

# Professional nurse autonomy: concept analysis and application to nursing education

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## Professional nurse autonomy: concept analysis and application to nursing education

Professional nurse autonomy, an essential attribute of a discipline striving for full professional status, is often confused with personal autonomy, work autonomy or aggregate professional autonomy. Using Walker & Avant's (1995) model for concept analysis, this paper presents an analysis of professional nurse autonomy. Professional nurse autonomy is defined as belief in the centrality of the client when making responsible discretionary decisions, both independently and interdependently, that reflect advocacy for the client. Critical attributes include caring, affiliative relationships with clients, responsible discretionary decision making, collegial interdependence, and proactive advocacy for clients. Antecedents include educational and personal qualities that promote professional nurse autonomy. Accountability is the primary consequence of professional nurse autonomy. Associated feelings of empowerment link work autonomy and professional autonomy and lead to job satisfaction, commitment to the profession, and the professionalization of nursing. A student-centred, process-orientated curricular design provides an environment for learning professional nurse autonomy. To support the development of professional nurse autonomy, the curriculum must emphasize knowledge development, understanding, and clinical decision making.

*Keywords:* autonomy, concept analysis, nursing education, professional nurse, professionalism

## INTRODUCTION

For many years, the nursing profession has been striving for full professional status (Bixler & Bixler 1945, Schutzenhofer 1988, Moloney 1992). Autonomy, an essential attribute for achieving professional status, can exist on both an individual or group level (Moloney 1992). Although the importance of professional nurse autonomy is addressed extensively in the literature, definitions of

professional nurse autonomy are inferred or loosely explicated, leading to ambiguous interpretations. Furthermore, the concept is often confused with personal autonomy, work autonomy and aggregate professional autonomy (Lach 1992).

Attitudes towards professional nurse autonomy are introduced during baccalaureate nursing education programmes. Therefore, if nursing is to achieve full professional status, analysis and application of the concept to nursing education is warranted. Using Walker & Avant's (1995) model for concept analysis, this paper clarifies the meaning of professional nurse autonomy at the

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individual level. Concept analysis involves describing uses of the concept, identifying the attributes, antecedents and consequences, defining the empirical referents and constructing demonstration cases. The article concludes with a discussion of application of the concept to nursing education.

## DESCRIPTIONS OF THE CONCEPT

### Differentiation of autonomy and professional autonomy

Autonomy, a complex, multidimensional phenomenon, is derived from the Greek words *autos* and *nomos*, meaning self and to rule or hold sway (Curtin 1982, Dempster 1994). The dictionary defines autonomy as 'the right of self-government; personal freedom; freedom of will; and a self-governing community' (Fowler & Fowler 1995 p. 85). Synonyms include independence, freedom, liberty, self-determination, self-government, self-rule and sovereignty (Kipper 1992). To distinguish the concept of interest from personal autonomy and other related terms, the various types of professional autonomy are explained.

Hall's (1968) classification of professional autonomy as a structural or attitudinal attribute forms the foundation for definitions cited by many disciplines. Structural or work autonomy is the worker's freedom to make decisions based on job requirements (Hall 1968, Engel 1970, Batey & Lewis 1982, McKay 1983). The bureaucratic hierarchy dictates the responsibility and authority of the individual. Attitudinal autonomy, the belief that one is free to exercise judgement in decision making, reflects the way individuals feel and view the work of the profession (Hall 1968).

Aggregate professional autonomy, which encompasses attitudinal and structural dimensions, is the socially and legally granted freedom of self-governance and control of the profession's activities without influence from external forces (McKay 1983, Chitty 1993). Because of the growing involvement of governmental agencies, absolute aggregate professional autonomy is unrealistic (Curtin 1982, Cherow 1994, Dempster 1994).

Despite organizational constraints, individuals may exhibit attitudes towards professional nurse autonomy and influence structural autonomy (Hall 1968). For purposes of this analysis, professional nurse autonomy is defined as belief in the centrality of the client when making responsible discretionary decisions, both independently and interdependently, that reflect advocacy for the client. The following literature review reflects the core ideas and research basis for the derived definition of professional nurse autonomy.

### Core ideas about professional nurse autonomy

Over 50 years ago, Bixler & Bixler (1945) noted that obstacles to overcome in achieving professional nurse autonomy are grounded in traditional conceptions of the term. Traditional views, based on a male model of autonomy that emphasizes control and separation, devalue the professional nurse's relationship with the client and the attitudes and behaviours of a primarily female profession (Schutzenhofer 1987, Boughn 1995). Evidence in the nursing and psychology literature indicates that the development of autonomy differs for men and women (Kurtines 1978, Gilligan 1982, Schutzenhofer 1987, Boughn 1995). Females develop autonomy within the context of relationships and the ethics of caring. Others argue that androgyny, a blending of traditional male and female characteristics, may be more relevant to professional nurse autonomy (Salladay 1991, Bradley 1993). Furthermore, helping behaviours are displayed more frequently by androgynous rather than sex-typed individuals (Senneker & Hendrick 1983).

Over 20 years ago, Pankratz & Pankratz (1974) recognized the uniqueness of professional autonomy in individual nurses. Professional nurse autonomy, defined as the nurse's perceived latitude or willingness to act as a responsible professional, emphasizes the dependence and independence between nurses and patients. The nurse's primary area of responsibility is patient advocacy. Others have also acknowledged the association between advocacy and autonomy (Curtin 1982, Pinch 1985, Cassidy & Oddi 1988, 1991).

Although Batey & Lewis's (1982) definition of autonomy is frequently cited in the nursing literature, the definition does not address advocacy or the centrality of the client. Autonomy, the 'freedom to make discretionary and binding decisions consistent with one's scope of practice and freedom to act on those decisions' (Batey & Lewis 1982 p. 15), could be applied to any profession. Gonzalez (1989) augments this definition by including the freedom to act within the context of responsibility and caring for others. Lach (1992) acknowledged that decisions may involve interdependence with other members of the health care team.

Despite conflicting views associated with professional nurse autonomy, the most recent definitions of professional nurse autonomy are based on Gilligan's (1982) female model of moral development and feminist theories. For example, Schutzenhofer (1987) claimed that her definition is based on feminist theories. Professional nurse autonomy is 'the practice of one's occupation in accordance with one's education, with members of that occupation governing, defining, and controlling their own activities in the absence of external controls'

(Schutzenhofer 1987 p. 278). The definition, however, reflects traditional views and does not address the relationship between the nurse and the client. In contrast, Boughn's (1995) definition clearly reflects the feminist perspective. Professional nurse autonomy evolves from the capacity for advocacy and activism for self to endorsement of advocacy and activism for others (Boughn 1995).

The evolving trend of shared control and interdependence in health care, another key component of professional nurse autonomy, is also relevant to the relationship context of contemporary definitions of the concept (Curtin 1982, McKay 1983, Grinnell 1989). Dempster's (1994) comprehensive definition encompasses self and other, or a joint locus of control. Autonomy is 'a dynamic process demonstrating varying amounts of independent, self-governed, not controlled, or not subordinate behaviours and sentiments related to readiness, empowerment, actualization, and valuation for autonomous performance' (Dempster 1994 p. 227). To achieve positive client outcomes in a complex health care system, professionals must be engaged in a collective enterprise. Autonomy, defined as 'both independent and interdependent practice-related decision making based on a complex body of knowledge and skill' (McKay 1983 p. 26), is manifested through communication of mutual respect and trust, both intra and interprofessionally (Grinnell 1989, Kramer & Schmalenberg 1993). Coser (1991) supported interdependence as an essential attribute of professional nurse autonomy and acknowledged the centrality of the client. Autonomous nurses define clients as part of their role set, are involved in complex roles, and continually articulate their role despite inconsistent, incompatible and conflicting expectations.

Interdependence stimulates and challenges individual opinion, guides and augments initiative, and demands individual responsibility and accountability, attributes strongly associated with professional nurse autonomy (McKay 1983, Grinnell 1989, Kramer & Schmalenberg 1993). Nurses must have confidence in their knowledge and be cognisant of the boundaries dictated by the scope of practice (Schutzenhofer 1992). The importance of knowledge is illustrated in Kramer & Schmalenberg's (1993 p. 59) simplistic definition of autonomy as 'the freedom to act on what you know'.

Autonomous decision making does not involve the exercise of routine tasks or the unquestioning enactment of physician orders (Coser 1991, Holden 1991, Kramer & Schmalenberg 1993). Instead, self-direction and intellectual flexibility are required to negotiate and compromise. Discretionary decision making is crucial to autonomous practice (Batey & Lewis 1982, Benner 1984, Holden 1991). Competent nurses exercise discretionary decision making by using the critical conscience to select a course of action consistent with the client's needs.

Individuals who exhibit professional nurse autonomy have the courage to make choices and assume responsibility for their actions (Holden 1991, Cherow 1994). A precursor to responsibility for others, however, is self-responsibility (Holden 1991, Boughn 1995). Responsible decision making requires individuals to examine their ethical values and to endorse ethical conduct, and is not based on emotional attachments or coercion (Pinch 1985, Holden 1991, Chally 1993). Instead, autonomous decisions link values with knowledge and are based on reason and deliberation.

Consequences of professional nurse autonomy include accountability, empowerment, and commitment to the profession. Accountability is often confused with responsibility (Batey & Lewis 1982, Chitty 1993). Being accountable for decisions and actions, implies disclosure to self, to the client, to the employing agency, and to the profession. True accountability leads to empowerment and a feeling of personal efficacy. Individuals who are empowered feel positive about their jobs and may in turn be able to influence the work environment (Alexander *et al.* 1982, Dwyer *et al.* 1992, Blegan 1993, Kramer & Schmalenberg 1993, Dempster 1994, Pearson 1995). Feelings of empowerment also strengthen the professional nurse's commitment to the profession and ultimately to the professionalization of nursing (Styles 1982).

In summary, the theoretical literature described professional nurse autonomy as a unique phenomenon that involves affiliative relationships with clients and collegial relationships with others. Discretionary decision making, a key component of professional nurse autonomy, is based on nursing knowledge, and not emotions or the exercise of routine tasks. Autonomous nurses are accountable for their decisions, feel empowered, and may influence the professionalization of nursing.

### Research on professional nurse autonomy

Although there is extensive research on autonomy in nursing, only studies frequently cited and recent dissertations that relate specifically to professional nurse autonomy were examined. Most of the reported research is descriptive, examining relationships between the concept and personal or work-related characteristics of students and nurses. The research literature on the effects of basic education on professional nurse autonomy for both student and registered nurse (RN) samples is inconclusive. The foundation for professional nurse autonomy, however, may be established during the baccalaureate educational experience.

Rhorer's (1989) cross-sectional simulated time series study examined the relationship between education, work experience and autonomy with a convenience sample of 213 entry level AD and BS students and a random sample of 102 new graduates and 123 experienced RNs. Using

two-way analysis of covariance (ANCOVA), Rhorer found no significant differences among the four groups related to basic educational preparation ( $F = 0.026$ ,  $P = 0.871$ ) as measured by the Pankratz Nursing Attitude Scale (PNAS). A statistically significant ( $F = 45.1$ ,  $P < 0.05$ ) main effect due to experience, however, was moderated by a statistically significant interaction effect between basic education and experience ( $F = 4.6$ ,  $P < 0.05$ ). Comparison of the mean scores of students with scores of experienced RNs from both educational groups revealed a greater increase in autonomy scores for the experienced BS group. These findings suggest that the foundation for professional nurse autonomy may be established with baccalaureate education.

Another cross-sectional study ( $n = 570$ ) of AD students and graduates and RN students and graduates enrolled in traditional and non-traditional BS programmes yielded similar results using Schutzenhofer's (1987) Nursing Activity Scale (NAS) (Keely 1990). A one-way analysis of variance (ANOVA) and post hoc analysis, revealed that AD students scored significantly higher than BS students ( $F = 7.696$ ,  $P < 0.01$ ). When the post-graduation scores of AD students were compared with those of BS alumni, however, BS alumni scored significantly higher.

To clarify the relationship between personal, work and professional nurse autonomy, Lach (1992) used the NAS to study a random sample of 239 hospital and 115 home health nurses. Regression analysis indicated that personal autonomy ( $r = 0.50$ ,  $P < 0.001$ ) accounted for 25% of the variance in professional nurse autonomy, while employment setting and work autonomy, respectively, accounted for 7% and 2% of the variance. A comparison of personal, work and professional autonomy scores between hospital and home health nurses revealed that home health nurses had significantly higher personal ( $t = -3.08$ ,  $P = 0.002$ ), work ( $t = -11$ ,  $P < 0.001$ ) and professional autonomy ( $t = -6.63$ ,  $P < 0.001$ ) scores.

With a convenience sample of 100 BS students, 1 month prior to graduation, Husted (1993) also found a significant relationship ( $r = 0.29$ ,  $P = 0.003$ ) between personal autonomy and professional nurse autonomy as measured by the NAS. Regression analysis revealed that 8% of the variance in professional nurse autonomy was associated with personal autonomy. The stronger relationship between personal and professional autonomy in Lach's (1992) study may have reflected the influence of work experience on the RN population.

To draw conclusions about the variables influencing professional nurse autonomy, the findings from Schutzenhofer & Musser's (1994) comprehensive study of nurse characteristics and professional nurse autonomy are compared with those of other related studies. Using the Nursing Activity Scale (NAS) with a random sample of 542 RNs, Schutzenhofer and Musser found no significant relationship between basic education and mean profes-

sional nurse autonomy scores. ANOVA with post hoc analysis, however, showed a significantly higher mean NAS score for those with an MSN degree ( $F = 2.00$ ,  $P = 0.04$ ). These findings are consistent with other studies suggesting a relationship between advanced education and professional nurse autonomy (Pankratz & Pankratz 1974, Cassidy & Oddi 1991, Collins & Henderson 1991, Lach 1992).

A comparison of practice setting revealed that public health nurses had significantly higher autonomy scores than did hospital-based nurses ( $t = 2.79$ ,  $P = 0.01$ ). Again, these findings are supported by other studies that identify public health nurses as more autonomous than hospital-based nurses (Wood *et al.* 1986, Lach 1992). Although type of hospital and staffing model were not significantly related to autonomy, clinical speciality was significantly related to the NAS score ( $F = 2.32$ ,  $P = 0.04$ ). Post hoc analysis revealed that psychiatric/mental health nurses had significantly higher NAS scores when compared to medical-surgical, maternal-newborn and critical care nurses, findings consistent with those of Pankratz & Pankratz (1974). Akoma (1993), however, reported no differences ( $KW = 3.43$ ,  $P = 0.18$ ) in NAS scores for a convenience sample of medical/surgical ( $n = 30$ ), critical care ( $n = 30$ ), and physician office nurses ( $n = 30$ ). Sample size and composition, as well as the use of a less sensitive non-parametric statistical test, may have influenced these findings.

Schutzenhofer & Musser (1994) also examined professional role as measured by subjects' primary position. Nurse managers had significantly higher NAS scores than did staff nurses ( $t = 5.09$ ,  $P = 0.001$ ). When the scores of clinical specialists and nurse practitioners were compared with those of nurse managers and staff nurses, the advanced practice nurses scored significantly higher. The relationship between higher levels of autonomy and the nurse management role is strongly supported by other studies (Pankratz & Pankratz 1974, Keely 1990, Collins & Henderson 1991).

Other personal and work-related variables that were reported as having non-significant relationships with autonomy include years of experience (Rhorer 1989, Collins & Henderson 1991, Lach 1992, Akoma 1993, Schutzenhofer & Musser 1994) and age (Pankratz & Pankratz 1974, Rhorer 1989, Collins & Henderson 1991, Hallsworth 1993, Schutzenhofer & Musser 1994). Although the possibility of a relationship between gender and autonomy was acknowledged, the small male sample groups rendered these data uninterpretable.

In summary, the research literature indicates that a baccalaureate education may provide a foundation for professional autonomy. Advanced education, however, is strongly associated with autonomy. Personal autonomy and work autonomy are also strongly related to professional nurse autonomy. Any direct relationship between

these variables may be obscured by the fact that individuals with high needs for achievement and autonomy tend to seek higher education and environments that are conducive to using their skills.

### DEFINING ATTRIBUTES

The most frequently occurring characteristics that distinguish professional nurse autonomy from other related phenomena are: (i) caring, affiliative relationships with clients; (ii) responsible discretionary decision making; (iii) collegial interdependence with members of the health care team; and (iv) proactive advocacy for clients.

Demonstration cases illustrate differences between the concept and other phenomena and further clarify the concept of interest (refer to Appendix 1). The model case includes all of the defining attributes and is a 'real life' example of the concept (Walker & Avant 1995). With the borderline case, the nurse could have stayed with the child and asked someone else to obtain the needed medication. Therefore, responsible discretionary decision making is not evident. The related case illustrates work autonomy. Although similar to professional nurse autonomy, the critical attributes are not evident. An example of a case that does not illustrate professional nurse autonomy is depicted in the contrary case. Clearly the nurse is merely following routines and is not attuned to the needs of the client. The invented case takes the concept out of its ordinary context to better visualize the critical attributes.

### ASSUMPTIONS, ANTECEDENTS AND CONSEQUENCES

The educational circumstances and personal attributes preceding professional nurse autonomy are based on the following underlying assumptions: (i) professional nurse autonomy is associated with attitudes that are learned during baccalaureate education; (ii) a relationship between attitudes and behaviour exists; and (iii) one can display autonomy despite organizational constraints.

The antecedents related to education include: (i) competence based on a strong knowledge base; (ii) a clear understanding of the scope of nursing practice; and (iii) a baccalaureate or higher degree in nursing. Personal attributes that precede professional nurse autonomy include: (i) self-respect or caring for oneself; (ii) personal autonomy; and (iii) androgyny.

The primary consequence of autonomy is accountability. Professional nurse autonomy leads to empowerment of self and others and may influence the individual's ability to change the work environment. The linkage between work autonomy and professional nurse autonomy is reflected in satisfaction with one's job, commitment to the profession and ultimately the professionalization of nursing.

### EMPIRICAL REFERENTS

Empirical referents are measurable, observable or verifiable components of the concept (Goosen 1989). Instruments designed to measure professional nurse autonomy include Pankratz & Pankratz's (1974) Nursing Attitude Scale (PNAS), the Nursing Activity Scale (NAS) (Schutzenhofer 1987), and Autonomy, the Caring Perspective (ACP) instrument (Boughn 1995).

The PNAS contains three sub-scales: (i) nurse autonomy and patient advocacy; (ii) patient's rights; and (iii) rejection of nurse's traditional role limitations. The tool has been criticized for concurrently measuring interrelated variables associated with nurse autonomy and containing several ambiguous items (Lach 1992, Schutzenhofer & Musser 1994). Content and construct validity are also questionable because the tool may be outdated and the expertise of the persons developing the items was never reported. Furthermore, the tool has been used to study student and community nurse populations when the original intent was for hospital nurses. Despite these weaknesses, Collins & Henderson (1991) found that subscale means in their study of nurses' ( $n = 208$ ) perceptions of autonomy were similar to those in Pankratz & Pankratz's (1974) original study.

The NAS measures the RN's exercise of autonomy in clinical situations (Schutzenhofer 1987). A recent factor analysis with a sample of 354 home health and hospital nurses revealed that two factors explain 30% of the variance (Lach 1992). Simple-independent autonomous decisions require basic knowledge about specific aspects of client care. Global-interdependent autonomous decisions are based on a broader knowledge base, require input from other disciplines, and affect wider areas of practice. Content validity was based on a review of current nursing literature and a survey of deans, directors of nursing service and clinical specialists at major hospitals in a large metropolitan area. Reported reliability from the initial two-stage tool development study and more recent studies is acceptable.

The ACP measures autonomy-related attitudes and behaviours of nursing students (Boughn 1995). Autonomy is demonstrated through regard for self, regard for others, advocacy and activism for self, and advocacy and activism for others. Reliability and validity was established over a 3-year period with a sample of 400 baccalaureate nursing students. Although the ACP has not been used in other studies, reliability and validity are well supported. The moderately high significant relationship ( $r = 0.56$ ,  $P < 0.01$ ) between the NAS and the ACP indicates that it may be possible to predict autonomy in practising nurses based on student's ACP scores.

In summary, two instruments measure attitudes and/or behaviours associated with professional nurse autonomy in practising nurses. The ACP, designed specifically for

students, is consistent with the construct measured by the NAS. Professional nurse autonomy is a concept that is based on the unique development of autonomy in female nurses. Common empirical referents are independent and interdependent decision making, and advocacy and caring.

### APPLICATION TO NURSING EDUCATION

Nurses begin to learn the knowledge, skills, attitudes and values associated with the professional role during the formal educational process. As primary socializers, nursing faculty play a significant role in promoting professional nurse autonomy (Jacox 1978, Batey & Lewis 1982, Schriener & Harris 1984, Schutzenhofer 1988, Boughn 1995). Through an interactional process students respond to the role cues of the primary socializer (Hurley-Wilson 1988). To reinforce professional nurse autonomy, students must view faculty and nurses in clinical agencies as autonomous role models.

Nursing education programmes have been accused of promoting attitudes of rigidity and conformity that limit students' abilities to learn professional nurse autonomy (Boughn 1987, Schutzenhofer 1992). To instill autonomy-related attitudes in students, a curriculum based on a nursing theoretical framework with a learner-centred design is needed. The theoretical framework provides structure for organizing the course content and the way nursing is taught. Application of a nursing theory to the curriculum helps students understand the relationship of nursing knowledge to practice, define the domain of nursing, and gain control over nursing practice (Schutzenhofer 1988, Moloney 1992). Furthermore, a more theoretically focused curriculum is related to higher levels of student autonomy than programmes that focus primarily on practice skills (Hallsworth 1993). Nursing models that emphasize partnerships, choice and advocacy are relevant to the definition of professional nurse autonomy and the current health care system (Bramlett *et al.* 1990, Watts 1990). Several contemporary nursing models embrace a dynamic patterning of relationships which emphasize the feminine principles of caring, cooperation, collaboration and mutuality (Sarter 1988). By incorporating concepts related to professional nurse autonomy, relevant curricular strands can be designed.

To promote professional nurse autonomy, the curriculum should have a strong liberal education foundation. The aim of a liberal education is to prepare a graduate who 'will exhibit qualities of mind and character that are necessary to live a free and fulfilling life, act in the public interest locally and globally, and contribute to health care improvements and the nursing profession' (Essentials 1987 p. 56). Interdisciplinary courses allow students to appreciate the complementary roles of nursing and other disciplines while practising interdependent decision making (McKay 1983). To develop awareness of the impact of

female socialization on autonomy, participation in interdisciplinary women's studies programmes is recommended (Boughn 1987, Schutzenhofer 1988).

With the increased use of technology and the changes in the age and health status of clients, curricula must also address sophisticated technical skills. Therefore, some structuring of the curriculum provides security for students as they integrate the diverse knowledge associated with nursing practice (Perry & Moss 1989). Courses that address professional issues, leadership, change theory and role theory should also be an integral part of the curriculum (Schriener & Harris 1984, Schutzenhofer 1992).

The curriculum should provide opportunities for developing the values, attitudes and behaviours that reflect professional nursing practice (Essentials 1987). Adoption of the AACN's seven essential values promotes a sense of commitment and social responsibility as well as sensitivity and responsiveness to the needs of self and others. Furthermore, these values reflect the androgenous qualities of the autonomous professional nurse. Caring should also be a core value espoused throughout the curriculum (Tanner 1990). Caring, however, can only be learned by experiencing caring between faculty and students in an environment that supports caring among faculty. Therefore, a major emphasis of the curriculum is on the processes that promote transactions between students and faculty.

Process designs enable students to become part of their own experience and knowledge production. To realize professional nurse autonomy, the relationships between faculty and administrators, faculty and faculty, and faculty and students must emphasize collegiality, cooperation and shared governance (Perry & Moss 1989, Schutzenhofer 1992, Koerner & Karpiuk 1994). Involvement in decision making at all levels of the educational institution is essential. Faculty must not be viewed as distributors of knowledge, but as individuals who present various theoretical positions and interpretations for exploration.

Designing a curriculum that enhances professional nurse autonomy is not easy, considering that most of the learning occurs in highly bureaucratic institutions (McDaniels 1983, Clare 1993). The separation of nursing education from the service arena also creates barriers (Moloney 1992). Changing the curriculum without changing the conditions of practice will probably increase frustration without empowering anyone (Clare 1993). Unification models that support joint appointments between the university and service setting encourage cooperation and collaboration in all areas of teaching, practice and research.

The experiences gained in the clinical area are essential for the development of decision making skills. Laboratory experiences that simulate situations requiring the exercise of professional nurse autonomy should be a prelude to the clinical practicum (Schutzenhofer 1988). Experiences in community and public health nursing familiarize students

with the more autonomous role of community nurses (Hallsworth 1993). For the final clinical practicum, students should select a clinical agency and a preceptor who demonstrates professional nurse autonomy. Clinical conferences, conducted by students and facilitated by faculty, promote exploration and discussion of clinical experiences and practice constraints. By encouraging students to engage in reflection and systematic inquiry about their experiences, they may be empowered to transform some of the contradictory aspects of their education and practice. Autonomous inquiry also encourages students to recognize that knowledge is socially constructed and open for debate and critique. With a process-orientated curricular design, the outcome of learning is self-development and internal self-regulation, behaviours essential for the practice of professional nurse autonomy.

## CONCLUSION

Professional nurse autonomy is a complex, multidimensional concept that may be a result of one's beliefs, life experiences and socialization. Additional research is needed to clarify the concept and its value to nursing education and practice. The socialization of women and professional socialization of nurses have been cited as factors that may inhibit the development of professional nurse autonomy. The derived definition of professional nurse autonomy, however, supports these attributes: caring, affiliative relationships with clients, responsible discretionary decision making, collegial interdependence with members of the health care team, and proactive advocacy for clients. For nurses to function as independent yet collaborative practitioners who advocate for clients and are accountable for their decisions, a blending of male and female attributes is necessary.

A curriculum that enhances professional nurse autonomy must change from an emphasis on training to education, from technique to understanding, from a focus on content to one that endorses autonomous decision making, and finally from ritualistic thinking to one that embraces inquiry. Nurses who successfully integrate the behaviours associated with professional nurse autonomy into their belief system, perceive that they are in control of the work environment and ultimately their profession. If professional nurse autonomy is a key element of professionalism, curricular evaluation must include criteria related to the development of attitudes towards professional nurse autonomy.

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## APPENDIX 1

### Demonstration cases

#### Model case

A nurse was caring for a child who was ventilator-dependent as a result of severe head and neck injuries sustained during an automobile accident. While repositioning the child, the parents asked if the child would ever be 'normal' again. The nurse knew that the child had a high cervical fracture and that the physician had told the family that their child would be ventilator dependent

for life. Realizing that the family had not truly heard the prognosis, the nurse sat with the family and asked them what they wanted for their child.

After listening to their tearful confession that they did not want their child attached to a ventilator for life, the nurse called a family meeting with the physician and the social worker. During the meeting, the nurse helped the family voice their concerns and plan for the peaceful death of their child.

#### *Borderline case*

On a very busy evening, the nurse heard a child crying. Upon entering the child's room, the nurse realized the child was alone and in pain. The child reached out to the nurse and screamed that she was afraid. The nurse sat with the child and comforted her. Realizing that there was no more pain medication in the child's bin, the nurse filled out a requisition and went to the pharmacy to obtain more medication for the child.

#### *Related case*

The nurse manager met with the nursing staff to discuss a new system of scheduling and unit assignments. The nurses were told

that they were responsible for making out their own work schedules and insuring that the unit had an appropriate mix of staff. Nurses were also asked to select primary clients and to assume responsibility for their care during the hospital stay. The nurses collaborated on their schedules and unit assignments.

#### *Contrary case*

The nurse arrives at the hospital promptly and carefully reviews the assignment sheet and care card. After listening to report and mapping out a schedule, the nurse begins to take vital signs on the assigned clients. Before the vital signs are completed, a mother asks when her child will be discharged. The nurse responds that she will have to wait until the doctor makes his/her rounds.

#### *Invented case*

A herd of elephants is travelling to a new watering ground. Before they reach their destination, an elephant notices that some of the herd is missing. The elephant lifts its trunk, makes a loud sound and urges the other elephants to follow. Together the elephants find their lost members and bring them back to the herd.