liked that you titrated drips and you had protocols and you followed those

protocols and you had a lot of leeway in how you managed people …" Anna, who

worked as a resource pool nurse and thus had experience working all over the hospital in

both the ICU's and on the general floors, found that if she knew the physician she would

have, "…more latitude to do other things" after getting orders for a patient. This latitude

was especially noticeable when it came to following order sets in the ICU,

> Within the orders sets, depending on what they were we were really given
> a lot of latitude to make our own choices about what is safest and what is
> best for the patient and what they need. Just talking about medications. We
> had sliding scales available for supplementation, usually there were sliding
> scales for the hemoglobin and hematocrit if they needed blood you weren't
> constantly… there were standing orders to order a chest x-ray if you
> needed to, there were standing orders to do a PRN EKG [as needed
> Electrocardiogram]if they were having chest pain, there were standing
> orders to do an ABG [arterial blood gas] if you felt that it was warranted.
> That was a nurse's judgment call.

Autonomy was increased even in the absence of order sets and protocols. Kisha, Jill, and

Anna talked about the expectation in the ICU that nurses would act in the best interest of

the patients even if it meant acting first and obtaining the orders later. Jill explained that,

> It was kind of an understanding that we could just do it. In the ICU there's
> a lot of standards and that's one of the standards. That critical care nurses
> are supposed to use their critical thinking skills and determine. It's implied
> more than written standard of care. We had a lot of implied standards.

The idea of implied standards was woven throughout the narratives of the ICU nurses in the study. Anna pointed out,

> I remember being in the ICU before we went to EPIC [electronic medical record] for all the orders we had the paper charts and there weren't like standing orders in the paper charts. It was really hard to flip back and find whatever, they just weren't there. But you know, your patient wasn't doing well you just called. You knew who the resident was but you were like, "I need a stat chest x-ray, I need respiratory here, I need blah, blah, blah." And then you would write all the orders in the chart later with the resident's name. It feels like the same concept now that the orders are in the electronic chart because those are all standing now, so you can just do them. Whereas before in the ICU it was almost expected that you do them and then get the order later.

Earned autonomy.

Earned autonomy reflects the participants viewpoint that autonomy was gained rather than assumed with their position as a registered nurse. The participants felt they earned autonomy with experience, by earning the trust of their managers and the physicians with whom they worked, and by gaining the respect of the physicians caring for their patients.

Experience.

Eight of the participants felt that autonomy increased with work experience. Several participants talked about how experience builds knowledge and brings with it a sense of confidence in knowing what to do. Kari explained,

> You're looking at all aspects of what's going on with the patient, what the concern is, what your background experience is. The longer you've been a nurse, the more you've seen, I think those nurses are even better at it. You just have more to pull from. Your book-learning of what you understand about the medical condition and what's going on. I think a combination of all those things that you use to make a decision about what you're going to do or not do, who to get involved.

Lisa described how experience helped her be vigilant to changes in her patients' conditions,

> Seeing certain things over and over and then you kind of notice a pattern and you know what you do that makes it better and you just do those things. I don't know. That's how I've done it. Because I can say, oh, I've seen this happen to one patient before and this is what we did about it and it worked, so let's do that with this person and see if it works.

While experience was an important component of autonomy, perhaps the biggest payoff came in the form of increased confidence which in turn increased the participant's sense of power. Kisha put it best when she said,

> But when I think of autonomy I think more of knowledge and experience that makes you powerful to be autonomous. That's like mixing all those words together to equal something (laughter). When I think of autonomy I don't think power, I think knowledge, education, experience that's what makes you autonomous.

The impact of this increased sense of power may be felt in every aspect of the participant's practice. Diane explains that even a little bit of confidence changes her practice. "You know, like the more I know now the more confident I can be and the more assertive I can be with the doctors." This confidence also translates into better decision making because according to Emma, "but you're also growing in your ability to assess a situation and your gut and your learning all that…"

Trust.

It is with the issue of trust and the consequences of nurses having physician trust that one can see the systemic nature of the exploitation of nursing practice. The participants repeatedly described the benefit of gaining the trust of the physicians as not

only enhancing their autonomy, but ultimately benefitting the physicians as well. Anna

explains the situation well,

> I don't want to say the nurses save the physician's asses. It's a mutual
> respect and a mutual kind of understanding that, from the nurse's
> perspective, we trust you to know to trust us that we can do this. That we
> can, that we got this. There's certain things they might not have protocols
> for but it's like, I know this doctor is going to want labs on this patient
> tomorrow morning. I know it. I know it just because of what they've got
> going on but they must have forgotten to order it. Do I page the physician
> at 2 in the morning and ask for those orders? Or do I just put them in and
> they'll come in the next morning and I know this physician and he or she
> will thank me for doing that. It's that relationship that helps autonomy for
> the nurses the most. It's when there's that trust and mutual understanding
> that we're in this together and we know that you are not going to harm the
> patient or kill the patient. You're not going to put in inappropriate orders,
> you're just doing what you know needs to be done because nurses are
> capable of that and we're not given enough credit. To do the things that we
> know need to get done for certain patients and certain patient populations.

Anna's example reveals not only the benefit to the physician, but also how entrenched the

exploitation of her knowledge has become. Anna, and other participants with similar

stories, relate that they are proud that the physicians trust them so much. While Anna

alludes to the problem when she says, "…we're not given enough credit" she does not

make a connection between her actions and the lack of credit. Diane also described a

situation in which she had the physician's trust,

> I'm not sure if it started off by her trusting me and just thinking that I was
> a fantastic person and being able to kind of write my own orders or if it
> was that she was just extremely busy and so then I just kind of did it and
> wasn't sure if that was my role or not. When I wasn't... She didn't yell at
> me so I kept on doing it and it kind of worked out great … I don't really
> even know how that trust or that autonomy happened. It just kind of
> formed into something that worked really well. She was a very, very, very
> busy doctor. Had lots and lots of patients and she always said how much
> she appreciated it. "I totally appreciate you. We kind of think alike." Gosh.
> I think that was the greatest compliment ever. It felt like we were a team

> taking care of the patients and then the patients got quality care because we were on the same team. So I don't know how that trust happened or how it formed. But it worked and I like it a lot.

Both of these examples reflect the exploitation of nurses' practice for the benefit and often the convenience of the physician. It is significant that both participants felt more autonomous when they had the physicians trust but failed to consider the larger consequences of that trust on nursing practice in general. Only one participant expressed discomfort with this arrangement. Emma explained,

> There are things that I have seen people do that I'm like I didn't think nurses were supposed to do that. And they're like, "Oh yeah! The doctor said it was fine!" I was like, "Yeah, they said it was fine, but if you jack something up you're not covered by anything." You need to still understand, I think you need to understand, as a good nurse, the laws that protect you like the Nurse Practice Act and the laws in Wisconsin that protect you. Also the protection that the doctor has in their role and their ability to say that they either never said that or can't help the fact that you jacked something up [made a mistake].

Many of the nurses used the words leeway or permission when discussing the issue of the physician trusting them. This permission varied with the physician and the circumstances. Anna explained,

> Depending on who I know the physician was and what was going on with the patient, it's almost like this is a critical situation and it's like permission almost. A lot of things get thrown out the window I feel. Including having to wait for permission to get an order to do something that the patient needs because the patient needed something 5 minutes ago, 10 minutes ago and it needed to get done. So I guess that's how I feel. It depends on how severe the patient's presentation is and it also depends on – like do I wait for the physician? It's like, oh it's Dr. B and Dr. B is a pain in the ass and I know he will chew me out and probably report me if I initiate things before he or she gets there. Whereas oh, it's Dr. C, he's going to expect that these are all in progress by the time he or she gets here to see the patient in 5, 10 minutes.

It is clear from Anna's example that her feelings of autonomy were context and physician driven. Not only did the circumstances matter, but who the physician was mattered a great deal for Anna's options. Even when discussing autonomy and decision making that falls within the nurse's scope of practice, participants perceived that the physician had great influence. Kisha talked about how the physicians with whom she worked trusted her ability to sedate her patients. She explained,

> I think your relationship with the physician is pretty, I shouldn't say pretty I should say very, important in your autonomy. The trust factor. And then them giving you almost permission if you want to call it permission, if you want to call it trust, confidence in your practice and knowing that you're doing the best for the patient. Their experience with you, prior cases with you I think helps build a relationship with doctors that allows them to trust you more and be more autonomous.

The experience level of the physician sometimes impacted the amount of leeway a participant felt she had. Terry related the following about her interactions with resident physicians at her hospital,

> I don't want to say they have the look of fear but you can tell in their voice over the phone that they're just shell-shocked and they really want your help. Then I guess the autonomy kicks in even more because then you're prepared to tell them what you think is going on and they're prepared to listen. So I feel more comfortable then. I'm even more autonomous because he's giving me the leeway to go ahead and order whatever it is you think you need.

Every participant felt that physicians had some control over their autonomy, either through negative influences or positive ones.

Respect.

All of the participants stated in at least one of their interviews that having the physicians respect was an important component of having autonomy as a nurse. Just as

trust was something the participants felt they had to earn in order to have autonomy,

respect followed a similar pattern. Participants related that respect from a physician

positively impacted their feelings of autonomy. Linda explained,

> It really depends on the doctor and how they respect nurses and what they
> think is the nurse's role actually. You can be very autonomous working
> with a physician but it depends on what they think your role is and how
> independent they see you working. And basically how your opinion is
> valued or not, right? Do they look at you as part of the team or do they
> look at you as someone who needs to do this task? I think it's really more
> physician based because you can see which nurses love where they work
> and how they're respected and what they can do and others who don't. A
> lot of it ties into the physician, it truly does. .

Though all of the participants said they felt respect for physicians because of the

physicians' education, few of them expressed the idea that nurses might earn respect by

virtue of their education. Instead, nearly all of the participants related a lack of respect to

some fault within themselves, to situations in which they did not present themselves in a

way the physician would respect. This was especially true when participants discussed

their early years as a nurse. Diane reflected about how it might be to return to unit on

which she first worked,

> I would probably have a little bit more respect from the doctors because
> I've been a nurse a little bit longer as opposed to brand spanking new. And
> I didn't have the confidence that I should have had either. Like just saying,
> "No! This is what I want! Will you write it?" Where I was like, "Do you
> think that maybe we could have…" Of course they're not going to be as
> open to hearing what I have to say because I was wishy-washy.

Emma expressed a similar way of thinking about respect when she tried to recall more

recent episodes of disrespect.

> I'm trying to think of a situation of disrespect recently. I can't think of one
> and I don't know if it's just the physicians I'm working with or again, how

I'm approaching them. Maybe I've developed a better communication style that doesn't warrant any disrespect. Like here's what's up. But maybe back in the day when I was younger and not as concise with what I was saying, the response was disrespectful because they were like, "Why are you wasting my time? Please explain to me what the heck you're talking about because I have no idea what
you're saying." Usually the disrespect I experienced or experience is down-talking, feeling diminished.

It is clear from these examples that there is a power differential influencing the interactions between physicians and nurses. Participants felt that when physicians respected nurses this power differential became less noticeable and that they had greater autonomy. Anna said that when physicians and nurses respect each other, "It's not a hierarchy. It's not like a power struggle." Anna continued,

When there's really good respect between the nurses and the physicians I feel like the patients get the things that they need more quickly because the nurses aren't afraid to approach the physicians or the physicians are comfortable. You don't have to go into detail and beg on your hands and knees to explain why you want this certain thing for this certain patient and everything flows. Everything flows.

Anna's response reveals the underlying power dynamic at work when she talks about not having to beg on "…hands and knees to explain why you want this certain thing…" While every participant felt that physician respect enhanced her autonomy most participants related that physician respect was not a universal occurrence. Emma explains,

I'm always pleasantly surprised when a physician is respectful still. Because that was not my experience from the beginning of nursing. So I never expect them to be nice. I always expect to be talked down to or demeaned in some way or yelled at or whatever.

However the positive influence of physician respect was noted even by the newest nurse. Zoey, who had been a nurse for 3 months related the following,

> I feel more inclined to make suggestions to the doctors that I think are much nicer and are willing to work with the nurses as opposed to the doctors who just strictly just expect the nurses to do their basic duties and not really make suggestions to the doctors about patient complaints whether it's about medication dosages changes or like whatever.

It is evident that the there is much to consider in order to understand the context in which autonomy occurs. Understanding the impact of workload and work environment is important. It is also necessary to develop a deeper understanding of the traditional healthcare hierarchy and its impact on nurse-physician communication.

Meaning of Autonomy

In exploring autonomy with the participants it was important not only to discover their experiences of autonomy but also to uncover the meaning they ascribed to their autonomous actions. Three themes developed through the analysis of the interviews - the importance of being part of the team, the freedom to make independent decisions, and the benefit of the actions to the patient. These themes will be explored in the following sections.

Part of the team.

Most of the participants talked about the importance of being part of the team. Jill talked about how the organizational hierarchy was flattened when the residents at her hospital respected the nurses,

> The residents, we utilized a lot, but it was more of a team effort as opposed to they were the residents and we were the nurses and we were to do what they wanted. I think that made a big difference. I think part of it had to do

with the fact that we were all the same age. They looked at us as peers, not
as subordinates.

Not feeling like a subordinate was important to the sense of autonomy for several of the

participants. Emma said, "when I worked with mid-wives or even now in the ER working

with physicians it feels much more colleague to colleague. They take your input and see

you as part of your team not as, 'You will do my bidding.'" The flattening of the

hierarchy was important to Mary as well. She talked about how her practice changed

once she got to know the physicians as people. "My practice was improved when I was

on that more personable level. I didn't feel like there was that difference in status. So

when I don't feel like there's that difference in status I'm able to communicate better with

these doc's. Like I can say what I'm thinking."

For many of the participants, physician respect was conveyed when physicians

included nurses as part of the healthcare team. Kisha talked about the stark contrast

between being a nurse on a general care unit and being a nurse in the Medical Intensive

Care Unit (MICU). When she, "… bridged over to MICU, that's when I really got it.

These doctors respect what I have to say. I'm involved in rounds. Like I'm a part of the

team. Where on the floor it's like task work. Just get it done." She said her favorite part of

being in the MICU was, "…being part of the team and feeling like I have some impact on

the situation …" Anna, whose position had her working on different units all over the

hospital noted that nurses needed to respect a physician's education but also that,

>…the physicians need to respect you as a nurse. You're not just there to
>turn the patient every two hours. You're not just there to take them to the
>bathroom. You're really an integral part of the healthcare team. The

physicians that see the nurses as an integral part that's where that respect comes…

Linda also felt that it was important that physicians see nurses are more than just there to do a certain task. She felt that,

You can be very autonomous working with a physician but it depends on what they think your role is and how independent they see you working. And basically how your opinion is valued or not, right? Do they look at you as part of the team or do they look at you as someone who needs to do this task?

The impact of physicians on nursing autonomy can be seen in Emma's statement,

I think no matter how young or old, no matter how long you've been a doctor, you have a personality that either supports teamwork or supports the hierarchy of I'm above you and I will tell you, the nurse, what to do. I will not respect what you have to say to me. I will do the opposite. I will be in a power struggle with you at all times.

It is clear from Emma's statement that the hierarchical nature of nurse-physician relationships can have a negative impact on nurse-physician interactions. When these relationships were more collegial, participants felt better about their practice. Diane talked about being appreciated by a physician with whom she worked and how, "It felt like we were a team taking care of the patients and then the patients got quality care because we were on the same team." For all of these participants autonomy meant feeling respected and being included in patient care. As Kisha put it, "… it's like you are an important part of this team, you have skills that are needed and valued."

Freedom of practice.

Nine of the participants said that autonomy meant they had the freedom to make decisions about their practice. Kari explained that she liked,

> … just having the ability to look at a situation or a scenario and deciding with your own knowledge, experience, background to act or do something a certain way. I think being in an environment that will allow you to do something. That will allow you to do that instead of telling you, 'No, you have to do this or do that.'

Autonomy meant that participants were able to rely upon their clinical judgment to make patient care decisions. Nurses who had worked in the intensive care environment talked about the importance of having control while using their clinical judgment. Emma described it this way,

> It always felt very like I was in control of watching hemodynamics and adjusting the medications based upon that. Or autonomy was making sure that people were progressing activity-wise so they could get out and go to the floor. Deciding like, this person's super orthostatic, they're not getting up to the chair. They're not going to make their 4:00 transfer time because they can't tolerate that activity and then communicating those decisions or choices…

However, intensive care nurses were not the only ones who felt that autonomy meant having control. Lisa said, "To me autonomy is how much control over my practice I have and who defines what I do or don't do and how much what I know and do is actually part of my care and how much of it is coming from someone telling me what to do and more like task-oriented."

Diane valued the independence that autonomy gave her. She liked, "…to be able to kind of have my own thoughts and prioritize my way not necessarily the way somebody else sees it. Because I don't think the way other people do sometimes." The ability to be creative was also important to other participants. Sydney noted, "When I think of autonomy it's more like doing something that you do that's different than the rest.

You kind of take it upon yourself to do it, to make the decision." Terry also felt that

autonomy meant that she could, "…think outside the box. To think on your own." Zoey

felt that thinking outside the box gave her, "…more tools and information to make the

best decisions that do empower you to be more independent and use your own judgment

as opposed to just going with what the doctor says."

Some of the participants talked about how autonomy increased their sense of

responsibility. Emma said that she felt an increased sense of responsibility with the ability

to make independent decisions. She said,

> Having confidence in yourself is really important because practicing
> autonomously also is a responsibility and with that responsibility you have
> to be able to take the good with the bad. So when things go awesome you
> have to be able to be like, "Yeah! I made that decision and look what
> happened!" But when things don't go well or you don't make the right
> decision you also have to be like, "I'm really sorry. I need to learn from
> that. But that was my fault."

Terry also talked about the responsibility to think outside the box and to take

responsibility for the care of the patient. She felt that it was important to act

autonomously in order to protect her license. She noted,

> I guess I've had enough times drilled into me that it's my license and it's
> my conscience. If I think someone isn't right and we don't have enough
> data to support that they are okay then more needs to be done.

This sense of responsibility was heightened for nurses working in critical care areas.

Anna also was troubled when a patient was not doing well. She explained,

> I remember feeling not so much worried that I'm going to get in trouble for
> not getting permission to do something or not initiating something. It's
> more so I'm scared that this patient is not going to do well. I'm afraid for
> the patient.

Perhaps most telling is the stress that participants felt went they were not able to

act autonomously. Sydney described it like this, "You feel like you're constantly

closed in a box, you have no wiggle room to make any decisions. It's so stressful,

it's really difficult."

Benefit the patient.

Acting in the best interest of the patient was the most frequently mentioned reason

participants gave for taking autonomous actions. Two themes were revealed through the

analysis of participants' comments about acting in the best interest of the patient. First,

participants acted autonomously when clear scope of practice concerns such as toileting,

bathing, and eating were involved. Second, the participants acted autonomously when the

patient had a critical need that needed to be addressed immediately. These will be

explored further in the next sections.

Nursing concerns.

Participants frequently named nursing concerns as a reason for autonomous

actions. Sometimes the participants felt that these concerns were, "…not on anyone else's

radar but the nurses." Anna talked about patients, "…having the dignity in going to the

bathroom and not having to go on a bedpan. The dignity of not starving after you've been

in the hospital for 48 hours and you finally had this test." Kisha also noted that the

physicians were not always aware of nursing concerns. She commented on how the, "…

little things like that can sometimes go a long way. Some things a doctor may not think

of, or it's not an order but it's a nursing intervention to keep your patient safe or have a

good outcome or better outcome than if you didn't do them." The distinction between

nursing intervention and medical intervention was blurred for some participants. This was

especially true when it concerned dietary orders. Sydney felt that autonomy was

important for nurses as long as it was,

> …within reason. You can't do crazy stuff like giving them twice the
> Morphine that's ordered. You can't do that, that's not acceptable. But you
> know, little things like holding that tube feed, giving an Ensure to a
> cardiac patient even though it's technically not on the diet list because he's
> not eating anything and it's the only thing he'll eat. Stuff like that is
> important.

Sometimes the blurred lines occurred when the patient had an physician's order that did

not reflect the current status of the patient. Anna talked about allowing patients with an

order for continuous telemetry to shower,

> Because by and large, in the past, 99.9% of the time when I've had to
> spend an hour or two hours to track down a physician to ask for an order
> to have the telemetry removed temporarily so they can take a shower, they
> always say, "Yes, why are you asking me? I don't care." So I've learned
> from that, from those experiences, it's almost not worth asking but the
> onus of the responsibility is still on the nurse. If something were to happen
> while that patient was in the shower that could have been picked up on a
> telemetry monitor that would still have been my fault. That's a judgment
> call that I'm making.

Anna's example demonstrates how medical orders sometimes do not consider all of the

nursing implications for patients. This disconnect becomes even more noticeable when

the nurse faces a patient care dilemma with a patient's safety at risk.

Doing what's right.

Many of the participants talked about the importance of doing the right thing

when they gave reasons for their autonomous actions. All of the participants related that

their autonomous actions were taken because they improved patient care in some way.

Lisa talked about the freedom of "as needed" pain (PRN) medication orders and how that

helped her provide better patient care. She remarked,

> A lot of times they'll write PRN orders for Tylenol, Percocet, Vicodin,
> Morphine, Dilaudid, all these things. Of course you're not going to give
> them all those things! I feel like that gives me a lot of autonomy to decide
> what's working for the patient and how often do they really need it?
> Should we give them both, but overlap them so there's less break in
> coverage? I like that. I have the ability to… I feel like I take better care of
> my patients because I get to know them and I can understand where their
> pain is and how to get it under control.

Participants also said that they felt good about their practice when they had more

autonomy. Diane talked about the time she spent as a mental health nurse working with

adolescents with eating disorders.

> I was the only nurse, I didn't have a tech. I worked with a couple of social
> workers and I got to do my groups and I scheduled them when I wanted.
> And I did a lot of things that really made me feel good. Like this is my
> practice. Talking with the patients, "Like, what do you want to talk about?
> How do we want this week to go?" And so I would really just be able to
> kind of give them what they wanted which made me feel fantastic and
> made them feel fantastic. And everybody was in a great little situation
> where we all won.

While Diane talked about the impact autonomy had on her personally most of the

participants took care to emphasize that the motivations for their actions came from a

desire to provide the best patient care they could. Emma said, "I always want to be

diligent to my patient because that is who I'm there for and they deserve that." Terry

explained that she often spoke up during patient rounds with the physicians because, "I

just think it's better patient care if everybody's on the same page. And I usually exercise

autonomy during those discussions too. If there's something that I think is important that

neither is pointing out, I'll bring it up." Sometimes autonomous actions were met with

resistance from the physicians. Kisha spoke about the negative consequences of calling a

physician in the middle of the night to report that a patient had a fever. She relayed,

> I guess you're trying to do the best for the patient. So you take the brunt of
> it. In the end I know my patient's outcome is going to be what it should be.
> I'm sticking up for the patient. I'm being the advocate. So, sure, if you
> want to yell at me because I woke you up at 5 o'clock in the morning fine,
> I don't care that's your job, And this is my job, that's why I'm here. So
> yeah, I guess the pushback was not pleasant. I mean I see that as my job.
> That's what I'm supposed to do.

Participants pointed out that they acted autonomously because it was the right

thing to do. Diane talked about a time that she placed a feeding tube in a patient with an

eating disorder who was refusing to eat. She placed the feeding tube and then called the

physician to confirm that this was the right course of action. She said,

> …I acted by myself because I knew that was the right thing to do. It turned
> out perfect. That kind of was the turning point for the young lady. She
> never thought that I would put it in because she said no. I'm like, "No, we
> agreed on this. This is what's going to happen." I don't know what would
> have happened to the girl if she would have continued to restrict and not
> eat. But it ended up turning out pretty good.

Diane was quick to reassure me that she did not often takes leaps like that in her practice.

She explained, "I'm fairly conservative. I won't make a leap until I feel like absolutely

this is the right thing to do and I'm fairly confident that it's going to turn out the way I

want it to." Doing the right thing became even more important for participants when they

were faced with a patient with urgent needs. Anna explained why she sometimes acted in

anticipation of physician orders this way,

> But what happens more frequently than not, is your patient's not doing
> well, you know the doctors are going to want a STAT chest x-ray or

they're going to want RT (respiratory therapy) there to initiate some
breathing treatments even if they don't have them ordered and so by
playing by the rulebook I almost feel like you'd be delaying treatment,
you'd be delaying care in a lot of those cases. So very often I'll be the one
calling or having the communicator [unit secretary], telling the
communicator to call x-ray. No the orders not in, but I know the doctor's
going to want it. We'll put the order in later. Call RT. RT asks me, "Oh
well, they don't have orders for a breathing treatment." Well yeah, they're
going to stop breathing pretty soon if you don't come. So that's not
playing by the rulebook and I could get in trouble for it but I couldn't very
well just let my patient suffer waiting for a physician or someone to come
to see them.

Kisha also talked about the importance of maintaining patient safety even when it meant

acting before she had a physician's order. She explained, "Like the patient is unsafe right

now and you need to do something. And that's why you go to school. You have to trust

your knowledge and know that this is your job." The sense of urgency to do the right

thing for their patients was based on a desire to prevent suffering. Anna explained it best

when she said, "Well, legally I have to wait for an order but ethically and personally you

can't just let this person sit and suffer when you know what needs to get done."

Gender's Influence

When considering the impact of gender on the participants' ideas about the

meaning of autonomy several themes were uncovered. The participants had very different

ideas about how gender affected them personally when compared to how gender affected

nursing as a whole. The participants also focused on the perceived differences in

autonomy between male and female nurses. Finally, the participants' discussions of the

physician-nurse relationship included strong evidence that games were a common

strategy.

Personal versus global influence.

Participants were of two minds when asked about how gender influenced their autonomy. Most participants felt that on a personal level their gender did not influence their day to day interactions or decision making process. At the same time many of the participants were able to point out instances of gender's influence on other nurses or on nursing as a whole. Several of the participants struggled to express their thoughts about autonomy and gender. They used words like "I don't know" and "It's hard" when trying to formulate their thoughts. When asked if she thought being a woman influenced her autonomous actions Kari said,

> I guess my thought is that... how being a woman has influenced my
> actions... I don't know. That's hard. I feel like there is an element where a
> lot of women might be more nurturing and caring versus maybe a male in
> the same position. But I feel like it's hard to say too because I worked with
> very, very - I don't know that I've ever worked with a male nurse to see if
> they're ...

She trailed off and did not really finish her thoughts. Terry also seemed surprised by the question of whether gender influenced her actions. She replied, "I don't think it does, does it? (laughter). I've never been a man so I don't know. How does .... I don't know how to answer that. I use all the experience I have and I don't necessarily think that my gender plays a role in what or how I do it." Jill also felt that gender did not influence her behavior. "I don't think being a woman had anything to do with it. It's unfortunately just the way I am. I don't know if it would be any different if I was a man."

While Sydney expressed the same sentiments as Jill when she said, "I don't know how my gender has affected me making autonomous decisions. I don't know that it

necessarily has. I'm trying to think if there might be a difference between a man and a woman. I don't really feel like there is a difference." Sydney did think that gender had a definite influence on her relationships with physicians. She felt that,

> … men are more confident and able to approach the physicians a little bit more easily. So I guess yeah, that does make a difference, for sure. I think it grows with time. Women maybe just take a little bit longer to be comfortable doing that. But I think looking back the men were always a little bit more forward about getting what they wanted. They approached the doctors more easily.

The idea of confidence and its relationship to gender was a common thread throughout the discussions. Often participants felt that lack of confidence was related to be a young, female nurse. Anna explained how she felt during the first two years of her nursing practice,

> But definitely I was more meek. I felt like I was more mild, almost more feminine in my requests or whatever. But now, I don't care but I don't know if that's because I'm married now. I have, not that I was trying to attract the doctors as partners. But the confidence that my husband has given me really kind of goes over into work because I don't feel like I have to prove myself to anyone any more. And I did when I was younger - totally, absolutely!

Sometimes participants were not able to determine if their actions were influenced more by their age or by their gender. Lisa struggled with this dilemma. When asked how she thought being a woman affected her actions she responded,

> I think, I don't know. I think more influence on the situation is how young I am and not necessarily... I don't know it might be a combination of both because sometimes I think there are still some men out there that kind of expect you to look up to them or do as they say. Especially a male physician and a female nurse. It kind of goes back to that whole stereotypical men being in charge. I guess I never really thought about it that way. I don't know.

Terry who is an older nurse new to the profession also felt that traditional male/female

roles were present in nurse-physician relationships. She said, "…traditionally it's a male

doctor and a female nurse. There's a certain expectation that you're submissive. That

certainly still holds true." Sydney also noted the existence of the traditional nursing role.

She said,

> I think sometimes there's a subservience. Especially the older doctors, the
> women are supposed to be underneath them. Care-giving women, the
> motherly. Like we're care-givers, that's what we do. We give massages
> and we follow their orders. So I think there's that kind of relationship
> sometimes. So that makes it hard if you have a doctor that you can tell is
> kind of in that mind-set.

 Anna also felt that young women in the profession had a difficult time, especially when

confronted with physicians who were domineering. She explained,

> Yeah, it's hard being a young woman in that profession at the bedside, in
> acute care because you are dealing with high stress situations, you're
> dealing with a lot of times male physicians, male attendings, and that
> gender role does come into play because you got the male doctor barking
> orders at you. You all the sudden feel, even if you never have thought you
> would feel this way in your life, all the sudden you're like, Oh my God,
> this man is yelling at me. I don't like how this feels. I've never had a man
> yell at me. For me, I've never had a man yell at me in my life. I had a good
> childhood. I didn't have any like, I've never been abused, I've never been
> mistreated by a man. But at the same time here I am at work and this man
> is yelling at me. This man who is by all means above me in many ways -
> pay grade, profession, everything. And all the sudden I'm scared. I
> shouldn't say scared but I kind of feel like a lot of young female nurses go
> through that same thing.

Anna goes on to compare this type of scenario to an abusive relationship and to note that

many young nurses find this situation intolerable and they leave nursing because of it.

Male nurses.

While participants felt that their gender did not personally influence their autonomous actions nearly every participant discussed their perception that male and female nurses are treated differently in the work environment. Some participants felt that nurse managers and other administrators treated male nurses more favorably. Sydney felt that her former nurse manager favored the male nurses. She noted, "The men that I've worked with have gotten away with a hell of lot more than the women that I've worked with. It seems like the managers always just love the male nurses." Kisha talked about the perception on her unit that male nurses are treated differently by management. She described her perception of different treatment by the new assistant manager affects the work environment.

> Some women have said, "Oh well, she'll talk to the men, or she favors the men." They're like just watch, all she does is talk to the male nurses. So then a seed is planted. You view that person differently and is she going to trust me? Or is she going to talk to me? Is my opinion valid in her world, or even regarded? Does she care?

This preference for male nurses was sometimes expressed by the participants themselves. Linda said,

> I can honestly tell you and this is a funny thing, when I've been on the floor when there's been some male nurses, I am happier on the floors where there's been some male nurses because they tend to be a little bit more even keel. They stay out of all that power struggle stuff. They don't seem to fight for that kind of I don't know if it's respect or what it is, but they tend to be ones that are functioning a little bit more autonomously…

Linda attributed this to male nurses being, "…a little bit more fact based. A little less emotion, right? Probably part of it is just that they're not coming from a standpoint of

being maybe a little bit subservient." Kisha also remarked that male nurses do not come from a subservient standpoint. When she saw, "…males in school and in the profession their societal influences come with them in the fact that they bring their maleness, if I can say this right. They bring their status in society with them."

The status that male nurses bring with them is perhaps seen best in the nurse-physician relationship. Many of the participants felt that male nurses had a gender-based advantage when interacting with physicians, especially male physicians. Emma talked about her perception that "…male nurses and male physicians, in my experience, always seemed more like collegial and on the same level and I saw less disrespect is always how I have felt." Anna also observed that male physicians were more likely to treat male nurses as colleagues.

> The male physicians and the male nurses - it's just like when I see them interact I just see buddies. I feel that overall there's an unspoken congeniality, an unspoken, "Oh hey! We're both dudes. Let's talk about dude stuff while we're at work." Then they bond immediately over that most of the time. Then everything else comes a lot easier for the male nurse in terms of approachability and talking to physicians and getting what they need and things like that.

Lisa remarked on the unique relationship that male physicians and male nurses seem to have and how it would be difficult for her to have the same type of relationship.

> … but it just seems like some of the male nurses we have are like pals, just very nonchalant. They're not, it's not so much like I'm talking to a doctor I need to be professional or respectful and this and that. It's more like, "Oh hey, I've got so and so, what do you think about this?" I don't know, that's just how it seems to me. Whereas if I and I think it's that whole male-female thing, if I were to act like their buddy they probably wouldn't respect me and what I have to say. It has to be professional so that they don't disregard what I have to say.

The effects of the gender gap are even more noticeable when nurses stand up for themselves or advocate for their patients. Diane noticed that,

> … in the ER when you work with a lot of male nurses, I feel like if they are standing up for themselves is simply them being assertive. Where if a female nurse does it it's more like she's being bitchy or you know. Where if a guy nurse and a guy physician kind of have words they're just simply having a discussion about what's best. Where if it's a woman in either of those positions it's like oh, they're fighting.

Sometimes participants felt that simply being a woman caused difficulties when interacting with male physicians. Anna talked about the differences she noticed when interacting with male and female physicians.

> A lot of the female residents and physicians I felt like I was on a first name basis with and there was a connection there - probably because we were both women. A lot of the male residents and doctors I never called them by their first name. I never felt like I had the opportunity or the window to get to know them on that level. There was definitely a hierarchy, absolutely, with the majority of them. I would stand to the side and wait until I was acknowledged to speak.

Waiting for a physician to acknowledge them was something participants felt they had to do as female nurses because there would be negative consequences if the did not. Diane noticed that male nurses in her unit were treated differently then she was. She shared the following experience,

> There was three new male nurses and they just go up into the doc box - there's like a little area where the doctors all chart and stuff - they just go in there. They like, not really interrupt, but I wait a very good time to interrupt the doctor, until they've like acknowledged me. Where the guys go up there, say what they need to say, they don't even care if the doctor is using that little Dragon thing, if they're dictating stuff. And I'm like, oh my gosh! And it went over well. Sure, yeah, what did you need? It must be really important because they're interrupting me. All three of these male nurses that started go up and do that and I was reprimanded when I did it, from one of the male doctors… But I was reprimanded and I've seen, because I

always chart just outside the doc box, I've seen all three of them go in there, not get reprimanded from the same doctor that I got reprimanded for it. I was like, oh my gosh! It must be because they're guys and they're like it must be important if they're interrupting. Like guys can just do that or something? No. So that I did think about it. But I've never tried interrupting again. You know what I mean? Like, I learned my lesson because I was like, oh no, I'm sorry about that.

Many participants spoke at length about the difficulty of establishing professional relationships with physicians, especially male physicians. The casual relationships that male nurses had with physicians were not possible because participants were concerned that such familiarity would be perceived as flirtation or other types of inappropriate behavior. This dilemma will be explored further in the next section.

The doctor-nurse game.

The doctor-nurse game was a term first coined by Stein (1967) to describe the complex social interactions that nurses and physicians have when discussing patient care issues. Participants discussed the difficulty in establishing relationships with physicians that were friendly but professional. Participants also revealed the importance of knowing how to approach a physician when they needed to meet a patient care need.

Professional relationships.

Participants talked at length about the relationships that male nurses were able to have with physicians, especially male physicians. They all noted the familiarity with which these two groups interacted. Lisa commented, "I feel like maybe the interactions that I've seen between male physicians and male nurses is a little bit more like buddy-buddy type thing and the male and female is a little more professional." It was clear from their comments that participants felt that having that level of familiarity with physicians

would weaken their professionalism. Participants made sure to emphasize that they tried

to maintain a professional demeanor so that physicians would not think participants were

flirting them. When asked if being a woman influenced how they interacted with

physicians most participants responded the way Emma did. She said,

> Um...I think that I'm not the kind of woman that interacts in a certain way
> because I'm a woman but I do think it can. I think if that's the type of
> woman you are. If you're coy and you want to be flirty and you want to
> giggle and laugh. Because I have seen that and I don't subscribe to it
> because I feel like it's a slippery slope. I feel like you're being
> manipulative. My fear always is, not fear, my goal always is is to be on a
> level of respect with whoever I'm working with - male, female, physician,
> nurse, tech or whatever. So I strive to not have there be some sort of
> relational aspects that gives them the ability to disrespect me.

Kisha also commented on the difficulty female nurses have with being overly friendly

with physicians. She noted that,

> … a nurse might be flirting with you one second but then when I need an
> order for this and you don't give it to me. I think you have to be careful
> how nurses form relationships with physicians, where to draw the line, I
> guess. Because you may not be taken seriously if you're known as goofing
> off or flirting one minute and then all the sudden you want to get serious. I
> think that you have to be careful. Because I think you just might be
> perceived differently. And that is definitely a gender thing.

Only one nurse admitted to consciously keeping the traditional nurse stereotype in order

to get what she wanted. Anna talked about how early in her career,

> A lot of the doctors that I had to deal with were male. The people I worked
> with, the majority were female. I definitely felt that I kind of played the
> difference sometimes as in, like in order... This is going to sound so bad...
> But in order to get what I want, you have to kind of keep that traditional
> female nurse role because then the doctors, the male doctors will respond
> to that … the more confident females nurses are often not taken as
> seriously or the male physicians just don't want to deal with them.

Emma also commented on the negative consequences that happened when she failed to live up to the traditional female nurse role and insisted on a professional relationship. She said,

> I know I would never manipulate someone. But it also works against me then because I'm not flirty and I'm not friends with the doctors. I think then sometimes it can affect sort of how they respond to your practice too - you know what I mean? Whereas if we were friends, they might let something go. Or they might be like, oh yeah, that's a really good idea. But if we're not friends and I just want to be colleagues it might be more like, "Why would you do that? I don't agree with that decision at all." And they would do the opposite.

It is clear from the participants' stories that gender plays a role in their every day interactions. The affects of gendered relationships between physicians and nurses on patient care are seen more clearly when participants discussed approaching a physician with a patient care need.

Knowing the right approach.

When participants were asked about the impact physicians had on nursing autonomy every participant responded with the same phrase - 'it depends on the physician'. Their elaborations on this response showed just how complex physician-nurse relationships could be. Some of the complexity was placed on the varied personalities of the physicians. Lisa explained,

> It's so individual, based on the doctor. Not all doctors are the same and they don't all want to be treated the same. Some want you to be more involved. Some don't want to have to make any decisions, they want you to already decide what to do and they'll say, "Yeah, that's okay." Whereas some want to make all the decisions and anything you say is, "Well just because you said, now we're not going to do this!" It's so dependent on which doctor.

Participants spoke a great deal about trying to figure out the best way to approach a physician. They used body language clues, other nurses experiences with the physician, and their prior experiences with the physician to determine their course of action. Sometimes despite their best efforts the relationship with the physician was strained. Emma explained,

> But I feel like your autonomy can be diminished if you're working with physicians who are retaliatory or anything like that. Once you've made a decision and they demean it then the next time you're like, "Oh, I'm not going to do that. I'm going to check first." Then they're like, "Why are you always asking me questions?" So it becomes very, almost adversarial versus working together. Again, a big part of working with anyone is personality and learning that.

Even Zoey, who had been a nurse for just 3 months, had learned that she was expected to anticipate physician needs. She stated,

> I just kind of try to anticipate what he expects, what he wants to know right off the bat about a patient. He can call in the morning and be like, what's this, what's that, what's this before I really even had a chance to get in the chart. He'll just hang up the phone if I don't know this stuff. Now that I know him I know he's going to call in the morning, I need to make sure I've got the majority of the stuff down so it keeps him happy.

The experience level of the participant did not seem to ameliorate this effect. Jill, with 28 years of nursing experience, also found that physician personality impacted her ability to be autonomous. When asked how working with physicians impacted her autonomy she replied,

> Depends on the physician. Which is whether or not you know them, they trust you, their attitude. We have one particular doctor who won't even acknowledge a nurse. You could go right up to him and say this is what I've noticed and whatever and he will turn his back on you and walk away. It makes it very difficult to work with him because he's not an active member.

Participants were even more likely to accommodate physicians with whom they had

difficulties communicating. Diane explained, "There's one particular doctor where I'm

like you might explode on me if I question you. But I would have more ducks in a row

with that doctor as opposed to one that I feel more comfortable with."

The impact of gender on nurse-physician relationships became even more clear

when participants shared how they decided how to approach a physician with a patient

care issue. Mary's example highlighted the dynamics of the doctor-nurse game. She

explained how she decided to approach different physicians.

> So you approach it in different manners, if you got time you can say, "Can
> you explain? I'm wondering..." You can play the idiot too. Or you can say,
> "I notice you wrote this, is this what you want?" If they still say, "Yeah,
> that's what I want." I would say, "Could you explain why, just for my
> personal reference, could you explain the difference between this
> medication and this medication and why we're using this medication." So
> you can do it in more of an educational way of speaking and sometimes
> that made it easier for them. They didn't think you were questioning their
> authority. It was more, "Okay, I'm going to teach this kid." versus they're
> questioning my authority. So different doctors need different approaches.
> Learning your docs!

Learning how to approach physicians was a common thread in all the discussions

concerning nurse-physician relationships. Sydney talked about how this was emphasized

even during her orientation period.

> It's kind of funny, when they first started training me they said, "This
> doctor, don't tell her what you want. You have to lead her into it." Because
> otherwise she gets kind of like, "No I'll tell you what to do!" Not in a bad
> way, that's just her personality. And then one doctor you can say, "Can we
> test for a BMP tomorrow?" You can just outwardly say that [to him].

This round about communication style was described by most of the participants. Linda

talked about approaching a physician about a patient with a fever. She explained,

Honestly, if their fever is going up you need orders for a cooling blanket or you might need all these different orders. You can't just do it. So the only autonomy you have is to get those orders, then do it. Still, you know what you want to put in place. *You might be, when you're talking, presenting things in a certain way so that you get the things that you want for your patient.* (emphasis mine)

This need to present things in a certain light was attributed to a need to not insult

the physician's intelligence and to maintain the hierarchy. Kisha noted,

So I think a lot of it is education but not making them feel like they're not competent or not knowledgeable. They're knowledgeable, clearly or they wouldn't be where they are. But also them being receptive to somebody who's of a lesser stature than them. I guess if you want to, some think that way. You're just a nurse, what do you know?

Diane explained that the need to be careful was even higher when approaching male

rather than physicians. She explained,

So I have noticed that where I feel like I approach it differently because I'm a woman. That I kind of have to plant the seed that the doctor had the idea. Especially if he's a male doctor. Then I kind of don't want to offend him or have a woman be telling him what to do.

Anna also explained how gender affected her interactions with physicians depending on

whether the physicians were male or female. She said,

I didn't interrupt the male physicians when I would feel comfortable interrupting female physicians to get what I needed. I wouldn't, depending on who was on call and depending on what I needed. If it was a male physician and I knew that they were grouches or whatever I would... It's not like I would... I never flirted with any physician but I would try to appease to their ego. I'd ask for something, I'd make a joke, so like (fake laugh) "Can I get that CBC?" (laughter) I would never do that with a female physician or another female.

It is clear from these examples that participants felt the effects of gender and status bias in their work environment. Participants also demonstrated gendered ways of considering power in their work places.

Power

When asked to consider the relationship between power and autonomy participants expressed surprised at the idea. They indicated that they felt physicians had power rather than nurses. Most of the participants preferred the word empowerment to the word power. In fact nearly all of the participants felt that power was a negative force and was to be avoided if possible. The next sections will delve more deeply into these responses.

Physicians and power.

Many of the participants considered power the purview of the physician. Sydney expressed this sentiment, "I think that the doctors have the power, I do. … When I really sit down to think about it I don't think that's the way that it should be and I don't think that's accurate. I think it should be shared equally." Anna thought that medicine and nursing had different ways of approaching things. When considering power she said, "Whereas power, I feel, is one person dictating to a bunch of people underneath and that might not be - that's a hierarchy, that might be the best way for medicine." Emma noted that a physician's desire for power affects nursing autonomy. She explained,

> So certain doctors go into it for the power and the control and I think they
> are less likely to allow you to be autonomous in that they will - either they
> don't trust their own practice enough to give you some leeway, or they
> disrespect who you are and what you are.

Kisha commented on how the image of the powerful physician is engrained in the cultural imagination.

> Where power I think of, and this is going to sound so weird, power, I think culturally, you would put that on a physician. Power. Because of how society views a nurse versus a physician. I think they would be like yeah, they're powerful. Where a nurse you wouldn't use that word. They'd use compassion, kind, skillful. But power would not be designated to someone because of that hierarchy that I think exists in the medical world.

It is not only the general public that views physicians as powerful. The participants' comments showed that the image of the powerful physician impacted their work environment as well.

Participants described a significant power differential between physicians and nurses. This was most evident when they talked about trying to meet a patient need. Lisa explained that it was hard to be autonomous because, "Sometimes you get that power struggle where people want it their way. So that kind of makes it hard when someone's ordering things and doing things because they have the authority to and not necessarily because it's the right thing." Participants reported that sometimes patient needs were difficult to meet because the physician perceived suggestions from the nurse as an attempt to usurp power from the physician. Emma described her interactions with several physicians,

> Like any suggestion you make they would do the opposite. It's really interesting. I'm like, that's so weird. I wasn't trying to have power over this situation. I was just making a suggestion and/or telling you something about the person and you just cannot hear it. The young doctor I'm thinking of, there's an old doctor that does the same thing. Just very interesting personalities.

Jill felt that most physicians were unwilling to listen to suggestions. She noted that,

"They're not open to suggestions. It's their way or the highway. They're the doctor, we're

just the nurse. They're definitely few and far between when there is someone who will

work with you as opposed to those who have that attitude."

Some participants expressed frustration at these situations. Diane spoke about the

frustration of being responsible for making sure the patient gets the right medication or

does not get the wrong medication but having no say in the medication ordered. She

commented, "So we get all the parts that are not so good because we did what the doctor

told us but we don't get the parts where, we don't get the power, the good parts of it, of

making a smart decision." Lisa described a situation in which a physician asked her

which medications he should order for a patient. She recalled,

> Well, it shocked the crap out of me! Like aren't you supposed to be the
> doctor? Aren't you supposed to be the one, the almighty in charge and
> you're asking me what we should do? I mean that's great, that's awesome
> because obviously I know, but it's frustrating because then he gets all the
> credit and I don't know. He has all the power and I'm just there. It's
> frustrating.

With these experiences as their reference point, it is no surprise that participants shied

away from using the word power and when they did use the word it was mostly in a

negative context.

Power as negative.

Most of the participants had strong negative comments about power. Some like

Diane felt that, "…power was like a really scary thing. And you don't want power because

that's intimidating." Diane's fear of power came from negative interactions with

physicians. She related the following about physician with whom she worked,

> Then I've been super intimidated by her the entire time. She walks around
> like she has all the power and to me she does. You know what I mean? I
> am terrified of her. I hate when I have her patients because I feel like I
> have to do just right with her.

Kisha found it difficult to consider power and nursing as compatible concepts. She

noted, "When I think of nursing I don't think of power. So that's hard for my mind to

wrap those two words together. It's like saying "mean and nursing" or "aggressive and

nursing" those words just don't match up in my mind necessarily." Emma also felt that

power was negative. She said, "I think of power and control when I hear power and then

I go to some sort of abuse dynamic which is where my mind goes always with power

and control." For Emma power was, "…more part of a problem. So if I'm in power I'm

going to be taking autonomy away from someone else. That's just sort of how it works in

my mind. So I guess that's why I give it a negative connotation because I think of it as

taking away from someone else." Participants struggled to find a word that was more

palatable to explain nursing power. Kari exemplified this struggle,

> I feel like there's an element to power where you're taking away someone's
> else control. I don't necessarily want to have power over someone else. I
> don't want power over my patient. I want them to ... it's more of like... to
> have power, it's like it takes it away somehow from somewhere else,
> someone else. Because power can be abused that I think that more that
> nurses are powerful... I don't like, there's something about power that I
> don't like. I think that there's a strength in nursing and that nurses are
> strong and that maybe a combination with respect. That we're respected as
> a profession and an individual; the combination of the two more how I'd
> like to describe it than power.

Often the participants resolved this dilemma by using the word empowerment,

sometimes interchangeably with the word power.

Empowerment seemed to be a better fit for most of the participants. Emma

explained why she was more comfortable with the word empowering to describe

nursing. She said,

> Power to me always feels like a negative, like you're wielding it over
> someone. Where empowering feels like supportive. So empowering feels
> like you're supporting others or you're supporting yourself. Whereas
> power over makes me think of being above and then being more part of a
> problem.

Anna also felt more comfortable using the word empowerment when talking about

nursing. She struggled to decide which concept was more appropriate. She explained,

> I still have trouble defining power because I don't know if ... You know,
> there's power and there's empowerment and I don't if one is better than the
> other, if we should be striving for one versus the other. I tend to go for
> empowerment because it's just from my own readings, my own historical
> whatever, things I've read, generally when people are in power it means
> there is a hierarchy and there's a struggle for that power.

Participants were hesitant to use the power in relation to autonomy. Kisha noted, "When I

think of power I think of domination, strength. Which is all good with autonomy. I'm not

saying that it's not related to it but I think there's other words like "empowering",

knowledge, experience, confidence first before power." Kari also preferred not to use the

word power when considering autonomy. She said, "There's something about the word

power that I don't like, actually. I think power can have a bad association to it. I think that

I would choose strength or something over the word power."

Power as positive.

Although most of the participants had negative things to say about power generally some of them described instances of nurses being powerful as a positive. Most often the participants spontaneously described a powerful nurse. Power for these participants was equated with experience, confidence, and autonomy. Kisha said that power was directly related to experience, especially experience acting autonomously. She noted that,

> ... if one time you're right with your autonomy. Say you decide to hang that NorEpi [Norepinephrine] and the physician is like, "That's a really good thing that you did that!" And you get confirmation that that was right I think you become powerful inside knowing that you have the skill and knowledge to make decisions on your own within a certain regard. But when I think of autonomy I think more of knowledge and experience that makes you powerful to be autonomous.

Kisha went on to describe a powerful nurse in this way, "A powerful nurse would be someone with experience because I do think you need experience to teach others and to know what to do, act effectively as a nurse. They're skillful, they know. Knowledge, education."

For several nurses power meant confidence in themselves. Sydney explained that power meant,

> Confidence, being able to talk to the doctors, being able to talk to the managers, and having a relationship with them. You know, like knowing them on a personal level. That to me is power. Having respect from other nurses, co-workers. If your co-workers don't respect you you don't have power I don't think. Like I said, the confidence in your own skills. Being confident in yourself, that's powerful. We all start out like not powerful at all. And hopefully, eventually we are a little bit.

This confidence sometimes translated into changing long-standing traditions

between physicians and nurses. Diane described an incident in which she continued to do

an admission assessment even after the physician entered the room - a situation in which

the nurse usually fades into the background and allows the physician to examine the

patient. She said,

> Because I felt powerful when I stayed in the room and went ahead and did
> my physical assessment. I felt like I had power not because anyone gave
> it to me or I earned it or did anything differently because I had personal
> power. My decision was to sit and continue for my patient and that's what
> I did. I felt like, Yes! I can do anything! You know? I felt very powerful.
> Wow, I did it! I did it!

Participants were still careful to note that they preferred other words to power, even when

they acknowledged that nurses were powerful in a positive way. Kari's struggle with the

use of the word power was typical of the way participants struggled with the term. She

stated,

> There's something about the word power that I don't like, actually. I think
> power can have a bad association to it. I think that I would choose
> strength or something over the word power. But I think that ... I don't
> know. I feel like nurses are powerful (laughter). It kind of makes me think
> of being an advocate. Partly because we aren't just like the one medical
> condition, trying to treat it, that we're advocating for more bigger picture.
> I feel like that's powerful. I feel like we are a powerful tool for the patient.

Anna also struggled with whether or not power was a positive thing for nurses to have.

She noted that even when nurses were in positions of powerful it did not always have a

positive outcome for nurses. She explained,

> I don't know if power is a good thing. So that's kind of where I would
> start. I think it's good to be in powerful positions. I mean I think it's good
> too, I think nurses need to be in powerful positions... I think it would be
> best suited for nurses to be in powerful positions. That's where it's going

to be. Because like I said I don't know if power is a good thing or a bad thing. With nurses in leadership and administrative positions and the board of directors and things of that nature, I think that is where it kind of needs to start because they're going to be the voice for the bedside nurses more or less. I've seen some nurses who have power and who are in powerful positions but they pander to the administration and the hospital instead, and not the nurses. So it's a very, it depends on the person and how you decide to use that position and the power comes with it.

It was clear from their discussion of power that participants were uncomfortable with the idea of power. They interpreted power as a negative tool wielded against them. Even when they discussed power in a positive context they struggled to use the word power.

Reactions to Participation

Research using standpoint theory as a guiding principle has an emancipatory aim in addition to its goal of gaining knowledge about a particular subject. Participants had a variety of reactions to their participation in the interview process. For some of them it was the first time they had considered autonomy and what that meant for their practice. Lisa explained,

When I first started talking to you, it's a lot of stuff that I'd never even thought of. I never really even thought that I wanted more autonomy. Going from my old job where I had pretty much no autonomy. I knew I was unhappy, I knew I didn't like that job, and now I have a new job and I know I like it and now I'm like I wonder if it is because I have more autonomy? I think it's a lot of people just don't know that it's a possibility.

Diane who, during the three week space of the interviews, stopped giving up her computer to physicians when she had charting to complete and who broke from tradition and finished her assessment while the physician waited for her to finish was perhaps the most transformed. She had this to say about the process,

> Even just thinking about autonomy it kind of gave me power because of that. I was practicing it. I didn't want to do it the first couple of times. The first time we met I started thinking about it and I'm like, come on! I think I do have autonomy. What in the world is it? Is it something that I've got? Do I not have it? Not here, did I have it there? You know. But I think even just thinking about and then practicing it makes you more powerful. Like I feel like I'm a stronger nurse even though I didn't learn anything more or do. It was already in there, I just kind of had to pluck it out. ... So I am practicing it a lot more which I know I would not have done if I hadn't talked to you.

While thinking about autonomy made Lisa and Diane feeling more autonomous, this was not the case for all participants. Several participants realized that they did not have as much autonomy as they had previously thought. Kari felt disappointed that the level of autonomy she felt like she had did not match the level of autonomy that she actually had. Kari, who worked as a Sexual Assault Nurse Examiner, explained that even though all of her decisions were based on protocols that she was required to follow she felt like she was making independent decisions. She explained,

> I think that the feeling of that just doesn't really match the way.... Because I'm not disappointed in what I do know and my level of autonomy. But I think the way it feels and the way I describe it don't really match up. Because I have that feeling that I'm making my own decisions and I'm doing it a lot. But I think that when I talk about it and look the minimal, basic facts, it's like I'm not really doing that a ton.

Kari was not the only participant that felt dissatisfied with her level of autonomy. Anna also described being upset as the interview process brought to light the limited amount of autonomy she had. She said,

> I was just talking to my clinical instructor today about it, that I was involved in this study with you and blah, blah, blah and I was like, you know, the thing that I'm taking away is I'm almost like upset. Not angry, not like mad, but I'm upset at how much bedside nurses aren't getting credit for. That's kind of my big take away from doing these interviews

> with you because we have the capability to be autonomous, we have the education to be autonomous and we are being autonomous very often when we don't even realize it, we don't even think about it. I never thought about it until I started talking to you about it and we're not getting the credit for it, so that's upsetting. Not like mad, angry - unsettling is the word.

Anna resolved this tension by stating that she was grateful that she was enrolled graduate school and would soon have more autonomy because she would soon be a nurse practitioner and would no longer be working at the bedside.

Summary

In this chapter participants told their stories of their autonomous actions and their thoughts on what helped or hindered those actions. They struggled to place those actions in the context of gender and power relations. They searched for the right words to express their experiences. The findings were considered in light of the research questions which helped unpack the meaning of participants' actions.

The first research question focused on nurses experiences of autonomy. It was discovered that the context of care played an important role in whether or not autonomy was possible. Several possibilities for autonomy were named - failed autonomy, earned autonomy, and assumed autonomy. Each of these possibilities was a unique context surrounding autonomy. For example in failed autonomy poor nurse-physician relationships and fear of negative repercussions prevented nurses from acting autonomously. Assumed autonomy occurred when the environment of the participant such as the unit on which she worked created the opportunity for autonomous actions.

Whereas earned autonomy reflected a context of trust and respect for the experience level of the participant which allowed autonomous actions to occur.

The second research question focused on the meaning that participants ascribed to their autonomous actions. Participants revealed that feeling as if they were part of the team was important. In addition, autonomy meant that participants had a certain sense of freedom to practice in the way they felt was best. The importance of best practice was emphasized repeatedly when participants revealed that autonomy meant doing the right thing for the benefit of the patient.

The next research question asked the participants to consider the impact of gender on their autonomous actions. While most participants felt that their behavior was not influenced by their gender, they did feel that gender affected nursing as a whole. This was especially true when participants revealed their perceptions of the difference in relationships between male nurses and physicians and female nurses and physicians. Though the participants denied gender-specific behavior, they all described playing the doctor-nurse game - which reflects a very gendered set of interactions between physicians and nurses.

The final research question, how are power and autonomy related when it comes to nursing practice - caused the participants the most difficulty. Most of the participants had only negative things to say about power. They viewed power as domination and control. In the minds of the participants power belonged to physicians and it was frequently abused in such a way as to limit nursing autonomy. Even when discussing power as a a positive participants struggled with the concept. Many of the participants

preferred words such as empowerment or strength over the word power. The reasons for

that will be explored in the following chapter.

Chapter Five: Discussion and Analysis

The phenomenological process is a circular one that begins with Pre-Understanding which was presented in Chapters 1 and 2. It continues with experience in which the researcher meets the lifeworld of the participant. This experience allows the researcher and the participants to co-create the meaning of the experience and these interpretations were presented through the lens of the participants in Chapter 4. In this chapter I will return to the Hermeneutic Circle at the points of interpretation and deep understanding in order to explore the deeper significance of the data (see Figure 5.1).

Figure 5.1 The Hermeneutic Circle and Autonomy
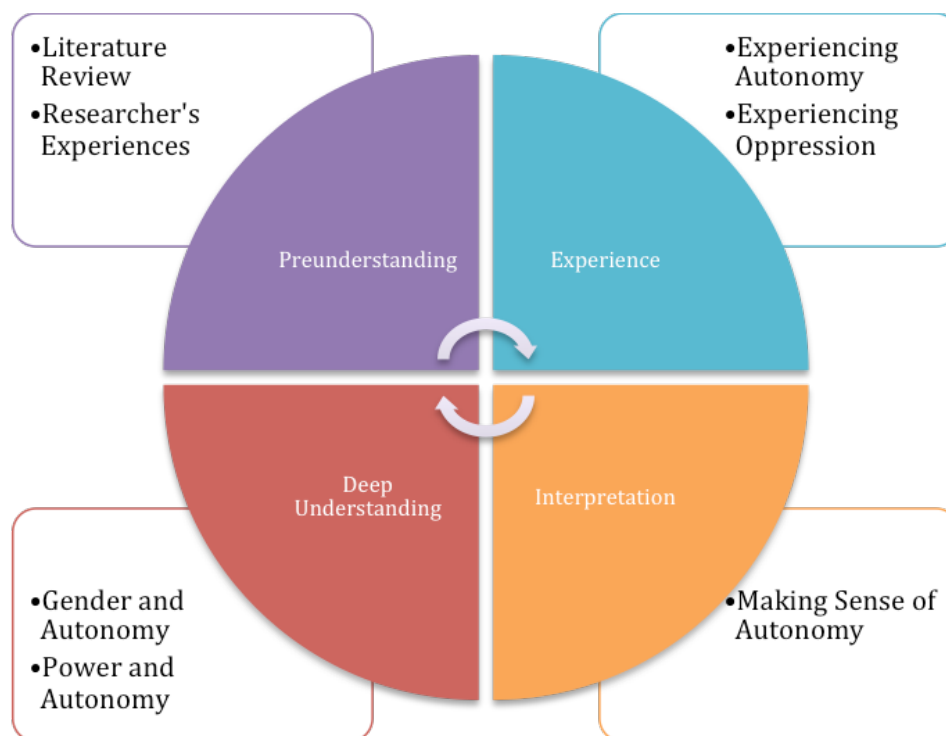
Phenomenology, standpoint theory, and power/knowledge theories all place the participant at the center of the interpretive process. In this chapter I will explore the four

major research questions presented in Chapter 1 and will offer a discussion of the findings presented in Chapter 4. A discussion of the implications and limitations of this study will be presented. Finally recommendations for research and practice will be offered. The concept map pictured in Figure 5.1 outlines the course of analysis for the rest of this chapter.

Experiencing Autonomy, Experiencing Oppression

Participants spent much of the first two interviews relating their experiences of autonomy. They described their autonomous actions as well as the contexts in which those actions occurred. What became clear during the interviews and during the analysis process was that the context was a vitally important factor in participants' autonomous actions. A close examination of the contexts uncovered a layer of oppression that blanketed their interactions. Iris Young (1990) laid out five characteristics which identify oppressed groups. These five characteristics are exploitation, violence, powerlessness, marginalization, and cultural imperialism (Young, 1990). While Young (1990) maintained that a group was oppressed if it exhibited just one of the characteristics, the analysis demonstrated that participants showed each of these characteristics. This finding is consistent with the argument made by Dubrosky (2013) that nurses are an oppressed group because they display characteristics in not just one but each of the categories enumerated by Young (1990). Indicators of oppression were woven throughout the participants' narratives on the context of autonomy whether the participants were discussing failed autonomy, assumed autonomy, or earned autonomy.

Poor nurse-physician relationships contributed to failed autonomy in many cases. A close look at the nature of the relationship however revealed that it was not as simple as miscommunication between a physician and a nurse or a missed opportunity to act. The relationships described by participants were often one in which verbal abuse was a possible outcome when participants tried to meet patient care needs by contacting a physician. Young (1990) described systemic violence as one aspect of oppression that is often overlooked; she includes verbal abuse in her definition of violence. Violence and the fear of violence work to keep oppressed groups in their place (Young, 1990).

The participants described being afraid to approach physicians either because they had been verbally abused in the past or because they had witnessed such abuse. This verbal abuse is the type of systemic violence Young (1990) described when she wrote that, "Members of some groups live with the knowledge that they must fear random, unprovoked attacks on their persons or property, which have no motive but to damage, humiliate, or destroy the person" (p. 13). Participants went through great lengths to avoid possible confrontations with physicians and expressed frustration that they could not always predict when a physician would have a such a negative reaction. The systemic and commonplace nature of this type of oppression is evidenced by the fact that participants felt it was their responsibility to avoid these confrontations by changing their behavior and by the fact the none of the participants related negative consequences for physicians who exhibited this type of behavior (Young, 1990). In fact several of the participants described how they had been called into their managers' offices to explain why they had upset the physicians in question.

Exploitation of participants was evident when participants discussed their lack of ability to control their own practice. Administrators and physicians determined the flow of their day rather than patient needs. This lack of control over their practice is a form of exploitation and powerlessness common to oppressed groups (Young, 1990). Young (1990) argued that exploitation occurs when there is "… steady process of the transfer of the results of the labor of one social group to benefit another" (p. 6). This transference was most readily apparent in participants' stories of how they earned the trust of physicians with whom they worked. The participants described how nice it was to have the physicians' trust because it meant that they could act autonomously without fear of reprisal.

Participants who had developed a trusting relationship with physicians were more likely to take actions before contacting a physician for those medical orders. The participants who exhibited this behavior did so because they felt comfortable that the physicians would back them up with orders at a later time. This way of defining autonomy is consistent with the definition of autonomy proposed by Kramer and Schmalenberg (2004c) who defined autonomy as "… the freedom to act on what you know, to make independent clinical decisions that exceed standard nursing practice, in the best interest of the patient" (p. 44). Often participants described autonomous actions that benefitted the patient and the physician but that did nothing to increase the de facto amount of autonomy they had. For instance, participants described obtaining lab work on patients because of a change in the patient's condition. They would receive the results and

then contact the physician for orders based on the results of the lab work. Participants cited not having to wake the physician, and easing the work load of the physician as benefits of having the trust of the physician; this demonstrates the oppressive nature of these relationships.

This approach to autonomy is also problematic because it requires nurses to document these actions as medical orders even when they occur before the physician is contacted. In the scenario described above, the nurse obtained lab work before contacting the physician - something she would normally need to do after contacting the physician. However, when the nurse documents this process, she documents that a change in the patient's condition was noted, the physician was contacted, and orders were received. The physician is happy to sign these orders because they eased his workload and the nurse is happy to document this way because she is happy that the physician trusts her. However, this way of proceeding serves to cover nursing knowledge and nursing practice by making it seem as if the nurse is simply following the physicians orders, when in fact the opposite is happening.

Young (1990) wrote that cultural imperialism exists when a dominant group's experience and culture is universalized and becomes the norm. According to Fletcher (2006), "The controlling groups have greater prestige, power, and status than the oppressed group. The characteristics of the oppressor become more valuable and the tendency is for the oppressed group to absorb these values" (pp. 51-52). Participants demonstrated this absorption of the values of the medical paradigm when they emphasized the importance of feeling like they were "part of the team". Often the primary

indicator that participants were part of the team was their inclusion in medical rounds with physicians. The dominance of the medical model was reflected in the language the participants used - invited in, included - language which indicated that nurses were being accepted and respected for their ability to fit into a medical model. Participants spoke of being an extension of the physician by virtue of their observation of patients and the reporting of important clinical data to physicians, an activity that as Fletcher (2006) argued, "…enables medical men to gain power. For example, nurses are often described as the physician's 'eyes and ears'. Nurses 'follow orders' and work in a system that often conceals nurses contributions" (p. 53).

Cultural imperialism was also evident in the language participants used to describe situations in which they acted autonomously. They spoke of "having permission" and the physician giving them "leeway" to make decisions. Many of the participants said outright that their autonomy was physician driven and physician dependent. It is this sense of permission that makes clear the hierarchical chain of command. The nurses who used the word permission felt that their autonomy came from the physician rather than it being an inherent part of their nursing practice. This situation was supported by nurse managers and hospital administrators who reinforced the hierarchy through policies and procedures that drive much of the nursing work in hospitals. This is typical of cultural imperialism as described by Young (1990) in which the medical model is privileged over all interdisciplinary models and becomes the expected norm. When this occurs, non-normative values are pushed aside as inferior to the dominant paradigm. Nursing as an

oppressed group must learn to fit into the dominant culture or risk being marked as "other" (Young, 1990).

Perhaps the most distressing symptom of oppression was the sense of powerlessness the participants described when discussing their every day work life. Participants reported feeling like they had no control over their work flow. They described being at the mercy of physicians' orders and the administration's time schedule for completing their work. Many of them stated that they felt like they had no control over their practice and more importantly, no way to change the situation so that they would have more control. This is consistent with Young's (1990) thoughts that, "…the powerless are situated so that they must take orders and rarely have the right to give them" (p. 10). This situation is exacerbated by a sense a fatalism in relation to the nurse-physician power dynamic. Participants relayed a sense of fear and hopelessness when discussing the possibility of confronting physicians and administrators with demands for changes to their work flow or environment. This sense of fear is common to oppressed groups and is often accompanied by submissive and acquiescing behaviors (Roberts et al., 2009). Finally, Young (1990) explained that the powerless often lack status and authority. Participants' sense of powerlessness was evident in their discussions of the difference in status between nurses and physicians. They spoke of patients not taking them as seriously as physicians. Additionally they often described a feeling of a lower status than physicians when discussing the nurse-physician relationship.

Many authors have argued that nursing is an oppressed profession (Dubrosky, 2013; Farrell, 2001; Fletcher, 2007; Roberts, 2000; Roberts et al., 2009). Participants' descriptions of their work environments demonstrated that oppression is an ongoing issue in the lifeworld of nurses in acute care hospitals. What remains difficult is discerning whether nurses are oppressed by virtue of their status in the hierarchy of the healthcare system or whether it is related to their status as mostly women in a culture that values men's work over women's work. I will explore the issue of gender more fully in a later section of this chapter.

Making Sense of Meaning

The meaning participants assigned to their autonomous actions reflected in part their enculturation as nurses. They spoke of being part of the team, having the freedom to make clinical judgments about their patients, and about doing the right thing.

Nursing education and culture support inter-professional collaboration as integral to nursing practice (ANA, 2010). Participants revealed this tendency to value collaboration when they talked about how their ability to act autonomously meant that they were seen as an integral part of the patient care team. They noted that when they were included in the team the traditional difference in status between physicians and nurses was lessened. Being included as part of the team held even greater significance for most participants - it meant that they were respected by the physician. Participants' belief that physician respect and trust were necessary components of autonomy demonstrates the relational nature of nursing autonomy. Shirley (2007) argued that, "We are not only

bound by our social relations but also constructed by them" (p. 20). MacDonald (2002) explained that autonomy was best understood by examining, "…the complex webs of personal and institutional relationships that make possible, or sometimes hinder, the making of real choices" (p. 195). The participants' responses to questions about autonomy revealed that the relational nature of autonomous actions played a crucial part in deciding whether or not they acted autonomously. Very often in the decision to act autonomously the participant considered the nature of the relationship they had with the physicians caring for their patients.

The importance of collaborative nurse-physician relationships has been explored by several authors in recent years. Papathenassoglou et al. (2012) looked at the nurse-physician relationship and moral distress among European Intensive Care Unit (ICU) nurses. They found that the autonomy of ICU nurses would be enhanced by beginning and sustaining nurse-physician collaboration. In addition they found an association between the severity of moral distress and the presence of poor nurse-physician relationships (Papathenassoglou et al., 2012). Similarly, Karanikola et al. (2014) argued that moral distress was associated with limited autonomy and problematic inter-disciplinary collaboration in Italian ICU nurses. Participants expressed moral distress when discussing occasions of failed autonomy and when describing poor nurse-physician relationships. Perhaps more importantly, participants talked about the stress they felt when taking autonomous actions. Many of them said they felt an intense sense of responsibility when acting autonomously and that this was stressful for them. Costa, Barg, Asch, & Kahn (2014) and Mason et al. (2014) found that autonomy was enhanced

when the culture of the unit supported mutual trust and respect between team members. In these studies mutual trust and respect was linked to lower incidence of moral distress.

The research on moral distress is especially important to consider when exploring the meaning of autonomy. Every participant said she acted autonomously because it was in the best interest of the patient to do so. This was true whether they were addressing nursing concerns or medical concerns. Karanikola (2014) wrote that, "Moral distress refers to a painful psychological disequilibrium that results from recognizing ethically appropriate action, yet not taking it, because of such obstacles as lack of time, supervisory reluctance, inhibiting medical power structure, institution policy or legal considerations" (p. 473). This certainly held true for participants in this study. The desire to do the right thing was the predominant theme when participants talked about why they acted autonomously. Many of the participants spoke about the distress they felt when they were unable to act in the best interests of their patients. Oftentimes this distress was because of real or anticipated negative reactions from physicians. The literature strongly links poor nurse-physician relationships with increased incidence of moral distress (Costa et al., 2014; Karanikola et al., 2014; Mason et al., 2014; Papathenassoglou et al., 2012).

Gender and Autonomy

Participants were conflicted when discussing the effect gender had on their ability to be autonomous. Most participants insisted that personally their actions were not mediated by their gender while at the same time they acknowledged that gender role considerations did affect nursing as whole. This tension was evident in the way participants talked about the issue of gender. Many of them had never considered the

impact of gender on their relationships in their work environments until the time of the

interview. Consistent with the goals of phenomenological research and of standpoint

theory in particular, participants came to a deeper understanding of the impact gender had

on their environment. Two themes were revealed by the analysis of the impact of gender

on autonomy. First, all of the participants perceived that male nurses were treated

differently than female nurses. Second, participants vividly recounted how they played

the doctor-nurse game first described by Stein in 1967.

Male nurses and privilege.

While most participants insisted that their gender did not affect their ability to be

autonomous, every participant commented on their perceptions that male nurses seemed

to have advantages that made it easier for them to be autonomous. Standpoint theorists

assert that the viewpoint of the oppressed is undistorted by privilege and as such is more

objective than the viewpoint of those in power (Harding, 2008, 2009; Rolin, 2009).

Female nurses are doubly oppressed as women and as nurses in the healthcare system

which places mostly male physicians at the top of the hierarchy (Ceci, 2004; Donchin,

1995; Dubrosky, 2013; Roberts et al., 2009). The observations of female nurses about

their work environment are therefore worth hearing. When discussing their male

colleagues, participants observed that male nurses had friendlier relationships with

physicians, and that they brought their socially sanctioned privilege as men with them

into the work place.

One of the most fundamental relationships between healthcare providers is that of

nurse and physician. Physicians rely on nurses, who are at the bedside 24 hours a day, to

monitor patients and to use their knowledge, education, and experience to maintain the

health of the patient. Nurses rely on physicians for orders for medications, tests, and

treatments. Good communication between nurses and physicians is pivotal to positive

patient outcomes. Recent trends encouraging inter-professional healthcare - which occurs

when various professionals work together to achieve positive patient outcomes - make

communication paramount to this process (Costa et al., 2014). Every participant

commented on their perceptions that communication between male nurses and physicians

was friendlier and more collegial. For most participants this was because many

physicians are male and there was a sense that male nurses were able to relate to

physicians first as males then as healthcare professionals.

Many participants stated that the danger of assuming a similar level of

friendliness with physicians was that they would be perceived to be flirting and not taken

seriously. This dilemma left participants in a double bind situation. A double bind occurs

when,

> The agent is given two (or perhaps more) injunctions as to how to behave,
> and these injunctions conflict, so that it is not possible to fulfill both of
> them. Furthermore, failure to comply with one or more of the injunctions
> has negative consequences, and the person cannot leave the situation.
> Finally, there is no way for the person to seek clarification … about what to
> do (K. K. Jenkins, 2014).

Participants described situations in which if they were friendly they were perceived as

flirting and the physician would not take them seriously but if they were professional they

were perceived as too aggressive and the physician would either ignore the participant's

suggestions or do the opposite in order to assert control. That this double bind was gender

based was evident in the participants' descriptions of interactions between male nurses and physicians. They noted that male nurses were able to be both friendly and assertive without negative consequences from the physicians.

The decision to be friendly versus professional was not the only double bind participants described. They said that if they acted autonomously the physicians would be upset because they were not consulted, however if they consulted the physicians about every decision they found that the physicians were upset because the participants were being bothersome. Some participants shared that the physicians would then wonder why the participants were asking for orders for "every little thing". According to Frye (1983) the double bind is, "One of the most characteristic and ubiquitous features of the world as experienced by oppressed people" (p. 376). The participants clearly expressed that they had very few options for actions and that each option came with the potential for negative consequences. Furthermore it was impossible for participants to predict which action would lead to the most serious negative outcome. In those situations, the participants put the well-being of their patients first and acted in the best interest of their patients. Additionally, participants shared their perceptions that male nurses did not necessarily suffer from this double bind in the same way. Their perception was that male nurses were more often seen as colleagues with physicians.

The ease with which male nurses interacted with physicians was attributed primarily to male nurses bringing with them their socially sanctioned status as males into the work environment. The participants perceived that male nurses were listened to more readily by both male and female physicians. They described a scenario in which male

nurses would simply walk up to a physician, often interrupting his or her work to discuss a patient need. Several participants noted that they tried never to interrupt a physician and would instead wait silently to be acknowledged by the physician. Several participants commented that they did this because of previous negative consequences experienced if they did not behave in this manner. Male nurses appear to bring with them certain privileges by virtue of their maleness that female nurses can never access. According to Bailey (1998) privilege makes a person's movement through the world easier. She also asserts that, "Although privileged persons feel ill at ease outside of their own worlds, they rarely lose privilege outside of their comfort zones" (p. 114). Bailey (1998) argues that being a member of the dominant group - in this case males - will almost always count in favor of the dominant group. While this study would certainly be strengthened by the voices of male nurses, it is important to pay attention to the voices of female nurses. Standpoint theorists argue that women, as an oppressed group have a clearer picture of reality than those who are not oppressed. From the participants' stories it seems clear that gender is playing a role in the oppression of nurses.

Playing the game.

Leonard Stein (1967), a physician, described the interactions between physicians and nurses as a game that both groups played which served to maintain hierarchical relationships. According to Stein (1967) nurses are frequently expected to make patient care recommendations to physicians in subtle, non-confrontational ways and physicians must learn how to pick up on these subtle clues in order to develop a plan of care for their patients. In 1990 Stein wrote that the game was no longer relevant because modern

nurses were unwilling to play the game (Holyoake, 2011; Stein, Watts, & Howell, 1990). Despite Stein's assertion that modern nurses were unwilling to play the game, the participants in this study described circumstances in which they behaved according to the rules he described in 1967. This is consistent with Holyoake's (2011) assertion that the game remains a reality for modern nurses working in direct patient care. Even when nurses do speak up their voices often go unheard. Corser (2000) found that contemporary nurses might be more likely to voice a concern to a physician but that if challenged by the physician they would defer to the medical order and the physician's authority.

Most participants did not recognize the way gender influenced their actions. However recent work by feminist nurse scholars demonstrates that nurses continue to be affected by traditional gender roles. Fletcher (2007) noted that, "Our culture and our organizations, including healthcare facilities, are not gender-neutral; they are strongly patriarchal" (p. 210). Kane and Thomas (2000) wrote that nurses continue to be frustrated with sexist beliefs and values that place nursing work as a woman's duty. Participants expressed in very direct terms the ways in which they "learned their doctors" as part of learning how to approach physicians so that they could meet patient care needs without upsetting or insulting the physicians. Every single participant took responsibility for making sure communication with the physician was acceptable to the physician and none questioned that the responsibility was the nurse's and not a shared responsibility between physicians and nurses. Participants commented that the more likely a physician was to

respond negatively, the more likely they were to use subtle communication techniques such as those highlighted by Stein (1967) in the doctor-nurse game.

These subtle communication techniques helped participants manage double-bind situations such as those described by Jenkins (2014). Participants may have resorted to these subtle communication methods as a way of maintaining politeness. Assertive communication by women challenges the socially constructed idea that women's communication should be polite above all else (Pfafman & McEwan, 2014). Subtle communication with physicians allows physicians to save face when interacting with nurses whom they perceive as lower in status. Pfafman & McEwan (2014) wrote that, "Because face is maintained through ritual practices governed by social norms, a socially appropriate *professional* identity can be at odds with a socially appropriate *gender* identity" (p. 203) (emphasis by the authors). Nurses are able to navigate the paradox of needing to be assertive in order to meet a patient need and needing to be polite in order to maintain a positive relationship with the physician by using polite communication techniques. Politeness theory asserts that the language used to deliver a persuasive message is an indication of the speaker's perception of the social relationship between the speaker and the listener (M. M. Jenkins & Dragojevic, 2011). Nurses make their suggestions in subtle ways as a deliberate strategy. This is consistent with the results of Pfafman & McEwan's (2014) study in which they found that politeness was a strategic choice made by the women in their study in order to be seen as appropriately female in their communications. Their conclusion that, "Feminine communication style is thus not a

powerless deficiency but an effectively polite strategy" is worth considering as we turn

our consideration to the participants experiences of power in their work environments

(Pfafman & McEwan, 2014, p. 216).

Power and Autonomy

Participants appeared to be surprised by the question of the relationship between

power and autonomy. Many of the them had not considered power and autonomy to be

related to each other. The fact that most participants had only negative things to say about

power might be explained by their experiences as an oppressed group in a system in

which power is wielded over them and in which they have little power themselves.

Views of power.

Power was primarily viewed as a negative force in the lifeworld of the

participants. They described power as a dominating force which often hindered their

ability to do their jobs. While this negative view of power was predominant, participants

were able to describe what a powerful nurse might look like. This led to a positive

consideration of power and its effects. Finally participants favored the relationally

negotiated term of empowerment which is consistent with feminist research that finds

that women favor relational definitions and expressions of power over hierarchical ones.

Power as domination.

The idea of power as domination is ubiquitous. Pierce & Dougherty (2002)

observe that power as domination is such a commonly accepted definition that scholars

researching power routinely fail to define power and instead base their work on the

assumption that everyone understands power in this manner. They also note that power as

domination is prevalent in the way modern organizations are structured; furthermore, "Constructions of power-as-domination both privilege and marginalize individuals or entire groups, which necessarily create social inequalities and serve organizational interests" (Pfafman & Bochantin, 2012, p. 576; Pierce & Dougherty, 2002). The construction of power-as-domination contributes to the oppression of nurses in the healthcare system.

According to Pfafman and Bochantin (2012) power as domination is a masculine conceptualization of power. Nurses, as mostly female workers, have different ideas of power - what it means and how one uses it. Feminist research finds that women prefer relationally negotiated definitions of power that lead to power being shared equally over those in which power is wielded by a powerful few (Ceci, 2004; Davies, 2003; Chinn & Falk-Rafael, 2015; Kane & Thomas, 2000; Pfafman & Bochantin, 2012; Pfafman & McEwan, 2014). Participants described their experiences with power as domination when discussing their interactions with physicians, nurse managers, and hospital administration. Most of the participants noted that power was something that was exercised over them and that kept them from practicing autonomously. In their view power supported the traditional hierarchy present in healthcare institutions and was used by those higher in the hierarchy to suppress autonomous nursing practice. Most participants spontaneously chose the word empowerment when discussing power. They indicated that they would like to be empowered to act; a word choice that demonstrates their lack of power in today's healthcare environment.

Empowerment.

Participants preference for the word empowerment over the word power is consistent with feminist research on gender and power that finds that women prefer definitions of power that are relationally negotiated over those that favor the clear boundaries of a hierarchy (Ceci, 2004; Davies, 2003; Kane & Thomas, 2000; Pfafman & Bochantin, 2012; Pfafman & McEwan, 2014). Participants conceived of empowerment as a type of shared power in which all players were equal members of a team. Empowerment was envisioned as a group effort where nurse managers, physicians, and hospital administration all worked with nurses to provide patient care. Nearly every participant spontaneously used the used empowerment in place of the word power. Some participants felt that power was not something that nurses should seek. This may reflect their enculturation as nurses in which they have learned from the beginning of nursing school to work towards empowering their patients to be as independent as possible. Nursing culture supports the tendency to view empowerment as positive and to view power as domination as negative (Bradbury-Jones et al., 2008; Udod, 2008).

Udod (2008) wrote that efforts to empower staff nurses fall short because of an incomplete understanding of power and its effect on staff nurses work life. Efforts to share hierarchical power with staff nurses may be misplaced. Participants were not interested in hierarchical power; they did not want to be 'in charge'. They were concerned with doing the right thing for the patient and with providing good patient care. Udod (2008) and Bradbury-Jones, Sambrook, and Irvine (2008) used French philosopher Michel Foucault to better understand power and empowerment for nurses. They argued

that Foucault's understanding of power as a strategy to achieve an outcome could be useful for nurses seeking to provide better patient care. Foucault's understanding of power is not hierarchical. In his view power is not something owned or possessed it is something used to cause an effect (Foucault, 1984). Power can be a productive force or it can be repressive and is used those who govern and by those who resist being governed (Cheek & Porter, 1997; Foucault, 1984; McNay, 1992). Nurses may benefit from such an understanding of power, indeed they might embrace such an understanding of power.

Power as a positive force.

Even though participants held largely negative feelings about power, they had positive things to say about powerful nurses. Often the participant spontaneously described a powerful nurse when asked to consider nursing and power. The descriptions of powerful nurses as knowledgable, self-confident, and on good terms with physicians reveals the relational nature of power for participants. They equated knowledge and experience with power. Again it is possible to see how Foucault might inform nursing's understanding of power. Foucault so closely linked power and knowledge that he considered them one term - power/knowledge (Cheek & Porter, 1997; Gastaldo & Holmes, 1999; McNay, 1992a). Foucault offers a view of power that is an alternative to the view of power as domination that is so present in today's healthcare system.

Participants felt that powerful nurses had more autonomy and were better able to meet patient needs. Many participants felt that maturity as both a nurse and a woman enabled the self-confidence nurses needed to be able to act autonomously. Several of the

participants explained that when they did not have confidence in themselves as women they did not have confidence in themselves as nurses. This is important to note because efforts to empower nurses may fall short if the nurses themselves lack the self-confidence to act on their empowerment.

Interrupting Domination

One of the goals of feminist research is to raise the consciousness of those involved in the research. Over the course of the three interviews participants had an opportunity to reflect on their nursing practice and on the amount of autonomy they had. Many of the participants came to the realization that they did not have as much autonomy as they would like to have in their practice. The process of responding to questions about their practice allowed them to more fully understand their work environments. In the final interview, which focused on the impact of gender on nursing practice, participants often reflected that they had never thought about these issues. Yet every one the participants discussed their perception that male nurses were treated more favorably by physicians. Many of the participants related that they enjoyed the interview process because they liked that they were being heard. The process of having one's voice heard and believed is one step towards overcoming oppression (Harding, 2009; Rolin, 2009).

The importance of feminist research for the future of nursing can be seen in the participants' reactions to questions about power. All of the participants felt that power was something negative and was something nurses do not have. Carter G. Woodson wrote that, "If you make a man feel that he is inferior, you do not have to compel him to accept an inferior status, for he will seek it himself." Participants in this study were clear that

they felt powerless and were equally as clear that they wanted nothing to do with having power. These internalized feelings about power serve to limit nursing practice in that they inhibit behavior that would lead to nurses gaining power. By eschewing power, participants are acquiescing to their oppressed status in the healthcare system. It will be impossible to help nurses overcome oppression if they continue to feel that power is only a negative force that has nothing to do with nursing.

Chinn and Falk-Rafael (2015) described an emancipatory group process that can be used to facilitate political and social change towards greater equality for oppressed groups. They posited that nursing might use this method to pull itself out of the oppression in which it finds itself entrenched. Peggy Chinn and her collaborators on the Nursing Manifest website have created a community for nurses seeking alternative forms of power to come together to work for positive changes in their work environments. Their vision of shared power that leads to well-being for nurses, physicians, and ultimately patients has the potential to offer nurses a way to regain control over their practice while honoring the collaborative impulse that is at the foundation of nursing. (Kagan, Smith, Cowling, & Chinn, 2009)

Limitations of the Study

Qualitative research is by its nature focused on a specific population. In this case acute care, bedside nurses provided a rich description of their experiences of autonomy and the meaning of autonomy. While all of the participants met the inclusion criteria to participate in the study, there were some limitations.

The first notable limitation is that all of the participants were female. While attempts were made by the researcher as well as the study participants to include male participants, those attempts were ultimately unsuccessful. Nearly all of the participants in the study spoke to their male colleagues and encouraged them to participate in the study. They reported that they told their male colleagues how nice it was to be heard and that they would have a captive audience. That their male colleagues chose not to participate leaves room for questions about why they would make this choice and opens the door for possibilities for further research to explore the experiences of male nurses who work at the bedside in the acute care setting.

The transferability of the results is an important consideration. The transferability of the results is limited by the recruitment strategy used. Most of the participants were recruited via an email sent to students enrolled in either a bachelors degree completion program or a bachelors degree to doctorate program. The fact that so many participants were enrolled in a degree program might have influence on perceptions of autonomy. In fact several of the nurses enrolled in graduate degree programs commented that they were glad they were in school because after they graduated they knew they would have more autonomy. Finally, the transferability is limited by the fact that all but one of the participants were of European descent. While nursing remains overwhelmingly a profession of European-American women, there is a growing diversity in nursing that is not reflected by the sample. While there were limits to the transferability research using these same questions might certainly be applicable to nurses who work in different settings or who have different educational and cultural backgrounds.

This study may have been limited by the type of interview selected to gather data. The semi-structured interviews allowed for participants to somewhat guide the interview process and as such I did not ask the exact same questions of every participant especially when probing questions were used. All but one of the participants were strangers to me which may have led to the participants to being more guarded in their answers. Multiple interviews were used as a way of getting to know the participants and putting them at ease so that they felt comfortable discussing topics that were of a sensitive nature. Also, many of the interviews took place in a public setting such as a cafe or a hospital cafeteria. While the participants chose the setting in which they would be interviewed, these settings may have inhibited some participants and kept them from delving as deeply into a subject as they might otherwise have done. Care was taken even in these public settings to choose a seating arrangement that was as private as possible.

Finally, the researcher's life experience as an acute care, bedside nurse must be considered when addressing the limitations to this study. While this life experience can form the basis for pre-understanding as shown in Figure 5.1, it is important for the researcher to bracket those experiences and put them aside during the research process. This was achieved through the use of a reflexive journal in which I recorded my own experiences with autonomy as well as my reactions to the participants stories throughout the research process. This helped create a space for the lifeworld of the participants to be seen in a more complete context.

Implications

There are very few feminist studies of nurses in the nursing literature. As this study was accomplished through a feminist lens it contributes to the understanding of nurses and gender issues in the workplace. The following sections will detail the implications this study has for education, research, practice, and policy.

Implications for nursing education.

Empowerment of nurses must begin as early as nursing school. This can be accomplished in several ways. First, the gendered nature of the nursing work environment needs to be acknowledged and discussed openly in the classroom. These discussions should serve to prepare nursing students to identify gender bias as well as offer them ways to address such bias when encountered. Second, nursing students should study feminist research methodologies and feminist theory. This will help produce a new generation of researchers who can apply these methods to their practice. It will also give them a language to use when advocating for changes to nursing practice. Finally, nursing educators should embrace feminist pedagogies. According to Welsh (2011), using a feminist pedagogy will increase the student's sense of personal empowerment. That sense of empowerment will be carried into the work environment and will have lasting repercussions as students graduate and move into the workforce.

Implications for nursing research.

The participants in this study talked quite openly about the impact gender had on their work environments. Given the paucity of feminist research on nursing practice it is important that more studies from a feminist perspective are completed in order to gain a deeper understanding of the impact gender issues have in the nursing work environment.

Feminist research is also important because it has an emancipatory aim that would be useful to nurses because it would help lift nurses up as they pursue greater professional recognition. Feminist research that includes the perspectives of male nurses will help determine whether nurses are oppressed because most nurses are women or because of long-standing traditions that place nurses near the bottom of the healthcare hierarchy. Research using Intersectionality Theory will help nurses explore the ways in which gender, class, and race interact to create privilege and oppression. This is especially important to consider because nursing continues to promote white, middle-class values which are not necessarily relevant to an increasingly diverse workforce.

While this study makes a contribution to the understanding of gender issues surrounding nursing autonomy its impact is limited by its small and homogenous sample. Larger studies using surveys developed by feminist researchers will help uncover the extent to which gender impacts nursing's work environment. A mixed methods approach using surveys to reach a large number of nurses and focus groups to help nurses begin a dialogue about gender issues would help researchers better understand the impact gender issues have on nursing autonomy. These methods, due to their larger sample size will allow for more generalizability and help fill in the gaps left by smaller, more focused research methods.

Post-modern research methods provide another useful avenue of inquiry when researching oppressed groups. Methods such as those used by critical social theorists have as their aim emancipation from oppression. One of the purposes of the research is to lift the participants out of the oppression the research uncovers. Emancipatory research

would help nurses by simultaneously uncovering oppression and helping nurses discover the resources to lift themselves out of oppression.

Finally, research that focuses on other areas of nursing practice besides acute care, bedside nursing is needed. Nursing practice takes place in a variety of settings including the clinic, the patient's home, and the long-term care setting. Additionally there are many types of hospitals - community, public, private, non-profit, and for-profit. Much of the research that has been done on autonomy has occurred at hospitals designated as Magnet hospitals, however those hospitals represent a very small number of hospitals in the United States (Kramer, Maguire, & Brewer, 2011). Understanding the impact gender has on nursing autonomy in all nurse practice settings will help nurses in their quest for greater professional recognition by forming a more complete picture of nursing practice across settings.

Implications for nursing practice.

Several conclusions can be drawn from this study about nursing practice. First, acute care, bedside nursing is practiced in a socially complex environment. Second, the complexity of the environment limits the scope of nursing practice. Finally, the difficulties nurses face in their work environment have a negative impact on patient care and ultimately, patient outcomes.

The culture of healthcare is socially complex. There is a clear hierarchy that ranks medicine at the top and that places nursing further down. In addition to the traditional hierarchy, gender must be considered. The fact that the overwhelming majority of nurses are women and that medicine has historically been dominated by men means that gender

issues compound hierarchical issues and create an oppressive work environment. This oppressive work environment makes it difficult for nurses to practice to the full extent of their education. In order to ameliorate this situation hospitals will have to dismantle the historical hierarchy and put in its place a more equitable system that allows nurses to have a scope of practice that matches their education. Feminist theory should be introduced to nursing education as a way of empowering nurses to overcome institutionalized sexism. Finally nurses should work to advance women's rights so that gender issues will have less of an impact on their work environment.

Participants shared how a difficult work environment had a negative impact on their practice. They described fear-based actions and reactions. The fear of upsetting a physician and as a consequence being yelled at by the physician was a common theme for most of the participants. This fear was compounded by gender issues. Nearly all of the participants discussed the importance of being professional. Professional behavior was almost always mentioned as an alternative to flirtatious behavior. Nurses working in acute care settings face these challenges every day. They must decide if and how they are going to approach a physician. Their approach is mediated by the physician's past behavior, by the gender of the physician, and the gender of the nurse. Female nurses appear to be caught in a double-bind when interacting with physicians. If they are overly friendly they are seen as flirtatious and are not taken seriously. On the other hand, if they appear to be too professional they are seen as usurping authority from the physician. This has a negative impact on patient care. Healthcare organizations must work to support nurses and reduce the impact of gender bias for female nurses. The administrative teams

of healthcare organizations need to hold physicians accountable for non-professional and sexist behavior. In addition health care facilities should strive to promote and hire more women into administrative and leadership roles.

When physicians and nurses do not communicate effectively patient care suffers. Participants described situations in which fear of the physician superseded their desire to meet their patient's needs. It is troubling that participants felt so much fear around their interactions with physicians. The delivery of safe healthcare relies on good communication between nurses and physicians. When one half of that equation is afraid to speak with the other half communication is going to fail.

Fear of negative consequences was not the only communication barrier. Gender issues created another barrier for participants. Society-driven norms that privilege male values create some of the difficulty. However, much of the difficulty discussed by participants had to do with societal norms concerning the proper comportment of women. Women in many workplaces struggle with having a professional identity (Pfafman & McEwan, 2014). Nursing is no exception. Participants found it necessary to draw boundaries around friendly behavior so that they would not be perceived as flirtatious. Those boundaries might serve nurses well in some instances but participants reported that when they limited their interactions to professional ones some physicians were less likely to do what was needed for the patient. In fact several commented that the physician would do the opposite. When nurses have to worry that their professional recommendations will lead to physician's reluctance to act communication breaks down. This leads directly to nurses playing the Doctor-Nurse Game described by Stein in 1967.

When nurses are forced to use these round about communication techniques patient care is compromised. Collaboration between nurses and physicians is impaired when nurses cannot be forthright with their observations and recommendations for patient care. Interdisciplinary education offers potential for mitigating some of these communication barriers. As healthcare providers learn together there will be fewer questions about the knowledge base each has. Early interdisciplinary education might also make it easier for physicians to see nurses as equal professionals with their own skills and knowledge base.

Implications for nursing policy.

This study revealed several areas that need to be considered when policy changes are proposed. First, the patriarchal nature of the healthcare hierarchy needs to be acknowledged and fundamental changes need to be made to the way healthcare is practiced in acute settings. Finally, is also important that new ways of communication between providers are developed.

The patriarchal nature of healthcare has resulted in nursing knowledge and skill being under-valued in the healthcare system (Henderson, 1994). Nurses are treated as interchangeable workers who are to do what they are told, when the are told to do it. Hospital policies often restrict nursing practice rather than enhance it (Bradbury-Jones et al., 2008; Udod, 2008). These same policies privilege male ways of communicating and of knowing. Nurses, who are overwhelmingly female, are often left out of the decision-making process when hospital policies are decided. Furthermore the policies are written to protect the institution rather than to guide nursing practice (Salhani & Coulter, 2009a). In order for change to occur nurses must be included in the decision-making process and

they must be included in a way that reflects their preferences in communication style and their ways of knowing. Hospitals should seek to fully acknowledge nursing skill and knowledge by treating them as knowledgable members of the healthcare team rather than as interchangeable bodies there to do specific tasks.

Effective communication between healthcare providers will improve patient outcomes. In order for physicians and nurses to communicate more effectively several changes need to occur. First, the traditional healthcare hierarchy needs to be dismantled. Neither nurses nor physicians are well-served by a system that demands subtle and face-saving styles of communication to be used. Open, direct communication between equal members of the healthcare team will be more effective in meeting patient care needs. Additionally, physicians need to be held accountable for their role in communication with nurses. Communication works in two directions and it will not be effective if only one half of the pair is concerned with the communication pattern. Interdisciplinary education where nurses and physicians learn together has the potential to alleviate some of the problems. When physicians better understand nursing education and knowledge they will be more likely to work collaboratively with nurses and others on the healthcare team (Kramer et al., 2006; Kramer et al., 2007). Finally physicians that are hostile in their communication style need to be held accountable for their actions. Patient care will continue to be compromised as long as physicians are allowed to use fear to get what they want. Hospitals need to put policies in place that hold nurses and physicians equally responsible for communication.

Conclusion

In this study I explored the autonomy experiences of acute care, bedside nurses. I considered the meaning nurses gave to autonomy as well as the impact that gender had on the meaning ascribed to participants' autonomous actions. Finally, I considered how the meaning nurses assigned to their autonomous action contributed to the amount of power acute care bedside nurses have in today's healthcare system. It was discovered that acute care, bedside nurses have experiences of autonomy that are both positive and negative and that the context in which those actions took place was important in determining the outcome.

Participants related that "feeling included" and having the freedom to act in the best interests of the their patients was important to them. This freedom to act was used to ensure positive patient outcomes for their patients. The participants revealed that sometimes they acted in the best interest of the patient even when they did not feel they had the freedom to act in such a way. They faced negative repercussions from physicians, nurse managers, and administration for their actions. Despite these negative repercussions, they acted with their patient in mind and without regard for the personal consequences they would face as a result.

When considering power and autonomy together the participants were clear that power was something that was meant to be shared equally rather than wielded over some. Participants view of power belied the traditional view of power found in today's healthcare system. Participants preferred the relationally negotiated concept of empowerment to power as domination which is in line with their enculturation as women and as nurses.

Moving forward it will be important to further explore the impact of gender on nurses' work environment. Interventions that consider the impact of gender will need to be developed. Policies that aim to change the work environment will have to consider new ways of understanding power and gender relations if they are going to be effective in creating change.

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Appendix A: Consent Form

University of Wisconsin – Milwaukee
Consent to Participate in Research

Study Title: Lived Experiences of Nursing Autonomy: A Phenomenological Exploration
Person Responsible for Research: Rebekah Dubrosky
Study Description: The purpose of this research study is to study the lived experiences of autonomy as practiced by acute care bedside nurses. This study is being done to help clarify the concept of autonomy for further research concerning autonomous nursing practice in acute care situations. The goals of the study are to better understand the context and consequences of autonomous actions taken by bedside nurses. Approximately 10 subjects will participate in this study. If you agree to participate, you will be asked to do three interviews that will last approximately one hour to one and a half hours each. During those interviews you will be asked to describe your experiences working in the hospital as well as how you feel about these experiences.
Altogether, this will take approximately three to four and a half hours of your time.
Risks / Benefits: While all reasonable efforts will be made to maintain your confidentiality there is a risk that your confidentiality could be compromised. To ensure your confidentiality, you will be assigned a pseudonym so that your real name will not be used, the names of the hospital where you worked will not be used, and your personal data will be stored on a password protected computer in a password protected file. Your consent forms with your identifying information will be kept in a locked file cabinet separate from the interview information.
Only I will have access to your real name. There will be no costs to you for participating in this study. There are no benefits to you other than to further research in this area.
Confidentiality: Identifying information such as your name, email address, and phone number will be collected for research purposes. This information will be used during the study so that I will be able to maintain contact with you until all your interviews have been done. Your responses will be treated as confidential and all reasonable efforts will be made so that no individual participant will be identified with his/her answers. None of the information you share will be shared with your employer, your supervisor, or any administrator in your facility. The interviews will be audio-recorded using a digital voice recorder. A pseudonym will be used in the transcription so that only I know your real name. All study results will be reported without identifying information so that no one viewing the results will be able to match you with your responses. Data from this study will be saved on a non-networked, password protected computer in a locked room in Cunningham 564 for 5 years. Only Rebekah Dubrosky will have access to your information. However, the Institutional Review Board at UW-Milwaukee or appropriate federal agencies like the Office for Human Research Protections may review this study's records.
Voluntary Participation: Your participation in this study is voluntary. You may choose not to take part in this study, or if you decide to take part, you can change your mind later and withdraw from the study. You are free to not answer any questions or withdraw at any time. Your decision to withdraw from the study will not affect your job or your relationship with your employer in any way. Your decision will not change any present or future relationships with the University of Wisconsin Milwaukee. There are no known alternatives available to participating in this research study other than not taking part.
Who do I contact for questions about the study: For more information about the study or study procedures, contact Rebekah Dubrosky at Dubrosky@uwm.edu
Who do I contact for questions about my rights or complaints towards my treatment as a research subject? Contact the UWM IRB at 414-229-3173 or irbinfo@uwm.edu.
Research Subject's Consent to Participate in Research:
To voluntarily agree to take part in this study, you must be 18 years of age or older. By signing the consent form, you are giving your consent to voluntarily participate in this research project.

_____I give my permission to audio-
Printed Name of Subject/Legally Authorized Representative   record my interview. _____

_____   _____
Signature of Subject/Legally Authorized Representative   Date

Appendix B: Demographic Sheet

Biographical Information Sheet

What is your name?	
How old are you?	
How long have you been a registered nurse?	
Where do you work?	
What type of unit do you work on?	
How long have you been working on this unit?	
What is your race?	
What is your highest degree in nursing?	
What is your highest degree?	
What is your gender?	

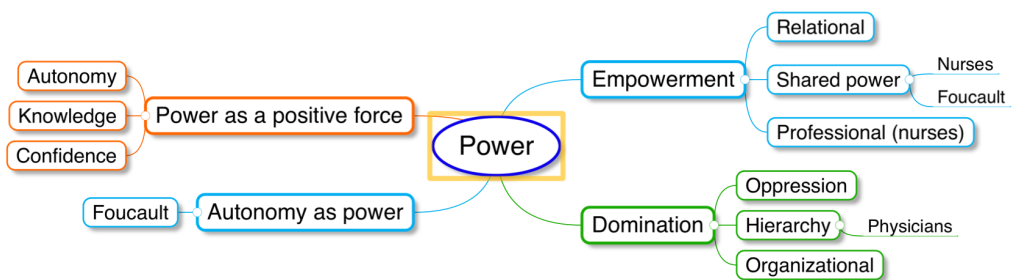**Appendix C: Coding Dictionary**

Code	Description
Autonomy	Instances of discussing autonomy in any context.
Characterisitics of Autonomy	Describes attributes of autonomy.
Team	Nurses describing the effect of teamwork
Leeway	Descriptions of variability in the way physician's orders are followed
Independent Decisions	When nurses decsribe making decisions independently
Confidence	When participants state that confidence is important
Inhibitors of Autonomy	Things that make decrease or impede autonomy
Time	Descriptions of the impact time available has on practice
Tasking	When nurses describe simply doing tasks as their practice
Physician Presence	Describing the impact of physician presence on nursing practice
Management Present	Describing the impact of the presence of management on nursing practice
Fear	When nurses indicate they are afraid of the consequences of their actions or interactions
Second Guessing	When nurses describe questioning their actions or interactions
Negative Repercussions	When a nurse experiences a negative reaction to her autonomous actions
Enhancers of Autonomy	Things that increase or support autonomy
Permission	Descriptions of doctors or management permitting certain behaviors
Trust	Descriptions of the impact of trust on autonomy
Approachable	When physicians are easily approached
Experience	Describing how experience impacts autonomy
Protocols	The impact of protocols on nursing practice
Manager Support	Impact of manager's support on nursing practice

Code	Description
Knowledge	Nurse describes what she knows.
Time to Think	When nurses describe the impact of time to think on their actions
Shift Worked	When participants describe the effect of the shift they work on their autonomy
Meaning of Autonomy	
Experiences of Autonomy	Descriptions of experiences of autonomy.
Positive Instances of Autonomy	Descriptions of nurse having autonomy.
Negative Instances of Autonomy	Descriptions of nurse lacking autonomy.
Nurse-Nurse Relationship	Instances of describing interactions between nurses.
Bounce Ideas	When nurses help each other through collaboration
Trusting Nurses	When participant describes instances of trusting co-workers
Guidance	More experienced nurses guiding the actions of less experienced nurses
Nurses Working Together	Descriptions of teamwork among nurses working together
Nurse-Physician Relationship	Instances of discussing the dynamics of nurse-physician interactions.
Knowing the right approach	When participant describes ways to approach a physician.
Respect	Describing the phenomenon of physician respecting nurse judgement.
Negative Instances of Respect	Nurse describes lack of respect from anyone.
Positive Instances of Respect	Nurse describes being respected by anybody.
Being Heard	Describes when physicians listen to nursing concerns
Part of the Team	Nurse describes being part of the care team.
Intuition	Nurses describing using intuition to make decisions
Power	Nurses describing power relationships in their practice environment
Empowerment	Participants describe the concept of empowerment

Code	Description
Powerless	When participants describe feeling powerless
Powerful	When participants describe having power
Power as Negative	When participants discuss negative feelings about power
Power as Positive	When participants describe positives feelings about power
Gender's Impact	Descriptions of the role gender plays in nurses' understanding of their autonomous actions.
Male Nurses	When participants describe the practice of male nurses
Self-Esteem	When participants discuss the effect of self-esteem on practice
Hierarchy	When participants use language that indicates a hierarchical ranking
Sensitivity	When participants discuss a nurses sensitivity to feedback and it's impact on practice
Scope of Practice	Describing nurse's perception of what nurses can and cannot legally do.
ADN vs BSN	Participants discussing the differences between ADN prepared nurses and BSN prepared nurses
Reactions to Study	When participants discuss the impact participating in the study has had on their lives/practice
Solutions	When participants discuss ways nurses can gain more autonomy
Cohesive	When participants discuss nurses working toegether
Education	When participants discuss the impact of education on autonomy
Age	When participants discuss how their age affects their nursing practice.
No Good Choices	When participants describe being stuck with no clear choice of action because inaction would compromise the patient but orders are not in place that allow for action.

Appendix D: Concept Maps

Autonomy
Knowledge
Confidence
Power as a positive force

Foucault
Autonomy as power

Power

Empowerment
Relational
Shared power
Nurses
Foucault
Professional (nurses)

Domination
Oppression
Hierarchy
Physicians
Organizational

Curriculm Vitae

Education

Doctoral Candidate **University of Wisconsin - Milwaukee.** Doctor of Philosophy in Nursing Candidate. Expected Graduation: 5/2015.

B.S.N. **Pace University.** Bachelor of Science in Nursing. 1999

B.A. **Berea College.** Bachelor of Arts in French. 1991.

Dissertation Title: Lived Experiences of Nursing Autonomy: A Phenomenological Exploration

Teaching Experience

¥ Teaching Assistant   Sept. 2011 to current

  Perspectives on Health Care Systems

  University of Wisconsin - Milwaukee

¥ Clinical Instructor   Aug. 2008 to Dec. 2014

  Foundations of Clinical Practice

  University of Wisconsin - Milwaukee

¥ Clinical Instructor   Sept. 2013 to Dec. 2013

  Clinical Reasoning

  University of Wisconsin - Milwaukee

¥ Instructor   Jan. 2011 to May 2011

  Health Assessment Laboratory

  University of Wisconsin - Milwaukee

Clinical Experience

¥ Froedtert Memorial Lutheran Hospital   May 2007 to Jan. 2010

   Unit: Medical Intensive Care Unit

   Population: Critical care patients

   Position: Staff Nurse

¥ St. Luke's Medical Center   July 2006 to June 2007

   Unit: Cardiovascular Intensive Care Unit

   Population: Patients recovering from open heart surgery

   Position: Staff Nurse

¥ Chippenham Medical Center   June 2005 to June 2006

   Unit: Cardiac Care Unit

   Population: Cardiac Intensive Care

   Position: Staff Nurse

¥ St. Mary's Hospital   Aug. 2002 to Aug. 2005

   Unit: Pediatric Intensive Care Unit

   Population: Children aged 0 to 21 years old in a small community hospital PICU

   Position: Clinical Nurse II

¥ University of Virginia Hospital Pediatric ICU   March 2001 to Sept. 2002

   Unit: Pediatric Intensive Care Unit

   Population: Children aged 0 to 21 years old in an 11 bed teaching hospital PICU

   Position: Staff Nurse

¥ Virginia Commonwealth University Health System   July 1999 to Oct. 2000

   Unit: Children and Adolescents Unit

   Population: Children aged 3 to 21 years old on a 25 bed inpatient pediatric unit

   Position: Staff Nurse

Publications/Presentations

Kako, P. & Dubrosky, R. (2012). Exploring the Lived Experiences of Stigma in HIV Positive Kenyan Women. Building Bridges to Research Based Nursing Practice Conference, Milwaukee, WI.

Dubrosky, R. (2013) Iris Young's five faces of oppression applied to nursing. *Nursing Forum, 48,* 205-210.

Kako, P. & Dubrosky, R. (2013) "You comfort yourself and believe in yourself": exploring lived experiences of stigma in HIV-positive Kenyan women. *Issues in Mental Health, 34,* 150-157.

Research Experience

¥ Research Assistant   July 2010 to July 2011.

Self-Management Science Center

University of Wisconsin – Milwaukee

HIV Transmission Risk, Access to Treatment, and Self Management of Illness Over Time: An In-Depth Longitudinal Study of HIV-Infected Women in Kenya

Principal Investigator: Dr. Peninnah Kako

¥ Project Assistant   Jan. 2010 to July 2010

Self-Management Science Center

University of Wisconsin – Milwaukee

Sleep and Post-Partum Depression in Low-Income Women

Principal Investigator: Dr. Jennifer Doering

Grants

Sigma Theta Tau – Eta Nu Graduate Student Research Grant   2012

Harriet H. Werley Doctoral Student Nursing Research Award   2013

Professional Development

¥ Midwest Nursing Research Society 36th Annual Research Conference   2012
Dearborn, MI

¥ Building Bridges to Research Based Nursing Practice Conference   2012
Milwaukee, WI

Affiliations/Memberships

¥ Sigma Theta Tau   May 20
   Current

¥ Midwest Nursing Research Society   Jan. 20
   Current

Interests

¥ Acute care nurses' work environments, especially nursing autonomy and barriers that keep
   nurses from practicing to the full extent of their scope of practice.

¥   Gender issues in nursing. How gender roles affect nursing's scope of practice and how gender roles influence the way nurses interact with one another and with other healthcare team members.