

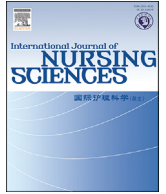
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Original Article

Nurses' lived experiences of professional autonomy in Iran

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ABSTRACT

Objectives: Nurses' autonomy is a complex and multi-dimensional concept that has often been overlooked. Although many studies have addressed patients' autonomy, there has been no assessment of nurses' experience of professional autonomy. The present study aimed to assess nurses' lived experiences of professional autonomy in Shiraz, Iran.

Methods: The present qualitative study was conducted in Shiraz (Iran) from January 2016 to February 2018. The target population was selected among nursing professionals employed by various hospitals affiliated to Shiraz University of Medical Sciences, Shiraz, Iran. The experiences of the participants were assessed through 14 in-depth semi-structured interviews. The response of the participants was analyzed using Van Manen's 6-step approach for interpretive phenomenology.

Results: Based on the analysis of the interviews, 4 themes, 11 categories, and 13 sub-categories were extracted. The themes were: Advocacy for patients and nurses, independence in the workplace, Involvement in professional decision-making, and Professional accountability.

Conclusion: Due to the intense interaction between nurses and patients, a better quality of care will be achieved if the professional autonomy of nurses is ensured. Healthcare authorities and hospital managers should provide the framework and permit the nurses to practically exercise full independence in the workplace.

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What is known?

- Autonomy is an abstract and complex concept, with which individuals gain the capacity to make an informed and independent decision in order to achieve the desired outcome. Although many studies have addressed patients' autonomy, there has been few assessment of nurses' experience of professional autonomy.

What is new?

- Due to the intense interaction between nurses and patients, a better quality of care will be achieved if the professional

autonomy of nurses is ensured. Healthcare authorities and hospital managers should provide the framework and permit the nurses to practically exercise full independence in the workplace.

1. Introduction

Autonomy is an abstract and complex concept, with which individuals gain the capacity to make an informed and independent decision in order to achieve the desired outcome [1–8]. Some scholars have even considered autonomy as an individual right [2]. Autonomy is a core ethical principle in the field of healthcare [1,9,10]. Nursing professional autonomy is a complex, multi-dimensional concept and the basis of professionalism [2,4,6,11,12]. It is considered a professional right to be able to function autonomously within the pre-defined framework of duties and working conditions [2,5]. However, professional autonomy does not contradict with full

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collaboration within healthcare settings, which are often complex and in which teamwork is a prerequisite [9,13]. Moreover, professional autonomy includes the right to independent decision-making and to have control over the core nursing activities [4,5,11,14]. Additional indicators of professional autonomy are critical thinking [6], clinical decision-making [5,6], freedom of action [2,13], and self-governance [4]. The extent of autonomy among nurses is associated with their level of knowledge and education [14,15] as well as life experiences, credence, and sociability [6].

Some researchers believe that the level of professional autonomy of nurses is a process developed through their interaction with and care for patients [1,11,17]. In addition, the degree of professional autonomy is associated with the type of nursing function. A study in Japan has reported that nurses working in operating theaters or intensive care units present a higher degree of professional autonomy compared to those in other departments [18]. In contrast, a study in the United States reported that nurses working on the internal-surgical, psychiatric, and maternity wards presented a higher degree of professional autonomy compared to those working on the intensive care unit [15].

Professional autonomy has become a prerequisite for nurses due to their wide range of functions and responsibilities [13,15]. On the other hand, excessive strain on nurses, due to work-related issues, has resulted in anxiety, job dissatisfaction, and the intention to change jobs [19]. Respect and professional autonomy are the main demands of nurses worldwide [12]. The fact that nurses experience burnout, dissatisfaction with their working conditions, and frequently switch jobs are indicative of the misperception about their need for professional autonomy [6,14].

While there are several studies on patients' autonomy [10,20–23], little attention has been paid to the concept of professional autonomy as experienced by the nurses. Current studies have mainly focused on the association between the concept of autonomy and parameters such as accountability [8], decision-making [24], specific personality traits [15], and job satisfaction [25]. To the best of our knowledge, there has been no assessment of nurses' lived experiences of professional autonomy. Consequently, a qualitative study was deemed necessary to better understand the concept of professional autonomy in accordance with nurses' values, credence, and culture. Hence, the present qualitative study was instigated to assess nurses' lived experiences of professional autonomy in Shiraz (Iran), using the phenomenological method.

2. Materials and methods

The present qualitative study was conducted in Shiraz (Iran) from January 2016 to February 2018. The target population was selected among nursing professionals employed by various hospitals affiliated to Shiraz University of Medical Sciences, Shiraz, Iran.

Based on the purposive sampling method, 12 individuals (9 women and 3 men) were recruited into the study. To ensure diversity and comprehensiveness of the information, the participants included nursing staff, head nurses, nursing supervisors, and nurse managers. The inclusion criteria were a minimum of 3 years of clinical experience, willingness to participate, and the capacity to provide meaningful information during the interviews. The exclusion criterion was the inability to express detailed lived experiences. Demographic characteristics of the participants are presented in Table 1.

2.1. Data collection

The experience of the participants was assessed through 14 in-depth semi-structured interviews, each lasting between 30 and 70 min. Note that a few participants were interviewed more than once in order to clarify ambiguities and obtain complementary information. The questions during the interviews were typically open-ended such as “What is your experience with professional autonomy?”, “What is your understanding of the term professional autonomy?”, and “What is the first thing that comes to your mind when the term professional autonomy is mentioned?” To probe for more information and clarifications, open-ended questions such as “Please elaborate further”, “What do you mean?”, and “Please expand.” were used.

2.2. Data analysis

The response of the participants was analyzed using Van Manen's 6-step approach for interpretive phenomenology. As described by Van Manen [30], these steps were: (1)Turning to the nature of lived experience; (2)Investigating experience as we live it; (3) Reflecting on the essential themes which characterize the phenomenon; (4)Describing the phenomenon in the art of writing and rewriting; (5)Maintaining a strong and orientated relation to the phenomenon; (6)Balancing the research context by considering the parts and the whole.

The most common technique used in phenomenology is bracketing, intuition, analysis, and description of a process which does not require to follow a specific sequence [27,32]. In the present study, steps 3–6 of Van Manen's approach were used for continuous analysis of the data without the need to follow the steps sequentially [30]. Data analysis started after the first interview and continued until no further new information was obtained [29,31]. At the end of each interview, the audio files were reviewed meticulously and the overall story was noted. Then the entire interview was transcribed verbatim and checked several times. Finally, the data were analyzed using steps 3–6 of Van Manen's methodology. Semantics were subsequently extracted and the themes and categories were

Table 1
Demographic characteristics of the participants.

| Participant | Sex | Age (years) | Marital status | Education level | Function | Working experience (years) |
|-------------|--------|-------------|----------------|-----------------|--------------------|----------------------------|
| P1 | Female | 40 | Married | BS | Nursing staff | 15 |
| P2 | Female | 35 | Married | BS | Nursing staff | 10 |
| P3 | Female | 43 | Single | BS | Nursing staff | 18 |
| P4 | Female | 42 | Married | MS | Nursing supervisor | 18 |
| P5 | Female | 46 | Married | BS | Head nurse | 23 |
| P6 | Male | 35 | Married | BS | Nursing staff | 13 |
| P7 | Female | 41 | Single | BS | Nursing staff | 15 |
| P8 | Female | 42 | Married | MS | Nurse manager | 17 |
| P9 | Female | 43 | Single | MS | Nursing supervisor | 19 |
| P10 | Male | 37 | Single | MS | Nursing staff | 14 |
| P11 | Male | 43 | Married | BS | Head nurse | 20 |
| P12 | Female | 39 | Married | MS | Nursing staff | 14 |

determined using continuous comparative analysis. The categories were defined by clarifying the internal semantic dimensions of each individual's experience, separating semantic statements, and semantic analysis. Then modification and balancing of the findings were performed. During the research, we maintained a conscious and strong connection with the semantic units, categories, and themes. In addition, the data were analyzed continuously throughout the research process. Moreover, balancing of the findings was carried out with continuous control of the components and the general concept. Finally, a detailed description of the phenomenon was produced while maintaining internal stability and part-whole relationships.

2.3. Data trustworthiness

The data accuracy was assessed using the criteria credibility, dependability, transformability, and confirmability [33,34]. Data credibility and dependability were achieved through triangulation (multiple data sources, data collection, and data analyses), researchers' established credibility, prolonged engagement with the findings, adaptation to participants' experiences, identification of dissimilar findings, member check, and external check [27,33,35,36].

To fulfill the transferability criterion and in order to ensure a similar understanding of the terms for all involved [36], we ensured adequate accessibility of the participants to detailed information, the diversity of participants (across different nurse rankings), and purposive sampling of those participants with detailed information [29,34,35,37]. Finally, the confirmability criterion was established through a detailed description of both the findings and study process and through auditing [36].

2.4. Ethical considerations

The research protocol was approved by the Research Committee of Shiraz University of Medical Sciences (code: 93-7297). Prior to the interviews, all participants were informed about the research goals and processes. In addition, the confidentiality of any disclosed information was guaranteed. Audio recording of the interview was stopped in case of objection by any participant. Written informed consent was obtained from all the participants.

3. Results

A total of 12 individuals (9 women and 3 men) aged 35–46 years participated in the study. The participants were either staff nurse ($n = 7$), head nurse ($n = 2$), nursing supervisor ($n = 2$), or nurse manager ($n = 1$) with 10–23 years of working experience (Table 1).

Analysis of the interviews resulted in 420 primary codes. Initially, 8 themes and 31 categories were extracted from the data. Following further analysis and combining items with strong similarities, a list of 4 themes, 11 categories, and 13 sub-categories were identified (Table 2).

3.1. Advocacy for patients and nurses

Under the theme "Advocacy for patients and nurses", two categories were identified, namely "support for patients' rights" and "support for nurses' rights". The participating nurses indicated that support for patients' rights is of prime importance. Some participants stated the main concern of nurses and head nurses on not being able nor having the authority to advocate patients' rights even in the case of patients with critical medical conditions. A nurse with 10 years of working experience commented on support for patients' rights and stated: "I cannot advocate the rights of a patient. In fact, we do not have the authority and are not even permitted to defend the rights of a patient in the presence of the treatment team and of physicians in particular. On this issue, we are simply powerless." (P2)

The participants believed that the rights of the patients and nurses are intertwined. Violation of nurses' rights would in turn negatively affect the rights of the patients. Nonetheless, in many cases, nurses would give higher priority to patients' over their own rights. A nurse with 15 years of working experience stated: "Instinctively, I will not compromise the patients' rights when my own rights are undermined. For example, I would not undermine the medical treatment of a patient because my monthly paycheck has not been paid on time." (P7)

In reality, despite a possible violation of nurses' rights, their professionalism prevented them from exacerbating the suffering of the patients. In this regard, a head nurse with 23 years of working experience stated: "The fact that my hard work and contributions are not recognized and appreciated by the treatment team does not mean

Table 2
Extracted themes, categories, and sub-categories from the interviews.

| Theme | Category | Sub-category |
|---|---|--|
| Advocacy for patients and nurses | Support for patients' rights | Violation of patients' rights and risk of harm Commitment to patients' rights Protection of patients' rights |
| | Support for nurses' rights | Violation of nurses' rights and lack of support Ability to pursue violated rights The right to protest |
| Independence in the workplace | Professional dominance by physicians Feudal mindset Discrimination against nurses in the workplace Administrative deficiencies | |
| Involvement in professional decision-making | Active role of nurses in the decision-making process Recognition of the right of independent decision-making by nurses | |
| Professional accountability | Involvement in working condition planning Misplaced accountability | Accountability for medical errors Accountability for shortcomings Accountability for the performance of others |
| | Activity within defined responsibilities and roles | Determination of job boundaries Clear professional framework A clear job description and execution within the pre-defined framework Imposing additional tasks |

that the patient should pay the price and suffer the consequences of my demotivation.” (P5)

Lack of effective support by the medical team and hospital authorities undermining their professional autonomy was another concern of the participants. In this regard, a nurse with 15 years of working experience stated: “A family caregiver of a patient physically attacked me, but my colleagues laughed about the event instead of confronting the caregiver and back me up.” (P1)

Another participant, a nursing supervisor with 19 years of working experience stated: “A family caregiver of a patient verbally insulted and physically attacked me. I filed an official complaint and took that individual to court. Eventually, after a long-winded process, the caregiver was charged with assault. Despite the verdict, to my surprise, the nursing manager blamed me for the event, and as a punishment, she transferred me to another ward.” (P9)

The participants were of the opinion that professional autonomy had to include freedom of expression, the right to protest, and the possibility to lodge a formal working-related complaint. The nurses mentioned various scenarios associated with the inability to pursue cases related to occupational injuries, lack of clear procedures and guidance on how to formulate a complaint, and losing out on benefits due to legal unawareness. A nurse with 15 years of working experience stated: “An oxygen cylinder fell on me and caused injuries. At the hospital, there was no clear procedure on how a complaint should be filed. Instead of being supportive, the nursing manager blamed me for the accident and stated that I should have secured the oxygen cylinder. The safety manager of hospital discouraged me from making an official complaint and stated that such complaints would not lead to compensation.” (P1)

The participants expressed their experiences regarding legal unawareness and lack of possibilities to pursue a case of violated rights. A head nurse with 23 years of working experience stated: “My justified complaint on a work-related case was dismissed outright. Unjustly, they punished me by partial withdrawal of benefits awarded based on the years of work experience. As I was unable to uphold my rights in previous instances, I decided not to pursue further cases in order to prevent such negative flashbacks.” (P5)

The participants also mentioned their experience of not being allowed to protest and express their dissatisfaction. A nurse with 10 years of working experience stated: “I have the right to protest and complain about the excessive number of patients assigned to me or tasks outside my job description (e.g., performing invasive procedures in the absence of the physician). Why should I always be the first person to deal with a patient's complaints and anger? Why the nursing manager is so authoritarian that no one dares to approach her?” (P2)

3.2. Independence in the workplace

The participants expressed their total dissatisfaction with the superiority complex and aggressive behavior by the physicians in dealing with nurses and patients. They viewed such a feudal mindset by the physicians as the main challenge to their professional autonomy and independence in the workplace. The participants had bitter memories of discrimination between nurses and the other medical staff. They were also disappointed with the way patients over excessively respected the physicians while looking down on the nurses. In this regard, a nurse with 15 years of working experience stated: “Once a family caregiver complained about the fact that the physician arrived late. The doctor was busy in his office and would not heed to my telephone request to attend to the patient. The caregiver lost his control and addressed me in an abusive manner while the doctor overheard the conversation through the phone. After a short while, the caregiver left and the doctor angrily approached me and made a scene. Eventually, the caregiver reappeared and only apologized to the doctor, despite the fact that I was at the receiving end

of all the insults from both the caregiver and the doctor.” (P1)

The participants mentioned various employment shortcomings due to administrative deficiencies. Typical examples were related to the lack of benefits and perks with respect to the location of the workplace, administrative errors in the registration of working hours, and job promotions and benefits awarded based on favoritism. A nurse with 10 years of working experience stated: “As a nurse, we are not permitted to work autonomously and our presence at work is monitored by administrative personnel who have no clue about the nursing job. We lose out on everything and we are not even permitted to cross-check our working hours in case of discrepancies.” (P2)

3.3. Involvement in professional decision-making

The participants considered direct involvement in the decision-making process, in terms of both the macro- and micro-level healthcare, as an integral part of professional autonomy. A nurse with 13 years of working experience stated: “On the macro-level, there is a need for focused attention for nurses from the government, parliament, and society as a whole. Accordingly, they should address workers' rights, salary payment rules for nurses, and the general status of nursing.” (P6)

In terms of micro-level healthcare, the participants expected involvement in general nursing planning and that their professional opinions would be taken into account in the decision-making process. They viewed professional autonomy to include having the authority to make decisions about healthcare services as well as the provision of patient care and treatment based on knowledge, experience, and the level of nursing responsibility. In this regard, a nursing manager with 17 years of working experience stated: “When I am asked to contribute to an assignment, I expect my participation and contribution to be recognized. My ultimate goal is to elevate the perspective of society on the nursing job.” (P8)

The participants concluded that, based on their past experience, nurses do not have the authority to make autonomous decisions and they are restricted in making decisions on the scope and tasks of the nursing job. A nursing supervisor with 18 years of working experience stated: “I do not have the authority to make autonomous decisions on clinical cases; it has to be initially approved by the nursing manager. Furthermore, I need to obtain management approval prior to any decision on an administrative aspect of the job.” (P4)

The involvement of nurses in formulating the key provisions of the labor contract (regulations, job termination) was also viewed as an important element of the decision-making process and professional autonomy. A nurse with 14 years of working experience stated: “I would like to have the freedom to terminate my contract or opt for early retirement at will.” (P12)

The decision to opt for early retirement was also viewed as an element of the professional decision-making process. A nurse with 14 years of working experience stated: “I should have the freedom to opt for early retirement, but such clause is not included in my labor contract.” (P10)

3.4. Professional accountability

The overall perception of the participants was that regardless of the nature of the medical shortcomings and problems in the workplace, it is always the nurses who are made accountable. Since nurses are directly and continuously in contact with patients and family caregivers, there is misplaced accountability by all parties involved. This is to the extent that nurses are made accountable even if the issue at hand is the result of shortcomings of the support team and para-clinic unit or caused due to the physician's error, absence, or laziness. Ultimately, it is expected from the nurses to fix

all sorts of problems. The participants indicated that due to the teamwork nature of medical care, in the event of a mistake or medical error, physicians and other members of the treatment team tend to blame the nurses and make them legally accountable or liable for possible financial compensation. A nurse with 10 years of working experience stated: *“A few years after a prostatectomy, the patient complained about impotency. As I was the nurse in charge of that patient at the time, I was made accountable. The issue was clearly due to surgical errors and had nothing to do with post-operative care. However, the surgeon partially blamed the nursing team in order to minimize his own legal responsibility and to reduce his share of the financial compensation to the patient.”* (P2)

Since nurses are directly and continuously in contact with the patients, they are forced to justify failures and answer to clients, patients, and even at times to other members of the treatment team. A nurse with 10 years of working experience stated: *“We have to justify the absence or late arrival of the physicians. We are expected to explain why there is a long waiting time, why the doctor did not consult adequately, or why no prescription was given. It seems that I have to cover for the shortcomings caused by the physician.”* (P2)

The working hours of hospital nurses was another issue for the participants. They indicated that job-related responsibilities may continue even beyond the end of their working hours. Typically, it is expected of them to respond to managerial questions beyond working hours; even on issues not directly related to their tasks and responsibilities. A nursing supervisor with 19 years of working experience stated: *“I have to be on standby even when I am off work to answer questions and resolve issues unrelated to my duties. Sometimes I receive calls from the management team during my leisure time requesting to return to the ward to handle an unplanned visit by an external inspector.”* (P9)

The participants associated professional accountability with the execution of tasks within the pre-defined job description. In this regard, the sub-categories extracted from the data analysis were the determination of job boundaries, the presence of a clear professional framework, clear job description and the execution of tasks within the pre-defined framework, and the imposition of additional tasks. The participants expressed the necessity of a clear definition of their tasks and the separation of responsibilities of nurses, physicians, and other members of the treatment team. A nurse with 18 years of working experience stated: *“The framework of the responsibility of nurses is pretty vague. Our rights and duties are not well-defined. Nobody fully knows how far they can push to claim their rights. I think it is a non-spoken arrangement that a nurse should carry out unrelated duties of secretaries and physicians. Since we perform various related and unrelated tasks, none of us knows our exact job description.”* (P3)

The participants felt obliged to carry out tasks beyond their job description and authority. The time a nurse spends on unrelated tasks undermines their main responsibility, which is providing clinical care to patients. This in turn negatively affects the quality of the provided nursing care. The participants experienced situations where unrelated tasks were imposed on them by the hospital management team. A nurse with 10 years of working experience stated: *“We carry out tasks that are beyond our job description and duties. These unrelated tasks are not covered by our insurance policy, which may lead to legal and financial problems. When we discuss such issues with the management team, they immediately add those tasks to our job description as a workaround rather than effectively addressing the core problem.”* (P2)

4. Discussion

In the present study, the lived experience of nurses of professional autonomy was examined based on the Van Manen's

approach. Four main themes were identified, namely Advocacy for patients and nurses, Independence in the workplace, Involvement in professional decision-making, and Professional accountability. Among these, the prominent theme was independence in the workplace. The categories associated with this theme were: professional dominance by physicians, feudal mindset, discrimination against nurses, and administrative deficiencies. The participants indicated that primarily these categories undermined their professional autonomy.

The findings of previous studies indicated that the dominance of physicians obstructed the provision of treatment and care by nurses [19,38]. In another study, professional autonomy was defined as independent but collaborative functioning in a complex clinical setting [13]. However, the autonomous functioning of nurses in such settings is restricted due to the dominant role of physicians as the sole responsible person for diagnosing and treating patients [39]. As a direct result of such unequal sharing of responsibilities in the healthcare system, nurses become demotivated, which in turn negatively affect the quality of care provided by them and other members of the treatment team [19]. Moreover, a feudal mindset in hospitals undermines the role and position of nurses. Consequently, they are often disrespected and at times insulted not only by the physicians but also by the patients and their family caregivers. Various studies have confirmed such disrespectful behavior towards hospital nurses [40–42].

Involvement in the professional decision-making process was a theme associated with the professional autonomy of the nurses. The three main categories of this theme were: playing an active role in decision-making, having the authority to make decisions, and involvement in drawing up employment regulations. Nurses preferred to be involved in the decision-making process related to their profession, such that their needs and opinions are taken into account. In various studies, professional autonomy was defined as independence, the ability to act purposefully, and the right to control one's professional and work environment [4,5,43]. In a study by Fagin, nurses' rights to participate in the policymaking process which directly affect nurses was emphasized [43]. In a study conducted in America, nursing autonomy was defined as the freedom to provide care autonomously, give clinical judgment, to be accountable for a wide range of activities, receive support, and collaborate with the treatment team in order to provide optimal care to patients [3]. Some studies have identified various factors that violated the nurses' rights toward effective involvement in the decision-making process and controlling their working condition. These factors were tough working conditions, imposing inappropriate work plans, assigning irrelevant tasks, compulsory overtime, and assigning tasks unrelated to the experience and education of a nurse. As a direct result, nurses experienced fatigue, anxiety, and disruption of their normal social interactions [12,38]. Along the same line, other studies considered freedom in making decisions and involvement in work planning and working conditions as the main elements of professional autonomy of nurses [2,4–6,11].

Another theme for professional autonomy was advocacy for patients and nurses. Support for patients' rights is the essence of the relationship between a nurse and a patient [44]. In the past, support for patients' rights was seen as defending those rights under threat. Nowadays, support for patients' rights is associated with the level of autonomy of a patient [45]. Some studies have described advocacy for patients as an element of professional autonomy of nurses [11,13]. A study conducted in Italy described professional autonomy as an opportunity for nurses to assess the needs of a patient and initiate appropriate action in line with their professional capabilities [39]. A previous study suggested that nurses would have a higher level of job satisfaction and tend to work longer in those medical centers where they could provide

more support to patients [46]. Another study also considered support for patients' rights as a part of the professional rights of the nurses [47–49].

The sub-categories of support for nurses' rights were the violation of their rights, ability to pursue violations, and the right to protest. A review of previous studies indicated that nurses have the right to refuse to perform certain medical care assignments incompatible with their abilities, readiness, and beliefs [43]. This concept was legally approved in the United States in 1995, allowing nurses to refuse certain assignments for which they do not have the required competence, abilities, skills, or training [49]. Based on our literature review, while we found many examples of disrespect for nurses as well as physical or psychological harm [38,40,42,50–54], there was no evidence of support for a theme related to nurses' rights as a dimension of professional autonomy.

The theme "professional accountability" was also associated with the professional autonomy of the nurses. The main categories of this theme were the lack of a clear job description and assignments within pre-defined roles and responsibilities. The participants indicated that many assignments, beyond the framework of their job description and responsibilities, were imposed on them. As a direct result, they were made accountable for assignments that were the responsibility of others. Generally, in addition to providing care and support to patients, nurses were exposed to a wide range of unrelated assignments. A clear framework for nursing duties and responsibilities is an essential part of the nursing profession, used as a guideline to provide better nursing quality and care to patients [19,54]. A study conducted in Turkey concluded that nursing activity performed within the framework of a clear job description and the withholding of unrelated assignments (secretarial activities, managing laboratory results) were essential to enhance the professional autonomy of nurses [12].

The sub-categories of misplaced accountability were: accountability for medical errors, accountability for shortcomings, and being held accountable for the performance of others. Previous studies have also described accountability as part of the professional autonomy of nurses [4,11,13]. Moreover, some researchers believe that professional autonomy does not refer to a fully independent and autonomous nursing function, but only to the accountability of nurses for duties defined [13]. Overall, the majority of researchers agree on the idea that professional autonomy can only be realized through accountability [2,13].

There are many reports on nurses having experienced being unappreciated and exposed to offensive behavior by the patients or their family caregivers as well as by other members of the treatment team [14,19,38,53]. In some cases, the blame on the nurses was unjust and a typical example of misplaced accountability. In 1994, nursing was officially recognized in Italy as a profession with defined responsibilities and accountability. In this regard, the authorities defined various aspects of the nursing job description, including the specific responsibilities of nurses as a member of a treatment team, specific areas of knowledge and practice, the presence of problem-solving skills, collaboration with the medical staff, participate in knowledge transfer to other team members, and the possibility to follow additional training [39].

The main limitation of the present study was the sole participation of clinical nurses. In addition, due to the nature of qualitative studies, our findings cannot be generalized. It is recommended that further studies include the experience of other nurses (instructors, mentors, and students) for a better understanding of the concept of professional autonomy.

5. Conclusion

The findings of the present study identified four themes

associated with the professional autonomy of the nurses, namely advocacy for patients and nurses, independence in the workplace, involvement in professional decision-making, and professional accountability. Due to the intense interaction between nurses and patients, a better quality of care will be achieved if the professional autonomy of nurses is ensured. Healthcare authorities and hospital managers should provide the framework and permit the nurses to practically exercise full independence in the workplace.

Authors' contributions

Study design: Elahe Setoodegan, Mahnaz Rakhshan and Sakineh Gholamzadeh; data collection: Mahnaz Rakhshan and Elahe Setoodegan; data analysis: Elahe Setoodegan, Mahnaz Rakhshan and Hamid Peiravi; manuscript preparation: Mahnaz Rakhshan, Elahe Setoodegan and Hamid Peiravi.

Conflicts of interest

The authors declare no potential conflicts of interest.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.ijnss.2019.05.002>.

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