ปัจจัยที่มีความสัมพันธ์กับความมีเอกสิทธิ์ในวิชาชีพของพยาบาลประจำการในโรงพยาบาลของรัฐ ประเทศเวียดนาม

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บทคัดย่อ

การวิจัยเชิงบรรยายและหาความสัมพันธ์ครั้งนี้มีวัตถุประสงค์เพื่อศึกษาระดับความมีเอกสิทธิ์ในวิชาชีพและระดับการประสานความร่วมมือระหว่างพยาบาลและแพทย์ และปัจจัยที่มีความสัมพันธ์กับความมีเอกสิทธิ์ในวิชาชีพของพยาบาลในโรงพยาบาลของรัฐ ประเทศเวียดนาม กลุ่มตัวอย่างเป็นพยาบาลประจำการที่ปฏิบัติงานในหอผู้ป่วยสามัญและหอผู้ป่วยวิกฤติ โรงพยาบาลของรัฐ 2แห่ง ในภาคเหนือประเทศเวียดนาม จำนวน 120 คน เลือกกลุ่มตัวอย่างโดยการสุ่มอย่างง่าย เก็บข้อมูลใช้แบบสอบถาม วิเคราะห์ข้อมูลด้วยสถิติพรรณนา สัมประสิทธิ์สหสัมพันธ์เพียร์สัน และการทดสอบทีแบบกลุ่มตัวอย่างอิสระ ผลการวิจัยพบว่า พยาบาลกลุ่มตัวอย่างรับรู้ความมีเอกสิทธิ์ในวิชาชีพและการประสานความร่วมมือระหว่างพยาบาลและแพทย์ ในระดับปานกลาง และอายุของพยาบาล จำนวนปีของประสบการณ์ทำงาน และระดับการประสานความร่วมมือระหว่างพยาบาลและแพทย์ มีความสัมพันธ์ทางบวกกับความมีเอกสิทธิ์ในวิชาชีพอย่างมีนัยสำคัญทางสถิติ ($r = .47$, $p < .001$, $r = .34$, $p < .001$, $r = .59$, $p < .001$ ตามลำดับ) และผลการทดสอบที พบว่าพยาบาลที่ปฏิบัติงานในหอผู้ป่วยวิกฤติ มีการรับรู้ความมีเอกสิทธิ์ในวิชาชีพสูงกว่าพยาบาลที่ปฏิบัติงานในหอผู้ป่วยสามัญ อย่างมีนัยสำคัญทางสถิติ ($p < .001$) ผลการวิจัยครั้งนี้เสนอแนะว่าผู้บริหารการพยาบาล ควรสร้างบรรยากาศการทำงานที่ส่งเสริมให้แพทย์และพยาบาลทำงานเป็นทีม เข้าใจ ยอมรับและไว้วางใจกัน เพื่อให้มีการประสานความร่วมมือที่ดีในการทำงาน และส่งผลต่อความมีเอกสิทธิ์ในวิชาชีพ

คำสำคัญ: ความมีเอกสิทธิ์ในวิชาชีพ, การประสานความร่วมมือระหว่างพยาบาลและแพทย์, เวียดนาม

Introduction

Professional autonomy is considered as an essential competent of nursing development. During decades, nurses had struggled to achieve credibility, autonomy, and power; and to be recognized as a professional working independently and walk abreast with other professionals in healthcare system. With the increasing emphasis on high quality of health care and professional development, autonomy of nurses continues to be a critical aspect of nursing professional practice for the 21st century [1].

The concept of professional autonomy is complex and there is no agreement on its definition. Professional autonomy indicates freedom for the professional to practice in accordance with his/her professional training[2]. It is the privilege of power for special persons or groups based on their expertise and knowledge relevant to their professions. Professional nurse autonomy implies independence, accountability, self-determination and professional control[3]. It means the capacity and power of the nurse to think and work autonomously in providing

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patient care, and accepts accountability for their decisions and actions in accordance with professional knowledge and standard[3].

Nurses practicing with full autonomy bring in benefit for nurses themselves, patient outcome and nursing professional. For staff nurses, autonomy is an essential component of clinical practice and necessary for the ability to practice to the full extent of their skills and knowledge[4]. They feel freedom to make decision and act base on their ability in patient care and other work in the ward, and lead to more satisfaction with their job. For patient outcomes, the development of professional autonomy in diagnosing and decision-making was vital in the provision of effective and timely care, enhancing patient safety, and lower mortality rates[5]. Professional autonomy strongly predicted nurses' perceptions of effectiveness of patient care and higher levels of autonomy were positively associated with nurse executives' perceptions of the quality of patient care delivered. In nursing profession, professional autonomy improves nurse retention[6], to maintain experienced and competent nurses[7] to provide service, lower staff turnover rates and increase respect, status, and recognition for nursing. Autonomy is one of the most important elements of achieving full professional status and professional development.

Several studies showed that many factors are related to professional autonomy of staff nurses. Firstly, age and years of experience were important factors to increase professional autonomy; this might be due to nurses who are older and have more working experience being more confident in decision-making[8]. Secondly, practice setting related to professional autonomy and in different practice settings, staff nurses have different level of professional autonomy[3]. Thirdly, nurse-physician collaboration has been identified as a way of redressing the power relationship and supporting nurses' autonomy[10]. Autonomy combined with collaboration may be the key to maximizing staff nurse potential, strengthening nurse's unique position in health care, and making a difference for patients. Previous studies showed that nurse-physician collaboration is positively associated with autonomy.[11,12]

Vietnam is a developing country in Southeast Asia. Physicians have been the main educators of nurses and nurses were influenced by physician perspective and could not recognize the separated role of their profession. In the past, a high percentage of staff nurses were female. Most females were less educated than men and traditional awareness of society assigned nurses to a lower position than physicians and considered them as physician assistants who obeyed the orders of any physician. Hence, nurses seriously lacked of autonomy at work. These problems have been lasting until now in the Vietnamese health care system. The concepts of professional autonomy remain ambiguous among staff nurses and nurse administrators. Factors that may be associated with autonomy among Vietnamese staff nurses have not been studied. It is crucial that nurse administrators need to know the level of nurse autonomy and the factors which affect professional autonomy in order to find to strategies to improve professional care services which will bring quality of care for patient as well as staff satisfaction at work. Thus, the purposes of this study were: (1) to examine level of professional autonomy and nurse-physician collaboration, (2) to examine relationships between staff nurse's age, working experience, nurse-physician collaboration and professional autonomy among staff nurses, (3) to compare the levels of professional autonomy between staff nurses working in general units and critical care units in public hospitals in the North of Vietnam.

Conceptual Framework

Conceptual framework of this study was based on theoretical literature and empirical studies of professional autonomy. Professional autonomy was defined as the state of being independent, free

and having self-determination within the scope of an individual's own practices[4]. Autonomy as an essential component of clinical practice and necessary for the ability to practice to the full extent of skills and knowledge[4]. The autonomy of nurses derived from two important sources: nursing knowledge and social relation or nurse position in the society[3]. From these two sources, personal factors and work-related factors are considered as the two main factors which affect professional autonomy[3]. Among personal factors or nurse's characteristics, age and year of experience have shown positive relationship with professional autonomy [7]. Nurses show more independence and decision-making ability when they are older and have more years of working experience[7]. Practice setting and nurse-physician collaboration are two components of the work-related factors. Practice setting has been researched in many studies and has shown both positive or negative relationships with professional autonomy[3,13,14]. Previous studies showed that nurse-physician collaboration has a significant relationship with professional nurse autonomy[11,12].

Methods

Design: A descriptive correlational design was used in this study.

Setting: This study was conducted in two public hospitals under supervision of Ministry of Health located in the North of Vietnam. They were Hai Duong province hospital and Viet Tiep hospital. These two hospitals are at tertiary care level (level 1) in the health care system of Vietnam, have similarity of organizational structure and policies, and numbers of beds (appropriately 1,000 beds). These hospitals provide health care service for adult, elderly outpatients and inpatients with all kinds of diseases, illnesses, and injuries. Each hospital has four medical wards (urology, gastroenterology, respiratory, cardiovascular- neurology); four surgical wards (urology, gastroenterology, traumatology-orthopaedics, brain injury) and two critical care units (medical and surgical). Each of medical or surgical wards or critical care units has one head nurse. There are around fifty staff nurses in each of medical or surgical wards and has around thirty staff nurses in each critical care unit. Head nurse are in charge of organizing, management, and carrying out a variety of work in the ward while staff nurses provide direct care for patients.

Sample: One hundred and twenty staff nurses were randomly selected from general units and critical care units of these two hospitals to participate in this study. The sample size was calculated by using a power analysis with G*Power 3.1.9.2 program. The level of significance (α) was set at .05 and the standard power was at .80 as usual in most of nursing studies[33], the effect size was estimated of 0.25[15]. The total sample size of study was calculated at 120. Participants were recruited by using simple random sampling technique from the list of staff nurse names from each hospital whom met the following criteria: 1) have been working at least one year as a staff nurse and 2) provide directly care for patients.

Instrument: Three self-report questionnaires were employed for data collection.

Demographic questionnaire was developed by the researchers which comprised of six items asking about nurse's characteristics including age, gender, education, marital status, working experience and practice setting.

The Collaboration Practice Scale was developed by Weiss and David[16]consists of two separate scales; one for physicians and the other for nurses. In this study, only the scale for nurses were used which had nine items. Each item was measured on a 6-point Likert type scale, ranging from never to always (never = 1 to always = 6). The total scores range from 9 to 54, higher scores indicate greater

use of collaborative practice by nurses. To determine levels of nurse-physician collaboration, the total mean scores were classified into 3 levels which were calculated as follows: the lowest observed mean score was subtracted from the highest mean score, and the result divided by 3, to yield three equal intervals of 1.66 points ([6-1]/3=1.66). Therefore, level of collaboration were classified as follows: 1.00 - 2.66 = low, mean score of 2.67 - 4.33 = moderate, mean score of 4.34 - 6.00 = high. This questionnaire was translated with permission of the original English version to the Vietnamese language version by using back-translation technique. The Cronbach's alpha coefficient of this questionnaire was .82.

Autonomy questionnaire. Professional autonomy of staff nurses were measured by Vietnamese autonomy questionnaire[17] which was modified from the Dempster Practice Behavors Scale (DPBS)[4]. The autonomy questionnaire consisted of four subscales. The readiness subscale measured elements of competence, skills, and mastery. The empowerment subscale measured the legitimacy of one's performance in a practice setting. The actualization subscale measured decision-making, and involved the dimensions of determination, responsibility, and accountability. Valuation scale measured elements of value, worth, merit. This questionnaire includes 30 items utilizes a five point Likert scale, each item score ranging from 1= Not all true to 5= Extremely true. The total scores range from 30 to 150, higher score represent the greater level of professional autonomy. The total mean scores were classified into 3 levels, which are calculated as following: The highest mean score was 5 and lowest mean score was 1, so taking the highest mean score minus the lowest score and then dividing for the score by 3, getting the result of interval level was 1.33 [(5-1)/ 3 = 1.33]. The range of mean scores correspond with level of professional autonomy respectively as follows: 1.00 - 2.33: low, 2.34 - 3.67: moderate, 3.68 - 5.00: high. The Cronbach's alpha coefficient of this questionnaire was .81.

Ethical considerations: This study was approved by the Institutional Review Board (IRB) Committee of Nursing Faculty, Burapha University, Thailand and Ethical Committee on Human Rights of Hai Duong province hospital and Viettiep hospital. Participation in this study was entirely voluntary. Participants were given written information explaining the aims of the study and procedures. Confidentiality and anonymity were preserved. Participants were informed about their right to withdraw from the study at any time and written consents were obtained.

Data collection procedures: Data collection was conducted from July 1st to August 30th 2015. After obtaining permission from the directors of two hospitals, the researcher contact head nurses of in each unit in the hospital to obtain the name list of staff nurses and seek help for data collection. Each unit the researcher contacted the selected participants, explained the objectives of the study, and invited them to participate in the study. Then they were given envelopes which contained participant information sheet, consent form to participate in the study and questionnaires. In case the selected participants were not on duty at that time, the researcher asked the head nurse to give an envelope to the selected participants. The participants were asked to return sealed envelopes to the head nurse of each unit. Two weeks after, the researcher collected the questionnaires from the head nurses.

Data analyses: Descriptive statistics were used to describe nurse's characteristics, level of professional autonomy and nurse-physician collaboration. Pearson correlation coefficient was used to explore the relationships between nurse's characteristics (age and experience), nurse-physician collaboration, and professional autonomy. Independent t-test was employed to compare the levels of professional autonomy between staff nurses working in general units (medical and surgical) and critical care units (Intensive Care Unit).

Result

There were120 staff nurses participated in this study. Most of participants were female (84.2%), and 55 % were married. Half of participants obtained nursing education at nursing secondary level (two years of nursing education after a high school) and 34.2% studied nursing at nursing college level (three years of nursing education after a high school). Only 15.8% of participants studied at a bachelor level (four years of nursing education after a high school). About half of participants (51.6%) worked in general units and 48.4% of participant worked in critical care units. The age of participants ranged from 22 to 54 years with the average being 36.44 years (SD = 9.2). Years of working experience as staff nurse ranged from 1 to 33 years (Mean = 14.53, SD = 9.0). Most of nurses had 10-20 years of experience (40%).

It was found that staff nurses had a moderate level of overall professional autonomy (Mean= 2.70, SD = 0.68). The subscales of readiness (Mean = 2.94, SD = 0.80), actualization (Mean = 2.94, SD = 0.79), valuation of professional autonomy (Mean = 3.00, SD = 0.81) were at moderate level. Empowerment was rated as the lowest score among subscale (Mean = 2.03, SD = 0.53). Staff nurses perceived nurse-physician collaboration at a moderated level (M = 3.20, SD = 1.37). (Table 1)

The bivariate analysis indicated that age and working experience had moderate positive relationships with professional autonomy (r = .470, r = .344, p < .01), while nurse-physician collaboration had a high positive relationship with professional autonomy (r = .592, p < .01). (Table 2)

There were different mean scores of overall professional autonomy between staff nurses working in general units and critical care units (t = -3.99, p = .000). The mean score of subscales were also different between staff nurses working in general units and critical care units. The staff nurses working in critical care units had higher level of professional autonomy than those in general units in both overall and subscales. The details were presented in table 3.

Discussion

In this study, staff nurses had moderate levels of professional autonomy. This result was congruent with previous researches[17,18]. However, this result was different from studies conducted in European countries. These studies indicated that staff nurses had high levels of autonomy[13,14]. This difference could be explained by the barriers to the nurses' professional autonomy such as hospital rules, traditional modes of supervision and control, hierarchical relations between physicians and nurses, and high workload of staff nurses in the Vietnamese health care system. Most of the staff nurses in this study had low level of education and low education leads to lack of respect by colleagues, inadequate opportunity for growth and lack of independence and freedom[19], limited participation in decision-making, not enough authority and lack of confidence when they take care for patients[17].

Staff nurses had moderate scores in subscales of readiness, actualization, valuation, and low levels of empowerment that were lower in comparison with the previous studies[13,14]. Findings about readiness subscale showed that the staff nurses working in hospitals in the North of Vietnam had moderate levels of skill, mastery and competence in performing their duties.The nurses who did not show self confidence for decision-making and performing independently and may require more preparation or special training. Low level of education of staff nurse could be the main reason for these problems[3]. The findings related to actualization subscale revealed that the participants' decision-making, responsibility, determination and accountability were lower in comparison with the

other studies[13,14]. The mean score of empowerment was at low level, it was lowest in comparison with other subscale in this study and lower in comparison with the other subscales in previous studies[31,32]. This means that the nurses in the present study do not have enough power nor receive an adequate amount of support and probably they feel barriers to obtaining their rights, or having legal authority. The mean score of valuation was moderate in this study but it was higher than other subscales in this study. In other words, indicating a perception of worth and usefulness associated with professional autonomy. However, the subscale score of nurses participating in this study was lower in comparison with other studies.

Nurse-physician collaboration was at moderate level; this finding was congruent with the results of previous studies[11,12]. In the context of Vietnam, physicians viewed collaboration as less important when compared with nurses, nurses were often considered as obeyers the orders of physicians and physicians as the leaders of healthcare teams. The lack understanding about each others' professional roles and task prioritizing, unclear or imprecise communication, unequal power and lack of respected also lead to ineffective collaboration. These problems frequently happen in work places. Physicians tended to display disruptive behaviors toward nurses, have minimal insights into nurse's role and used words that were rude and humiliating. Nurses did not feel confident or assertive enough to communicate and discuss patient care on equal platform with physicians. Nurses perceived a power imbalance between both professions. The physicians have greater power in decision-making, less interest in collaboration or shared decision-making but for nurses these things are necessary to provide effective patient care. This inevitably caused nurses to experience a lack of autonomy and lower professional worth with respect to decision-making. These reasons may explain the result of this study that nurse-physician collaboration had positive relationship with professional autonomy.

The findings of this study indicated that age and working experience had positive relationship with professional autonomy. In this study most of staff nurses were over 30 years old and had 10-20 or over 20 years of experience. It is probable that the more years of age and experience, the more knowledge, skill in patient care staff nurses had. More experienced nurses feel more confident, independent, and responsible for decision-making, patient care and they had earned respect and trust of colleagues and other professionals. Thus, experienced nurses had professional autonomy. In the contrast, young nurses had less experience, they lack of knowledge, skill to deal with clinical situations. They were often under the supervision of the senior nurses or head nurses and in position of learning practice; most of staff nurses in this study had just two years of training so they were not empowered in all duties, and felt lack of authority, and professional autonomy.

In regard to practice setting there were different mean scores of overall professional autonomy between staff nurses working in general units and critical care units. The mean score of subscales were also different between staff nurses working in two practice settings and the mean scores of professional autonomy of staff nurses in critical care units were higher those in general units. This difference could be explained that critical care units differ from general units both in terms staff numbers and patient diagnostic groups. The most common patient groups in critical care units are serious conditions such as cardiovascular surgery patients, abdominal and lung disease patients, patients with serious infections. The majority of the units is for adult patients, or is mixed units with both adults and children. The critical care units also

differ from others whether or not doctors are present around the clock. Nurses have to make quick and independent decisions in acute situations, have the right to choose their own approach in patient care, the right to participate in value discussions concerning patients and assume responsibility for their own actions. Thus, staff nurses working in critical care units often have more authority and autonomy than nurses in other units. Most patients in general units are in or out patients with minor illnesses or chronic diseases. Nurses in general units mostly do routine work such as taking vital signs, administering medication, and assisting physicians in performing treatment procedures and filling-out nursing documents. Staff nurses have limited participation in decision-making, not enough authority, and lack of confidence when they take care for patients. In the present study, although both staff nurses in critical care units and general units had moderate level of professional autonomy.

Limitation and Recommendation

One main limitation of this study is the sample which was recruited in only two hospitals in the North of Vietnam which may limit the generalization of the study findings. It is recommended that further study should be included staff nurses in other regions of Vietnam or across settings of the country. This study was only interested in factors of age, working experience, practice setting, nurse-physician collaboration. Therefore, future research should include others factors that may associate with professional autonomy such as empowerment, baccalaureate preparation, self-efficacy, professional role, and gender stereotyped personality trait.

Conclusion

This study revealed that staff nurses in the north of Vietnam had moderate levels of professional autonomy and nurse-physician collaboration. There were positive relationships between age, working experience, nurse-physician collaboration and professional autonomy and there were significant difference of professional autonomy between staff nurses working in critical care units and general units. It can be inferred that professional autonomy of staff nurses can be improved when they have good preparation in knowledge, skill with a support-working environment.

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Table 1: Comparison of mean scores on professional autonomy between staff nurses working in general units and critical care units (n = 120).

Professional autonomy	General unit (n = 62)		Critical care unit (n = 58)		t	p
	M	SD	M	SD		
Overall	2.48	.68	2.94	.58	-3.99	.000
Subscale						
Readiness	2.67	.81	3.17	.69	-3.62	.000
Empowerment	1.82	.42	2.20	.57	-4.03	.000
Actualization	2.67	.84	3.16	.62	-3.58	.000
Valuation	2.75	.82	3.25	.69	-3.61	.000

Table 2: Pearson correlation coefficient between staff nurse's age, working experience, nurse-physician collaboration, and professional autonomy (n = 120)

Variables	Professional autonomy	
	r	p
Age	.470**	.000
Working experience	.344**	.000
Nurse-physician collaboration	.592**	.000

Table 3: Comparison of mean scores on professional autonomy between staff nurses working in general units and critical care units (n = 120).

Professional autonomy	General unit (n = 62)		Critical care unit (n = 58)		t	p
	M	SD	M	SD		
Overall	2.48	.68	2.94	.58	-3.99	.000
Subscale						
Readiness	2.67	.81	3.17	.69	-3.62	.000
Empowerment	1.82	.42	2.20	.57	-4.03	.000
Actualization	2.67	.84	3.16	.62	-3.58	.000
Valuation	2.75	.82	3.25	.69	-3.61	.000

Professional Autonomy and Its related Factors among Staff Nurses in Public Hospitals in The North of Vietnam

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Abstract

This descriptive correlational study aimed to determine level of professional autonomy, level of nurse-physician collaboration and factors related to professional autonomy among Vietnamese staff nurses. One hundred and twenty of staff nurses were randomly selected from general units and critical care units of two public hospitals in the north of Vietnam to participate in the study and then were asked to complete set of self-report questionnaires. Data were analyzed by descriptive statistics, Pearson's correlation and independent t-test. The result revealed that nurses reported a moderate level of professional autonomy and nurse-physician collaboration. Nurse's age, working experience, nurse-physician collaboration were positively significantly correlated with professional autonomy (r = .47, $p < .001$, r = .34, $p < .001$, r = .59, $p < .001$, respectively). Professional autonomy was significantly different between staff nurses working in general units and critical care units ($p < .001$). Implications are that nursing administrators should create opportunities for nurses and physicians interact in teamwork, to understand, respect, and trust each other to improve collaboration and increase professional autonomy among nurses.

Keywords : professional autonomy, nurse-physician collaboration, vietnam

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