Professional Autonomy of Occupational Health Nurses in the United States

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ABSTRACT
Autonomy, the freedom to practice independently and to exercise professional judgment in practice activities, is a central element for professional practice. Numerous articles and studies have reported on professional autonomy in general nursing practice; however, professional autonomy for occupational health nurses has not been explored in depth. This article advances the development of a body of knowledge relative to professional autonomy in the practice of occupational health nursing. This article also provides an overview of professional autonomy in nursing practice; discusses the nature and importance of professional autonomy in the occupational health practice setting; reports findings from a seminal study of occupational health nurse autonomy; and addresses professional autonomy in the context of collaborative practice.

Sociologists’ writings throughout most of the 20th century identified concerns with defining professions to clearly distinguish them from other occupations, addressed internal homogeneity within professions, and incorporated professions’ network of social and economic relations. Many writings presented or debated various positions on definitions and characteristics of professions and the process of “professionalization.”

Among the characteristics consistently identified was a profession’s ability to function independently. “Autonomy is regarded as an important dimension of professionalism” (Engel, 1970, p. 12). Freidson (1984) described autonomy as traditional for professions and later referred to a profession as “an institution that controls its own work, organized by a special set of institutions sustained in part by a particular ideology of expertise and service” (Freidson, 1994, p. 10). Scott (1998) noted, “One of the primary strengths of a full-fledged professional is that he or she is deemed capable of independent decision making and performance, and this includes coordinating work with others as required by the situation” (p. 256).

Historically, nursing has not always been viewed as a profession (Etzioni, 1969), but changes in the philosophies and structure of nursing, the educational pathways for nurses, the health care system, and society have led to generalized recognition of nursing as a profession. Where that recognition is withheld, it may be attributed to structural constraints that are applicable to all health care professionals: “given the organizational structure of health care practice environments today there are few if any autonomous decision makers” (Liaschenko & Peter, 2004, p. 489).
According to MacDonald (2002), “Professional bodies typically have the authority to determine educational and licensing standards, to set and enforce standards of technical excellence and ethical propriety and to grant and revoke licenses to practice” (p. 196). Timmermans and Oh (2010) consider the implicit social contract between the profession and the state a defining characteristic that distinguishes professions from other occupations. A profession “makes successful claims for specialized and valued skills meriting legal protection provided by the state”; enjoys the “legal privilege of training and certifying new members”; and meets the state expectation of focusing “on the needs of its clients using scientifically validated knowledge” (Timmermans & Oh, 2010, p. S95). Nursing satisfies these criteria for a profession. State licensure ensures that only nurses who have met regulatory standards call themselves nurses; licensure is regulated by state nursing boards; standards for nursing education are set by boards of nursing; and licensed nurses are held to the requirements of state nurse practice acts and standards of practice (National Council of State Boards of Nursing, 2011).

The literature about professional autonomy has focused on general nursing practice, including how professional autonomy is conceptualized and actualized, is perceived by nurses in various settings at different stages of their careers, is measured, and affects other facets of nursing. In part to understand and find solutions for the current nursing shortage, the relationship between autonomy and nurses’ job satisfaction and the impact of dissatisfaction on nurse retention have been studied. Searches for explanations of high nursing turnover rates and factors contributing to the nursing shortage often focus on job satisfaction. Job satisfaction, a complex of organizational, individual, and environmental characteristics, has long been viewed as a critical factor in nurse retention (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Blegen & Mueller, 1987; Kovner, Brewer, Wu, Cheng, & Suzuki, 2006).

Autonomy in their work environment has been described as an important element for nurses (Nevinjon & Erickson, 2001) and autonomy of practice has been identified as a key contributor to nurses’ job satisfaction (Aiken et al., 2002; Blegen, 1993; Finn, 2001; Kangas, 1999; Kovner et al., 2006). In 2004, a survey of a national sample of registered nurses found that dissatisfied nurses reported limited opportunity to influence decision making; nurses who were more satisfied reported more opportunities as did those nurses who held master’s and doctoral degrees (Ulrich, Buerhaus, Donelan, Norman, & Dittus, 2005). Sochalski (2002) suggested that lower levels of satisfaction reported by staff nurses in the 2000 National Sample Survey of Registered Nurses (NSSRN) may have been related to perceptions of control over work. A cross-sectional study by Kovner et al. (2006) found high autonomy to be among the work attitude variables significantly contributing to satisfaction.

**OCCUPATIONAL HEALTH NURSING PRACTICE**

The practice of occupational health is multifaceted and considered to be highly collaborative, requiring a team of interprofessional practitioners at the worksite and in the community. Wachs (2005b) noted that “occupational health and safety is best safeguarded with all members of the occupational health team working together as a unit to ensure American workers are safe today and will not experience adverse health effects because of uncontrolled exposures decades later” (p. 158). The occupational health team includes occupational health nurses, occupational physicians, industrial hygienists, safety professionals, behavioral health professionals, epidemiologists, toxicologists, ergonomists, and human resource specialists (U.S. Department of Labor, Occupational Safety and Health Administration, 2011b). Occupational health nurses comprise “the largest group of health care providers serving workers, worker populations and community groups” (American Association of Occupational Health Nurses, Inc. [AAOHN], 2009).

Data from the most recent (2008) NSSRN indicate that an estimated 19,000 occupational health nurses are currently employed in the United States (Health Resources and Services Administration, Office of Information Technology, 2011). A summary of descriptive characteristics of occupational health nurses, based on secondary analysis of responses from nurses reporting employment in occupational health settings in the 2008 NSSRN, was recently reported by Thompson and Wachs (2012). AAOHN describes modern occupational health nurses’ roles as diverse and their position responsibilities as wide ranging: “Today, the scope of practice includes disease management, environmental health, emergency preparedness and disaster planning in response to natural, technological and human hazards to work and community environments” (AAOHN, 2009). Ward, Beaton, Bruck, and de Castro (2011) describe occupational health nurses as facing “an array of professional practice demands and responsibilities, including combinations of direct care, administration, consultation, management, teaching, and research” (p. 402).

The 2008 NSSRN questionnaire asked respondents to indicate the percent of time spent on various nursing activities during a usual work week (Human Resources and Services Administration, 2010). In aggregate, occupational health nurses reported spending half their time (50%) in patient care and charting; 11% in consultation with agencies and/or professionals; 9% in administration; 8% in non-nursing tasks; 7% in teaching, precepting, or orienting students or new hires; 6% in supervision and management; 2% in research; and 9% in non-specified activities (Thompson, 2011). “Care of workers was the dominant function (more than 50% of the nurses’ time) for more than two fifths (44%) of occupational health nurses. Approximately 14% of occupational health nurses reported having no client care included in their position description” (Thompson & Wachs, 2012, p. 128).

Occupational health nurses practice in a variety of settings. The employment setting reported by occupational health nurse NSSRN respondents shifted somewhat from 1992 to 2008. The majority (55%) of occupational health nurses responding to the 2008 NSSRN described their employment setting as private industry (Thompson
PROFESSIONAL AUTONOMY IN OCCUPATIONAL HEALTH NURSING PRACTICE

In the early years, occupational health nursing was viewed as an independent nursing practice, with many occupational health nurses the only health professional at the worksite; however, it was not necessarily viewed as autonomous practice. In the preface to her second book on occupational health nursing, Brown (1981) noted her earlier delineation of the occupational health nurse-physician relationship, describing it as collaborative but as “based on the physician’s responsibility for medical practice” (p. x). In the years since that publication, occupational health nursing practice, reflecting both internal and external forces of change, has progressed from that initial limited frame. The roles of today’s occupational health nurses are diverse and their position responsibilities have greater breadth. Numerous writings note the expanding role of the occupational health nurse and describe that role as one of autonomous practice (Garrett, 2005; Rogers, Randolph, & Ostendorf, 2011; Salazar, Kemerer, Amann, & Fabrey, 2002).

The value of autonomy in occupational health practice settings as a component of job satisfaction or a factor in recruitment and retention has not been a focus of research. In a small study of job satisfaction that drew its sample from AAHOHN members in one Midwestern state, researchers found that occupational health nurse respondents were significantly more satisfied with independence than the normative group of hospital nurses to whom they were compared (Conrad, Conrad, & Parker, 1985).

Autonomy in occupational health nursing practice was the central topic of a 2008 dissertation study that used both structural and individual levels of analysis and was guided by the concepts of Abbot’s System of Professions (1988). (A detailed description of the study method-
describes itself as “active on a number of Public Policy issues that impact the profession and/or the health and safety of workers, worker populations and community groups. The association takes actions in addressing and/or supporting occupational and environmental health nurse advocates with local, state and federal issues through a number of strategies, such as providing comments/testimony and writing letters, developing position statements and practice resources and establishing partnerships with other agencies and organizations” (AAOHN, 2011).

In Abbott’s System of Professions (1988), work is one of three major interacting elements that influence the development, form, and fate of professions, and mastering the abstract knowledge necessary to the profession is noted as supporting jurisdictional strength. AAOHN has delineated a scope of practice (AAOHN, 2004) as well as competencies (AAOHN, 2007) for occupational health nurse practitioners.

Within the scope of practice are clinical and non-clinical elements such as health evaluation of workers, assessment and treatment of occupational illnesses and injuries, worker surveillance and hazard detection, case management, health education and promotion, regulatory compliance, emergency preparedness, research, and program management. These practice elements fit with the characteristic described by Abbott for tasks of professions (i.e., they are amenable to expert service). Additionally, they require a specialized knowledge that is clearly linked to the professional practice of occupational health and reflected in the competencies delineated for occupational health nurse practitioners.

The second phase of the study consisted of quantitative analysis of data from the 2004 NSSRN, which, among other hypotheses, tested the prediction that occupational health nurses would exhibit more characteristics of autonomy than nurses in other strategically selected settings. (Details about the NSSRN study methodology can be found in Human Resources and Services Administration, Bureau of Health Professions [2006a, 2006b].) The primary comparison group was nurses employed in hospital settings because this is the most studied of the nursing employment settings and is generally viewed as less supportive of nursing autonomy than other settings, despite recent efforts to encourage institutional structures that increase nursing empowerment (Ulrich, Buerhaus, Donelan, Norman, & Dittus, 2007; Upenieks, 2003). Two other employment settings, community/public health and school health, were also used for comparison, based on published studies reporting higher levels of autonomy for nurses in these settings than for hospital-based nurses (Passarelli, 1994; Schutzenhofer & Musser, 1994; Smith, McAllister, & Crawford, 2001; Smith Battle, Diekemper, & Drake, 1999).

Because a direct measure of autonomy was not available in the NSSRN data set, the study used characteristics indicative of autonomy based on Abbott’s concepts regarding the value, power, and prestige of knowledge for jurisdictional strength, the autonomy inherent in advanced nursing practice, and the autonomy reflected by position title. These characteristics included graduate education, professional certificates, advanced practice preparation and certification, and expert-rated position autonomy or non-staff position (i.e., positions not included in the NSSRN researchers’ list of staff positions). A composite autonomy measure was constructed from the four autonomy indicator variables based on the number of autonomy indicators reported by each nurse respondent.

Chi-square tests were used for population comparisons and ordinary least squares and logistic multiple regression analyses to examine effects of the independent variables on the predicted outcomes. Analyses considered and controlled for the influence of other characteristics relevant to the dependent variables age, gender, race/ethnicity, region of employment, work-time status, and salary. The Table summarizes the results of the chi-square tests.

Overall, the quantitative empirical data provided support for the premise that differences in characteristics of autonomy exist between occupational health nurses and nurses employed in comparison settings. The results indicated that certain indicators of autonomy were significantly higher for occupational health nurses than for nurses in comparison settings.

Of the autonomy indicators examined, occupational health nurses were significantly more likely to have higher proportions of professional certificates than all three of the comparison groups. The composite autonomy score for occupational health nurses was significantly higher than scores for hospital and school health nurses.

Occupational health nurses had significantly more autonomy indicators than hospital nurses. Occupational health nurses were significantly more likely to hold master’s or doctoral degrees, report having one or more professional certificates, have a non-staff/more autonomous position, and have a higher composite autonomy score than nurses in hospital settings. Although more occupational health nurses had advanced practice education and certification than hospital nurses, the difference was not significant. No significant differences were found in the proportion of nurses with advanced practice education and certification when comparing occupational health nursing with the other nursing settings, perhaps reflecting the generalized nature of this autonomous nursing characteristic.

The significance of noted differences varied slightly in the regression models, with variations primarily reflecting the complex nature of the control variables included in the models. (Tables 5.10 to 5.22 in Thompson [2008] provide details of the regression model analyses.) The study findings substantiated that characteristics of autonomy vary by nursing settings, with the occupational health setting providing particular support for autonomy among nurses.

Since that study, data reported by Thompson and Wachs (2012) showed that occupational health nurses are “continuing the trend toward higher educational preparation, 18% of occupational health nurses reported having a master’s or doctoral degree . . . . An estimated 2,464 occupational health nurses (~14%) have advanced practice certification, and almost half (47%) of the estimated
occupational health nurse population hold one or more current national nursing certificates, including skill based (e.g., life support, resuscitation), case management, or occupational health certificates” (p. 129). Although these data have not been comparatively analyzed with data from other nursing settings, the increase in the proportions of these two autonomy indicators for occupational health nurses provides additional support for earlier findings.

### AUTONOMY AND COLLABORATIVE PRACTICE

Rogers et al. (2011), discussing occupational health nursing education, noted, “Occupational health nurses practice with a significant degree of autonomy complemented by an interdependent role with other interprofessional members of the occupational health team” (p. 243). Occupational health nursing, as indicated earlier, is considered a highly collaborative practice; the scope of practice for occupational health nurses delineated by AAOHN begins with a requirement for collaboration with “employees, employers, members of the occupational health and safety team and other professionals” (AAOHN, 2004, p. 270).

The organization and structure of the occupational health team will be influenced by the characteristics of the specific occupational health setting. As Wachs (2005a) points out, “Not all occupational health and safety programs, services, and challenges require a team approach. The occupational health nurse is often the coordinator of the team and must decide in which situations a team is necessary” (p. 170). Occupational health nurses, regardless of the nature of their role within the team, can influence the success of the team by understanding the elements necessary to maximize team performance and ensuring those elements are in place. According to Petri (2010), “The elements that must be in place before interdisciplinary collaboration can be successful are interprofessional education, role awareness, interpersonal relationship skills, deliberate action and support” (p. 73).

In discussing the relational nature of nursing autonomy, MacDonald (2002) contended, “Attention to the social and contextual factors that facilitate meaningful autonomous action is crucial to advancing our understanding of the relationships between professionals and patients, as well as between different groups of professionals” (p. 194). Factors such as trust and respect have been consistently identified as essential for collaboration (Tschannen et al., 2011). Grover (2005) described communication as “essential to occupational health nurse practice,” given the importance of its interdisciplinary nature (p. 182). The occupational health nurse can model effective communication styles that support trust and respect and be attentive to communication barriers.

Collaboration has been defined as “individuals with varying background and expertise communicating effectively with one another in a non-hierarchical fashion, committed to problem-solving, in search of solutions that cannot be determined with one’s own limited scope of knowledge” (Tschannen, 2005, p. 17). The April 2005 issue of the AAOHN Journal focused on collaboration, with articles discussing many aspects of collaboration, including the importance of collaboration to occupational health nurses.

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**Table: Chi-square Analysis of Autonomy Indicators Comparing Nurses Employed in Hospital, Community/Public Health, and School Health Settings to Nurses Employed in Occupational Health Settings**

<table>
<thead>
<tr>
<th></th>
<th>Graduate Education</th>
<th>Professional Certificates</th>
<th>Advanced Practice</th>
<th>Non-Staff Position</th>
<th>Expert-Rated Position Autonomy</th>
<th>Composite Autonomy</th>
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<tbody>
<tr>
<td>Hospital (n = 16,720)</td>
<td></td>
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<tr>
<td>chi-square</td>
<td>9.5%</td>
<td>15.5%</td>
<td>6.3%</td>
<td>24.8%</td>
<td>7.3%</td>
<td>37.2%</td>
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<td>Community/public health (n = 3,256)</td>
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<tr>
<td>chi-square</td>
<td>0.02</td>
<td>12.6%</td>
<td>0.03</td>
<td>14.2%</td>
<td>76.5%</td>
<td>32.4%</td>
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<tr>
<td>School health (n = 967)</td>
<td></td>
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<tr>
<td>chi-square</td>
<td>21.2%</td>
<td>7.6%</td>
<td>12.0%</td>
<td>18.8%</td>
<td>10.9%</td>
<td>35.4%</td>
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<tr>
<td>Referent occupational health (n = 277)</td>
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<tr>
<td>chi-square</td>
<td>5.6%</td>
<td>29.6%</td>
<td>1.8</td>
<td>119.9%</td>
<td>410.7%</td>
<td>70.2%</td>
</tr>
<tr>
<td>Overall chi-square</td>
<td>117.2%</td>
<td>50.4%</td>
<td>44.2%</td>
<td>2025.4%</td>
<td>6588.6%</td>
<td>1756.5%</td>
</tr>
</tbody>
</table>

Note. *Compared having a position rated as 1 (low autonomy) to positions having higher ratings (1.9 to 5); % = 4, 5 ratings. 
| p | .05. |
| **p | .001. |

*Chi-square Analysis of Autonomy Indicators Comparing Nurses Employed in Hospital, Community/Public Health, and School Health Settings to Nurses Employed in Occupational Health Settings*
IN SUMMARY

Professional Autonomy of Occupational Health Nurses in the United States

Thompson, M. C.

Workplace Health & Safety, 2012; 60(4), 159-165.

1

Autonomy, the freedom to practice independently and to exercise judgment in practice activities, is a central element for professional practice and an important dimension of professions. Nursing satisfies stated criteria for a profession and has been generally recognized as a full profession for some time.

2

Occupational health nurses' roles are diverse, their position responsibilities cover a broad spectrum, and their practice is described in the literature as autonomous. Research has identified evidence of increased professional autonomy for occupational health nurses and has shown that the occupational health setting provides particular support of nursing autonomy.

3

The practice of occupational health is multifaceted and is considered to be a highly collaborative practice, requiring a team of multidisciplinary practitioners at the worksite and in the community. The estimated 19,000 occupational health nurses currently employed in the United States comprise the largest group of occupational health practitioners. The occupational health nurse, often the coordinator of the occupational health team, can influence the success of the team by understanding the elements necessary to maximize team performance and ensuring those elements are in place.

health and safety, the challenges it poses in occupational health settings, and the skills, such as effective communication, that form the basis for successful collaboration. Occupational health nurses interested in enhancing their knowledge of collaborative practice will find the information provided in this issue of value.

REFERENCES