In a previous article,1 we described how staff nurses, managers, and physicians working on units with confirmed healthy work environments judged “competent performance of nurses.” Although related to all of the essentials of a healthy work environment,2 competent performance is a sine qua non for autonomous decision making, the essential professional work process we discuss in this article.

Autonomy has long been cited as 1 of the 3 cornerstones of excellent, magnetic work environments.3 Progress in identifying organizational structures and best practices that enable clinical autonomy has been inhibited by widespread confusion, lack of precise definition of clinical autonomy, and failure to distinguish between organizational and clinical autonomy. The following excerpt4 from groups of staff nurses illustrates this confusion:

What is autonomy? I wish I knew. I’ve been trying to get an answer to that since nursing school. I know I’m for it and am supposed to want it, but truthfully I’m not sure what it is . . . not having to follow bureaucratic rules and chain of command? . . . Autonomy is making decisions—not always having to ask? Autonomy must have something to do with bureaucracy and size because many nurses in this hospital said that as we merged and got bigger, we lost our autonomy.

In 2001, staff nurses in 14 magnet hospitals identified 8 essentials of a healthy (ie, job satisfying and professionally productive) work environment,2 1 of which is clinical autonomy. Six studies related to the 8 essentials of magnetism have been conducted (Table 1). In both the 2001 study2,4-7 on the dimensions of magnetism and the 3 studies1,10-16 to identify structures, interviewees provided hundreds of examples and descriptions in response to requests and questions such as the following:

- Describe a situation in which you functioned autonomously.
- What does the concept “autonomy” mean to you?
• What do you consider before making an autonomous decision?
• What are the best leadership practices that enable you to function autonomously?

Through constant comparative analysis, we generated grounded theories from which we constructed the magnet hospital staff nurses’ definition of autonomy and the items for the Clinical Autonomy subscale of the Essentials of Magnetism (EOM) tool. In the 2 psychometric studies summarized in Table 1, respondents from both magnet and comparison hospitals completed the EOM; the construct validity of the EOM was established by comparing the scores of nurses in these 2 groups of hospitals. Nurses in magnet hospitals consistently reported healthier work environments, including opportunity and support for autonomous clinical practice, than did staff nurses in comparison hospitals.

This article is not based on a single research study. It is a synthesis of the results from 6 studies on the essentials of magnetism conducted from 2001 to 2007 as they pertain to clinical autonomy and the results of an informal survey at

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**Table 1** Overview of six research studies conducted on the essentials of magnetism

<table>
<thead>
<tr>
<th>Year</th>
<th>Name of study (published reports)</th>
<th>Purpose</th>
<th>Sample</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>Dimensions of magnetism 2,4,7</td>
<td>To ascertain the steps and components of the work processes that staff nurses identified as essential to productivity of quality patient care.</td>
<td>279 staff nurses (SNs) and 132 managers (NMs) and leaders in 14 magnet hospitals</td>
<td>Individual interviews with staff nurses; group interview with NMs and nurse executives</td>
</tr>
<tr>
<td>2003</td>
<td>EOM psychometric 8,9</td>
<td>To test the construct validity of the Essentials of Magnetism tool (EOM), that is, that magnet hospital staff nurses will score higher than their non-magnet counterparts; and to establish the psychometrics of the tool</td>
<td>3602 staff nurses in 26 magnet and comparison hospitals, plus an additional 1000 nurses nationwide on-line</td>
<td>Essentials of Magnetism tool (EOM)</td>
</tr>
<tr>
<td>2004</td>
<td>RN-MD structure-identification 10,11</td>
<td>To identify structures and ‘best practices’ that enable development of collegial/collaborative RN-MD relationships</td>
<td>67 SNs, 43 NMs and 31 MDs on 44 units in 5 high RN-MD relationship-scoring hospitals</td>
<td>Individual interviews; single-item indicators</td>
</tr>
<tr>
<td>2005</td>
<td>Autonomy structure-identification 12,13</td>
<td>To identify, through EOM scores, the clinical units with highest autonomous practice; and to identify structures and ‘best practices’ that support the practice of clinical autonomy</td>
<td>131 SNs, 81 NMs and 55 MDs on 74 units in 8 high autonomy-scoring magnet hospitals</td>
<td>Individual interviews; single-item indicators</td>
</tr>
<tr>
<td>2006</td>
<td>Six essentials structure-identification 14,15</td>
<td>To identify, through EOM scores, the clinical units with the healthiest, staff nurse-confirmed work environments; and to identify structures and ‘best practices’ that support 1) competent performance, 2) education, 3) control of practice, 4) perceived adequacy of staffing, 5) a patient-centered culture; and that foster 6) nurse manager support.</td>
<td>244 SNs, 105 NMs and 97 MDs on 101 units in 8 hospitals with confirmed healthy work environments; 46 representatives from other professional departments</td>
<td>Individual interviews; single-item indicators’ Participant Observations in Central and Unit Council Meetings, unit staff meetings; evidence-based practice team meetings</td>
</tr>
<tr>
<td>2007</td>
<td>EOMII psychometric 16</td>
<td>To test the construct validity and establish the psychometrics properties of the Essentials of Magnetism II</td>
<td>10,514 SNs in 34 magnet and comparison hospitals</td>
<td>EOMII</td>
</tr>
</tbody>
</table>

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Authors

Marlene Kramer is vice president, nursing, at Health Science Research Associates, Apache Junction, Arizona.

Claudia Schmalenberg is president, nursing, at Health Science Research Associates, Tahoe City, California.

Corresponding author: Marlene Kramer, RN, PhD, FAAN, PO Box 7667, Tahoe City, CA 96145 (e-mail: mcairzona@juno.com).

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the 2006 National Training Institute in Anaheim, California, of critical care nurses about their perceptions of autonomous practice. Unless noted otherwise, all excerpts are from interviews with staff nurses in the 2001 study2,4 or in the 2004 to 2007 structure-identification studies.1,10-16 All the speakers are staff nurses unless noted otherwise. Suggestions offered are specifically addressed to clinical nurses and what these nurses might do to improve their work environment with respect to autonomous practice.

Status of Autonomous Practice in Hospitals

Staff nurses perceive and report that they feel that they should practice autonomously, that it is expected of them, but that they receive little support for doing so.19 In the 15 years from 1974 to 1991, nurses reported only low to moderate autonomy scores.18,19 Part of the problem may be due to inadequate, faulty, inconsistent measurement. When autonomy is measured by means of items such as “Nurses need more autonomy in their daily practice,”19 it is impossible to know which of the 34 different definitions of autonomy in the literature is being used as a referent.12 Hence, the results cannot be interpreted accurately. However, when results from 3 different studies10,12,13 by 3 different investigating teams of 3 different samples of staff nurses, some of whom were nurses in magnet hospitals, in which the same instrument22 was used to measure autonomy were compared, the level of autonomy was only moderate; there was little change in level of autonomy during 20 years and little support for autonomous practice.

This moderate level and lack of support for autonomous practice were also evident in a 2001 interview study2,4 of 279 staff nurses in 14 magnet hospitals. When we asked nurses to describe a situation in which they functioned autonomously, 39% provided examples and descriptions indicating limited, unsanctioned, unsupported, or no autonomy.4 By 2004, more than 100 hospitals, 80% of them magnet hospitals, had been tested by using the EOM containing the Clinical Autonomy subscale. Although autonomy scores in magnet hospitals were significantly higher than those in comparison hospitals, the scores still were only moderately high.21 In 2003, the mean autonomy score for magnet hospitals was 78.59, 70% of the total possible score; in 2006, the mean score was 76.38, 68% of the total possible score.8,17

What Is Clinical Autonomy?

Definition

No word engenders more misunderstanding, confusion, and differences in conceptualization than does the word autonomy. Six different descriptors—clinical, job/work, professional, individual, practice, and organizational—are used, and, to add to the confusion, autonomy is dynamic; it changes over time. As an experienced nurse said, “In the 1980s, refusing to give a patient a contraindicated drug was an act of heroism; in the 1990s, it was an example of autonomy; today, it’s standard practice.”

Staff nurse interviewees had a clearer and more consistent understanding of what constitutes clinical autonomy than what is indicated by the descriptions and definitions in the literature.4,12 They demonstrated this by their high similarity in examples of autonomy, descriptions of steps and components of the autonomy process, and illustrations of impediments to autonomous practice. When staff nurses use the word autonomy, they mean clinical autonomy; sometimes, clinical autonomy is also termed practice or professional practice autonomy. Staff nurses do not group clinical autonomy with control of practice and ability to self-govern as was done by directors of nursing in 1982 and has continued in much of the literature today.24 Today’s magnet hospitals staff nurses and their Canadian counterparts25 clearly distinguish the self-determination, self-regulation, control of practice characteristics of a profession from the autonomy characteristic, that is, “the freedom to make decisions about the service needs of clients” as defined by Flexner.20-22

The following definition of autonomy was constructed through constant comparative and thematic analysis18 and from the grounded theory of autonomy generated from the examples and descriptions provided by staff nurses interviewed in hospitals all across the United States:

Autonomy is the freedom to act on what you know in the best interests of the patient . . . to make independent clinical decisions in the nursing sphere of practice and interdependent decisions in those spheres where nursing overlaps with other disciplines. . . . It often exceeds standard practice, is facilitated through evidence-based practice, includes
being held accountable in a constructive, positive manner, and nurse manager support. Autonomous practice includes both types of decision making—indepen- dent and interdependent.

Crucial Components

Understanding the concept of unique and overlapping (U/O) spheres of practice and their relationship to type of decision making (independent or interdependent) is essential for safe, effective autonomous practice. U/O spheres may also be termed separate and combined. The knowledge and activities of nurses and the knowledge and activities of physicians or other health professionals can be envisioned as 2 or more partly intersecting spheres (see Figure). The more discrete and separate knowledge and activities of each professional are indicated by the parts of the sphere that do not intersect. Those that are shared are indicated by the overlapping areas. Usually health maintenance, prevention, and caring dominate nurses’ unique sphere, whereas curative, diagnostic, and prescriptive functions dominate the physicians’ unique sphere. Professionals make independent, patient-centered decisions in their unique spheres of practice. Nurses may seek counsel and advice from peers, but the decision making is individual and independent, as is the accountability for decisions made. Decision-making responsibility and accountability are interdependent and relational in the overlapping sphere.

The first of the following excerpts illustrates autonomous action in the nursing-unique sphere; the second exemplifies autonomous decision making and action in the overlap sphere of practice.

From previous experience and knowing this particular patient, I decide whether alternating pain meds is better than giving a single type of pain med all the time . . . deciding when to get the patient out of bed—the patient may become tachycardiac vs possibly getting a deep vein thrombosis.

An elderly patient with advanced Alzheimer’s and decreased mental status was ordered to have magnetic resonance imaging to rule out brain metastasis? Stroke? There was no reason for it. It wasn’t going to change his treatment one bit. And it would have been very hard on the patient because, at best, he would have had to have conscious sedation; at worst, a general anesthetic. I talked to the resident about it yesterday, and he said he wanted it done because the family wanted to know. I took it to the team, and we decided not to do it. I talked with the brother and when I explained that it would not make any difference in care, he called the rest of the family and they understood.

Adoption of the U/O Concept Into Practice

Although U/O spheres of practice and the corresponding types of decision making have long been heralded in the literature, only recently has adoption of the concept in nurses’ professional practice become evident. In a 1980 classic book on autonomy, Mundinger emphasized that autonomous practice is not a nurse providing medical care without medical supervision or a nurse practicing medicine without a license; rather it is a nurse providing nursing therapy that complements and at times overlaps medical therapy. In the same year, the American Nurses Association and the American Medical Association combined commission on collaborative practice recognized the U/O spheres of practice and called for “the formal development of Scope of Practice documents.” In their 1980 Social Policy Statement, the American Nurses Association emphasized that clinical autonomy and collaborative relationships between nurses and physicians are true partnerships in
which power is held and valued by both participants with recognition and acceptance of separate and combined spheres of activity, responsibility, and accountability. In the 1983 original magnet hospital study, all of the autonomy examples cited were in the nursing-unique sphere of practice, for example, preadmission programs for children, counseling for pregnant adolescents, and support services for senior citizens. The overlap sphere was alluded to when it was noted that in settings without a house staff, nurses perceive themselves as having greater autonomy and responsibility in decision making and in management of patient care. The current magnet program of the American Nurses Credentialing Center defines autonomy as “independent judgment exercised within a multidisciplinary approach to patient care.” This somewhat contradictory definition does not address U/O spheres of practice or corresponding types of decision making, nor are these addressed in either the Forces of Magnetism or in the suggested sources of evidence.26

Despite the overt approval by national professional nursing and medical organizations, no evidence of widespread, consistent use of the concept of U/O spheres of practice was reported until 2001, when staff nurses in 14 magnet hospitals were interviewed.4 When asked to describe a situation in which they practiced autonomously, many nurses inquired, “Do you want me to describe a patient care or a nursing care decision?” Interviewees’ descriptions indicated that autonomous patient care actions were decisions that “extend beyond the usual parameters of nursing to other disciplines,” essentially the same as decisions made in the overlapping sphere of practice. Nursing care decisions were independent actions focused in the nursing arena only, the same as the nursing-unique sphere of practice. Scope of practice emerged as 1 of the 3 dominant themes when the examples and descriptions of autonomy were categorically analyzed; frequency of action and organizational sanction for autonomous practice were the other 2. A total of 43% (n = 117) of the nurses cited autonomous patient care actions; 17% (n = 47) cited nursing care actions.2

Tracking the performance of several research samples (Table 1) on the U/O item of the Autonomy subscale of the EOM provides further evidence of the power and use of this U/O spheres concept as a critical element in autonomous practice in magnet work environments. The Autonomy subscale of the EOM II contains this item: “On this unit, nurses make independent decisions within the practice sphere of nursing and interdependent decisions in those spheres of practice where nursing overlaps with other disciplines such as medicine and respiratory therapy.” Not only do nurses in magnet hospitals consistently score significantly higher on the total Autonomy scale than do their counterparts in nonmagnet hospitals, but the percentage of staff nurses in magnet hospitals who responded affirmatively to the U/O item increased from 83% of 279 nurses in 200133 to 90.2% of 3602 nurses in the 2003 study8 to 94% of 3510 nurses in the 2006 autonomy structure-identification study.12,13 The percentage of positive responses in comparison hospitals has remained low, decreasing from 38% in 2003 to 29% in 2006.8,17

The results of the autonomy structure-identification study12,13 provide additional evidence of increased recognition and use of the concept of U/O spheres of practice.

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**Understanding the concept of unique and overlapping spheres of practice and corresponding types of decision making is essential to autonomous practice.**

**Health maintenance, prevention, and caring predominate in nursing’s unique sphere; curative, diagnostic, and prescriptive functions dominate in the medical sphere of practice.**

**Safe, quality patient care, professional job satisfaction, and nurse retention demand autonomous decision making from all professional practitioners. Nurses want to make decisions that promote quality patient care.**
When presented with 8 of the 34 definitions of autonomy found in the literature, 60% of the 267 staff nurses, nurse managers, and physicians interviewed selected 1 of the following 2 definitions as representative of their understanding of the concept of autonomy. Both definitions recognize the concept of U/O spheres of practice.

1. Autonomy is the freedom to act on what you know; to make responsible, independent decisions in the nursing sphere, and interdependent decisions in that sphere of practice where nursing overlaps with other disciplines.

2. Autonomy is responsible, discretionary decision making, collegial interdependence, proactive advocacy for patients and affiliative relationships with clients.

A total of 31% of the 267 interviewees selected 1 of the 2 following literature definitions to represent their understanding of autonomy. Both of these definitions acknowledge mainly or only the overlap sphere.

1. Autonomy is an environment in which nurses are given command of their expert knowledge and allowed authority and accountability in decision making; it is independent judgment within a multidisciplinary context.

2. Autonomy is the power, authority, and accountability to perform actions and skills in the practice arena where nursing and medicine overlap. It includes skills such as administering narcotics in an emergency without a medication order, altering a patient’s mechanical ventilation after arterial blood gas results, and pulling back a pulmonary catheter after interpretation of a chest radiograph.

**Reasons for Differential Use of the U/O Concept and High Autonomy Scores**

The U/O concept and corresponding different types of decision making are not included in the American Nursing Credentialing Center definition of autonomy for magnet designation. Not all magnet hospitals score at the level noted in the previous samples, nor do all nonmagnet hospitals score low. The percentage of nurses in magnet hospitals who respond affirmatively to the item on U/O spheres of practice is sometimes as low as 37%, and in some comparison hospitals, as many as 85% of nurses respond affirmatively to this item.

The differences in scores occur because in some hospitals, approval and sanction from the leadership create the interest, excitement, and security for clinical nurses to practice autonomously. One staff nurse remarked as follows:

“We're caught between a rock and hard place. The state board, regulatory agencies, and the hospital keep our decision making in a straitjacket. Yet we know, and the doctors know and urge us to make the decisions we need to, to save patients, to reassess, to prevent complications, to provide quality care, and to advocate for the patient.”

Several nurses from a single unit who came to the 2006 interviews as a group had this to say:

Autonomous practice can be scary. You might make a mistake; of course, you may also save the patient’s life or avert harm. But face it; it’s a risk. It’s safer for you not to take the chance, but not so good for the patient. One time I persisted in getting something that I thought my patient needed only to be embarrassed when it was pointed out that I had neglected to consider some fact. But my nurse manager told me to “never doubt” myself. “Think it through and then act. Together we’ll deal with the consequences.” You’ve got to have that kind of support or else functioning autonomously is just too risky.

Executive-level nurses, managers, and staff nurses in the 8 magnet hospitals that participated in the autonomy structure-identification study provided considerable evidence of the support present in their hospitals for autonomous practice. The following are examples:

- Nurses from 2 of these hospitals presented papers on autonomy at the 2006 National Magnet Hospital Conference.
- Four hospitals had hosted a national speaker or workshops on clinical autonomy for their staff within the preceding 2 years.
- Many of these 8 hospitals had active evidence-based practice teams, often interdisciplinary, that focused on knowledge and best practices that formed the basis for autonomous decisions in both the U/O spheres of practice. In 1 hospital, an evidence-based practice team of management and staff nurses was examining management
practices for communicating organizational sanction of autonomy to staff nurses.

- In 1 hospital, all new hires completed a computerized critical thinking course. Although autonomy is more than critical thinking, such thinking is an important and essential aspect.
- Most of the hospitals promoted collaborative nurse-physician and interdisciplinary relationships necessary for safe and effective autonomous practice, particularly in the overlap sphere of practice. Several hospitals used the SBAR (situation-background-assessment-recommendation) situational briefing model; 2 had longstanding, well-functioning collaborative practice programs with collaborative practice orders that allowed staff nurses’ considerable autonomy in decision making.

Why Should Nurses Practice Autonomously?

If the risk involved is so great, why should staff nurses make autonomous decisions? Such decisions are essential for patients’ safety, nurses’ job satisfaction, and nurse retention. Nurses want to make decisions that promote quality patient care. They perceive autonomy as an, if not the, essential component of professional practice. Physicians rated autonomous decision making as the highest indication of competent performance of staff nurses. Most recently, the Institute of Medicine recommended that a higher level of clinical autonomy be given to staff nurses and that they be trusted and supported in using the outcomes of evidence-based practice initiatives to make decisions about patients’ care.

When Are Autonomous Decisions Needed?

Unmet patient needs and rapidly changing conditions are the stimuli for autonomous actions. In the autonomy structure-identification study, we inquired, “What situations or patient needs most frequently motivate you (or staff nurses) to autonomous action?” Interviewees described examples that fit into 6 domains. Table 2 presents each of these domains with its primary motivating factor or patient need. Examples of the emergency domain were often in the overlap or combined sphere of practice. Need to rescue and patient advocacy tied for highest frequency, with physicians citing more need to rescue and nurses more patient advocacy examples.

We probably comment more often on the first example I gave you… I suspect the nurses think we see only their swift and proper decision making in emergency situations. I wonder if they know how much we appreciate their autonomous decisions in preventing harm and complications and in the coordination and teaching they do. (Physician)

Triage decisions varied by unit and tended to be unit specific; these included referrals to the proper place and person for care and the adequacy of preparation for treatments, procedures, or surgery. Patients with multiple comorbid conditions who had several physicians ordering multiple and sometimes conflicting treatments gave rise to the coordination and integration domain.

These autonomy domains are not pure; overlap occurs. Although all domains can be present on any clinical unit, patients’ needs tend to vary by units. The emergency and need to rescue domains are far more common in critical care units than in other units. Coordination and integration are predominate needs of patients in geriatric and rehabilitation units but are also needed, perhaps to a lesser degree, in critical care. Each domain requires different knowledge, assessment, competencies, and decision-making skills.

Most likely autonomous practice would increase, along with improved quality of patient care and nurses’ job satisfaction, if unit orientations and meetings included discussions of the frequently made autonomous

<table>
<thead>
<tr>
<th>Autonomy domains</th>
<th>Patient needs and motivating factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency</td>
<td>Save patient's life</td>
</tr>
<tr>
<td>Need to rescue</td>
<td>Patient safety, prevent harm or complications</td>
</tr>
<tr>
<td>Patient advocacy</td>
<td>Mental and physical well-being of patient</td>
</tr>
<tr>
<td>Triage (when and where to send patients)</td>
<td>Effective and efficient patient care</td>
</tr>
<tr>
<td>End of life</td>
<td>Quality of life or quality of death</td>
</tr>
<tr>
<td>Coordination - integration</td>
<td>Holistic patient care</td>
</tr>
</tbody>
</table>
decisions on the unit and the knowledge and competencies needed to make those kinds of decisions.

Clinical Units Reporting the Most Autonomy

On which clinical units do nurses report the most autonomous practice? In the autonomy structure-identification study,12,13 we selected our interviewees from those clinical units in the 8 magnet hospitals in which staff nurses had previously confirmed that they could and did function autonomously. Every oncology unit (n = 18) in the 8 hospitals scored high enough on the Autonomy subscale of the EOM to be selected for individual interviews with staff nurses, managers, and physicians. All of the orthopedic units had similarly high scores, but only 7 of the 8 hospitals had such units and then usually only 1 unit. Procedural outpatient clinics had the next highest scores. Intensive care units (ICUs) were markedly underrepresented in the high-scoring unit sample; only 8 of 34 units in the 8 hospitals reported extensive autonomous practice as measured by the Autonomy score on the EOM.12,13

Data from the autonomy structure-identification study12 is not the only evidence for this ordering of units with respect to degree of reported autonomous practice. Almost the same unit lineup was found in the 2006 six essentials structure-identification study1,14-16 on 101 units in 8 other magnet hospitals. Oncology units reported the highest scores for autonomous practice; next, in order, were procedural outpatient departments and orthopedic units; combined ICUs were third from the bottom.35

The placement of ICUs in the unit lineup is puzzling and counterintuitive, particularly because ICU nurses usually report a greater need for and score higher in autonomy than do nurses in other specialty areas.36 Why did nurses in some ICUs (8 of 34) report appreciably more autonomy than did nurses in other ICUs? To explore this question, we conducted informal inquiries of individual and groups of ICU nurses during the 2006 American Association of Critical-Care Nurses National Training Institute in Anaheim. We explained the counterintuitive finding and asked the nurses for their ideas, insights, and explanations as to why this finding might have occurred. A dominant explanation was that the increased use of intensivists and having physicians present almost all the time preclude the need for autonomous decision making in
the overlap area. Another popular explanation was that autonomy in
the nursing-unique sphere was so much a part of everyday practice in
the ICU that ICU nurses did not consider it or report it as autonomy. In
a completely different study, Canadian nurses reported a similar expla-
nation for why ICU nurses may have low autonomy scores. The follow-
ing incident related to us by an experienced ICU nurse, describes
what one nurse learned from a colleague about the importance of
autonomous, “caring” decisions and actions in the nursing-unique sphere
of practice.
I was working in an ICU
some 8 to 10 years into my
career. This unit had not
only very high acuity and
intensity but many elderly
patients. The nursing and
medical staff (and I among
them) were really committed
to doing what was needed
to treat these patients’ ill-
nesses and failing bodies.
One night I was caring for
an elderly lady who had
been in the ICU for over a
week. I don’t recall her
diagnosis. She had severe
anasarca and was barely
responsive. She looked
miserable, and I’m sure
that in addition to the myr-
iad of drips and tubes, I
managed her pain. We
were performing a proce-
dure that involved inject-
ing iced saline into
(probably) a Swan-Ganz
line to, somehow through
temperature measure-
ments, calculate cardiac
outputs. All this is really
just staging for the most
amazing autonomous act
of “caring” that I have ever
seen . . . one that changed
me as a nurse.
A fellow nurse asked if I
needed any help as there
was a break in his work-
load (I don’t recall how or
why . . . perhaps his patient
had coded and died). I felt
that although I was busy, I
had things under control
and so I declined his kind
offer. He stood there for a
moment, didn’t say any-
thing to me but then pro-
ceeded to “nurse this lady.”
He went to the foot of the
bed, spoke kindly to her,
something like “I bet your
feet are really cold and
uncomfortable,” and began
to gently rub and massage
her feet. He did this on and
off for a couple of hours,
stood there gently rubbing
her feet, talking to her, while
I continued to regulate
drips, monitor physiologi-
cal parameters, etc, etc,
etc. And you wouldn’t
believe the look of peace,
of comfort, that came over
this lady’s face.
I’ve remembered this inci-
dent for more than 20
years. Who was the nurse
who cared for this patient?
Who made the really
important autonomous
decisions for this lady at
this time? What was the
nursing action that the
patient really benefitted
from? If I recall correctly,
the lady died between this
night and when I was next
scheduled to work. And
neither my actions nor
those of my colleague’s rub-
bing would have saved her
life but who provided her
comfort and caring when
she needed it most? It was
amazing to me what I had
missed. I’m forever grateful
to my colleague for provid-
ing this lady what was truly
an autonomous nursing
action and for showing me
much more about the pro-
fession that I had chosen.

What Can Clinical Nurses
Do to Secure Autonomy-
Friendly Environments?
The 267 staff nurses, nurse man-
gers, and physicians working on
the 74 units in 8 magnet hospitals
who had high scores in autonomy in
the autonomy structure-identification
study, described structures and
best practices that enabled staff
nurses to make autonomous deci-
sions. Three structures and best
practices that have particular rele-
vance for clinical nurses are discussed
in the following sections.

Define What Clinical Autonomy
Means
Autonomy cannot be safely and
effectively pursued with appropri-
ate accountability without an
understanding of the U/O spheres
of practice by staff nurses, manage-
ment, administration, and other
disciplines. This pursuit of autonomy
cannot be done without agreement
about what clinical autonomy is and
how it is to be interpreted, at least
on each unit and in each hospital.
Staff nurses can exert leadership in
this endeavor. They can bring the issue to a staff meeting. They can ask their colleagues to describe their understanding of the concept of autonomy. They can discuss the risks and benefits involved. The 4 definitions provided earlier may be a good place to start. Staff nurses can discuss the differences between independent decision making and interdependent decision making that involves input from other disciplines. What can and should nurses do if their assessments and observations indicate that patients’ needs are not covered by current orders or require action outside nurses’ current scope of practice? As a physician said, “Pretending that risks and impediments to autonomous practice don’t exist will not make them go away.”

As professionals, clinical nurses, particularly those in magnet hospitals, have the obligation and responsibility “to do something about the autonomy mess” not only in the places where they work but also with their school alumni and faculty, with the American Nurses Credentialing Center, and with professional nursing specialty organizations. Nurses can ask themselves, what were they taught about clinical autonomy in their nursing programs? What have they learned since beginning professional practice, and what would they like to see incorporated into the curriculum in the schools of nursing they attended? The original Forces of Magnetism originated from interviews with staff nurses and directors of nursing in the original 41 magnet hospitals. Who better than professional nurses in currently designated magnet hospitals to advise the American Nurses Credentialing Center about the current practice of clinical autonomy and evidence to support that practice? The American Association of Critical-Care Nurses is the only professional specialty organization that recognizes U/O spheres of practice as essential for autonomous practice. If more impediments to autonomous practice are perceived by critical care nurses than by nurses on other units, critical care nurses need to initiate discussion of this issue, not only in ICUs and in the employing hospitals but also in meetings of their specialty organization.

Participate in Periodic Renegotiation of the Scope of Practice

Since the 1970s, scope of practice has been termed redefining domain boundaries, shifting limits on action, knowledge and responsibility to meet patient needs, performance of skills beyond professional jurisdiction, role enlargement or expansion, and
situational credentialing. Negotiation relative to scope of practice is particularly necessary in the overlapping sphere of practice. Interviewees in the autonomy structure-identification study identified 3 levels or patterns of autonomous decision making and action. The first, do and inform later, is based on a history and mutual trust between physicians and nurses and is probably the most frequent autonomous action in the overlapping sphere of practice.

I had a patient go into respiratory distress. I assessed the patient—rapid respirations, anxiety, color, etc.—gave him more oxygen, ordered a chest x-ray because I thought it was fluid overload. Then I called the doctor and gave him a complete report. It was fluid overload and we got him out of that fast.

The second level of autonomous action, persist until the patient gets what he or she needs, involves repeatedly contacting the same physician, contacting other physicians, going “up the chain of command,” or electing not to follow an order or a protocol that the nurse judges to be inappropriate for this patient in this situation. The second excerpt about the elderly patient with Alzheimer’s disease in the section “Crucial Components” is an example of this type of autonomous action.

The patient was in for a brain bleed, and I’d been caring for him for several days. He had many comorbidities and had to be suctioned frequently. I tried to keep these to a minimum because of the increased intracranial pressure, but I still had to do it quite often to keep him from choking on his secretions. The doctor came in while I was to lunch and ordered that the patient not be suctioned oftener than once an hour. Well, I knew that was a “no go.” I contacted Dr ____, but he was tied up; I contacted Janie, the respiratory therapist, and Dr Allan, the clinical pharmacist, and explained the situation, and gave them a chance to think about what they might recommend and then got back to the office nurse and we set up a conference call between Dr ____ and the 3 of us to see how we could take care of this problem, not increase the pressure, but yet keep the patient breathing and comfortable.

Renegotiation of scope of practice also takes place in unit operations meetings or as a part of interdisciplinary rounds, such as are frequent in medical ICUs, neonatal ICUs, stroke units, and trauma units, or in regularly scheduled interdisciplinary meetings to develop, assess, and evaluate nurse order sets, collaborative practice orders, critical pathways, protocols, and rapid response team directives. It is through the process of developing, assessing, and evaluating the effectiveness of orders and protocols that renegotiation of what decisions and activities are best for quality patient care takes place. Interviewees, both nurses and physicians, were concerned about “one size fits all” protocols with required implementation, such as restraints or electrolyte replacement, for all patients in a specific group. These protocols were strongly criticized as constrictive, restrictive, and of little value in autonomous decision making because they provided little room for judgment and appropriateness for individual patients. Sometimes a protocol does not fit this particular patient, at this particular time, in this particular context.

The role of clinical nurses in all of this negotiation is to participate, lobby for clarification, and identify what is needed. In the nursing-unique sphere of practice, renegotiating scope of practice is dictated by best practices, new developments in the field, or new technologies and is largely a matter of intraprofessional dialogue. The overlap sphere
requires interprofessional dialogue and negotiation.

**Obtain the Administrative Sanction and Support Needed**

In the 2006 autonomy structure-identification study, interviewees identified administrative sanction, approval, and support as a best practice enabling staff nurses to make autonomous decisions. This finding is not new. This same best practice was 1 of the 3 themes that emerged from the analysis of the hundreds of examples and descriptions of autonomous practice provided by the 279 staff nurses interviewed in 2001. “I can not and will not practice autonomously if I don’t have at least the support and approval of my nurse manager.” Interviewees noted that if a nurse did not have this support, the only alternative was to “back stage,” or as their Canadian counterparts said, “You’ve got to go in the ‘back door’ and live with the risk that you might get jumped on for trying to do the best you can for your patient.” Several interviewees remarked that the only support they got for autonomous decision making was from their peers or from physicians.

Additional autonomy-enabling structures and best practices were identified by interviewees or through an in-depth analysis of operational and evaluation data collected from each of the 8 hospitals as part of the autonomy structure-identification study. The most extensively cited structures were evidence-based practice teams, activities, and initiatives. To practice autonomously, a nurse must know, must have up-to-date knowledge backed by research and evidence: “Our evidence-based practice teams generate the knowledge upon which protocols and critical pathways are based.” The most effective teams were interdisciplinary evidence-based practice teams of nurses, physicians, pharmacists, and therapists organized around patient care problems.

A second autonomy-enabling practice signifying administrative sanction was the inclusion of autonomy-related concepts in the criteria for career ladder programs or in the criteria for a similar bonus value-added program. All 8 hospitals in the autonomy structure-identification study had some type of professional advancement program. Often, the criteria for advancement centered on participation or leadership in educational or research activities or on council or practice improvement agendas. Of the 8 hospitals that had the highest autonomy scores of more than 100 hospitals tested with the EOM, 2 based all or a large part of their career ladder criteria on the steps and components of autonomy, specifically designating the type of decision making, sphere of practice, and risk taking as advancement criteria. In 6 of the 8 hospitals, spheres of practice and related decision making were spelled out in documents entitled Scope of Practice, Definitions of Nursing, and Models of Professional Practice.

A third structure that communicates administrative/organizational sanction and support for autonomy is performance appraisal documents. Four of the 8 hospitals cited this type of sanction. In 3 of the 4 hospitals, identification of practice spheres and types of decision making were listed as subbehaviors and competencies; in 2, “negotiating scope of practice with physicians and other disciplines” was cited as an advanced staff nurse competency; in all 4, independent and interdependent decision making were defined and listed as major competencies of a professional nurse. The fact that only 4 of these 8 magnet hospitals cited sphere of practice and type of decision making in their performance appraisals, and that in none of the 8 hospitals were these competencies expected of entry-level nurses, supports staff nurses’ contentions that autonomous decision making is exceptional rather than beginning or standard nursing practice.

Staff nurses can take action to obtain the administrative support needed for autonomous practice. Nurses must ask for the support; they have an obligation to make their expectations known. If a nurse wants to practice autonomously and feel that patients need and deserve the best that the nurse can give, he or she must ask that clinical autonomy be defined, discussed, and included in performance appraisals and in clinical advancement criteria. Nurses must bring the issue to practice councils.

Sometimes nurses are made to feel that they do not have the support of leadership and/or management in making autonomous decisions in the best interests of patients. An experienced nurse related the following:

My patient’s BP suddenly dropped, and I gave her a bolus of fluid, which, for this patient at this time, was the right thing to do, but I didn’t have a specific order. As soon as the...
blood pressure came back up, I put in a call, but it was a while before the doctor got back to me. The patient’s BP would have bottomed out if I had not done that, but my nurse manager made me feel like I was a criminal or at the very least, walking on eggs. The doctor was pleased; I got great thanks and support from him.

Unless these issues are openly discussed and brought to the attention of management and leadership, clinical nurses will never really find out if they are or are not expected to function autonomously.

Summary

Staff nurses in magnet hospitals describe autonomy as the freedom to act in the best interests of patients, to make independent decisions in the nursing sphere of practice and interdependent decisions in those spheres in which other disciplines overlap with nursing. Autonomous practice is essential for safe and quality patient care and for nurses’ job satisfaction. Nurses on oncology, procedural outpatient, and orthopedic units report more autonomous practice than do nurses on other units. Six domains of autonomy based on patients’ needs were described; many of these are unit specific. Improving the work environment so that nurses can function autonomously is a responsibility of both leadership and clinical nurses. Clinical nurses can exert leadership by defining autonomy, at least for their unit or service. Periodically renegotiating the scope of practice and obtaining administrative support and sanction will do much to secure autonomy-friendly work environments.

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