

Deanship of Graduate Studies

Al-Quds University



**Job Autonomy As Perceived By Nursing Managers In
Governmental Hospitals In The MOH- Gaza
Governorates**

Submitted By:

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Governmental Hospitals In The MOH- Gaza
Governorates**

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Thesis Approval

Job Autonomy as Perceived by Nursing Managers in Governmental Hospitals in The MOH- Gaza

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Dedication

Heartfelt thanks for all those who encouraged and assisted me in achieving my degree.

To my family ... my father's soul... my mother ... my brothers and sisters ... I deeply appreciate that you were always there in spirit with me ... gave me the support and space I needed to realize this accomplishment ... and inspired me with your own achievements.

Khalil M. Shaqfa

Declaration

I declare that this research is my own work and that no part of it has been copied from any other previous works on the subject, except in such instances where acknowledgment has been duly made.

Signature

Khalil

Khalil Mostafa Shagfa

Acknowledgement

After, I express my praise and gratitude to Allah the almighty for giving me such a great strength, patience, courage and ability to complete this research, and peace and blessings of Allah be upon the noblest of all Prophets and messengers, our prophet Muhammad, all thanks for Allah who granted me the power and capability to complete this thesis.

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Abstract

Job autonomy plays an important role in nurses' job satisfaction, retention and quality of patient care. It is argued that for nursing managers, job autonomy and job satisfaction may be interrelated. Thus, the assessment of job autonomy among nursing managers in health organizations is important for policy and administration purposes as well as professional purposes.

The overall aim of this study was to assess the job autonomy among nurses as perceived by nursing managers in the governmental hospitals in Gaza governorates in order to promote professionalism in nursing.

A descriptive, analytical cross sectional design was used. Subjects of this study were 301 nurses who represented all the formally assigned nursing managers in governmental hospitals. Self-administered questionnaire was used and 238 participants completed the questionnaire with a response rate of 83%. Data were analyzed using the SPSS program. The content validity was validated by ten experts. The reliability test using Cronbach Alpha coefficient was 0.707.

The study extracted six dimensions for autonomy which are: general perspective, (m=3.47), managerial style (m=3.82), job description (m=3.69), job satisfaction (m=4.09), nursing career (m=3.69) and work preference (m=3.06). The highest mean score among dimensions is job satisfaction domain and the lowest is work preference domain (m=3.06). The vast majority of nursing managers (94.2%) preferred to be supervised by a person from the same profession, in addition, nursing managers called for allowing the Chief Nursing Manager in the MOH to overall supervise all nurses in the organization (39.0%).

The majority of nursing managers who were working in clinical settings (60.9%) believed that they had adequate autonomy within their work arenas. However, 72.6% of nurse managers believed that the current management style at the MOH inversely affects nursing autonomy. The study results also showed that there were no statistically significant differences in reference to the job title and education level (P-value = 0.131 and 0.097 respectively). In contrary, results revealed that there are statistical significant differences at 0.05 between males (M = 3.52 out of 5) and females (M = 3.33); in the favor of males (P value = 0.003). Also, the result showed that there are statistical significant differences in perceptions about autonomy in reference to age were younger felt more autonomous than older counterparts (P value = 0.004).

It is concluded that there is a great need to enhance job autonomy among nursing managers through having clearer roles and responsibilities, adopting more effective leadership practices, and developing more flexible work system.

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List of Abbreviations

APRNs	Advanced Practice Registered Nurses
ANA	American Nurses Association
CONP	Clinical Nurse Autonomy and Control Over Nursing Practice
CBO	Competency-Based Orientation
GS	Gaza Strip
MOH	Ministry of Health
NGOs	Non Governmental Organizations
PCBS	Palestinian Centre Bureau of Statistics
PNA	Palestinian National Authority
PhD	Philosophy Doctor
SPSS	Statistical Package for Social Sciences
TQI	Total Quality Improvement
UNRWA	United Nations For Relief And Work Agency
WB	West Bank
WHO	World Health Organization

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Chapter I

Introduction

1.1 Introduction

In today's health care environment, the role of the nurse has become more complicated, and is linked to multiple responsibilities. Major changes have been taken place in health care systems globally. These changes include, but are not limited to, a shortage of nurses, shortened lengths of stay in hospitals, an increasing emphasis on cost effectiveness, downsizing of health facilities, and an increase in patients with acute and chronic diseases (Davidson et al, 1997; Baker et al, 2000; Curtin, 2000). These changes increase the need for autonomous nursing practice. Enhancing nurses' autonomy has been of interest to those who wish to maintain nursing standards and promote the professionalism of nursing. Autonomy is viewed as a positive concept for nurses, influencing job satisfaction, retention and quality of care. Today, when staffing levels are reduced in hospitals, there are concerns about a decline in the quality of care because of the increased demands of workload and patient acuity. These demands may also influence the autonomy of nurses (Mrayyan, 2004).

Nursing is the member of the team that implements the medical plan of care. One physician described this role by saying that nurses run the show we advise (Snelgrove & Hughe, 2000). This is not an inferior role. Only nursing has the education, experience, and continuous access to the patient to implement the plan of care and monitor the ongoing results of treatment. Without this implementation the plan is simply an idea on paper. Further, nursing occupies a position that enables it to coordinate the services of other team members. Thus we see nursing controlling hospital bed allocation, scheduling ancillary testing, medication administration, as well as discharge planning. When a physician needs a particular service or task accomplished, they frequently look to nursing to make it happen. If it is correct that power derives from access to resources and the ability to coordinate cooperation, then nursing enjoys a powerful place on the multidisciplinary team (McDonald, 2004).

For many years, the nursing profession has been striving for full professional status. Autonomy, an essential attribute for achieving professional status, can exist on both an individual or group level (Moloney, 1992). The Nursing profession has grown significantly in the past recent years in Gaza/ Palestine. It has become an extremely important component in the Health Care System, taking in consideration the fact that nurses represent the majority group among all Health Care providers.

In 1925, nursing education started, affiliated to a number of missionary hospitals, developed or organized and had a limited information base. In 1968 the Practical School of Nursing was established in Gaza at Shifa Hospital, the study was for 18 months. In 1976 the Qualified School of Nursing (MOH) in Gaza was established for three year study (staff nurse). Most of the graduates from these programs were hospital-based and medically oriented. In 1992 another nursing program was started at the Islamic University, which graduates Bachelor degree in nursing. In 1995 the Qualified School of nursing was developed to Palestinian Collage of Nursing. During the Israeli Civil Administration, there was regulatory body for nursing, taking the responsibility of developing nursing education and practice and was initiating the nursing identity.

Major improvements however were made immediately since the establishment of Palestinian National Authority (PNA). The PNA assumed responsibility for the health sectors. Nursing received strong support in terms of both human resources development and institutional building. The MOH established a nursing department with staffing and administrative support and this department took the responsibility to develop nursing practice and education, but it started work mainly in the governmental sector, since it had received partially development during Israeli Civil Administration.

Attitudes towards professional nurse autonomy are introduced during baccalaureate nursing education programs. Medical dominance of health care in Gaza has traditionally been the organizing principle in health care delivery. Medical power is evidenced through the professional autonomy of doctors through their decision making in resource allocation in determining overall directions of health care such as high technology treatment through dominance over allied health occupational groups through their administrative influence and through the collective influence of medical associations.

1.2 Research problem

Nursing is now a real problem in understanding the issue of the independence of its members for their nursing and administrative hierarchy and the impact on the quality of service and understanding of themselves and also of the other categories of health care system. Some issues related to job autonomy remain unclear. Are nurses autonomous? Do they have a control over their work related issues? How the autonomy of nurses transforms through the different periods? Are they satisfied about the level of autonomy? Do the current status affect the quality of nursing services? This study tries to bring certainty about these issues and discuss them.

1.3 Justification of the study

Given the importance of job autonomy among nursing managers and its impact on the leadership style, communication, decision making, supervision, satisfaction and belonging, as well as delivery and quality of care , the factors that affect job autonomy should be addressed.

In Gaza, there is no previous studies that address this issue and take autonomy as a main topic. This study is needed for strategic planners, policy and decision- makers in the MOH for better identifying factors that affect job autonomy in order to improve and maintain the productivity, efficiency and quality of the health care services.

Nursing is clearly an autonomous and distinct scientific discipline. For entry into practice, nurses are educated by nursing scholars typically in nursing degree programs lasting two or four years at universities and colleges, using textbooks authored by those scholars, many of whom are at the forefront of health care research. About 10,000 U.S. nurses have Ph.D's in nursing (Another 10,000 nurses have PhD's in other health-related fields and work in nursing), and close to 380,000U.S. nurses have master's degrees in nursing. These nurses-not physicians--are the theoretical and practical leaders of the nursing profession.

This study will be a chance for managers to express their feelings and suggestions .The conflict between managers of health care activities are increasing ,the responsibilities and authority of them is over lapping and this is clearly observed. These matters urges the

researcher to study this subject, and the results could explore the needs of nursing managers and determinate the job autonomy among them.

I worked as a chief manager of nursing field of the MOH, and I face a lot of problems such as no clear job descriptions, frustration, work over load and inability to take decisions.

1.4 Aim of this study

The overall aim of this study is to assess the nursing job autonomy as perceived by nursing managers in the governmental hospitals in the Ministry of Health (MOH) in Gaza Governorates.

1.5 Objectives of the study

- 1- To assess the status of job autonomy as perceived by nursing managers.
- 2- To describe the relationship between job autonomy and socio-demographic characteristics.
- 3- To rank in order the areas that enhance sense for job autonomy.
- 4- To identify factors that affect job autonomy.
- 5- To provide the decision makers with a helpful suggestions and recommendations.

1.6 Research questions

- Is the nursing profession in Gaza strip autonomous?
- How nursing managers does perceived job autonomy?
- What are the factors affecting job autonomy?
- How can nursing managers rank the areas in which can enhance sense of job autonomy?
- Is job autonomy influencing nursing job satisfaction?
- Are their variations in autonomy perception between male managers and females?
- Is there a relationship between experience and perception of job autonomy?
- Is there a relationship between perception of job autonomy and the following variables (type of organization- nursing qualification – position- leadership style of top managers)?

1.7 Feasibility and cost

This study will be conducted as a part of the researcher study at the school of public health, Al-Quds University. Agreement and ethical approval were obtained from the MOH which make the implementation of the study more visible. The study was self funded, coordinated and supervised by the school of public health.

1.8 Theoretical definitions of terms:

Autonomy concept

Nursing has traditionally been depicted as a “silent partner” to medicine or “the last link in the chain of power” that has sustained the organization of health care (Adamson and et al, 1995). To be autonomous means not only that you are independent of others, but also that you are acting according to your own standards and ideals; Crebolde.;2001

Job autonomy

Is the freedom to make discretionary and binding decisions that are consistent within one’s scope of practice and the freedom to act on those decisions (Lewis, 2006).

Nursing manager

A registered nurse who perform leadership functions of governance and decision-making within organizations employing nurses. He/she maintain processes common to all management like planning, organizing, staffing, directing and controlling. A good nurse manager should be open to anything in the environment and be sensitive to the needs of the staff under her/his management (www.wikipedia.org).

Governmental hospital

A hospital administered by officials of the city, country, state, or nation (www.mondofacto.com, online medical dictionary).

Nursing

Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations.(The American Nurses Association, 2010)

Job

A piece of chance or occasional work; any definite work undertaken in gross for a fixed price; as, he did the job for a thousand dollars.

A public transaction done for private profit; something performed ostensibly as a part of official duty, but really for private gain; a corrupt official business (ARD dictionary, 2004).

profession

The body of persons engaged in an occupation or calling: to be respected by the Medical profession (ARD dictionary, 2004).

1.9 Operational definitions of terms:

Job autonomy

Is a status; in which a hospital nursing manager including (a hospital nursing director, a nursing supervisor, and a head nurse) within Gaza governmental hospital feels he or she is free to make discretionary decisions that are consistent within one's scope of practice and the freedom to act on those decisions.

Nursing manager

A registered nurse working in Gaza governmental hospital, who assumes a managerial position in a hospital, formally assigned manager, either being a hospital nursing director, a hospital supervisor, or a head nurse, he/she coordinates staff to assure that effective nursing services are provided, and assumed this position for more than one year at MOH hospitals

Gaza Governmental hospital

A hospital located in Gaza strip, directed by the Palestinian ministry of health (MOH), and administered by health and managerial professionals.

1.10 Demographic context

Palestine (historical Palestine) is a small country, its area about 26,323Km². Now Palestine comprises two areas separated geographically, the West Bank (WB) including Jerusalem and Gaza Strip (GS), with total area of 6,020 Km²(Palestinian Centre Bureau of Statistics (PCBS, 2010). GS is a narrow band of land located on the south of Palestine, constituting the coastal zone of the Palestinian territory along the Mediterranean Sea between Egypt and historical Palestine. It is 45 Kilometres long and 6-12 Kilometres wide with an area of 365 Km²(PASSIA, 2008). The strategic position of it, is being at the cross road of Africa, Asia and Europe made it target for and conquerors over the centuries. According to PCBS survey which has been carried out in 2009, the total population in the WB and GS is 3,761,646 inhabitants, of them 1,561,906 (67.9% are refugees) were living in GS concentrated mainly in 7 towns, 10 small villages and 8 refugee camps (PCBS, 2010). GS is lying on the cost of the Mediterranean Sea with a population density of 4,118 inhabitants per Km².

The Palestinian society is considered a young population, age structure in the GS is similar to that in many developing countries with 49.3% of people aged less than 14 years and sex ratio is 103 males per 100 females (PCBS, 2010).

According to the last available statistics, the percentage of illiteracy in GS is 5.5% of the population more than 10 years old, compared with 11.3% in 1997 for the same group of population (PCBS, 2010).

According annual report of nursing unit 2011, shows that hospital nurses 1789 nurse means one hospital nurse to 873.1 from population.

1.10.1 Socio-political context

West Bank, GS and Jerusalem have been occupied by Israel after the Six Day War in 1967. GS was run by Egypt between 1948 and 1967 after the partition of the British Mandate of Palestine and the declaration of what is called "Israel". Afterwards, Israel built further settlements in the occupied land (Bhat, 2008). The implementation of the partial autonomy in 1994 and the establishment of the Palestinian Authority (PA) had its impacts on the society after the many devastating wars and the long years of occupation and dispersion over the globe (Hamad, 2009). However, Israel still holds overall sovereignty over the GS. It has the upper hand over borders, movement of goods and travellers in and out of GS, particularly the Palestinians themselves. It also controls trade, the commercial market, water, the main sources of energy, the means of communications and the overall security. Hence, it still has a hold over the Palestinian economy (Hamad, 2009).

Since 2000, there has been a chronic down turn in wage income from Israel due to the security closure of the borders between GS and surrounded countries till it reached the zero level now. This has been complicated by the massive contraction of employment opportunities inside GS due to the current collapse of economy due to production factors such as lack of raw materials, fuel and electricity as well as to market failure resulting from closure, lack of transportations and widely prevailing poverty.

1.10.2 Socio-economic contexts

Economic crisis has been caused by restriction on the movement of people and goods. The Palestinian recession is among the worst in the modern history; average personal incomes have been declined by more than a third since 2000 and nearly a half of Palestinian now live below the poverty line, 43% still live below the poverty average (World Bank, 2004). According to the PCBS, the subsistence poverty was 23% and that 56% of all households in the occupied Palestinian territory are living below the poverty line (80% in 2006 – versus 63% in 2005 – in the GS and 43% in the WB) and that means that over two million people are attempting to subsist on less than \$ 2 / person / day (PCBS, 2007). According to World Bank approximately 3 out of 5 Palestinians live under the income poverty line and one third

of the Palestinians live under the consumption poverty. Despite poverty the Palestinians are eager to learn, literacy ratio in 2004 among those aged 15 years and more is 92.3% (male: 96.5%, female: 88%) which is considered among the highest percentage of literacy rates of Arab countries (PASSIA, 2008).

1.10.3 Health care context

Palestine experience in health care system is unique and complicated. The several years of occupation and the following unilateral withdrawal of the Israelis from GS did strongly influence the health care system in Palestine. The consequences of closures and separation formed a great challenge for the ministry of health as it created obstacles regarding the accessibility to health care services and affects the unity of the health care system in all Palestinian governorates (MOH, 2004).

Health care services in Palestine are provided by five sectors, which is Ministry of Health (MOH), UNRWA, Medical Military Services, Non-Governmental Organizations (NGOs) and private sector. MOH is the main health care provider; it provides primary, secondary and tertiary services and purchases some services from private providers locally and abroad (MOH, 2006). MOH plays the main role in providing and controlling immunizations scheme, public health activities, licensing and registration of health facilities. Health care financing is mainly provided through the government, apart from the out-of-pocket health financing which is the first source of health financing in Palestine (MOH, 2006). Additionally, external donations constitute a considerable source for health funding. UNRWA mainly provides primary health care services to the refugee population. The Medical Services for Police provides preventive and curative services for policemen, general security persons and their families, in addition to the general population. UNRWA operates 20 PHC centres (WHO, 2009). The NGOs sector is to facilities supported by international organizations, to community health centres. The NGOs sector operates about 50 centres (WHO, 2009). The private for-profit health sector also provides the three levels of care through wide range of practices (WHO, 2009).

1.10.4 Hospitals in Palestine

In Palestine the secondary healthcare is provided by governmental, non-governmental, UNRWA and private sectors. MOH is responsible for a significant portion of the secondary

healthcare delivery system (60-70% of general and specialized hospital beds) and more than this proportion in hospital services (about 70% of hospital services). In 2005, there are 43 general hospitals with 3,726 beds, 10 specialized hospitals with 812 beds, 19 maternity hospitals with 322 beds and four rehabilitation centers with 165 beds (MOH, 2006).

MOH Hospitals

The MOH owns and operates 25 hospitals (13 in GS and 12 in the WB), furnished with 2,815 beds (1,499 in GS and 1,316 in the WB), from these hospitals there are the general hospitals with 2,163 beds (1,199 in GS and 964 in WB), two psychiatric hospitals with 319 beds (280 in WB and 39 GS), one ophthalmic hospital in GS with 31 beds and two Pediatric hospitals in GS with 222 beds (MOH, 2006).

Hospitals in Gaza Governorates

Ministry of Health in Gaza Strip owns thirteen hospitals have reached their clinical capacity until 2008 about 1593 beds. Majority of these beds are allocated in three large hospitals: Al-Shifa, Nasser and the European Gaza Hospital. Hospitals Specialized accounted for (89%) of their beds from the four main disciplines and branches (medicine, surgery, children, women and obstetrics), and reserved the rest for intensive care services in their various forms.

Shifa Hospital is a medical complex includes three hospitals: the surgery hospital, medical and Obstetrics & Women's Hospital. The clinical capacity is a total of 500 beds. The hospital has a staff of all specialties, a total of 1201 employees. Nasser Medical Complex is a Medical complex, contain two hospitals: Nasser (medical and surgery) and Mubarak Hospital (obstetrics and women, and children), the clinical capacity is a total of 258 beds. European Gaza Hospital is a hospital in the southern Gaza Strip, provide medical, surgical, and pediatric services. The total clinical capacity is about 207 beds, the hospital serves the east area of Khan Younis and the northern area of Rafah, the total number of hospital staff in all specialties, is about 709 employees. Dr. Abdel Aziz Rantisi Pediatric hospital is a children's Hospital is working to provide specialized medical services for children, and the clinical ability of current operating stage is about 49 bed, start working in 2008. Al-aqsa Martyrs Hospital provides medical, surgical, pediatric, and women and obstetrics services, the clinical capacity is about 103bed, the total number of hospital staff in all specialties, is about

392 employees. Al Emaraty Crescent Hospital is specialized hospital of gynecology and obstetrics services, the clinical capacity is about 40 beds. the total number of hospital staff in all specialties, is about 219 employees.

Mohamed Al-Durra Hospital for Children is a hospital provides pediatric services, has the capacity of 72 bed, the total number of hospital staff in all specialties is about 176 employees. Nasser Pediatric Hospital is a hospital offers pediatric services, and clinical capacity is 151-beds. Kamal Adwan Hospital is a general hospital provides surgical, pediatrics and medical services, and clinical capacity is 73-beds. Ophthalmic Hospital is a specialist hospital providing services of ophthalmology, the clinical capacity is 40 beds, has an eye surgery. The total number of hospitals staff in all specialties, is 90. Beit Hanoun Hospital is provides surgical, pediatric and medical services, the clinical capacity is 36-bed hospital, has a total of 192 employees.

Psychiatric Hospital is specializes in providing psychiatric services, the clinical capacity is 39 beds, being the only specialist hospital in the area mental sector, the total number of hospitals staff in all specialties, 87 employees. Abu Yousef Al Najjar Martyr Hospital provides medical, surgical, and pediatric services, the clinical capacity is 40 beds. the total number of hospital staff in all specialties, 226 employees (MOH, 2009).

Nursing Manpower in Hospitals and their characteristics

Distribution of nurses in Gaza Governmental hospitals depends primarily on the number of beds, capacity of beds and how consider the hospital small or big one, which the MOH divided hospitals into three categories, the first category named small hospital under 100 beds, the second category named the big hospital, the third category named complex as Nasser, and Shifa complex, there are variations between hospitals by the ratio between the nurses numbers and beds numbers because of the services provided in these hospitals, Shifa Hospital is a medical complex has ratio of 0.75 nurse per bed, Nasser Medical Complex 0.73 nurse per bed, Kamal Adwan Hospital, European Gaza Hospital, Al-aqsa Martyrs Hospital and Pediatrics hospital in Gaza City, all of these hospitals considered big hospital about one nurse per bed, the remain hospitals ranges between 39 beds such as psychiatric hospital and 90 beds such as Beit Hanoun Hospital has about 1.2 nurse per bed (Nursing Unit report 2010).

Distribution of nursing managers also depends on the previous characteristics that we needed for each department head nurse who is closely responsible on sub ordinates and their activities their technical and administrative manners, we must have 4 nursing supervisors in duties at least, one supervisor for quality assurance, another one for in service education, and we also needs two or three internal departments supervisors, in the big hospitals we added more supervisors because of more departments and activities.

Nursing supervisors who work in duties have a great tasks and play a manager roles who was left to home afternoon such as knowledge about serious cases in over all the hospital, absents of nurses and how to solve problems, cooperation between health teams, follow up transportations for nurses at the end of shifts, and how to deal with referral patients between local hospitals or referral to another countries, and he makes a detail report to his manager, Building nursing manager is responsible of nurses and their activities in his building and makes report to the hospital nursing manager (Annex 13).

Chapter II

Conceptual Framework and literature review

2.1 Conceptual Framework

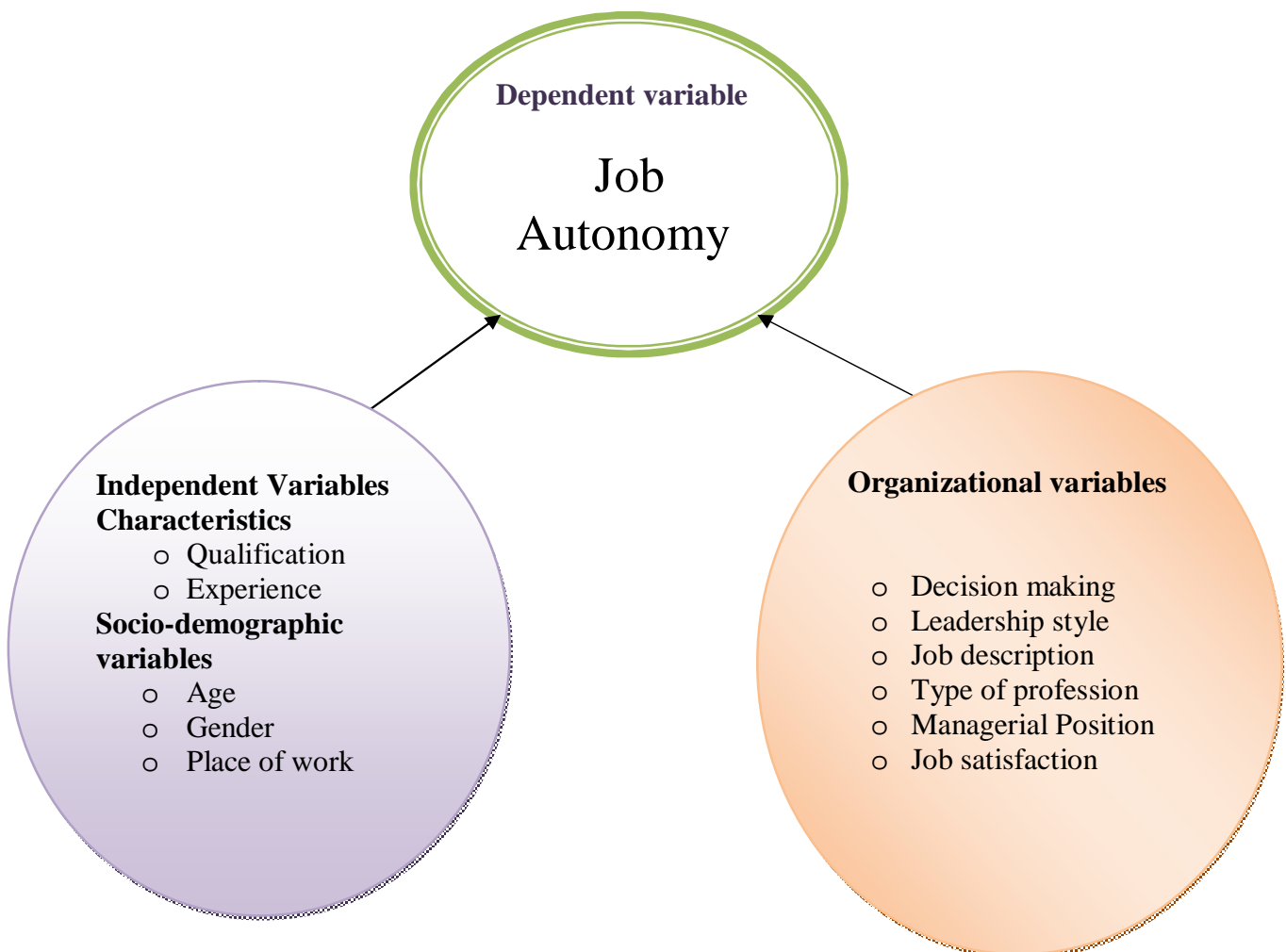


Fig 2.1: Conceptual Framework

Conceptual frameworks act like maps that give coherence to empirical inquiry" (Wikipedia, 2008). Framework can be used as the basis for measurement of the performance of the public health system as a whole or of a specific public health organization. The developed model will allow public health researchers, practitioners, and policymakers to more effectively examine the relationship between the practice of public health and population outcomes and will contribute to the development of a science base for the public health system (Arden 2001).

Conceptual framework consists of two categories, each one contribute to the job autonomy in which job autonomy affected by them. The first category characteristic variables include personal and demographic variables in which job autonomy will be measured by them adopted from questionnaire. This could be discussed by study the variations in job autonomy perception among male and female managers, in any category of age feeling of more job autonomy, how educational level may influence job autonomy, are the managers who more experts feel sense of job autonomy, in which the nursing manager perceive it in every settings in all over hospital wards and areas, the statistical significance differences also could be tested to determine the extent of this relations. The second category include the other variables which consisted of organizational variables such as decision making, leadership style, managerial position, job satisfaction, each of them are interrelated and could be tested by some of questions related to each other.

There is an important organizational variable which called job description may restrict job autonomy because it depends on laws, protocols and policies insisted with job description.

2.2 Literature Review

2.2.1 Introduction

Nurses' autonomy is a phenomenon of international relevance that is linked to work environment. (Varjus et al, 2003) describe the autonomy of Finnish intensive care unit nurses as being a part of empowerment. The majority of nurses reported that they had more autonomy in decision-making about patient care than about unit operations. The autonomy of nurses is linked to their managers' leadership style; leaders are recognized as central to nursing teams (Kosinska & Niebroj, 2003) and clinical supervision can promote autonomous behaviors in nursing professionals (Berggren & Severinsson 2003). Nurse managers who enhance staff nurses' autonomy are also likely to enhance their job satisfaction and decisions to stay in their jobs (Huff 1997; Seguin 2003). In addition, a manager who is considerate to staff, values their input, and supports personal development has a direct effect on retention (Boyle et al, 1999).

It is this attitude that limits autonomous practice. The professional nurse will aggressively seek out all relevant information about the patient and ensure that significant results are provided to the physician, or other appropriate team members, in a timely manner (Ellis and Hartley, 2001).

Confusion about the autonomous nursing practice can lead to serious errors. Manias and Aitken, (2004) report the comments from a graduate nurse who stated that a physician had ordered a medication every six hours but she chose to give it every four hours 'because I knew other patients who got it every four hours and I knew it would not be effective every six hours'. This is not autonomous nursing. This is a medical decision that only the physician is qualified to make. The autonomous nursing response would be to discuss any ineffectiveness with the physician so that the medication can be adjusted properly without putting the patient at risk for toxicity or adverse reactions. This episode does raise the question about who really is the nursing client. Autonomous practice can only occur when both nursing practice and nursing clients are clearly identified (Ellis and Hartley, 2001).

The profession also has many of the hallmarks of autonomous practice, though that issue is more complex because of the social, legal and economic limits under which nurses have traditionally operated. Current state laws typically define nursing practice in broad terms that do not depend on physicians, nurse-controlled state boards administer rigorous licensing examinations, and nurses have independent malpractice liability and codes of ethics. Though there is clearly a significant overlap with medicine, nursing is not a subset of or dependent on medicine.

Even in the managed care era, nurses have significant autonomy in clinical settings. Nurses typically are hired, fired and managed by other nurses. In hospitals, where most U.S. nurses work, registered nurses are managed by other nurses in a chain of command reaching up to a chief of nursing (or sometimes, patient care services). Contrary to the great majority of popular media depictions, nurses do not report to physicians in hospital care settings. Indeed, physicians do not have expertise in many areas of nursing practice, and even where they do, nurses' patient advocacy duties require that they actively resist any care plan that they believe is not in the patient's best interest. This is also the basic structure in nursing homes and other assistive care facilities, where many other nurses work. And in public schools and other public health positions, nurses are effectively autonomous within the scope of their professional duties. Even the nurses who work in what are commonly called "physicians' offices" are operating autonomously within the scope of their nursing practice, though they may be employees of the practice. Since today such offices often include Advanced Practice Registered Nurses (APRNs), it would be more accurate to call them "advanced practitioners' offices," or even better, "outpatient health offices," which would not ignore the contributions of registered nurses and other health workers in such outpatient settings.

Based on the foregoing it is clear that nursing is a profession, unique, identifiable and autonomous. As a profession, nursing has the authority and responsibility to define its standards of practice. ... It is clear that the profession of nursing, though closely related to the practice of medicine, is, indeed, distinct with its own licensing scheme, educational requirements, areas of specialization, Code of Ethics, models, theories and contract with society. The standard of care for nurses arises from the very nature and scope of nursing and is derived from the nursing process. The nurse is not a "junior doctor" nor is the nurse a mere "underling" of the physician. To so hold would negate the existence of nursing as a profession and would render the Nurse Practice Acts of every state, commonwealth and

territory meaningless. It is unlikely that any physician, unless he/she has completed a nursing program and has practiced as a nurse, can offer competent, reliable expert opinion on these nursing standards (www.nursingadvocacy.org).

2.2.2 Nurse power

Nurses historically had limited power in the health care system, a situation that has its roots in many of the traditional aspects of nursing. Changes may not occur as rapidly as desired, and nurses often are frustrated because of their inability to influence the system. Many new graduates are especially distressed to learn that, as individuals, they cannot affect the system. Somehow they expect that if they speak with a voice of reason and act in the best interest of their clients, others will respond positively. Nevertheless, things are changing in nursing. Nursing organizations are working to provide nurses with a voice at higher decision making levels in health care. By understanding the political realities and the ways in which decisions are made, and by working together to speak with a united voice, nurses can increase their power in the system. Nursing education programs increasingly try to educate nurses to act as client advocates and agents of change. Collective bargaining and shared governance have provided nurses with mechanisms for demanding recognition of the importance of their role and for being participants in decision making processes (Ellis and Hartley, 2001).

It is axiomatic that if nursing is to be autonomous it must exercise power. How then is that power acquired and to what extent can it be exercised? Power, in the sense of having the authority to accomplish the work, is part of being a professional. This professional power is a power to accomplish; it is a Power to as compared to a Power against or a Power over. This power as mastery (rather than a power over others) is a fundamental part of nursing practice. It is displayed as the ability to mobilize resources and evolves from two capacities: (1) Access to resources, information, and support, and (2) the ability to get cooperation (Ellefsen, & Hamilton, 2000). Wherever nursing exercises this power it is recognized and rewarded with full team membership. This recognition is often more personal than corporate. The ability of nursing to recognize and utilize its power for the benefit of common goals determines whether it will be recognized as powerful and autonomous. A study of Australian general duty and critical care nurses (Chaboyer, and Patterson, 2001) noted that collaborative relationships cannot evolve unless individuals value and respect each other's competencies. They must also view themselves as a team with common goals. In this study critical care

nurses were seen as more collaborative with the biomedical model, engaged in more teamwork, and participated in medical conferences. They were also more often accepted as colleagues by the medical staff. Nurses are not forced to practice autonomously. Physicians and other team members will consciously or unconsciously compensate for poor nursing performance. Managers may assign these dependant nurses less challenging patients. And there may not be an immediate financial penalty for less professional performance. The attitude of these dependant nurses may be summed up by a graduate nurse who stated that it was the physician's responsibility to look up the pathology and lab reports: 'It's not my job to ring him up and tell him the patient has a high potassium' (Manias, & Aitken, 2004).

Power is exerted in the health care system by those who control finances, those who control access, and those with special knowledge. Historically, nurses and consumers have enjoyed little power in the system. Both are working to gain recognition and to affect more significantly the way the system functions.

Nursing is an autonomous, self-governing profession, a distinct scientific discipline with many autonomous practice features. Despite what the media may portray, nursing is not directed by physicians, even though nurses have less practical power than physicians do. In addition to extensive medical expertise, nurses have a unique, holistic patient advocacy focus, a unique scope of practice, and a unique body of knowledge, including special expertise in areas such as patient education, wound care and pain management. There are a number of reasons for the common misperception that nurses report to physicians. Of course, nurses and physicians collaborate as members of the health care team. But historically, nurses have deferred to physicians, for reasons including the imbalance of power among the genders. Today, physicians combination of economic power and social status is unmatched. Physicians still have more years of formal education than most (but not all) nurses. And over 90% of nurses are still female, at a time when women have a much wider range of career choices. Most physicians are not well-informed about nursing, and many refer to anyone working in the health care setting who is not a physician as a "nurse." Many physicians regard themselves as being essentially in charge of patient care. Consistent with this authoritarian vision, physician disrespect and disruptive behavior, including verbal and even physical abuse, remain issues in many care settings. As a result of these and other factors, many nurses remain reluctant to challenge physicians or assert themselves generally. In

addition, recent developments in health care have led to some confusion as to professional identity among patients and others (<http://www.nursingadvocacy.org>).

2.2.3 Physician power

Physicians historically had almost unlimited power within the health care system. They determined who entered the system and when. They decided if and when other services and personnel would be used, and they determined when clients would leave the system. As a group, physicians have opposed changes that would disperse power in the system, arguing that they are the most educated and knowledgeable of all health care providers and that their professional judgment should be accepted. Those favoring increased distribution of power have argued that more competition, more choice for consumers, and input from a greater variety of health care providers and from consumers will make the system more balanced and more responsive. Despite changes, physicians are still powerful in the health care system (Ellis and Hartley, 2001).

2.2.4 Nursing mandate

Nursing's mandate provides the reason for our existence and delineates the position nurses hold on the multidisciplinary team. There is a role that nursing plays that no other member of the team can fill. That mandate can be simply stated as the implementation, management, and monitoring of the therapeutic plan of care. This is caring for the patient in a way that no other member of the team can. Only nursing has the combination of education, resources, and continuous contact with the patient that is necessary to ensure the medical plan of care is implemented, monitored and modified as necessary to reach the discharge goals for each patient. Before a meaningful discussion of nursing autonomy is possible, it is important to understand this mandate. Knowing the role nursing fills is necessary in order to recognize who nursing's clients really are. Professional power and autonomy are always exercised for the service of the client. The legal and professional relationships with the client provide the framework within which autonomy operates. To speak of personal autonomy without reference to these complex relationships, within which a profession operates, is to speak of anarchy. Yet this is often the case when nurses discuss autonomy. O'Connell and Warelow (O'Connell B & Warelow P, 2001) cite as evidence of the "questionable" autonomy or even the lack of professional autonomy the situations where nurses felt that they could not

influence the medical care of the patient or where the physician could over ride a nursing decision. There was not even recognition that the medical role and nursing role are complementary. The physician did not order the treatment the nurse decided was appropriate and that was enough to create a sense of powerlessness in the nurse. These are not isolated views and reflect confusion over the exercise of clinical autonomy and power. Keenan (Keenan J, 1999) acknowledged the difficulty of defining autonomy and reviewed various uses and conditions for its application. She draws the distinction between personal and occupational autonomy and discusses some of the requirements for being autonomous. However, in the end she states that, given the nursing's historical lack of power vis a vis the medical profession, full professional status is probably not possible. Fortunately, this bleak position is not only untrue but nurses around the world are actively practicing full professional autonomy (Ellis and Hartley, 2001).

2.2.5 Why the Confusion about nursing's role?

The confusion about nursing's role goes back to the early post-Nightingale days. At that time physicians largely controlled the hospitals including the hiring and firing of nurses and the setting of nursing policy (Godden & Forsyth, 2000). Florence Nightingale distanced herself from the conflict and tension inherent in nursing's effort to find it's own place in the care team. An outgrowth of these roots led to the widely accepted myth that physicians cure and nurses care. This myth, alone, has done much to diminish the perception of nursing's real role and function. In 2003 Gerrish and et al interviewed 18 educators in Master level programs in nursing. They were looking for the common essential core values these educators held for nurses. Recurrent themes were focused on the power of the nurse, blurred boundaries between nursing and medicine, and relations with other professionals. Conspicuously absent was a focus on caring. As they noted, the supposed centrality of emotion work and caring is one of nursing's myths. Holistic emotion work is a secondary consideration in modern health care and claiming such work as a basis for professional jurisdiction may not be an effective way of achieving professional status. Central to this myth is the self-assertion by nursing that it is the profession that cares about the patient. There is no mandate for nursing in this, since it is clear that other professions also care about the patient. Physicians care deeply about the patient and the outcome of patient care, as do respiratory therapists, housekeepers, and the patient's family. Two problems that arise from focusing on caring *about* the patient are that

nurses lose sight of who their clients really are and second, they lose their grip on what the real nursing mandate is: caring for the patient. As Gerrish et al (2003) noted, “the work that nurses now undertake caring for patients makes it increasingly difficult to engage in the kind of work in which they also care about them; a little more realism may make a more sustainable professional future”. This does not mean that modern nursing is devoid of human feeling or that nurses should care less about their patients. Rather, it means that caring about the patient must find its expression in caring for the patient (Gerrish, McManus, & Ashworth, 2003) .

2.2.6 Relevance of the political process for nurses

Nurses always have been involved in politics. Florence Nightingale used her contacts with powerful men in government to obtain supplies and the personnel she needed to care for wounded soldiers in the Crimea. Hannah Ropes was able to fight incompetence and obtain decent care for wounded Civil War soldiers because she understood who the influential people in Washington were and who would be receptive to her efforts on the soldiers’ behalf. Modern times are no different. With many voices competing to be heard in the decision making circles of any nation, the person who understands power and politics is the one most likely to obtain the resources needed to accomplish desired ends.

The political process in the nursing profession takes many forms. Nurses can be involved as individuals, but they are far more effective when they work in groups. Because nursing is the largest single health care occupation, nurses have many votes. For this reason, legislators pay attention to positions held by groups of nurses.

Collaboration with physicians works very well with autonomy in nursing

Standards of practice in nurses’ professional organizations should include those actions over which the nurse has autonomy. These practice standards should ideally distinguish between entry-level and advanced level standards. Such standards can act as a vision for the profession. Autonomy is enabled by research that is conducted by nurse scientists. As nurse scientists continually examine the effects of nurses’ practice and actions, autonomy will be further enhanced. For example, if nursing science discovers that certain types of daily exercise and ambulation with patients with cancer improves depression, then nurses will be in an informed position to teach and counsel newly diagnosed patients about the importance and

frequency of daily walking, even during chemotherapy. Such a recommendation would be the opposite of what many nurses would have recommended a few years ago. By conducting scientific studies in areas of nursing practice, nursing science adds to the nurse's ability to act autonomously on the basis of best evidence (Lewis, 2006).

2.2.7 Definitions of autonomy

Autonomy is a concept found in moral, political, and bioethical philosophy. Within these contexts, it refers to the capacity of a rational individual to make an informed, un-coerced decision. In moral and political philosophy, autonomy is often used as the basis for determining moral respectability for one's actions. In medicine, respect for the autonomy of patients is an important goal, though it can conflict with a competing ethical principle, namely beneficence. Politically, it is also used to refer to the self-governing of a people (www.wikipedia.org) Monday 6/7/2010.

Linguistically, Oxford English Dictionary (1994) defined autonomy clearly as "independence". Mosby's Medical, Nursing and Allied Health Dictionary (1994) defined autonomy as "the quality of having the ability to function independently". Also autonomy was defined in (Merriam Webster's Collegiate Dictionary, 1996) as "the quality or state of being self-governing; the right of self-government; Self directing freedom and especially moral independence", and (Merriam Webster's, 2002) also defined autonomy as "a. the quality or state of being independent, free, self directing; b. independence from the organism as a whole in the capacity of a part for growth, reactivity, or responsiveness". Moreover, Dictionary of The English Language (2006), defined autonomy as "self government with respect to local or internal affairs; granted autonomy to national minority or a self-governing state, community, or group". A synonym of autonomy includes freedom, liberty, self-determination, self-rule, self-government, independence and sovereignty (Kipper, 1992). Sociologically, individual autonomy is seen as a type of individual freedom of action where the personal decides his or her own line of action in agreement with a plan chosen by himself or herself (Abramson, 1985).

Autonomy is the freedom to make discretionary and binding decisions that are consistent within one's scope of practice and the freedom to act on those decisions (Lewis, 2006).

Autonomy is the freedom to make discretionary and binding decisions consistent with one's scope of practice. Discretionary and binding decisions mean that the nurse has control over the knowledge needed to make the decision. She or he does not need to turn to others in order to know or understand. Instead, the training and education of the nurse has provided him or her with the requisite information and understanding to make the decision. For example, a nurse is educated to know how to assess vital signs and patient symptoms. These include deciding if a patient's blood pressure is elevated beyond a normal range; it also includes judging whether a patient is excessively perspiring or hyperventilating. Such assessments are part of a nurse's knowledge and understanding. Discretionary and binding decisions mean that no one "above" the nurse needs to give approval or permission for the nurse to take action on an assessment or observation. If an act requires permission or approval from someone else, the act is not discretionary and the nurse is not acting with autonomy. An example of a discretionary and binding decision includes a nurse's decision to reposition a patient in order to maximize chest excursion and reduce cardiac work (Lewis, 2006).

Another example of a discretionary and binding decision is a nurse's decision to measure input and output on a patient whose level of hydration is of concern to the nurse. Both decisions are within the nurse's scope of practice knowledge and no one needs to make these decisions for the nurse. Rather, the nurse is able to independently make these decisions and all of them are within his or her scope of practice. Autonomy includes the freedom to act on the binding decisions the nurse makes. The nurse does not need to obtain permission from others to carry out actions she has decided on. Instead, the nurse's education has prepared her to enact the decisions. For example, a nurse can decide to initiate an educational teaching plan with a new mother who is trying to initiate breast feeding her newborn but who is not being consistently successful. No one needs to give the nurse permission to do this education with the mother. For example, a nurse can initiate a teaching plan for a caregiver at home who does not understand when or how to interpret the patient's symptoms or does not know when to decide to administer a medication. Again, the nurse can carry out these teaching plans and no one needs to give him or her permission to do them(Lewis, 2006).

2.2.8 Differentiation between autonomy and professional autonomy

Autonomy, a complex, multidimensional phenomenon, is derived from the Greek words *autos* and *nomos*, meaning self and to rule or hold sway (Curtin 1982, Dempster 1994). The dictionary defines autonomy as 'the right of self-government; personal freedom; freedom of will; and a self-governing community' (Fowler & Fowler 1995).

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

2.2.9 Autonomy as Attitude and Structure

Autonomy has both a personal or attitudinal dimension as well as a structural dimension. Both are important. Autonomy is part of a nurse's attitude and is reflected in statements like these, "This nurse has a high personal sense of autonomy," and, "This nurse is committed to an autonomy of practice," and "This nurse values autonomy of practice." Each of these statements reflects nurses who value, want, or embody an attitude of autonomy. If a nurse is to practice with autonomy, he or she must perceive and value the freedom to do so and be willing to exercise autonomy. If a nurse does not value autonomy or does not perceive the freedom to carry out autonomous acts, then the nurse will not be autonomous. Autonomy involves structure. Structure includes the structure of a health care agency, the scope of practice that is described in nurses' practice literature, nurses' license laws, nurse organization's professional practice standards, advanced practice certifications, and knowledge development within nursing science. Each will be briefly considered. The structure of a health care agency reflects the degree of autonomy of nurses. Agencies vary enormously on the extent to which a nurse is encouraged, hired to do, and positively rewarded for carrying out discretionary and binding decisions and actions. If a nurse must seek permission for practice acts that are within his or her educational training before she or he carries them out, there is essentially no autonomy allowed by the agency. If, however, a nurse is promoted, given merit pay increases, and valued when she or he carries out discretionary and binding decisions for patient care, then the agency's structure supports and encourages autonomy. Autonomy is affected by the scope of practice that is described in

nurses' practice literature, license laws, and practice standards. These documents are essential for advancing and supporting autonomy in nursing. If the practice literature emphasizes non-discretionary and non-binding decisions, they are not supporting autonomy. One could even argue that they are holding back autonomy. Nurses' license laws should clarify the domains of knowledge and skills over which the nurse can make discretionary and binding decisions. Clear laws should reflect clarity on the nurse's assessment responsibilities, on binding decision-making responsibilities, and on delegated responsibilities. The literature should be examined and evaluated for text that discourages autonomy or encourages nurses' dependency on others for making most of the decisions for nurses. What do the license laws state about nursing actions? A review of these laws can be illuminating (Lewis, 2006).

The text of these laws may include language that works against autonomy in nursing. For example, if the text of the practice law states that nurses must seek pre approval to initiate patient care plans, the law is working against autonomy. If the law states that nurses serve patients at the discretion of the physician, the law is working against autonomy. Functioning with autonomy as nurses is different than functioning collaboratively with physicians. Nurses do function collaboratively with physicians, but that does not preclude them from functioning autonomously within their scope of practice. These two issues should not be confused with each other. Core ideas about professional nurse autonomy Over 50 years ago, it was noted that obstacles to overcome in achieving professional nurse autonomy are grounded in traditional conceptions of the term. Traditional views, based on a male model of autonomy that emphasizes control and separation, devalue the professional nurse's relationship with the client and the attitudes and behaviors of a primarily female profession. Evidence in the nursing and psychology literature indicates that the development of autonomy differs for men and women (Kurtines, 1978; Schutzen, 1987).

Females develop autonomy within the context of relationships and the ethics of caring. Others argue that androgyny, a blending of traditional male and female characteristics, may be more relevant to professional nurse autonomy (Salladay 1991; Bradley 1993). Furthermore, helping behaviors are displayed more frequently by androgynous rather than sex-typed individuals (Senneker & Hendrick, 1983).

Over 20 years ago, it was recognized the uniqueness of professional autonomy in individual nurses. Professional nurse autonomy, defined as the nurse's perceived latitude or willingness

to act as a responsible professional, emphasizes the dependence and independence between nurses and patients. The nurse's primary area of responsibility is patient advocacy. Others have also acknowledged the association between advocacy and autonomy (Curtin 1982, Pinch 1985, Cassidy & Oddi, 1988, 1991).

2.2.10 Attributes of autonomy

The purpose of the recognizing or identifying attributes of the concept is to differentiate and distinguish autonomy from other related or similar concepts. From reviewing the existing related literature of the autonomy concept many attributes are put forward:

Self-governance: is the heart of autonomy and is depend on a method of laws and principles, some writers referred to governance as the right, liability and capability to establish or create environment and make decisions applicable to one's professional practice to keep control over self, working conditions and practice (Ellis and Hartley, 2001).

Independence: it is essential attribute reflect freedom of individuals. Self-control: autonomous individuals must have ability to do freely without any competence restriction exhibited in constantly increasing creative life that is fully one's own, this idea brings an existing awareness of liability for self and ability to control self (Ellis and Hartley, 2001).

Freedom: a self-generated, self-won, and free from external inducements. Therefore, autonomy is a feature ideal, the same with the ability to self-direct according to life plan that matches to the personals long term interests and nature (Ellis and Hartley, 2001).

Decision making: also is a vital attribute in the concept of autonomy, because individual ability to become autonomous depends on his/her capability or capacity to make choice among alternatives. Ellis and Hartley (2001) stated that “the autonomous person is capable for making rational and unconstrained decisions and acting on those decisions. An individual is to be considered rational when he is capable of choosing the best means to some end”.

Reflection: one of the most directly associated attribute with decision making attribute is the critical reflection. Ellis and Hartley (2001) described reflection as being “sensitive to thought and being guided by it, autonomy is the carrying out of reflectively endorsed purpose”.

Knowledge: capacity, ability, competence are others attributes of autonomy. The significance of knowledge is demonstrated in Ellis and Hartley (2001) unsophisticated definition of autonomy as “the freedom to act on what you know”. Moreover. Ellis and Hartley (2001. state the competence is the cornerstone of autonomy. Therefore, Person autonomous must have knowledge base, capacity, and competence to be able to create effect and to be able to increase his scope of skills that motivate that capability. Also some nurse writers have associated knowledge base and competence with the attainment of autonomy.

Self-determination: a lot of nurse writers suppose that self-determination is significant attribute to achieve autonomy in effective method. Interdependence, some nursing authors such as Ellis and Hartley (2001) believe the interdependence relationships with individuals are necessary to achieve autonomy.

Judgment: person must be able to make judgment based on knowledge and experience which lead to making good decision to become autonomous (Ellis and Hartley, 2001).

Related concepts

There are many concepts which give the same meaning of autonomy, according to Ellis and Hartley (2001).

The related concepts of autonomy are: Control, freedom, authority, power, independence, responsibility, professionalism.

Antecedents

Antecedents are the conditions or events that must required or occurred before the autonomy process begins, from the literatures of autonomy (proposed that the antecedents of autonomy are: The Individuals must have the abilities to prioritize part or aspect of knowledge of personal believes and values related to circumstances., must have experience to act perfect autonomously.

The Individuals must have education to act as individuals autonomous, The individuals must also have abilities or capabilities to self-discipline to act autonomously, and to make

judgment, The individuals or groups must have morals, and ability to reason and critical thinking skills to act autonomously.

The individuals must also have abilities to distinguish or discriminates their knowledge either experiences or educational levels related to conditions, And the Individuals must accept or agree to their scope of responsibilities to act autonomously.

Finally, the Individuals also must have a good knowledge to develop competence and fully exposure to systems of laws, principles, standards, and believes (Ellis and Hartley, 2001).

Consequences

Consequences refer to product or outcomes of the autonomy process. According to Ellis and Hartley (2001), the outcomes of autonomy process include the followings:

Accountability, it is the most obvious consequence identifiable for the autonomy concept. It defined as the answerability and responsibility to power or authority for person actions, when person develop into ready to act autonomously the person must be prepared to accept responsibility and answerability for his/her actions.

One of the consequences of autonomy is improved or achieved individual professional status, as a result of autonomy process, individuals autonomous will have power, authority, commitment and freedom to do actions based on scope of their responsibilities, and personal satisfaction.

Finally, autonomy process will lead to achieve individuals or groups empowerment that will lead to improve trust, self-awareness, and self-efficiency among individuals and improve ability of individuals to change their work environment and assist them to create more satisfied environment under name professional practice environment.

2.2.11 Challenges of Autonomy in a country

A country rich in heritage and deeply rooted values that include harmony, respectfulness, deference, gentleness, and modesty. None of these values need to be changed in order for nurses to function with autonomy. Autonomy does not conflict with these values. But autonomy does require that a nurse carry out discretionary professional acts based on the authority of knowledge and license. Furthermore, autonomy does not cause disharmony with physicians or elders. Autonomy includes acts that are concordant with harmony. Do not confuse respectfulness with inappropriate deferral or modesty. Autonomy in nurses' practice

contributes to the well-being of patients and adds to the quality of services and care that patients receive. Functioning with others in harmony does not require that a nurse is meek as a mouse. when autonomy is effective, the nurse's acts are focused on the patient and the patient's well-being. As such, autonomy brings out the best of nursing practice to the patient (Lewis, 2006).

Some challenges in Gaza strip include but are not limited to the dominance style of physicians, social culture and historical background of nurses (bad image), unavailability of special high education in nursing, scars of man power and non-presence of job description.

Autonomy is never focused on the self

There is a “growth pain” in evolving structures and laws that encourage nurses' autonomy. Tension will naturally come from working through and generating new working relationships and structures. This is a good, natural tension as nurses and other health care workers talk about, plan, and work through new and better ways of working together for the benefit of patients. Differing expectations can be made clear. For example, if nurses were historically expected to not initiate patient teaching plans or counsel patients but now claim such activities as part of their autonomy, others will need to have such actions interpreted. If the acts of autonomy are clearly focused on the well-being of patients, tension will be easily managed or avoided. Again, autonomy is never focused on the self or on personal power. It is instead focused on carrying out acts that benefit patients. Concluding Remarks Florence Nightingale's Pledge is the essence of nursing and reminds us of the importance of both autonomy and collaboration with physicians: “I solemnly pledge myself before God and in the presence of this assembly, to pass my life in purity and to practice my profession faithfully. I will abstain from whatever is deleterious and mischievous, and will not take or knowingly administer any harmful drug”(Lewis, 2006).

2.2.12 Autonomy and worker satisfaction

The relationship between decision autonomy and worker satisfaction has been studied since the inception of occupational psychology. It is a common finding that increased decision autonomy is associated with increased worker satisfaction. In a major survey of the occupational psychology literature. Work attributes such as task autonomy, responsibility, control and complexity, all have mental challenge in common. Locke argued that the degree

of challenges has an inverted U function relationship with work satisfaction. That is moderate level of challenge result in high satisfaction levels where as too much or too little challenge result in diminished satisfaction. Other studies in occupational psychology have also shown that achievement or accomplishment in decision making is positively associated with task and work satisfaction. Hence, for higher levels of satisfaction to result, the individual must be mentally challenged on the job and achieves successful outcomes or progress (Keenan, 1999). In critical care environment, however, the studies have been performed in the general nursing context. It can be argued that the critical care environment is qualitatively different from other nursing environments. In contrast to most other forms of nursing there is a sustained exposure to life-threatening crisis situations and higher levels of decisional stress. It has been argued that critical care nurses must be able to diagnose in both the biomedical domain as a competent physician adjunct and in the nursing domain as an expert clinician (Keenan, 1999).

2.2.13 Clinical autonomy

A solution to this apparent paradox is found in Cash's (Cash, 2001) concept of clinical autonomy in relationship to contractual space. He argues that all professions operate within boundaries and use procedures that are generally accepted by the discipline. The real question is not whether there are boundaries but who is setting and regulating them. In the United States, as in many other countries, nurses supervise nurses. Nursing administrators write the policies and procedures that control individual nursing practice in a given institution. Nurses sit on the regulatory boards that govern the licensing and legal practice of nursing. This subordination of individual autonomy to occupational autonomy compares very favorably to the experience of general practice physicians in the United Kingdom who were regulated and administratively controlled by government regulations and professional practice groups (Harrison S, and Dowswell G, 2002). This was illustrated in the United States by the response to a very popular television program titled "emergency nursing". This program portrayed nursing in a very subservient role which drew an open letter to the producer from the president of the Emergency Nursing Association (Robinson K, 2004). After pointing out that nursing is an independent profession that is not controlled by physicians and is not obligated to carry out questionable or erroneous orders, she goes on to note that physicians do not hire, fire, supervise, or discipline nurses. Nurses are "hired by the hospital to care for patients while physicians only have admitting privileges". Robinson then notes the following statistics. In the United States, nurses hold 32.9% of the Director of Emergency Services

positions while physicians hold 35.4%. When it comes to Emergency Department managers and assistant managers, 73.9% are nurses compared to less than 1% who are physicians. Robinson points out that “without nurses there is no health care”. In modern health care institutions nursing is controlled and regulated by a department of nursing. Nursing is represented at the executive level on operational boards and nurses write the nursing procedures and policies. The Chief Executive Officer of a large regional hospital recently circulated an open letter to all the hospital staff in which he stated, “We can not accept any reluctance to question an action or order regarding patient care. All members of the team are to accept responsibility - if you see a problem, you own it until it is resolved or it has been appropriately passed on to someone who can. All personnel are absolutely obligated to express concern about any potentially unsafe order or care. Medical Students and Residents should recognize that our nurses spend the most time with our patients. Their observations and experiences are a major resource, which should be cherished and accessed” (Bagley D, 2004).

2.2.14 Job Description

Job description form another important aspect of any organization. Job descriptions are written statements, usually found in policy manuals, that stipulate the duties and functions of the various jobs within the organization, and the scope of authority, responsibility, and accountability involved in each position. Job descriptions should explain the role of each individual working for the company or organization, from the chief executive officer to the janitor. Sometimes job descriptions are very specific; other times they are more broadly stated. If broadly stated, policy and procedure manuals may help to specify a task or responsibility. Job descriptions provide the foundation for performance standards for each position and should provide the basis for evaluation. Job descriptions also may include competencies expected of employees and can provide the basis for Competency-Based Orientation (CBO). As the RN delegates more and more care to those with lesser educational preparation, it is critical that job descriptions provide sufficient description of the competencies of various workers, so that the document can be used to guide delegation activities. Job descriptions also are important when cross-training is used in the organization. Cross-training involves teaching one member of the health care team to perform functions usually associated with another position. For example, a respiratory therapist might learn to perform basic patient care skills and, when not needed for respiratory therapy treatments, be

available to answer lights and respond to patient needs. Cross-training is viewed by some administrators as a method by which costs can be reduced through the efficiency of having an individual able to do more than one set of tasks within the organization. The effectiveness of cross-training between different disciplines has not been well documented. However, cross training of nurses between differing specialties has become common, and many nurses welcome the employment flexibility this provides. Job descriptions also may describe clinical ladders. A clinical ladder differentiates and defines the skills and performance expected of nurses in terms of advancing levels. Typically, three or four levels of performance are defined, with each higher level having greater responsibility and authority than the previous one. A new graduate usually enters the system as a Clinical Nurse One (or similar title), moves to Clinical Nurse Two, and then to Clinical Nurse Three as that individual becomes more proficient. Salary increases typically accompany movement from one level to another, as does the responsibility the individual is expected to assume. Sometimes additional formal education or continuing education is required for advancement. Through this process, the nurse is supported and encouraged to develop greater clinical expertise. The clinical ladder also serves as a mechanism for recognizing and rewarding nurses who wish to remain in direct care positions rather than seek administrative positions (Ellis and Hartley, 2001).

2.2.15 Policies, Protocols, Procedures, and Standards of Care

A policy may be defined as a designated plan or course of action to be taken in a specific situation. In organizations, the governing board holds the responsibility and authority for assuring that appropriate policies are adopted. The governing board usually delegates the development of policies to the chief administrative officer. The administrator usually delegates the responsibility for development of policies for a specific department to individuals or groups in the department that will be most affected by the policy. Once their work is completed, the policy is returned to the governing board for review, possible revision, and adoption. The management within the organization is responsible for assuring that the policies are followed and that more specific policies are developed if necessary. Written copies of all policies usually are placed in a policy manual that is available in each department, or a current copy may be available on-line in the institution's computer network. On-line policy manuals assure that all departments are referring to the most current policy and that the information is always available. Depending on the area in which you are employed, you will find varying needs for referring to the policy manual in your role as a

new employee. As you might anticipate, the need for special policies related to occurrences in an emergency department, delivery room, or a critical care unit is greater than in a general medical or surgical unit in a hospital. When you are confronted with a new nonclinical problem to solve and you are unsure of what action to take, always check your policy manual to see if it offers guidance. Special unit policies are sometimes termed protocols. For example, the protocol for dealing with a patient seen in the emergency department suffering from a dog bite determines which local authorities should be notified, who is responsible for seeing that they are notified, and perhaps general management of the wound. Procedure manuals contain the written instructions describing the accepted method for satisfactorily performing a particular nursing activity (procedure), often describing it in a number of steps. Procedure manuals should be found in each unit or department. For example, in the manual, you could find a procedure for changing the dressing on a central intravenous line, for administering chemotherapy agents, and for doing many other procedures, such as catheterizations. Institutions are giving nurses more responsibility for developing institutional policies and procedures, and serving as representatives to various committees that monitor, review, and update policies and procedures. As hospitals move to broader spans of control and to greater involvement of all employees in decision-making, grassroots participation in policy formation is becoming more common. The nature of a policy and the breadth of its scope will determine whether it needs further review within the organization. Standards of care are authoritative statements that describe a common or acceptable level of client care or performance that have some similarity to policies and procedures. Thus, standards of care define professional practice. In 1991, the American Nurses Association (ANA) formulated general standards and guidelines for nursing practice. They apply across the nation and are broad and general in nature. They are now in their second edition and represent more than 20 areas of specialty practice. (The standards can be purchased from ANA as a package or for single specialty areas.) Similarly, state practice acts contain language describing the standard of practice that applies to all nurses licensed in that state (Ellis and Hartley, 2001).

Each agency also may develop standards of care for patients with selected health care problems. These more detailed and specific standards may take the form of standard nursing care plans. Some standards are being incorporated into documents termed care pathways, critical pathways or clinical pathways. These are intended to serve as guides to direct the health care team in the daily care. It organizes and sequences the care and describes the care required for a patient at specific times in the treatment. It involves a multidisciplinary

approach and identifies both the care activities and the outcomes for each 24-hour period of hospitalization. These specific standards of care become the basis for evaluation of care, quality improvement within the organization, and cost analysis (Ellis and Hartley, 2001).

2.2.16 Shared governance

Shared governance is a professional practice model in which the nursing staff and the nursing management are both involved in decision-making, as opposed to the administrative decision area being controlled by management. It originated during the mid-1980s and gained status and recognition as an alternative to bureaucratic management during the 1990s. This structure allows nursing staff to make major decisions within the organization and attempts to get the decision-making process as close to where the action is occurring as possible, typically through the development of internal councils. Often, this pattern of organization is paired with the concept of total quality improvement (TQI), which has as its hallmark emphasis on the customer. Ellis and Hartley (2001) states “TQI and shared governance (1) empower all employees, (2) encourage decision making at the appropriate level within the organization, (3) promote teamwork with consensus and shared responsibility, (4) encourage and recognize employee contributions, and (5) provide opportunities for personal growth.” There is no single model for shared governance. The shared governance format may take several approaches, including a councilor model in which committees and councils have defined authority and functions, a congressional model that involves an elected representative system, or an administrative model consisting of committees or forums in which people communicate and share ideas (Porter-O’Grady, 1987). The committees or councils result in staff actively participating in management, and, as a consequence, gaining autonomy, control over the work environment, and greater job satisfaction. Often, councils report to a nursing executive board that serves as a coordinating and approval body. Within this framework, the nurse is held to greater accountability within the context of peer-defined and peer-operated parameters (Porter-O’Grady, 1990). The traditional role of the supervisor as one who hires, evaluates, promotes, and fires becomes a thing of the past. The inability to make this change has been a major impediment to the success of shared governance. Many managers find their new and changing role difficult to accept. The shared governance model has become widespread in hospitals. Its implementation requires that staff nurses participate in professional development sessions that increase nurses’ understanding of the decision-making process, team building, group dynamics, leadership, and budgeting. Many have

questioned the continuance of shared governance models in today's health care system. The re-engineering and restructuring of the health care delivery system, which has resulted in multihospital systems, consolidations, mergers, and the use of nurses as primary care providers and case managers, also may result in the demise of shared governance, or in its assuming a different format. The time involved in shared governance is costly to an organization, and the cost-effectiveness of shared governance in terms of patient outcomes is being questioned (Ellis and Hartley, 2001).

2.2.17 Strategies for enhancing autonomy

While a nurse's scope of practice is legally defined based on educational qualifications and specific experiences, professional and organizational expectations determine the degree to which autonomous practice occurs. As described in the following section, strategies for enhancing autonomy are based on setting clear expectations for autonomous decision making and providing support for increasing the knowledge and expertise of nurses.

Clarify Expectations about Clinical Autonomy

Professionally and organizationally sanctioning and supporting the application of nursing knowledge and expertise in the care of patients has been associated with enhancing autonomous nursing practice (Kramer & Schmalenberg, 2003). Nurses can enhance autonomy by clearly communicating and organizing their work to ensure that they have the freedom to act on nursing decisions using sound clinical judgment. Describing expected behaviors involves communicating that nurses are expected and encouraged to make decisions about clinical patient care that are based on the science and art of nursing. This involves setting an expectation of independent nursing action and supporting decision making within the scope of nursing practice. In addition, because nursing practice involves both independent and interdependent actions, clearly identifying acceptable responses to situations that are at the edge of nurses' commonly accepted scope of practice is helpful in this process (Stewart, Stansfield, & Tapp, 2004). Examples of such identifications include outlining expectations related to verbal physician orders and establishing protocols for over-the-counter medications. Behavioral expectations can be formally outlined in orientation programs, demonstrated by preceptors, and highlighted through ongoing discussions about clinical practice (Marla and Weston, 2010).

In addition to clearly defining expectations for autonomous clinical practice, incorporating nursing knowledge and expertise into clinical practice embeds autonomous practice into patient care. For example, patient care rounds can be organized in a way that ensures that nurses contribute to decision making about the treatment plan of patients. The nurse is positioned to discern subtle trends and changes in a patient's condition, to know the unique personality and strengths of the patient, and to have established a caring relationship with the patient. Including nurses in clinical rounds maximizes the valuable contribution of their unique perspective and information in the care of patients. With nursing input, more diverse solutions can be explored, patient care planning is more robust, interdisciplinary communication is improved, and care coordination can provide for more effective implementation of plans (Marla and Weston, 2010).

Recognizing autonomous practice can reinforce verbally communicated expectations. For example, acknowledging exemplary performance by having nurses share clinical examples that highlight autonomous practice provides a venue for displaying sanctioned autonomous practice. Nursing grand rounds, poster sessions on clinical case studies, and/or situations shared during staff meetings can all be used to illustrate examples of autonomous nursing practice. In addition, emphasizing expected behaviors through recognitions and rewards outlines for nurses the realm of autonomous actions. Clinical ladder programs formally reward and recognize clinical practice, further delineating expected autonomous actions.

Role modeling expected behaviors also reinforces autonomous clinical practice. Novice nurses quickly observe the nature of clinical judgment and autonomous nurse actions demonstrated by more senior colleagues and use these observations to identify accepted levels of independent and interdependent decision making. Clinical nurse leaders and clinical nurse specialists in the practice setting can engage in behaviors reflective of autonomy and serve as an ongoing resource for role modeling, coaching, and mentoring excellence in clinical practice.

A component of coaching for autonomous behavior includes addressing when behaviors are not within the range of expected actions. For example, if nurses are not making the expected autonomous decisions, coaches can compare actual with expected actions to show how to make the expected nursing contributions and behaviors more explicit. Addressing inappropriate actions using constructive feedback can guide autonomous nursing practice. If

nurses take clinical actions that are not appropriate or not successful, constructive feedback can redirect their practice patterns (Marla and Weston, 2010).

Studies have suggested that creating a climate that is supportive of nursing practice will augment the level of autonomous practice. For example, nurses working in Magnet hospitals perceived that managers were more supportive of their independent clinical decision making than did nurses working in non-Magnet hospitals (Upenieks, 2003). Because of perceptions of support, nurses in Magnet hospitals may be more willing to assume the risk for making autonomous patient care decisions. Building trust in the clinical setting by supporting nursing actions that may be risky, yet are safe, encourages innovative practice and enhances autonomy (Marla and Weston, 2010).

Enhance Competence in Practice

The establishment of the sound clinical judgment needed for autonomous practice requires a foundation of nursing expertise. Although difficult to define, nursing expertise is a combination of knowledge and skill along with extensive experience (Jasper 1994). Thus, implementing strategies to increase the competence of nurses by creating a learning environment can foster autonomy. Stewart, Stansfield, and Tapp (2004) reported that autonomy can be fostered by enhancing competence and confidence through strategies such as teaching rounds, formal continuing education, and a climate of inquiry in everyday practice. Also during staff meetings, clinicians can share complicated patient scenarios that have challenged their autonomous decision making to both exemplify excellence in practice and receive feedback on how to further enhance patient care. Promoting evaluation of autonomous practice in this way allows for unique variation in culture and norms between units (Marla and Weston, 2010).

Encouraging the continuous examination of practice allows nurses to reflect on the degree of autonomy present in their decision making. In addition, establishing an evidence-based practice approach may develop and enhance autonomy. By identifying and evaluating relevant research while simultaneously assessing and incorporating information about patient preferences into their plans, nurses have the opportunity to make autonomous patient care decisions. Further, development of skills related to communication, interdisciplinary teamwork, and negotiation can assist nurses to master the skills necessary to advocate for their patients.

Creating an environment that supports both formal and informal continuing educational opportunities and learning provides for autonomous clinical practice. Baccalaureate-prepared nurses have reported a higher preference for both clinical autonomy and Clinical nurse autonomy and control over nursing practice (CONP). In addition, master's-prepared nurses have reported significantly higher professional autonomy in clinical nursing situations compared to nurses prepared with a diploma or associate degree. Further, Ericsson, nurses with specialty nurse certification and specific clinical training demonstrated higher levels of expertise. Tuition reimbursement and support for returning to school can enhance the development of skills and competence needed to support autonomous practice (Marla and Weston, 2010).

The importance of the culture of learning cannot be stressed enough. For example, while nurse managers at non-Magnet hospitals focused on adequate staffing as a critical element, managers at Magnet hospitals emphasized educational opportunities and an autonomous climate as being a vital factor for nurse satisfaction (Upenieks, 2003). In the Mrayyan study (2004) supportive management, education, and experience were identified as the three most important factors in enhancing autonomy over patient care and unit operations.

In summary, autonomy can be increased by strategies that incorporate the unique knowledge and expertise of nurses into clinical patient care. Clarifying the expectation that valuable nursing knowledge should be applied in the practice setting provides the framework for enhancing clinical autonomy. Professional enrichment and education build the clinical knowledge and competence that is a necessary foundation for nurse autonomy. Most nurses practice as employees, and as a result must structure their work within imposed rules that have a profound effect on their practice (Hess, 2004). To truly control their practice, nurses must have both the right and the power to make decisions affecting the rules surrounding their practice. Nurses must create and use decision-making structures at the workgroup, organizational, and professional levels of practice.

Establish Participative Decision Making

The structure of an organization or profession operationalizes goals and values in support of achieving desired outcomes. An organized structure for nurse participation in decisions, along with an explicit communication processes contribute to enhancing CONP. Kramer and Schmalenberg (2003) have shared that nurses in organizations with high levels of CONP describe an operative structure that is in place, one that is recognized as authoritative by

others. The representatives in the structure are known and some input is sought and expected from all nurses. In addition, staff nurses have responsibility and accountability for the issues and solutions discussed within the structure. The classic example of such a structure is a shared governance council with nurses actively managing decisions related to their practice.

The importance of nurses having responsibility and accountability for professional and practice issues cannot be stressed enough. The structure for CONP is one in which the responsibility for nursing care of patients is placed with staff nurses (Hinshaw, 2002). Historically the concepts of empowerment and participatory management have been laden with a paternalistic tone of people in positions of authority allowing staff to provide input and participate in some operations. Fundamentally, this is where many shared governance programs go awry. In these situations, although an organizational structure is established and nurses are permitted to provide input into key decisions, the ultimate authority for the decision making continues to reside with managers and administrators. In contrast, autonomy and CONP need to be founded on a process of engagement where nurses, as knowledge workers, are expected to make and own decisions (Porter-O'Grady, 1997).

Because nurses typically work as employees within a larger structure and within the healthcare system itself, nurses must have a formal structure for participating in organizational and system decisions. For example, within employment settings, nurses should be included along with physicians and administrators on key organizational committees that establish patient care policies and procedures. The expectation should be set that nurses will share a full and equal voice in, and responsibility for making patient care decisions (McKay, 1983). Not only does this foster strong, productive nurse-physician and nurse-administrator relationships, it also contributes to necessary interdisciplinary richness (Hinshaw, 2002). Whatever organizational structure is used, nurses should be able to make program and resource decisions without going through layers of bureaucracy that stifle innovation and implementation. In addition, to be involved, nurses must be active on hospital and professional committees. Organizing an "involvement-friendly environment" where it is easy for nurses to participate in meetings will increase CONP. Nurses can maximize the opportunity for colleagues to attend meetings or complete committee work by adequately staffing for patient care. Fundamentally, nurses need to foster the understanding that their work involves both the direct clinical care of patients as well as the management of the context in which that care is delivered. As a result, both clinical patient care and

organizational and committee work are within the realm of nursing practice. Nurses cannot effectively practice without the right resources (including an appropriate amount and mix of caregivers, supplies, and supporting systems) or without the necessary evidence-based policies and practices. To control practice, nurses must have some influence over necessary resources and policies for their practice (Hess, 2004). To do so, nurses must ensure that they and their colleagues are well-represented and able to be influential whenever and wherever key decisions are being made that will impact the nature, scope, and context of their practice.

Enhance Competence in Decision Making

Although it is important that clinical nurses serve on committees, they are generally underprepared to do so; hence they are challenged in representing their needs. Studies find that clinical nurses participate to a greater extent in decisions related to clinical patient care decisions than to unit or organizational decisions (Blegen et al, 1993 & Anthony, 2001). Consequently, clinical nurses' experience and competence in participating in group decision making, influencing organizational processes, and impacting policy is somewhat limited. More frequently nurses are invited to provide input into the decision but are not involved in making the selection or final choice in the decision that is made (Anthony, 1999; Issel & Anderson, 2001). Generating alternatives, as well as choosing alternatives, planning implementation, and evaluating results, have been found to be significantly related to satisfaction and influence (Black & Gregersen, 1997; Issel & Anderson, 2001). Clinical nurses working in Magnet hospitals distinguish between participative management, which they articulate as providing input or sharing an opinion, and CONP, which they articulate as actually selecting among the available options regarding practice policies, practice issues, and personnel issues affecting nurses (Kramer & Schmalenberg, 2003b). In other words, developing skill in generating alternatives and selecting a final choice, coupled with ensuring that there is a structure for both input and decision making enhances nurses' satisfaction and influence.

As a result, investing in teaching nurses about the decision-making process, coaching them through early decision making, and supporting both successful and unsuccessful decisions will foster an environment for increasing autonomy and also CONP. Expecting nurses to participate without allowing opportunities to acquire prerequisite skills will result in either frustration or apathy (Hess, 2004). Ensuring that nurses develop the skills to manage meetings, gather and analyze existing evidence, explore alternatives, and make sound

decisions will support CONP. In this way, nurses will have the knowledge and ability to not only make recommendations but also be empowered to enact decisions.

Nurse leaders, whether in management, clinical, educational, or research positions, can be taught facilitation skills to enhance their ability to garner discussion that leads to identification of group expertise without dominating the discussion or decision making. Naturally, during decision making, creative tensions will emerge by exposing differences in perspectives and gaps between organizational visions and current realities (Burns, 2001). Teaching leaders to pose questions that expose assumptions and challenge sacred cows can help to illuminate tensions and paradoxes, thus ultimately fostering creative new solutions.

In summary, CONP can be increased by strategies that ensure nurse participation in key decisions within the organizational and professional structure. Establishing the structures and processes for active nurse input and decision making provides the framework for enhancing CONP. Because many nurses have little such experience, investing in teaching and supporting decision making related to the context of nursing care is necessary to build competence for CONP.

Role of nursing managers

Although leadership can come from any nurse, designated leaders remain extremely influential for enhancing both autonomy and CONP. Consistently the recommendation is made to create strong, visible nursing leadership in the nursing department and at the unit level to increase autonomy and CONP (Hinshaw, 2002). Nurse managers in particular are instrumental in producing the conditions for autonomy and CONP. Manager leadership behaviors have been shown to influence staff decision-making patterns (Taunton, Boyle, Woods, Hansen, & Bott, 1997). In studies comparing Magnet and non-Magnet hospitals, greater accessibility of nurse leaders, support of autonomous decision making by leaders, and access to work empowerment structures were found to be the most significant elements accounting for differences in empowerment and job satisfaction (Kramer & Schmalenberg, 2002). In a qualitative study, seven staff-nurse focus groups identified and rank ordered the skills needed by a nurse manager to effectively manage a patient care unit. The top three management skills in descending order were effective communication, remaining available to staff, and involving staff in decision making (Maceri, 2006). Supervisor support was positively correlated with nurses reporting more control over their work and higher

satisfaction. Nurse manager actions, specifically those encouraging nurses to communicate openly with other healthcare team members, supporting nurses to resolve conflicts, and encouraging leadership, were associated with increased nurse participation in patient care and conditions of work decisions (Mrayyan, 2004).

In addition to the critical role of the nurse manager, executive leadership is critical to creating an environment that is supportive of autonomy and CONP. Organizationally, a visionary nurse executive who trusts and values nursing staff is essential for creating the context for high levels of autonomy and CONP. A chief nurse executive who (a) advocates for a strong, influential nursing presence in the organization; (b) is open and communicative; and (c) supports participative management is associated with a professional environment that includes autonomous clinical practice and nursing control over practice (Hinshaw, 2002). Upenieks (2003) reported that when the entire executive team, and not just the nurse executive, offered support of nursing, a climate was established that endorsed autonomous nursing practice.

Thus, the role of formal nurse leaders is powerful in establishing the context for autonomy and CONP. In contrast to the traditional command-and-control management style that results in stabilization of practices, enhancing autonomy and CONP involves leadership that encourages and fosters new ideas and innovation. This sort of 'controlled destabilization' has been found to be a characteristic of Magnet facilities (Freidson, 1988). In other words, nurses use the word autonomy to describe the freedom to make decisions about an individual patient, while sociologists use the word autonomy to describe the freedom of a profession, such as nursing, to make independent decisions about its body of knowledge and its work.

Nurses today have the opportunity, even the obligation, to ensure and enhance both autonomy and CONP by influencing social, political, and economic factors related to their practice. Even as the importance of nurses' contributions have become increasingly clear through studies demonstrating that nursing practice impacts the quality of patient outcomes in hospitals, the underlying technical expertise and unique knowledge needed to influence these outcomes is largely unclear to the public and even to nurses themselves. In spite of years of desire and demonstration to the contrary, the public's perception of nursing practice is still largely that of a handmaiden to the physician (Buresh & Gordon, 2001). Although the public highly regards nurses, they do not highly value nurses in terms of believing that nursing care is equally as important as medical care in contributing to health (Gordon, 2005). Nurses can

promote and expand their autonomy and CONP by publicly identifying their unique expertise in health and patient care in easily understandable terms in a way that shows the value of their nursing expertise. Nurses need to communicate that their work involves an exclusive knowledge base and skill set that is different from and even unknown by physicians. This knowledge/skill set includes monitoring of patient and public health status (surveillance); managing complex, highly technical interventions; integrating and coordinating healthcare services; and providing relevant education and emotional support in furthering health (Institute of Medicine, 2004).

Lack of clarity about the contribution of nursing may be related to the multiple educational levels and diversity of roles within the profession. Nurses earning diplomas or associate degrees often do not have content in their curriculum to prepare them to advocate in the social or political context. Further, the lack of acknowledgement, even within the profession, of the wide range of roles and expertise that constitute nursing contributes to the devaluing of the work. Although nurses conceptually describe the profession as caring for the individual, family, and community, nurses often discount colleagues not providing direct patient care by describing them as "not real nurses." This negating of nurses' contribution to the managerial, policy, educational, and research components of professional practice diminishes the recognition of the full contribution of nursing knowledge and expertise (Truth about Nursing, 2006). None-the-less, all nurses have a contribution to make upstream in the social and political process. For example, novice nurses with entry level degrees can communicate about the role and responsibility of registered nurses with their individual patients. Colleagues with advanced degrees can serve as primary investigators to conduct research to demonstrate the impact of nursing practice. All nurses can acknowledge their colleagues' contributions in various roles and practice settings, and thereby assist the public to value the depth and range of the nursing profession in healthcare.

Similarly, nurses can influence the economic and political factors that enable or constrain nurse autonomy and CONP. Conversations about reforming the United States (U.S.) healthcare system have placed U.S. nurses in a desirable position of having enormous influence in the dialogue. Certainly decisions about the economics of healthcare influence the practice environment and degree of autonomy and CONP of nurses. Just as the transition from fee-for-service to prospective payment influenced the context of nursing practice, decisions on future payment structures for healthcare will impact the practice of nursing. In

this climate, nurses need members of their profession to have economic and political prowess to proclaim what is unique to nursing and negotiate for their professional role (Turler & Ray, 2000). In this venue, professional nursing associations can have a powerful impact on promoting autonomy and CONP both by enhancing the skills of nurses and by leveraging a collective response in the political arena. In addition, appointing and electing nurses to positions with political influence on local, state, and national levels can ensure that nurses' unique expertise is included when decisions that will influence nursing practice are made.

2.2.18 Summary of literature review

In the conclusion of this chapter, there some factors than enhance autonomy in hospitals, several studies found the relationship between autonomy and nurses satisfaction. Nurses can enhance autonomy by clearly communicating and organizing their work to ensure that they have the freedom to act on nursing decisions using sound clinical judgment also they must incorporate nursing knowledge and expertise into clinical practice . Studies have suggested that creating a climate that is supportive of nursing practice will augment the level of autonomous practice

Encouraging the continuous examination of practice allows nurses to reflect on the degree of autonomy present in their decision making. In addition, establishing an evidence-based practice approach may develop and enhance autonomy. Creating an environment that supports both formal and informal continuing educational opportunities and learning provides for autonomous clinical practice.

Professional enrichment and education build the clinical knowledge and competence that is a necessary foundation for nurse autonomy.

Studies revealed that greater accessibility of nurse leaders, support of autonomous decision making by leaders, and access to work empowerment structures were found to be the most significant elements accounting for differences in empowerment and job satisfaction

Chapter III

Methodology

3.1 Introduction

This chapter presents the study methodology. The chapter includes study design, type of study sample, study population, and ethical consideration. Also it presents the instrument, piloting, data collection process, data prescribing, and data analysis. Finally, it presents selection criteria and limitations of the study.

3.2 Study design

The design of this study is a descriptive analytical, cross sectional one to measure job autonomy as perceived by nursing managers in the governmental hospitals in the MOH-Gaza Governorates. This design is chosen because it is the useful design for descriptive analysis of the study construct, and it is less expensive and enable the researcher to meet the study objectives in a short time.

3.3 Study population

The study population consisted of all nursing managers in governmental hospitals (census) at the MOH- Gaza Governorates, The total number of nursing managers was 301 classified as 13 nursing hospital managers, 5 building managers, 121 nursing supervisor, and 162 head nurses.

The researcher selected the population from all the 13 governmental hospitals from all different levels of managers (nursing directors, nursing supervisors, and head nurses). The researcher only received 238 questionnaires nursing managers classified as 10 nursing hospital managers, 5 building nurses managers, 89 nursing supervisor, and 134 head nurses, 63 subjects excluded from the study population, 15 were pilot study, 48 refused to participate in this study.

3.4 Period of the study

The study was conducted during the period from May 2010 to November 2010, including questionnaire design, experts opinion, pilot study, and data collection and analysis for pilot study slight modifications were made, then in September 2010 the questionnaire distributed by four trained nurses to all subjects who explained the questionnaire to them, data was collected and analysis was done in the end of September 2010.

3.5 Selection criteria

3.5.1 Inclusion criteria

- A hospital director of nursing, nursing supervisor and a head nurse working in governmental hospitals- Gaza Governorates managed by MOH-
- Formally assigned managers.
- A manager who assumes the position for more than one year.

3.5.2 Exclusion criteria

- Nursing managers who are locally assigned (not formally).
- Managers who are in long vacation and on maternity leave during the study period.
- Nursing manager who assumes the position for less than one year.

3.6 Instruments

The instrument was a self-constructed questionnaire which included likert scale and close ended questions. It was designed to be clear and easy to read with no complex terms, leading and double parallel questions. The original questionnaire was formulated in Arabic language and translated into English language (annex 5). The Arabic and English version (annex 4) were reviewed by a list of experts to judge its validity and reliability to answer research questions (annex 8). The questionnaire was divided into five parts with a total of 77 questions. The first part included (14) questions about personal and socio-demographic data.

The second part included 8 questions about general attitudes. The third part included (9) questions about job autonomy as perceived by nursing managers. The fourth part included (37) questions about factors affecting job autonomy. The fifth part included (1) question about ranking the areas in order to enhance job autonomy.

3.7 Data collection

Data has been collected by the research himself and a trained staff nurses of each hospital using the self-constructed questionnaire. The researcher assistance have received a complete explanations about aim, objectives, research questions and meaning of each question before data collection. The researcher supervised the work through the time of data collection in the end of September 2010, all data was obtained papers were coded and tested then the analysis was done by using SPSS and started in writing the results .

3.8 Pilot study

The pilot study has been conducted by the researcher prior to data collection by using a sample of (15) participants selected randomly (10 male and 5 female) from different levels of hospitals managers. It was conducted to examine the response rate and clarity of the questionnaire. The response rate was 83.0%. some modifications were done after the result of pilot study and the questionnaire was finalized. Nursing managers who participated in the study were excluded from the study population

3.9 Ethical Consideration and procedures

The researcher was committed to all ethical considerations required to conduct are search. First, approval was obtained from the School of Public Health(Al-Quds University), and Helsinki Committee to carry out the study (annex 6). and an approval letter was obtained from the ministry of health (annex 7).

3.10 Validity

To check validity the researcher performed internal consistency test between each statement and the dimension it belongs to. The results are illustrated on the tables in (Annex3, pages 95, 96, 97).

3.10.1 Face validity

For the purpose of ensuring validity, the researcher submitted the questionnaire to experts in this field to judge face and content validity. Their suggestions were considered.

3.11 Reliability

To check internal consistency, the researcher calculated the correlation between each statement and the dimension it belongs to, then calculated the correlation between dimensions and the total score of the scale. The results are illustrated below in table (3.7).

Table 3.1: Cronbache Alpha Coefficient

	Items	Alpha
1	Assessment of job autonomy status as nursing managers perspective	0.672
2	Managerial style with job autonomy	0.730
3	Job description with job autonomy	0.682
4	Job satisfaction with job autonomy	0.780
5	Nursing career environment with job autonomy	0.744
6	Work place with autonomy	0.775
Total		0.707

3.12 Data entry and analysis

3.12.1 Data entry

The following steps was used in data entry

- The data entry was done after over viewing of the filled data abstract sheets
- Designing a data entry model using the computer statistical package for social sciences (SPSS) and EXCELL software.
- The variables of abstracts sheets was coded then entered onto the computer by the researcher.
- After that the data was cleaned to ensure correct entry.

3.12.2 Data analysis

After over viewing the questionnaire, each one was coded. The accepted number of the questionnaire was 238. This step was followed by designing an entry model using the statistical package of social science (SPSS). The coded questionnaires were entered by the researcher. Data cleaning was done by checking out a random number of the questionnaires in two occasions and through exploring frequencies for all variables. Then, the data was analyzed; Frequency tables were conducted for the study variables, Means and standard deviation were computed for the continuous numeric variables, reliability and validity of the instrument were tested. Then, advanced statistical analyses were conducted to examine the potential relationship between variables. An independent t-test and one way ANOVA statistical test was used to investigate the relationships between the independent study variables and sub-scales of autonomy perception by nursing managers.

Chapter IV

Results

4.1 Introduction

This chapter represents the finding of the study, the descriptive analysis of the study variables as frequency and percentage distribution, which provides a description and summary of the data. Additionally, this chapter presents the main domain of job autonomy as labeled by the researcher and the relationship between the selected independent variables and the domain of job autonomy.

4.2 Characteristics of the study population

4.2.1 Distribution of study population according to gender, age, marital status and education

Table 4.1 Distribution of Study Population According to Gender, Age, Marital Status and Education

Items	Number	Percentage
Sex		
Male	181	76.1
Female	57	23.9
Total	238	100.0
Age		
35 years and less	65	28.1
36 to 45 Yrs	114	49.4
More than 45 Yrs	52	22.5
Total	231	100.0
Marital Status		
Not Married	15	6.3
Married	223	93.7
Total	238	100.0
Education		
Diploma	23	9.7
BSc	173	72.7
Post graduation	42	17.6
Total	238	100.0

As shown in the table (4.1) the majority of the study population were males 76.1, while females represented only 23.9% of the study sample and this result is consistent with the distribution of all nursing personnel in which male nurses are dominant.

Also, the same table shows that 49.4% of the study population age was between 36-45 years, while the least age group was more than 45 years. The majority of the study population were married and they represented 93.7%. Also, the table shows that the subjects were represented in three groups according to educational level. Most of the subjects 72.7% had bachelor degree in nursing, followed by those who had postgraduate degree 17.6%, while those who had diploma represented 9.7%.

4.2.2 Distribution of study population according to level of experience

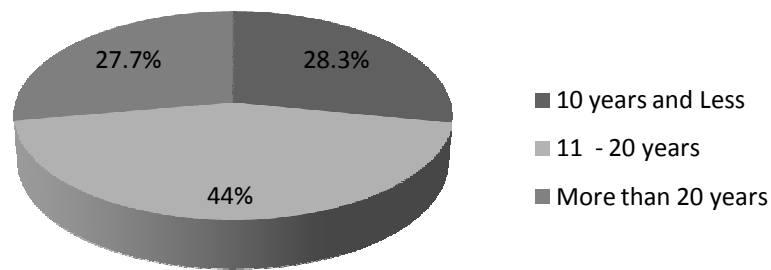


Figure 4.1: Distribution of Study Population According to Total Level of Experience

Figure (4.1) shows that the majority of study population 44% had experience level from 11 – 20 years, followed by those who had experience level less than 10 years, while 27.7% of study population were more than 20 years of experience.

4.2.3 Distribution of study population according to level of experience within managerial title

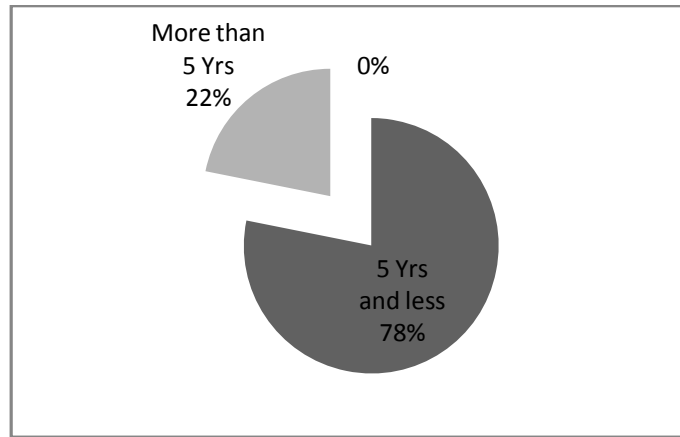


Figure 4.2: Distribution of Study Population According to Level of Experience Within Managerial Title

Figure (4.2) shows that 78% of study population had 5 years of experience and less, while 22% had more than five years of experience.

It is observed that highly experienced managers were the least percentage among managers and this may be due to political situation and conflicts that happened in 2007. Many nursing managers were left their positions and the MOH were substituted them with other managers from regular nurses.

4.2.4 Distribution of study population according to the title

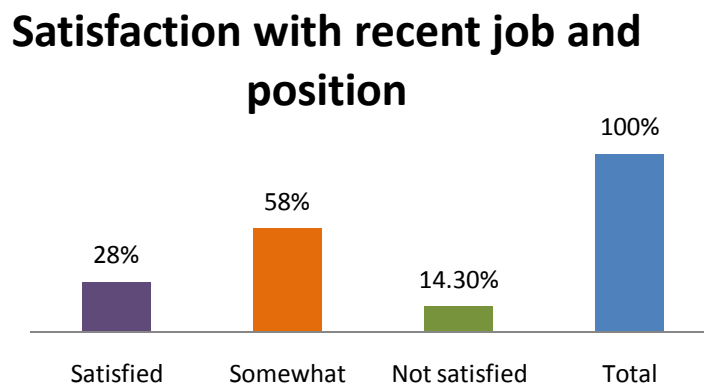


Figure (4.3): Distribution of the Study Population According to the Title

Figure (4.3) shows that 56.3% from the study population were nursing department managers, 37.4% were nursing supervisors, 2.1% were building managers while 4.2 % were hospital nursing managers, This distribution is consistent with division of labor and staffing system.

4.2.5 Distribution of the study population according to the Presence of relationship between managerial style practiced in the MOH and feeling of job autonomy

Table 4.2: Distribution of the Study Population According to the Relationship between Managerial Style and Feeling of Job Autonomy

Variable	Number	Percentage
Yes	91	38.2
Somewhat	118	49.5
No	28	11.7
Missed	1	0.42
Total	238	100.0

Table (4.2) shows that the majority of nursing managers (87.7%) express that leadership style currently used may be a cause for a sense of less job autonomy, even though 49.5% didn't frankly expressed their feelings and they may be afraid to express their true feelings, due to political situation and their commitment to currently governmental authority, Also, the result revealed that the majority are fighting toward gaining more autonomy and willing to be more autonomous, (Q2, part2, annex page 119).

4.3 Job autonomy status for all nursing managers perspectives

Table 4.3: Job Autonomy Status for all Nursing Managers Perspectives

Job autonomy status from all nursing managers point of view			
Disagree	No opinion	Agree	Total
19.8	19.2	60.9	100.0%

Table (4.3) showed that (60.9%) of study population have job autonomy, 19.85 don't have job autonomy, while 16.2% of them have no opinion about this issue, the researcher suggests

the reason may be that above 93% from subjects are nursing department managers and nursing supervisors who closely leading nurses and led by nurses, all of them do their tasks in free and has no interference from any external or internal powers, and the majority of their tasks are pure nursing procedures and duties which reflect that they work independently and the managers are from the same profession.

4.4 Job autonomy status for different nursing managers perspectives

Table 4.4: Job Autonomy Status for Different Nursing Managers Perspectives

Title	Disagree& strongly disagree %	No opinion %	Agree &strongly agree %	Total %
Head nurse	19.7	19.1	61.2	100.0
Nursing supervisor	31.0	19.0	50.0	100.0
Building manager	14.0	60.0	28.0	100.0
Hospital manager	11.0	70.0	19.0	100.0

Table (4.4) showed that (61.2%) of head nurses having status of job autonomy and 19.7% of them don't have autonomy, followed by nursing supervisor 50.0%, while 19.0% have no opinion.

In addition, the table showed that 28.0% of building managers having status of job autonomy, 14.0% don't have, and 60.0% of them have no opinion. In contrast, only 19.0% of hospital managers have status of job autonomy, while 70.0% of them have no opinion, and 11.0% don't have autonomy.

This finding revealed a state of ambiguity and debate regarding the state of autonomy among nursing managers as observed in their answers. The majority of manager's answer yes (60.9%) about having autonomy while high percentage of them answer with somewhat (49.5%) and (38.7%) (question 16) with yes about the relationship between leadership style and state if autonomy. Also, 72.6% (question 41) of managers agree and strongly agree about the statement "The leadership style currently used in M.O.H affects negatively the state of

autonomy for nursing managers. On the other hand 74% agree and strongly agree with the statement "Interference of hospital manager in nursing work give me feeling of no autonomy (question 43). In respect to job description, 31.1% answer No and 28.2% answer somewhat "question (1) .In addition that 42% answer somewhat and 8.1% answer no (question No. 19) "Do you think that the items included in job description keep your autonomy in managing nursing services". These findings revealed that nursing managers are not well oriented about the job description even though this is a policy which is something questionable??!!.

The finding revealed that the majority of head nurse of study Pop" reported that they are autonomy in managing nurses services in their departments, while the majority of nursing managers agreed that in order to enhance state of autonomy the director of nursing in M.O.H should has full responsibility and authority on the nursing staff and nursing activities in all governmental health organizations, furthermore, they prefer to be in charged by a boss from the same profession "nursing". These finding support the expected, debate state of ambiguity, and apposition dominated in health.

4.5 Ranking clauses that make sense for job autonomy

Table 4.5: Ranking Clauses that Make Sense for Job Autonomy

Clause	Rank	%
When nursing director of nursing unit at the ministry gain full authorities and powers on nurses & nursing activities.	1	39.0
When direct leader from the same profession.	2	24.7
Gaining full autonomy in taking the appropriate decisions	3	20.6
No influence of informal or external power	4	20.5
Participating and sharing in making decisions	5	20.1
When nursing manager proud to be a nurse.	6	18.8
When nursing managers and leaders gain more recognition and respect from their superiors	7	14.3

Table (4.3) showed that, 39% from the participants opinions said that the sense for job autonomy achieved “when nursing director of nursing unit at the ministry gain full authorities and powers on nurses & nursing works”, followed by clause stated “When direct leader from the same profession of you” that represented 24.7%. While 14.3% from the participants opinions were “When nursing managers and leaders gain more recognition and respect from their superiors” and it represent the least one.

This reflect the position in Gaza strip regarding level of nursing management, the nursing unit manager don't have the full validities for managing of nurses that made a type of incompetence in nursing work and nursing management. This result is inconsistent with leadership style in the ministry which insist that the hospital director should be the responsible for all staff including nursing. This style of leadership is used since three years , also the result revealed that nursing managers are not satisfied about the attitude of high level managers in MOH, regarding nursing profession and job.

4.6 Distribution of the study population according to the satisfaction with recent job and position



Figure 4.4: Distribution of the Study Population According to the Satisfaction with Recent Job and Position

Figure (4.4) showed that 27.7% of nursing managers are satisfied, 58% said that they are Somewhat satisfied, while 14.3% are not satisfied. This revealed that the majority 85.7% of nursing managers were satisfied with different levels and this could be explained by that

many of newly assigned managers were not be expected themselves to be managers in this time being, Also, the promotion matter cause or factor keep good satisfaction .

4.7 Presence of job description for the position in the hospital

Table 4.6: Presence of Job Description for Your Position in the Hospital

Are there job description for your position in the hospital	No.	%
Yes	97	40.7
Somewhat	67	28.2
No	74	31.1
Total	238	100.0

Table (4.6) showed, it is shown that, (40.7%) of the participants have a job description for their positions in the hospital, while (31.1%) of the participants don't have it. The results revealed that there is ambiguity unclear, un updated, and non approved job description. Also the situation of job description is differ from one organization to another. In EGH, the job description is clear, updated and approved while in other hospitals; traditional policies are used which play a core role in distributing tasks for health care provider including administrative staff, taking in consideration that job description often reduces a sense of autonomy by its laws, policies and restrictions which affect negatively the sense of autonomy.

4.8 Preference that your boss or direct supervisor should be from the same profession

Table 4.7: Preference that Direct Supervisor Should be from the Same Profession

Do you prefer that your boss or direct supervisor should be from the same profession (Nursing)..?	No.	%
Yes	225	94.5
Somewhat	10	4.2
No	3	1.3
Total	238	100

Table (4.7) showed that, the majority of participants (94.5%) prefer to be supervised by the same profession (nursing). This creates type of responsibility for who supervise and understanding for whom being supervised. This results revealed that nursing managers prefer to be autonomous and this attitude is consistent with previously used style in managing health services. In my opinion, as in many other countries, nurses supervise nurses. Nursing administrators write the policies and procedures that control individual nursing practice in a given institution. Nurses sit on the regulatory boards that govern the licensing and legal practice of nursing, and having the same language in performing nursing tasks and procedures.

4.9 Autonomy feeling among managerial levels

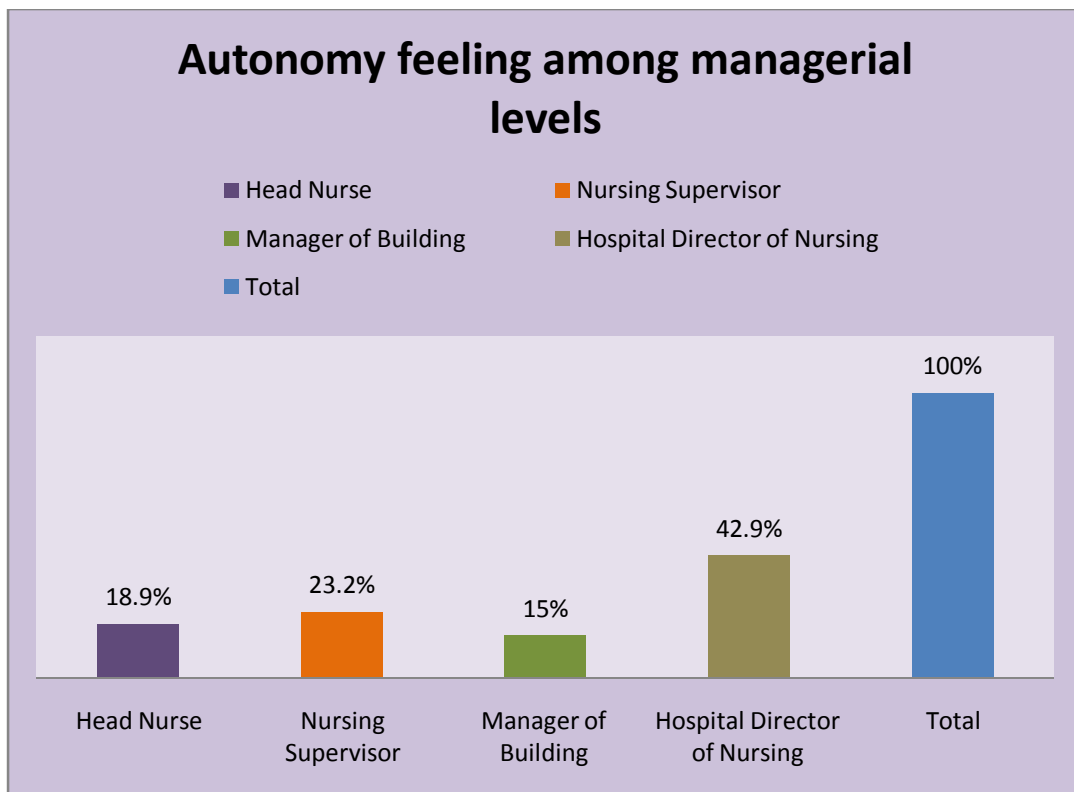


Figure 4.5: Autonomy Feeling among Managerial Levels

Figure (4.5) showed that (42.9%) of the participants agreed that the hospital director of nursing have the most one who feel of autonomy, followed by nursing supervisor (23.2%), head nurse (18.9%), and building manager represented 15%. The results revealed the gap between the attitudes, 42.9% of participants expected that top level nursing managers are more autonomous than other levels and this may be originated from the expectation that highly promoted managers are always the best even in autonomy.

4.10 Comparison between Domains

Table 4.8: Comparison between Domains (N= 238)

	Items	Mean	Mean Difference	Std
1	Assessment of job autonomy from nursing managers perspective	3.47	3.44	0.42
2	Managerial style with job autonomy	3.82	3.86	0.50
3	Job description with job autonomy	3.69	3.67	0.46
4	Job satisfaction with job autonomy	4.09	4.00	0.55
5	Nursing career with the nature and job autonomy	3.69	3.67	0.66
6	Work place with autonomy	3.06	3.10	0.76
Total		3.50	3.49	0.30

Table (4.8) showed that the most strong domain is the fourth domain. "There is a relationship between job satisfaction and job autonomy" (M =4.09). this result was highly consistent with previous studies which revealed that there is strong positive relationship between job satisfaction and level of job autonomy in both directions "vice versa". This result is consistent with the result of Finn, (1986) which revealed that autonomy must be the most important job component for registered nurses' job satisfaction. Also, this results is consistent with the result of Stamps and Piedmont, (1986) which showed that professional autonomy is ranked as one of the most important factors contributing to nurses' job satisfaction. Autonomy is also considered an essential component for professional development in nursing, which effects directly in job satisfaction (Hart and Rotem,1995). In contrast, this result is consistent with the result of Stamps and Piedmonte,(1986) which showed that restricted autonomy in turn limits job satisfaction. It is a common finding that increased decision autonomy is associated

with increased worker satisfaction. In a major survey of the occupational psychology literature. Work attributes such as task autonomy, responsibility, control and complexity, all have mental challenge in common. Hence, for higher levels of satisfaction to result, the individual must be mentally challenged on the job and achieves successful outcomes or progress

4.11 Differences in job autonomy domains related to gender

Table 4.9: Differences in Job Autonomy Domains Related to Gender (N= 238)

Domains		gender	N	Mean	Std	t	Sig.
1	Assessment of job autonomy from nursing managers perspective	Male	181	3.52	0.40	3.021	0.003*
		Female	57	3.33	0.46		
2	Managerial style with job autonomy.	Male	181	3.87	0.48	3.031	0.003*
		Female	57	3.64	0.52		
3	Job description with job autonomy	Male	181	3.75	0.45	3.762	0.000***
		Female	57	3.49	0.46		
4	Job satisfaction with job autonomy	Male	181	4.10	0.55	0.792	0.429
		Female	57	4.04	0.54		
5	Nursing career with the nature and job autonomy	Male	181	3.76	0.65	3.227	0.001**
		Female	57	3.44	0.64		
6	Work place with autonomy	Male	181	3.54	0.27	4.352	0.000***
		Female	57	3.35	0.33		
Total		Male	181	3.52	0.40	3.021	0.003**
		Female	57	3.33	0.46		

N = number of participants * significant at 0.05 ** significant at 0.01 *** significant at 0.001// not significant

Table (4.9) showed that there are statistical significant differences at 0.05 in the total score of scale between male (M = 3.52) and female (M = 3.33) in the favor of male subjects, t value =3.021 and P value = 0.003. Also, differences were significant in all domains of the scale except domain (4) The relationship between job satisfaction and job autonomy t value was 0.792 and P value was 0.429. In the previous study revealed that the significant results could

be explained by the Arabic culture in which male are the dominant and perceive more autonomy than females mostly in all life aspects, in this study female managers from subjects are led by male managers. Non-significant results could be explained by that there is strong relationship between job satisfaction and job autonomy, both gender are situated under the same work policies, work conditions and same salary and privileges.

4.12 Differences in job autonomy domains related to work in favorite department

Table 4.10: Differences in Job autonomy Domains Related to Work in Favorite Department (N= 238)

Domains		Fav. Dep.	N	Mean	Std	t	Sig.
1	Assessment of job autonomy from nursing managers perspective	Yes	212	3.49	0.41	2.609	0.010*
		No	26	3.27	0.46		
2	Managerial style with job autonomy.	Yes	212	3.80	0.51	-1.044	0.297//
		No	26	3.91	0.36		
3	Job description with job autonomy	Yes	212	3.69	0.45	0.461	0.645//
		No	26	3.65	0.56		
4	Job satisfaction with job autonomy	Yes	212	4.10	0.55	0.721	0.472//
		No	26	4.02	0.56		
5	Nursing career with the nature and job autonomy	Yes	212	3.69	0.66	0.334	0.739//
		No	26	3.65	0.68		
6	Work place with autonomy	Yes	212	3.51	0.29	1.484	0.139//
		No	26	3.41	0.37		
Total		Yes	212	3.49	0.41	2.609	0.010*
		No	26	3.27	0.46		

N = number of participants

* significant at 0.05

// not significant

Table 4.10 showed that, there are no statistical significant differences between working in favorite departments with the total of domains. This is explained by; most nursing managers were working in the preferred department from their point of view and subjected under the same conditions, but it is showed that there is statistical significant difference between

working in favorite departments with the domain (1) Assessment of job autonomy status as an opinion of nursing leaders. This could explain the person who is working in the favorite place is more satisfied than others and it is revealed that satisfaction is highly related positively with level of autonomy.

4.13 Differences in job autonomy domains related to age

Table 4.11: Differences in job autonomy domains related to age(N= 238)

Domains		Age	N	Mean	Std	F	Sig.
1	Assessment of job autonomy from nursing managers perspective	35Yrs and less	65	3.51	0.39	5.764	0.004*
		36to 45 Yrs	114	3.53	0.38		
		More than 45 Yrs	52	3.30	0.50		
		Total	231	3.47	0.42		
2	Managerial style with job autonomy	35Yrs and less	65	3.87	0.59	0.711	0.492
		36to 45 Yrs	114	3.78	0.45		
		More than 45 Yrs	52	3.83	0.48		
		Total	231	3.82	0.50		
3	Job description with job autonomy	35Yrs and less	65	3.68	0.50	0.901	0.407
		36to 45 Yrs	114	3.66	0.45		
		More than 45 Yrs	52	3.76	0.44		
		Total	231	3.69	0.46		
4	Job satisfaction with job autonomy	35Yrs and less	65	4.10	0.57	0.425	0.654
		36to 45 Yrs	114	4.06	0.56		
		More than 45 Yrs	52	4.14	0.51		
		Total	231	4.09	0.55		
5	Nursing career with the nature and job autonomy	35Yrs and less	65	3.81	0.71	2.325	0.100
		36to 45 Yrs	114	3.60	0.61		
		More than 45 Yrs	52	3.74	0.71		
		Total	231	3.69	0.67		
6	Work place with autonomy	35Yrs and less	65	3.52	0.32	0.297	0.743
		36to 45 Yrs	114	3.49	0.26		
		More than 45 Yrs	52	3.48	0.35		
		Total	231	3.49	0.30		
Total		35Yrs and less	65	3.51	0.39	5.764	0.004*
		36to 45 Yrs	114	3.53	0.38		
		More than 45 Yrs	52	3.30	0.50		
		Total	231	3.47	0.42		

N = number of participants

* significant at 0.05

// not significant

Table (4.11) showed that there are statistical significant differences between age of the study population and the total of domains as $f= 5.764$ and P value = 0.004 which is statistically significant.

Also there are statistical significant differences between age of population of the study and the domain (1) Assessment of job autonomy status as an opinion of nursing leaders, as $f = 5.764$ and P value = 0.004 .

There are no statistical significant differences between age and the other domains. The result revealed that younger managers perceived more autonomy than oldest ones and this could be explained by oldest managers on line of burning out and don't give importance to the state of autonomy. The younger are looking to improve the educational, professional and autonomous level.

4.14 Differences in job autonomy domains according to total experience

Table 4.12: Differences in job autonomy domains according to total experience (N= 238)

Domains		Total experience	N	Mean	SD	F	Sig.
1	Assessment of job autonomy from nursing managers perspective	5Yrs and less	67	3.55	0.40	3.165	0.025*
		From 6 to 10 Yrs	66	3.50	0.40		
		from 11 to 20 Yrs	77	3.44	0.38		
		More than 20 Yrs	27	3.27	0.58		
		Total	237	3.47	0.42		
2	Managerial style with job autonomy	5Yrs and less	67	3.96	0.53	2.980	0.032*
		From 6 to 10 Yrs	66	3.79	0.38		
		from 11 to 20 Yrs	77	3.76	0.54		
		More than 20 Yrs	27	3.67	0.48		
		Total	237	3.82	0.50		
3	Job description with job autonomy.	5Yrs and less	67	3.67	0.40	0.158	0.924
		From 6 to 10 Yrs	66	3.68	0.46		
		from 11 to 20 Yrs	77	3.72	0.53		
		More than 20 Yrs	27	3.67	0.45		
		Total	237	3.69	0.46		

4	Job satisfaction with job autonomy	5Yrs and less	67	4.24	0.49	2.657	0.049*
		From 6 to 10 Yrs	66	4.01	0.49		
		from 11 to 20 Yrs	77	4.06	0.66		
		More than 20 Yrs	27	3.99	0.48		
		Total	237	4.09	0.55		
5	Nursing career with the nature and job autonomy	5Yrs and less	67	3.71	0.77	0.771	0.511
		From 6 to 10 Yrs	66	3.70	0.57		
		from 11 to 20 Yrs	77	3.60	0.66		
		More than 20 Yrs	27	3.81	0.60		
		Total	237	3.68	0.66		
6	Work place with autonomy	5Yrs and less	67	3.57	0.28	2.482	0.062
		From 6 to 10 Yrs	66	3.49	0.22		
		from 11 to 20 Yrs	77	3.46	0.34		
		More than 20 Yrs	27	3.43	0.36		
		Total	237	3.50	0.30		
Total		5Yrs and less	67	3.55	0.40	3.165	0.025*
		From 6 to 10 Yrs	66	3.50	0.40		
		from 11 to 20 Yrs	77	3.44	0.38		
		More than 20 Yrs	27	3.27	0.58		
		Total	237	3.47	0.42		

Table (4.12) showed that there are statistical significant differences between current experience and total of domains as $f = 3.165$ and $P \text{ value} = 0.025$. This could be explained by all managers were located under the same policies, work condition, and the same leadership style, the study of this result support the opinion of younger managers feel more autonomy than older managers and the newly managers motivated towards work more than oldest managers and their feeling of autonomy is high and have no challenges in their work, the oldest managers look to the conditions and situation subjectively, more logical, and may they feel frustrated more than the newly assigned managers.

4.15 Differences in job autonomy domains according to managerial position

Table 4.13: Differences in job autonomy domains according to managerial position(N=238)

Domains		Title	N	Mean	SD	F	Sig.
1	Assessment of job autonomy from nursing managers perspective	Department Manager	134	3.47	0.43	1.896	0.131
		Nsg Supervisor	89	3.43	0.40		
		Building Manager	5	3.53	0.29		
		Nursing Hospital Manager	10	3.76	0.37		
		Total	238	3.47	0.42		
2	Managerial style with job autonomy	Department Manager	134	3.74	0.49	3.814	0.011*
		Nsg Supervisor	89	3.88	0.51		
		Building Manager	5	3.77	0.44		
		Nursing Hospital Manager	10	4.21	0.25		
		Total	238	3.82	0.50		
3	Job description with job autonomy	Department Manager	134	3.65	0.48	1.877	0.134
		Nsg Supervisor	89	3.69	0.43		
		Building Manager	5	3.80	0.49		
		Nursing Hospital Manager	10	4.00	0.44		
		Total	238	3.69	0.46		
4	Job satisfaction with job autonomy	Department Manager	134	4.15	0.52	1.997	0.115
		Nsg Supervisor	89	4.04	0.56		
		Building Manager	5	3.64	0.84		
		Nursing Hospital Manager	10	4.00	0.60		
		Total	238	4.09	0.55		
5	Nursing career with the nature and job autonomy	Department Manager	134	3.64	0.65	3.299	0.021*
		Nsg Supervisor	89	3.72	0.65		
		Building Manager	5	3.36	0.45		
		Nursing Hospital Manager	10	4.26	0.75		
		Total	238	3.69	0.66		

6	Work place with autonomy	Department Manager	134	3.48	0.28	4.024	0.008* *
		Nsg Supervisor	89	3.49	0.29		
		Building Manager	5	3.43	0.45		
		Nursing Hospital Manager	10	3.80	0.25		
		Total	238	3.50	0.30		
Total	Department Manager	134	3.47	0.43	1.896	0.131	
	Nsg Supervisor	89	3.43	0.40			
	Building Manager	5	3.53	0.29			
	Nursing Hospital Manager	10	3.76	0.37			
	Total	238	3.47	0.42			

N = number of participants * significant at 0.05 ** significant at 0.01// not significant

Table(4.13) shows that there are no statistical significant differences between job title and job autonomy, as $f=1.896$ and P value = 0.131. But, the table shows that there is statistical significant difference between job title and the second dimension (The relationship between managerial style and job autonomy), as $f=3.814$ and P value = 0.011.

Also the table shows that there is statistical significant difference between job title and the fifth dimension (The relationship between nursing career environment and job autonomy), as $f=3.299$ and P value = 0.021. In addition, there is statistical significant difference between job title and the sixth dimension (The relationship between work place and autonomy), as $f=4.024$ and P value = 0.008.

The difference was for nursing hospital managers with mean 3.76, followed by building manager with mean 3.53. this could be attributed to the perspectives of head nurses and nursing supervisors, as they see that the hospital nursing managers and the building manager have more authority and power, also the head nurses and nursing supervisors represent the big number of study population (223).

4.16 Differences in job autonomy domains according to education

Table 4.14: Differences in Job Autonomy Domains According to Education (N= 238)

Domains	Education	N	Mean	SD	F	Sig.
Assessment of job autonomy from nursing managers perspective	Diploma	23	3.3527	.48623	2.016	.135
	BSc	173	3.5022	.40818		
	Post graduate	42	3.3995	.42082		
	Total	238	3.4697	.42009		
Managerial style with job autonomy	Diploma	23	3.6646	.60088	1.909	.151
	BSc	173	3.8117	.44401		
	Post graduate	42	3.9150	.62713		
	Total	238	3.8157	.49860		
job description with job autonomy	Diploma	23	3.6304	..58594	.641	.528
	BSc	173	3.6782	.43713		
	Post graduate	42	3.7540	.49556		
	Total	238	3.6870	.46281		
Job satisfaction with job autonomy	Diploma	23	4.2174	.77907	.688	.503
	BSc	173	4.0763	.51913		
	Post graduate	42	4.0714	.54068		
	Total	238	4.0891	.55161		
Nursing career with the nature and job autonomy	Diploma	23	3.5845	.78153	5.505	.005**
	BSc	173	3.6268	.62544		
	Post graduate	42	3.9868	.66901		
	Total	238	3.6863	.66151		
Nursing career environment with job autonomy	Diploma	23	2.8739	.85558	.775	.462
	BSc	173	3.0827	.70944		
	Post graduate	42	3.0667	.88143		
	Total	238	3.0597	.75588		
Total	Diploma	23	3.3978	.44359	2.356	0.097
	BSc	173	3.4919	.26822		
	Post graduate	42	3.5623	.30064		
	Total	238	3.4953	.29638		

Table (4.14) shows that there is no statistical significant difference between different level of education and total domains of job autonomy as $f = 2.356$ and P value = 0.097, but, there is statistical significant difference between fifth dimension (The relationship between nursing career environment and job autonomy) and different level of education as $f = 5.505$ and P value = 0.005. This result is consisted with previous studies which revealed that there is a positive relationship between levels of education and level of perceived autonomy. Highly educated personnel allowed expected that there are better than other in qualifications, given better conditions and salary, and who are motivated more by certificates, salaries and qualifications, more self esteem and self image confidently more its normally enhances the sense of job autonomy .

4.17 Differences in job autonomy domains according to satisfaction

Table 4.15: Differences in Job Autonomy Domains According to Satisfaction (N= 238)

	Domains	Satisfaction	N	Mean	Std	F	Sig.
1	Assessment of job autonomy from nursing managers perspective	Yes	66	3.57	0.37	9.874	0.000***
		To some extent	138	3.49	0.40		
		No	34	3.20	0.47		
		Total	238	3.47	0.42		
	Managerial style with job autonomy	Yes	66	3.68	0.48	3.806	0.024*
		To some extent	138	3.88	0.46		
		No	34	3.82	0.62		
		Total	238	3.82	0.50		
3	Job description with job autonomy	Yes	66	3.64	0.43	0.665	0.515
		To some extent	138	3.72	0.44		
		No	34	3.66	0.61		
		Total	238	3.69	0.46		

4	Job satisfaction with job autonomy	Yes	66	4.11	0.57	3.232	0.041*
		To some extent	138	4.13	0.49		
		No	34	3.87	0.71		
		Total	238	4.09	0.55		
5	Nursing career with the nature and job autonomy	Yes	66	3.73	0.64	0.472	0.624
		To some extent	138	3.69	0.65		
		No	34	3.60	0.75		
		Total	238	3.69	0.66		
6	Work place with autonomy	Yes	66	3.56	0.25	10.611	0.000***
		To some extent	138	3.52	0.26		
		No	34	3.29	0.41		
		Total	238	3.50	0.30		
Total		Yes	66	3.57	0.37	9.874	0.000***
		To some extent	138	3.49	0.40		
		No	34	3.20	0.47		
		Total	238	3.47	0.42		

N = number of participants * significant at 0.05 *** significant at 0.001 // not significant.

Table (4.15) showed that , there are statistical differences between satisfaction and the total domains, and between satisfaction and domains 1 and 6 as $f = 9.874$ and $P \text{ value} = 0.000$.and the study revealed that there is a relationship between level of satisfaction and level of job autonomy. In addition, there is a relationship between satisfaction, preferred place of work, managerial style used and job autonomy.

Chapter V

Conclusion and Recommendations

5.1 Conclusion

This study was carried out to examine the nursing job autonomy as perceived by nursing managers in the governmental hospitals in the ministry of health (MOH) in Gaza Governorates. The number of staff who received questionnaire was 286 participants with response rate 83%. The majority of participants was male (76.1%), the married ones (93.7), about half of participants (49.4%) at the age between (36) and (45), also about (72.7%) have BSc degree. The highest percent of participants (44.1%) had experience 11 to 20 years. Head nurses represented the majority of study population (56.3%).

The study explored perception of autonomy in relation to some demographic variables including gender, age, years of experience, and the level of education. The results of the study highlighted some indicators that might help decision-makers to act toward raising and reinforcing autonomy that could lead to improving work delivery to the highest possible levels within the available resources.

Looking to the domains of autonomy, the study subjects reported that the majority of nursing managers express that leadership style currently used may be a cause for a sense of less job autonomy among many managers, even though about half of the subjects didn't frankly expressed their feelings and they may be afraid to express their true feelings, due to political situation and their commitment to currently governmental authority. Also, the result revealed that the majority are fighting toward gaining more autonomy and willing to be more autonomous.

The study labeled six domains had relationship with autonomy with somewhat differences as the following: The relationship between job satisfaction and job autonomy ($M = 4.09$), The relationship between managerial style and job autonomy ($M = 3.82$), The relationship between job description and job autonomy ($M = 3.69$), The relationship between nursing career environment and job autonomy ($M = 3.69$), The relationship between work place and

autonomy ($M = 3.06$). Even though the mean of autonomy assessment status as perceived by nursing managers (3.47).

This study explore the main opinion to increase and enhance nursing job autonomy from the different levels of nursing managers who agreed with the first priority " When nursing director of nursing unit at the ministry gain full authorities and powers on nurses & nursing activities" as it has a wide role in causing less job autonomy.

The majority of participants (94.5%) prefer to be supervised by the same profession (nursing). This creates type of responsibility for who supervise and understanding for whom being supervised. This results revealed that nursing managers prefer to be autonomous and this attitude is consistent with previously used style in managing health services, as in many other countries, nurses supervise nurses. Nursing administrators write the policies and procedures that control individual nursing practice in a given institution. Nurses sit on the regulatory boards that govern the licensing and legal practice of nursing.

This study revealed that There is a relationship between job satisfaction and job autonomy" ($M = 4.09$). this result was highly consistent with previous studies which revealed that there is strong positive relationship between job satisfaction and level of job autonomy in both directions "vice versa".

There are statistical relationship between male ($M = 3.52$) and female ($M = 3.33$) in the favor of male subjects. Male managers perceive more autonomy than female ones as male are the dominant and perceive more autonomy than females mostly in all life aspects. Non-significant results could be explained by that there is strong relationship between job satisfaction and job autonomy, both gender are situated under the same work policies, work conditions and same salary and privileges.

There are statistical relationship between age of population of the study and job autonomy.

The result revealed that younger managers perceived more autonomy than oldest ones and this could be explained by oldest managers on line of burning out and don't give importance to the state of autonomy. The younger are looking to improve the educational, professional and autonomous level, no statistical differences between job title and job autonomy.

There is no statistical significant difference between different level of education and job autonomy, There are relationship between satisfaction and job autonomy, which concluded that the more satisfied the more autonomous and vice versa, the study revealed that there is

positive relationship between level of satisfaction and level of job autonomy, In addition, there is a relationship between satisfaction, preferred place of work, managerial style used and job autonomy.

The findings and answers revealed ambiguity and debate in many issues related to assessment of autonomy state, relationship between job autonomy and leadership style, the negative effect of currently used leadership style on job autonomy status, questionable remarks about having job description and its contents.

5.2 Recommendations

In the light of the study result, the researcher suggests the following:

Nursing managers in governmental hospital reported relatively low job autonomy and this could be improved by addressing the key domains identified in the study, which could be considered as a construct model frame for the nursing managers.

- Managers need to create a supportive organizational culture which is characterized by the team work spirit, fairness, caring trust.
- Managers have to improve the state of autonomy and satisfaction for nursing managers and staff
- To reduce the ambiguity and role conflicts, managers need to develop common ground rules and regulations , providing job description and defining scope of professional practice.
- Managers have to modify their leadership tend sharing decisions and participatory nursing manager in all issuer relating to health service and system.
- Manager have to do best regarding improve the image of nursing profession in both formal and social aspect.

5.3 Suggestion for further research

- Conducting more studies about assessment of job autonomy in nursing profession as this play a fundamental role in job satisfaction, retention, performance and quality of care.
- Conducting further studies about relative factors affecting job autonomy in nursing profession include all health organizations.

Conducting studies about how to promote job autonomy in nursing profession.

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PCBS, (2010): Palestinian Central Bureau of Statistics.

Annex (1): Palestine Map



PCBS, (2010): Palestinian Central Bureau of Statistics

Annex (2): Gaza Strip map



PCBS, (2010): Palestinian Central Bureau of Statistics

Annex (3): SPSS (output) tables

7.	Title		
	Department Manager	131	55.0
	Nsg Supervisor	89	37.4
	Building Manager	8	3.4
	Nursing Hospital Manager	10	4.2
	Total	238	100.0
8.	Experience with title		
	5Yrs and less	186	83.8
	More than 5 Yrs	36	16.2
	Total	222	100.0
9.	Education		
	Mid Diploma	23	9.7
	BSc	173	72.7
	High Diploma	11	4.6
	Master	31	13.0
	Total	238	100.0
10.	Looking for another work		
	Yes	44	18.5
	No	194	81.5
	Total	238	100.0
10.1	Income increasing		
	Yes	30	68.2
	No	14	31.8
	Total	44	100.0
10.2	Bothering the current work climate		
	Yes	4	9.1
	No	40	90.9
	Total	44	100.0
10.3	Change the daily routine		
	Yes	5	11.4
	No	39	88.6

	Total	44	100.0
10.4	Professional development		
	Yes	13	29.5
	No	31	70.5
	Total	44	100.0
10.5	Better social status		
	Yes	6	13.6
	No	38	86.4
	Total	44	100.0
10.6	To gain more job autonomy		
	Yes	6	13.6
	No	38	86.4
	Total	44	100.0

Table (2) General Attitude

Sn.	Items	Nu.	%
	15- Are you satisfied in your work		
	Yes	66	27.7
	To Somewhat	138	58
	No	34	14.3
	Total	238	100.0
	16- Do you think that there is a relationship between managerial style practiced in the MOH and your feeling of job autonomy?		
	Yes	91	38.2
	Somewhat	118	49.5
	No	28	11.7
	Missed	1	0.42
	Total	238	100.0
	17- Are you think that work conditions in your hospital(working environment – working shifts - working hours – hotel services) are suitable for employee		

	workers ..?		
	Yes	28	11.9%
	To Somewhat	124	52.5%
	No	84	35.6%
	Total	236	100.0%
	18- Are there job description for your position in the hospital..?		
	Yes	97	70.8%
	To Somewhat	67	28.2%
	No	74	31.1%
	Total	238	100.0%
	19-Are you think that the clauses included in job description keep your autonomy in managing nursing services in your department..?		
	Yes	48	49%
	To Somewhat	42	42.9%
	No	8	8.2%
	Total	140	100.0%
	20-Do you feel that job description clauses were appropriate with your position..?		
	Yes	47	49%
	To Somewhat	41	42.7%
	No	8	8.3%
	Total	96	100.0%
	21- Do you prefer that your boss or direct supervisor should be from the same profession (Nursing)..?		
	Yes	225	94.5%
	To Somewhat	10	4.2%
	No	3	1.3%
	Total	238	100%

	22- Do you see that there are a conflict between managers of different categories in your hospital...?		
	Yes	101	42.4%
	To Somewhat	107	45%
	No	30	12.6%
	Total	238	100%
	23- Are the official letters flow sequence according to the routinely ..?		
	Yes	98	41.2%
	To Somewhat	110	46.2%
	No	30	12.6%
	Total	238	100%
	24- Are you satisfied with sequence of used communication channel in managerial relationship to currently used in the MOH...?		
	Yes	41	17.2%
	To Somewhat	117	49.2%
	No	80	33.6%
	Total	238	100%
	25- Are there crossing between channel of communication in leadership style currently used in the MOH...?		
	Yes	84	35.3%
	To Somewhat	127	53.4%
	No	26	10.9%
	Total	238	100%
	26- What is the leadership style used in your organization from your point and view...?		
	Democratic	29	12.2%
	Dictatorial	29	12.2%
	Anarchic	27	11.3%

	Mixed Manners	135	64.3%
	Total	238	100%
27- Do you think that channels of communication are unclear and routinely understood...?			
	Yes	51	21.4%
	To Somewhat	151	63.4%
	No	36	15.1%
	Total	238	100%
28- Do you think that administrative sequence in your hospital and ministry lead to delay or hampering a lot of official letters and feedback...?			
	Yes	81	34.2%
	To Somewhat	109	46%
	No	47	19.8%
	Total	237	100%
29- Is there any favouring or distinction through applying and dealing with rules between employees categories...?			
	Yes	177	74.4%
	Somewhat	34	14.3%
	No	27	11.3%
	Total	238	100%
30- In your opinion, which of the following administrative & leadership positions feel of autonomy within your organization...?			
	Head Nurse	44	18.9%
	Nursing Supervisor	54	23.2%
	Manager of Building	35	15%
	Hospital Director of Nursing	100	42.9%
	Total	238	100%

Table (3) Evaluation of job autonomy

Sn	Items	Never Agree		Disagree		No opinion		Agree		Strongly agree	
		No.	%	No.	%	No.	%	No.	%	No.	%
31	I have a lot of autonomy in managing the services in my hospital/department	6	2.5	40	16.8	45	18.9	138	58	9	3.8
32	I feel that I have a respect and consideration in my organization	2	0.8	16	6.7	38	16	165	96.3	17	7.1
33	Respect of my boss give me a feeling of more autonomy	3	1.3	5	2.1	19	8	140	95.1	70	29.5
34	All my subordinates conform and apply my directions instructions	6	2.5	16	6.7	36	15.1	156	65.5	24	10.1
35	Leadership style currently used in MOH give me sufficient authorities to control nursing work affairs and issues	18	7.6	54	22.7	67	28.2	95	39.9	4	1.7
36	Informal powers reduce the feeling of autonomy	10	4.2	34	14.3	59	24.8	96	40.3	39	16.4
37	Social relationship affect negatively the job autonomy of the managers	22	9.2	59	24.8	62	26.1	85	35.7	10	4.2
38	Cross the rules of communications affect	6	2.5	23	9.7	26	10.9	129	54.2	54	22.7

	negatively on job autonomy										
39	Nursing decisions were taken independently without interference from others	34	14.3	71.	29.8	59	24.8	58	24.4	16	6.7

Sn	Items	Never Agree		Disagree		No opinion		Agree		Strongly agree	
		No.	%	No.	%	No.	%	No.	%	No.	%
40	managerial style currently used health work by bureaucratic method tends to be authoritarian in operating health services	13	5.5	65	23.5	49	20.6	93	39.1	27	11.3
41	Democratic style currently used effect negatively on job autonomy among nursing leaders and managers in hospitals	4	1.7	23	9.7	38	16	116	48.7	57	23.9
42	Democratic style give me a feeling of autonomy	3	1.3	10	4.2	21	8.8	142	59.7	62	26.1
43	Interference of hospital manager in nursing work give me feeling of no autonomy	3	1.3	24	10.1	35	14.7	112	47.1	64	26.9
44	Joining with department/hospital meeting give me a feeling more autonomy	4	1.7	7	3	29	12.3	161	68.5	34	14.5
45	Traditional and routine operating work in hospital has negative effect on	4	1.7	21	8.9	48	20.3	138	58.2	26	11

	feeling of autonomy										
46	Increasing number of managers decrease a feeling of autonomy	2	0.8	13	5.5	25	10.5	144	60.8	53	22.4

Sn	Items	Never Agree		Disagree		No opinion		Agree		Strongly agree	
		No.	%	No.	%	No.	%	No.	%	No.	%

Job description give me to me sufficient feeling of job autonomy

47	Job description give me to me sufficient feeling of job autonomy	7	2.9	16	6.7	24	10.1	129	54.2	62	26.1
48	Current job description need modification to be more suitable for my job and position	2	0.8	20	8.4	58	24.5	109	46	48	20.3
49	Currently used job description give me a feeling of autonomy	3	1.3	53	22.3	64	26.9	93	39.1	25	10.5
50	Actual job description specify clearly my administrative authorities	12	5.1	63	26.6	65	27.4	87	36.7	10	4.2
51	Unclear job description lead to negative effect of job autonomy	1	0.4	6	2.5	28	11.8	144	60.5	59	24.8
52	Perform tasks and duties out of my specific authorities don't give me that feeling of autonomy	5	2.1	16	6.7	34	14.3	119	50	64	26.9

1. The relationship between job satisfaction and job autonomy:

Sn	Items	Never Agree		Disagree		No opinion		Agree		Strongly agree	
		No.	%	No.	%	No.	%	No.	%	No.	%
53	Gaining higher academic qualification give me more job autonomy	10	4.2	27	11.3	46	19.3	109	45.8	46	19.3
54	Working in my preferred department give me a feeling of job autonomy	1	0.4	13	5.5	11	4.6	143	60.1	70	29.4
55	Job satisfaction has positive effect on job autonomy	3	1.3	0	0	9	3.8	139	85.4	87	36.6
56	Recognition of my manager give me a feeling of job autonomy	1	0.4	5	2.1	11	4.6	136	57.1	85	35.7
57	The extent of authorities which are provided to me, has a closely relationship with the feeling of autonomy	1	0.4	7	2.9	24	10.1	138	85	68	28.6

1. The relationship between nursing career profession and job autonomy:

Sn	Items	Never Agree		Disagree		No opinion		Agree		Strongly agree	
		No.	%	No.	%	No.	%	No.	%	No.	%
58	I prefer that my direct superiors will be from the same profession (Nurse)	1	0.4	2	0.8	1	0.4	92	38.7	142	59.7
59	I m proud to be a nurse	1	0.4	7	2.9	14	5.9	113	47.5	103	43.3

60	Decision makers in the ministry are not interested with nurse's needs, issues, and worries	1	0.4	17	7.2	35	14.8	93	39.2	91	38.4
61	As a manager nurse I can't practice my authorities	20	8.4	101	42.4	56	23.5	52	21.8	9	3.8
62	The vision of decision maker's expecting that nursing is not necessary to be autonomous profession.	65	27.3	35	14.7	20	8.4	58	24.4	60	25.2
63	Decision maker's vision expecting that nurses are just an assistants for physicians	53	22.3	29	12.2	33	13.9	77	32.4	46	19.3
64	Decision maker's vision expecting that nurses shouldn't join their ideas to make decisions and planning	70	29.4	33	13.9	15	6.3	59	24.8	51	25.6
65	Nursing job should be autonomous	7	2.9	2	0.8	6	2.5	69	29	154	64.7
66	Nursing managers do not have good status as other ones from staff categories in the ministry	13	5.5	26	10.9	30	12.6	98	41.2	71	29.8

The relationship between place of work and autonomy

Sn	Items	Never Agree		Disagree		No opinion		Agree		Strongly agree	
		No.	%	No.	%	No.	%	No.	%	No.	%
67	My organization allow me sharing making decision	24	10.1	57	23.9	65	27.3	87	36.6	5	2.1

68	My organization provide suitable work conditions & circumstances for nursing work	16	6.7	46	19.3	72	30.3	99	41.6	5	2.1
69	My organization has an effective managerial relationship and communication	19	8	57	23.9	76	31.9	81	34	5	2.1
70	My organization consider nurses needs and nursing professional issues	16	6.8	44	18.6	68	28.7	96	40.5	13	5.5
71	My organization characterized by practicing a democratic managerial style	32	13.4	54	22.7	83	34.9	62	26.1	7	2.9
72	In my organization, I feel more psychological easy and support	16	6.7	39	16.4	74	31.1	98	41.2	11	4.6
73	My organization has no exterior interventions and influences	29	12.2	105	44.3	66	27.8	31	13.1	6	2.5
74	In my organization, all duties and tasks progress within rules, regulations and labeled directions	23	9.7	44	18.6	77	32.5	88	37.1	5	2.1
75	In my organization, nursing manager has a great regarding and respect from his/her subordinates	19	8	38	16	91	38.2	81	34	9	3.8
76	In my organization, nursing manager has full authorities and power on nursing staff	13	5.5	27	11.3	35	14.7	113	47.5	50	21

Validity domain1 Assessment of job autonomy status as nursing managers perspective

Items	r	Sig.
Q31	0.580	0.001
Q32	0.526	0.001
Q33	0.535	0.001
Q34	0.417	0.001
Q35	0.550	0.001
Q36	0.303	0.001
Q37	0.214	0.001
Q38	0.355	0.001
Q39	0.504	0.001

Validity domain2: Managerial style with job autonomy

Items	r	Sig.
Q40	0.587	0.001
Q41	0.686	0.001
Q42	0.423	0.001
Q43	0.617	0.001
Q44	0.274	0.001
Q45	0.613	0.001
Q46	0.620	0.001

Validity domain3: Job description with job autonomy

Items	r	Sig.
Q47	0.512	0.001
Q48	0.636	0.001
Q49	0.580	0.001
Q50	0.063	0.001
Q51	0.620	0.001
Q52	0.678	0.001

Validity domain4:Job satisfaction with job autonomy

Items	r	Sig.
Q53	0.714	0.001
Q54	0.799	0.001
Q55	0.692	0.001
Q56	0.711	0.001
Q57	0.684	0.001

Validity domain5: Nursing career environment with job autonomy

Items	r	Sig.
Q58	0.298	0.001
Q59	0.152	0.019
Q60	0.454	0.001
Q61	0.428	0.001
Q62	0.819	0.001
Q63	0.795	0.001
Q64	0.836	0.001
Q65	0.374	0.001
Q66	0.614	0.001

Validity domain6: Work place with autonomy

Items	r	Sig.
Q67	0.722	0.001
Q68	0.788	0.001
Q69	0.845	0.001
Q70	0.816	0.001
Q71	0.791	0.001
Q72	0.712	0.001
Q73	0.574	0.001
Q74	0.775	0.001
Q75	0.793	0.001
Q76	0.649	0.001

- Last certificate.....

Practical Nurse PN Diploma BSN

Post Graduation Master Degree PhD Degree

- Have you try to find another work ? Yes No

If the answer is “yes” in the previous question, Please answer the following question

What is the cause?

- () To increase income
- () To change the routine of life
- () Better social status
- () Professional development
- () To gain more job autonomy
- () Bothering the current work climate

Others:

.....

Part 2:

General Attitudes:

- Are you satisfied in your work?

() yes () To somewhat () NO

- Do you think that there is a relationship between managerial style practiced in the MOH and your feeling of job autonomy?

() yes ()To somewhat () NO

- Do you think that work conditions in your hospital(working environment – working shifts - working hours – hotel services) are suitable for employee workers ..?

() yes ()To somewhat () NO

- Is there job description for your position in the hospital..?

yes To somewhat NO

If the answer is yes please answer the next two questions:

- Do you think that the clauses included in job description keep your autonomy in managing nursing services in your department..?

yes To somewhat NO

- Do you feel that job description clauses were appropriate with your position..?

yes To somewhat NO

- Do you prefer that your boss or direct supervisor should be from the same profession (Nursing)..?

yes To somewhat NO

- Do you see that there are a conflict between managers of different categories in your hospital...?

yes To somewhat NO

- Are the official letters flow sequence according to the routinely ..?

yes To somewhat NO

- Are you satisfied with sequence of used communication channel in managerial relationship to currently used in the MOH...?

yes To somewhat NO

- Are there crossing between channel of communication in leadership style currently used in the MOH...?

yes To somewhat NO

- What is the leadership style used in your organization from your point and view...?

democratic bureaucratic anarchic Mixed

Manners

- Do you think that channels of communication are unclear and routinely understood...?

yes somewhat NO

- Do you think that administrative sequence in your hospital and ministry lead to delay or hampering a lot of official letters and feedback...?

yes somewhat NO

- Is there any favoring or distinction in applying and dealing with rules between categories of employees...?

yes somewhat NO

- In your opinion, which of the following administrative & leadership positions feel of more autonomy within your organization...?

Head of Department Nursing Supervisor

Manager of Building Hospital Director of Nursing

Part 3:

Please put the sign (√) toward the right column of the table according to your opinion:

Assessment of job autonomy status from nursing managers point and view:

Key: 1 = Totally Refuse 2 = Disagree

3 = May be Or May be not 4 = Agree 5 = Totally Agree

#	Clause	1	2	3	4	5
31	I have a lot of autonomy in managing the services in my hospital/department					
32	I feel that I have a respect and consideration in my organization					
33	Respect of my boss give me a feeling of more autonomy					
34	All my subordinates conform and apply my directions instructions					
35	Leadership style currently used in MOH give me sufficient authorities to control nursing work affairs and issues					
36	Informal powers reduce the feeling of autonomy					
37	Social relationship affect negatively the job autonomy of the managers					
38	Cross the rules of communications affect negatively on job autonomy					
39	Nursing decisions were taken independently without interference from others					

Part 4:

Factors affecting job autonomy of nursing staff

2. Relationship between managerial style& decision making in respect to job autonomy :

#	Clause	1	2	3	4	5
40	managerial style currently used health work by bureaucratic method tends to be authoritarian in					

	operating health services					
41	Democratic style currently used effect negatively on job autonomy among nursing leaders and managers in hospitals					
42	Democratic style give me a feeling of autonomy					
43	Interventions of hospital manager in nursing work give me feeling of no autonomy					
44	Joining with department/hospital meeting give me a feeling more autonomy					
45	Traditional and routine operating work in hospital has negative effect on feeling of autonomy					
46	Increasing number of managers decrease a feeling of autonomy					

3. The relationship between job description and job autonomy:

#	Clause	1	2	3	4	5
47	Job description give me sufficient feeling of job autonomy					
48	Current job description need modification to be more suitable for my job and position					
49	Currently used job description give me a feeling of autonomy					
50	Currently used job description specify clearly my authorities					
51	Unclear job description effect negative the feeling of job autonomy					
52	Perform tasks and duties out of my profession \duties don't give me a feeling of autonomy					

4. The relationship between job satisfaction and job autonomy:

#	Clause	1	2	3	4	5
53	Gaining higher academic qualification give me more job autonomy					
54	Working in my preferred department give me a feeling of job autonomy					
55	Job satisfaction has positive effect on job autonomy					
56	Recognition of my manager give me a feeling of job autonomy					
57	The extent of authorities which are provided to me, has a closely relationship with the feeling of autonomy					

5. The relationship between nursing career profession and job autonomy:

#	Clause	1	2	3	4	5
58	I prefer that my direct supervisors will be from the same profession (Nurse)					
59	I m proud to be a nurse					
60	Decision makers in the ministry are not interested with nurse's needs, issues, and worries					
61	As a manager nurse I can't practice my authorities					
62	The vision of decision maker's expecting that nursing is not necessary to be autonomous profession.					
63	Decision maker's vision expecting that nurses are just an assistants for physicians					
64	Decision maker's vision expecting that nurses					

	shouldn't join their ideas to make decisions and planning					
65	Nursing job should be autonomous					
66	Nursing managers do not have good status as other ones from staff categories in the ministry					

6. The relationship between place of work and autonomy:

#	Clause	1	2	3	4	5
67	My organization allow me sharing making decision					
68	My organization provide suitable work conditions & circumstances for nursing work					
69	My organization has an effective managerial relationship and communication					
70	My organization take care for nursing and nursing professional issues					
71	My organization characterized by practicing a democratic managerial style					
72	In my organization, I feel more psychological easy and support					
73	My organization has no exterior interventions and influences					
74	In my organization, all duties and tasks progress within rules, regulations and labeled directions					
75	In my organization, nursing manager has a great regarding and respect from his/her subordinates					
76	In my organization, nursing manager has full authorities and power on nursing staff					

77. Which of the following clauses give you a sense of job autonomy : please rank the number of clauses according to priority(importance from your point of view):

- () Participating and sharing in decisions making .
- () Gaining full autonomy in taking the appropriate decisions.
- () No influence of informal or external power.
- () When direct leader from the same profession.
- () When nursing director of nursing unit at the ministry gain full authorities and powers on nurses & nursing activities.
- () When nursing manager proud to be a nurse.
- () When nursing managers and leaders gain more recognition and respect from their superiors.

Annex (5): questionnaire(Arabic version)

كلية الصحة العامة

School of Public Health

جامعة القدس – فلسطين

استبانة

(مفهوم الاستقلال الوظيفي لدى مسئولى التمريض في المستشفيات الحكومية التابعة لوزارة

الصحة -قطاع غزة)

**Job Autonomy As Perceived By Nursing Managers In Governmental
Hospitals In The MOH- Gaza Governorates**

الرقم المسلسل :

الرقم المبرمج :

زميلي / زميلتي العزيز / ة :

* يسعدني جداً مشاركتكم الفاعلة في هذا البحث الذي هو جزء من رسالة الماجستير في كلية

الصحة

العامة – جامعة القدس

* الغرض من هذه الدراسة هو معرفة مدى إدراك (وجهة نظر) مسئولى التمريض

بالمستشفيات التابعة لوزارة الصحة بقطاع غزة من (مدراء ومشرفين ورؤساء أقسام) بمفهوم

الاستقلال الوظيفي.

* الدراسة سوف تشمل جميع مسئولى التمريض بالمستشفيات التابعة لوزارة الصحة بقطاع غزة

يستثنى من ذلك من لم يمض على تكليفه بالمنصب مدة ثلاث سنوات.

* هذه الإستبانة أداة قد تعكس رأيكم ومدى شعوركم بالاستقلال الوظيفي

* النتائج قد تكون مرشداً وموجهاً للمسؤولين وحافزاً لهم تساعدكم في اتخاذ القرارات و القيام بنشاطات تساعد على تحسين مستوى الاستقلال الوظيفي لمسئولي التمريض وهذا سوف

ينعكس بدوره على مستوى الخدمات الصحية المقدمة للمرضى بالمستشفى.

* السرية التامة مكفولة ولا داعي لكتابة الاسم على الاستبانة

* البحث ممول من قبل الباحث فقط

* إننا نقدر و نثمن وقتكم .. لذا نستأذنكم بتخصيص عشرون دقيقة تقريباً لتعبئة هذه الإستبانة.

* يرجى الإجابة على جميع الأسئلة الواردة في الإستبانة وفق ما تراه حيث لا توجد إجابات أو آراء صحيحة وأخرى خاطئة.

* رغم أنني أرحب بمشاركتكم إلا أنه من حقك عدم المشاركة إذا أردت ذلك.

* سوف أكون متواجداً في المكان خلال عملية جمع البيانات وجاهز لأي استفسار.

شاكرين حسن تعاونكم

مع فائق الاحترام والتقدير.

الباحث

خليل مصطفى شقفة

Aug.2010

استبانة

(مفهوم الاستقلال الوظيفي لدى مسؤلي التمريض في المستشفيات الحكومية التابعة

لوزارة الصحة- قطاع غزة)

من فضلك أجب على جميع الأسئلة التالية بعد قراءتها جيداً

الجزء الأول: معلومات شخصية

1. الجنس :

ذكر أنثى

2. العمر : سنة

3. أسم المؤسسة:.....

4. الحالة الاجتماعية

أعزب / آنسة متزوج /ة

مطلق /ة أرمل /ة

5. عدد سنوات الخدمة في مجال المهنة

6. عدد سنوات العمل بالمستشفى :.....

7. القسم الذي تعمل به

8. هل تعمل في القسم الذي تفضل العمل به ؟

نعم لا

9. الوظيفية الحالية (موقعك)

رئيس قسم مشرف تمريض مدير مبنى مدير تمريض المستشفى

10. المدة التي عملتها مسئولاً للتمريض بالقسم الحالي.....

11. ما هي درجتك الوظيفية

12. المرحلة الدراسية التي أكملتها (آخر شهادة)

دبلوم متوسط بكالوريوس دبلوم عالي

ماجستير دكتوراه

13. هل تحاول إيجاد عمل آخر ؟

نعم لا

إذا كانت الإجابة نعم من فضلك أجب عن السؤال التالي :

14. ما هو السبب :-

لتحسين الدخل الاستياء من جو العمل الحالي

لتغيير روتين الحياة الطموح المهني

تحقيق مكانة اجتماعية أفضل لتحقيق مزيد من الاستقلال الوظيفي

أسباب أخرى (حدد).....

الجزء الثاني:

توجهات عامة

15. هل تشعر بالرضا الوظيفي بالعمل

نعم إلى حد ما لا

14. هل تعتقد أن هناك علاقة بين النظام الحاكم في الوزارة وشعورك بالحرية في إدارتك

للتمريض في القسم / المؤسسة

نعم إلى حد ما لا

هل ظروف العمل بالمؤسسة (ساعات الدوام- فترات العمل- الخدمات الفندقية- بيئة العمل) مناسبة

17.

للعاملين بالتمريض

نعم إلى ما لا

18. هل يوجد وصف وظيفي للمنصب الذي تشغله

نعم إلى ما لا

إذا كان الإجابة بنعم أجب عن السؤالين التاليين (19 - 20)

هل مضامين الوصف الوظيفي توفر لك الشعور بالحرية و الاستقلالية في إدارتك للقسم /

19. المؤسسة

نعم إلى ما لا

نعم إلى ما

هل تعتقد أن بنود الوصف الوظيفي تتناسب مع موقعك الوظيفي (المنصب)

20.

نعم إلى ما لا

21.

هل تفضل أن يكون مسئولك المباشر من نفس التخصص (تمريض).

نعم إلى حد ما لا

22.

هل هناك صراعات بين مسئولي الفئات المختلفة بالمؤسسة / القسم

نعم إلى حد ما لا

23.

هل تتم المراسلات (التوصل) التمريضي عبر التسلسل الإداري في المستشفى / الوزارة ؟

حسب الأصول

نعم إلى حد ما لا

24.

هل أنت راض عن التسلسل الإداري الموجود حاليا في الوزارة .

نعم إلى حد ما لا

25.

هل هناك تقاطعات في الاتصال والتواصل خلال النمط الإداري المعمول به في الوزارة.

نعم إلى حد ما لا

26.

بماذا تصنف النمط الإداري المعمول به في المؤسسة ؟

ديمقراطي بلطوي فئوي مزيج من الأنماط

27.

هل تعتقد أن خطوط الاتصال والتواصل غير مفهومة أو واضحة .

نعم إلى حد ما لا

28.

هل التسلسل الإداري يؤدي إلى تعطيل الكثير من المراسلات والردود عليها .

نعم إلى حد ما لا

29. هل هناك تمييز في المعاملة وتطبيق القوانين بين فئات العاملين ؟

نعم لا ليس لدي رأي آخر

30. في اعتقادك أي من المناصب الآتية أكثر شعوراً بالاستقلال الوظيفي في مؤسستك

رئيس قسم مشرف ترميز مدير مبنى مدير التمريض بالمستشفى

الجزء الثالث: يرجى وضع الإشارة (U) في العمود المناسب أمام كل عبارة كما يلي

تقييم حالة الاستقلال الوظيفي من وجهة نظر مسؤولي التمريض

م	العبارة	لا اتفق مطلقاً	لا اتفق	لا اتفق ولا اختلف	اتفق	اتفق مطلقاً
31	أتمتع بالحرية في إدارتي للتمريض بالمستشفى / القسم					
32	أتمتع بالمكانة والأهمية بالمؤسسة التي اعمل بها					
33	احترام وتقدير المسئول لي يعطيني الشعور بالمزيد من الاستقلال الوظيفي					
34	يقوم المرءوسين لدى بتنفيذ التعليمات الصادرة عنى					
35	النمط الإداري المعمول به بالمؤسسة /الوزارة يعطيني الصلاحيات الكافية لضبط الأمور وتسيير العمل التمريضي ؟					
36	القوى الخارجية الغير رسمية تقلل من الشعور بالاستقلال الوظيفي					

					العلاقات الاجتماعية لها تأثير سلبي على الاستقلال الوظيفي للمسئول	37
					تجاوز التسلسل الإداري المتبع له تأثير سلبي على الاستقلال الوظيفي	38
					تتخذ قرارات التمريض بشكل مستقل دون تدخل الآخرين	39

الجزء الرابع:

العوامل التي تؤثر على الاستقلال الوظيفي للعاملين في مهنة التمريض

1. علاقة النمط الإداري وصنع القرار في الاستقلال الوظيفي

م	العبارة	لا اتفق مطلقاً	لا اتفق	لا اتفق ولا يختلف	اتفق مطلقاً
40	النمط الإداري المعمول به حالياً يميل إلى السلطوية في تسيير العمل الصحي				
41	النظام الإداري في وزارة الصحة أثر سلباً على الاستقلال الوظيفي لمسؤولي التمريض في المستشفيات				
42	النمط الإداري الديمقراطي يعطيني الشعور بالاستقلال الوظيفي				
43	تدخل مدير المستشفى في سير العمل التمريضي لا يعطيني الشعور بالاستقلال الوظيفي				

					المشاركة في اجتماعات القسم / المستشفى تعطيني الشعور بالاستقلال الوظيفي	44
					العمل الإداري التقليدي يؤثر سلباً على شعوري بالاستقلال الوظيفي	45
					تعدد المسؤولين يقلل من الشعور بالاستقلال الوظيفي	46

2. علاقة الوصف الوظيفي بالاستقلال الوظيفي

م	العبارة	لا أتفق مطلقاً	لا أتفق	لا أتفق ولا يختلف	أتفق مطلقاً
47	الوصف الوظيفي يعطيني قدر كافي من الاستقلالية الوظيفية				
48	الوصف الوظيفي الحالي بحاجة إلى إعادة نظر لينسجم مع طبيعة عملي ومركزي الوظيفي				
49	الوصف الوظيفي الحالي لا يشعرني بالاستقلال الوظيفي				
50	الوصف الوظيفي الحالي يحدد بوضوح صلاحياتي الإدارية				
51	عدم وضوح الوصف الوظيفي يؤثر سلباً على الشعور بالاستقلال الوظيفي				
52	القيام بأعمال ليست من واجباتي المهنية لا تعطيني الشعور بالاستقلال الوظيفي				

3. علاقة الرضا الوظيفي بالاستقلال الوظيفي

م	العبارة	لا اتفق مطلقاً	لا اتفق	لا اتفق ولا اختلف	اتفق مطلقاً
53	حصولي على شهادات عليا يعطيني الشعور بالاستقلال الوظيفي				
54	العمل بالقسم الذي أريده يعطيني الشعور بالاستقلال الوظيفي				
55	الرضا الوظيفي يؤثر ايجابيا علي شعوري بالاستقلال الوظيفي				
56	تقدير المسئول المباشر لي يعطيني الشعور بالاستقلال الوظيفي				
57	حجم الصلاحيات الممنوحة لي له علاقة وطيدة بمدى شعوري بالاستقلال الوظيفي				

4. علاقة طبيعة مهنة التمريض والاستقلال الوظيفي

م	العبارة	لا اتفق مطلقاً	لا اتفق	لا اتفق ولا اختلف	اتفق مطلقاً
58	أفضل أن يكون مسؤلي المباشر وإدارتي العليا من نفس التخصص (ممرضاً)				
59	أنا فخور بمهنة التمريض التي أنتمي إليها				
60	صانعي القرار بالوزارة لا يهتمون بهموم واحتياجات التمريض				
61	كوني ممرضاً لا أتمكن من ممارسة صلاحياتي كمسئول على التمريض				

					يرى المسؤولون / صانعي القرار أنه ليس بالضرورة أن يكون التمريض مهنة مستقلة	62
					يرى المسؤولون / صانعي القرار أن التمريض مساعد للطبيب	63
					يرى المسؤولين / صانعي القرار أن التمريض ليس بالضرورة أن يشارك في صنع القرار ورسم السياسات	64
					من الأفضل أن تكون مهنة التمريض مستقلة وظيفياً	65
					مسئول التمريض لا يتمتع بمكانة مثل مسؤولي الفئات الأخرى بالوزارة	66

5. علاقة مكان العمل بالاستقلال الوظيفي:

م	العبارة	لا أتفق مطلقاً	لا أتفق	لا أتفق ولا أختلف	أتفق مطلقاً
67	مؤسستي تتيح لي الفرصة للمشاركة في صنع القرار				
68	مؤسستي توفر الظروف المناسبة للعمل التمريضي				
69	مؤسستي تتميز بالتواصل الإداري الفاعل				
70	مؤسستي تهتم بمهنة التمريض والعاملين بها				
71	مؤسستي تتميز بأن فيها نمط إداري ديمقراطي				
72	في مؤسستي أشعر بالراحة النفسية في العمل				
73	مؤسستي ليست عرضة لتدخلات من القوى الخارجية				

					74	في مؤسستي يسير العمل في إطار الأنظمة والقوانين الموضوعة
					75	في مؤسستي يلاقي مسئول التمريض بالتقدير الكافي على انجازه
					76	في مؤسستي مدير التمريض له صلاحيات وسلطات كاملة على التمريض

77 - أي من الخيارات الآتية يشعرك بمزيد من الاستقلال الوظيفي (رقم حسب الأولوية من وجهة

نظرك)

- () - المشاركة في صنع القرار وأخذ المشورة
- () - امتلاك الحرية في اتخاذ القرار الذي يجده المسئول مناسب
- () - عدم تدخل جهات خارجية في عمل المسئول
- () - عندما يكون المسئول المباشر من نفس المهنة
- () - عندما يكون مدير وحدة التمريض بالوزارة له صلاحيات وسلطات كاملة ومباشرة
- () - عندما يعتز مسئول التمريض بالمهنة التي ينتمي إليها
- () - عندما يلاقي المسئول الاحترام والتقدير من المستويات الإدارية العليا

الباحث / خليل مصطفى شقفة

Annex (6): Approval from Helsinki

15

Palestinian National Authority
Ministry of Health
Helsinki Committee



السلطة الوطنية الفلسطينية
وزارة الصحة
لجنة هلسنكي

التاريخ 7/6/2010

Name:

الاسم: خليل مصطفى شقفة

I would like to inform you that the committee has discussed your application about:

نفيدكم علماً بأن اللجنة قد ناقشت مقترح دراستكم حول:-

Job autonomy as perceived by nursing managers in governmental hospitals in the MOH-Gaza Governorates.

In its meeting on June 2010 and decided the Following:-

و ذلك في جلستها المنعقدة لشهر 6 2010

To approve the above mention research study.

و قد قررت ما يلي:-

الموافقة على البحث المذكور عاليه.



Signature

توقيع

Member

Member

Chairperson

عضو

عضو

Conditions:-

- ❖ Valid for 2 years from the date of approval to start.
- ❖ It is necessary to notify the committee in any change in the admitted study protocol.
- ❖ The committee appreciate receiving one copy of your final research when it is completed.

Annex (7): Approval from MOH

Palestinian National Authority
Ministry of Health
Nursing Directorate



السلطة الوطنية الفلسطينية
وزارة الصحة
وحدة التمريض

Date: 19/04/2010

حفظه الله

السيد / د. باسم نعيم
معالي وزير الصحة

السلام عليكم ورحمة الله وبركاته ..

الموضوع: بحث رسالة الماجستير

تهديكم وحدة التمريض أطيب التحيات و أعطرهما.. يرجى التكرم بالعلم بأنني بصدد الإعداد للبحث الخاص برسالة الماجستير (الإدارة الصحية) من كلية الصحة العامة جامعة القدس " أبو ديس " بعد أن أنهيت وبنجاح المساقات الدراسية المطلوبة.

عنوان البحث:

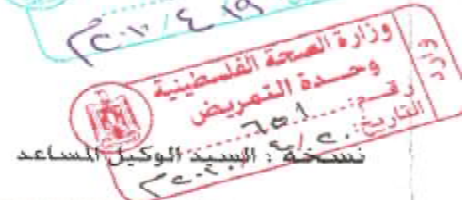
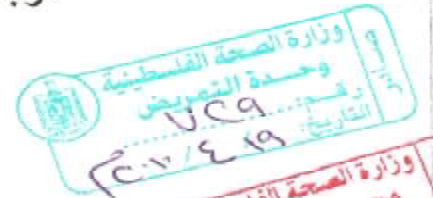
مفهوم الاستقلال الوظيفي لدى مسئولى التمريض بالمستشفيات التابعة لوزارة الصحة بقطاع غزة
(Job autonomy as perceived by nursing managers in Gaza governmental hospitals)

هذا وقد تم أخذ المصادقة على موضوع البحث /الرسالة من رئاسة الكلية و اللجنة الخاصة بموضوع الرسائل و الدراسات في جامعة القدس. ونأمل من الله إتمام الدراسة لما في ذلك مصلحة العمل وأن ينفعنا الله بما علمنا ويعلمنا ما ينفعنا ويزدنا علماً وأن تنعكس نتائج هذه الدراسة بشكل ايجابي على واقع التمريض ومستوى الخدمات التمريضية، وسنوافيكم بخطوات إجراء الدراسة و مستجداتها كل في حينه.

نرجو موافقة ودعم معاليكم

وبارك الله فيكم

أ. خليل مصطفى شقفتا
مدير وحدة التمريض



فلسطين - غزة - شارع العيون - مجمع النصر الطبي هاتف : +970 8 2879851 فاكس : +970 8 2879844

Website: <http://www.nursing.gov.ps>

Email: nursing@moh.gov.ps

Al Oyoun St. - Gaza - Palestine

Tel: +970 8 2879851

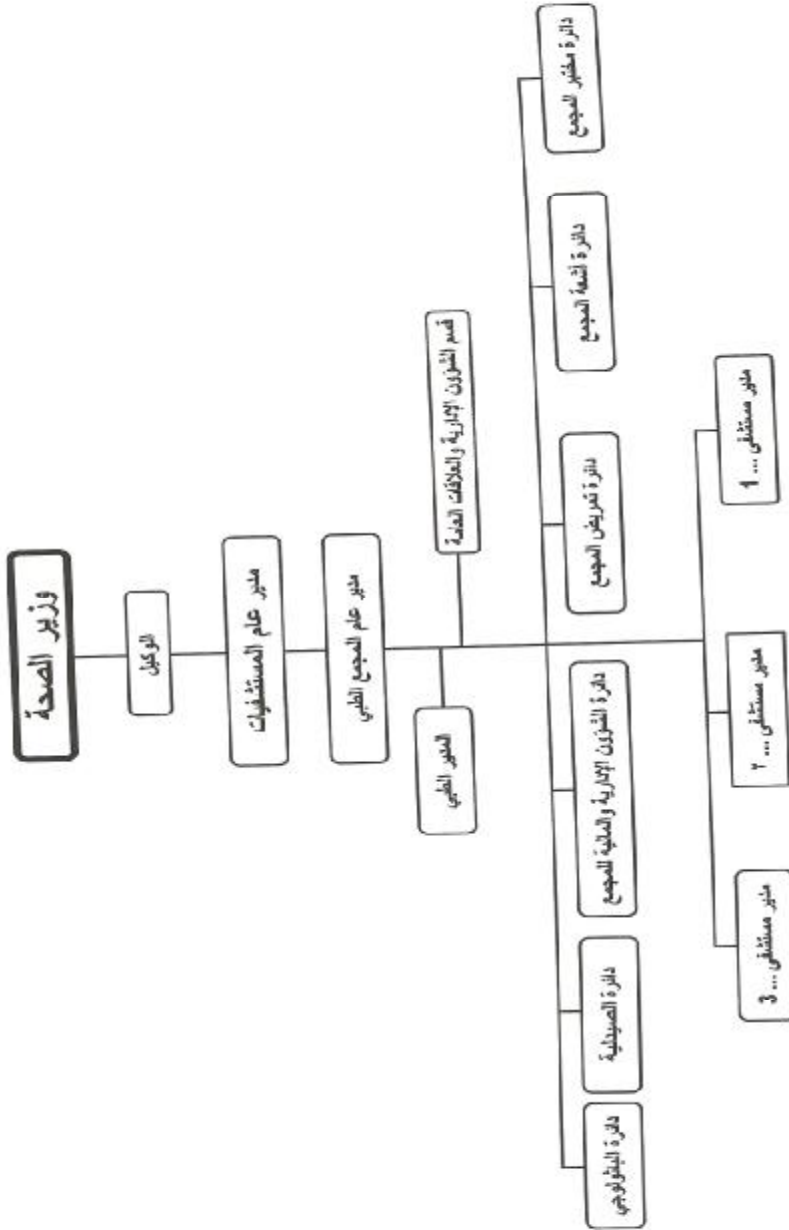
Fax: +970 8 2879844

Annex (8): Experts panel

Name	Place
Dr. Bassam Abu Hamad	AlQuds University
Dr. Yehia Abed	AlQuds University
Dr. Yousef Abu safia	AlQuds University
Dr. Ashraf Aljedi	Islamic University
Dr. Saadi Abu Awwad	Scientific Research
Dr. Moatasem Salah	Palestine College of Nursing
Mr. Khalil Abu Shoaib	Palestine College of Nursing
Mr. Ibrahim Mansour	Nursing Unit - MOH
Mr. yousef Awad	Palestine College of Nursing
Mr. A. Mottaleb Alkahlout	Alrantisi Specialist Hospital

Annex (9): Organizational structure of MOH

٤١. مجمع طبي



Annex (11): Approval request from AlQuds University to human resources directorate

Al-Quds University
Jerusalem
School of Public Health



جامعة القدس
القدس
كلية الصحة العامة

2010/7/11

الأخ/د. ناصر أبو شعبان المحترم
مدير عام تنمية القوى البشرية-وزارة الصحة
تحية طيبة وبعد،،،

الموضوع: مساعدة الطالب عليل مصطفى شقفة

يقوم الطالب المذكور أعلاه بإجراء بحث بعنوان:

"Job Autonomy as Perceived by Nursing Managers in Governmental Hospitals in the MOH- Gaza Governorates"

كمستطلب للحصول على درجة الماجستير في الصحة العامة-مسار إدارة صحية و عليه نرجو التكرم للإعجاز لمن ثرونه مناسب لتسهيل مهمة الطالب في جمع البيانات اللازمة من مشراء و مشرفي و رؤساء أقسام التمريض العاملين في جميع المستشفيات التابعة لوزارة الصحة.
علماً بأن المعلومات ستكون متوفرة لدى الباحث و الجامعة فقط.

و اقبلوا فائق التحية و الاحترام،،،


د. إسام أبو حمدان
مسئق عام برامج الصحة العامة
كلية الصحة العامة
جامعة القدس
College of Public Health
AL-QUDS UNIVERSITY

نسخة

- ملف

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Gaza Branch/telefax 08-2884422-2884411

Sphealth@admin.alquds.edu

فروع القدس/التلفاكس 02-2799234
فروع غزة/التلفاكس 08-2884422-2884411
ص.ب-51000/القدس

Annex (12): Approval from Hospitals general directorate

Palestinian National Authority
Ministry Of Health
Hospitals General Administration



السلطة الوطنية الفلسطينية
وزارة الصحة
الإدارة العامة للمستشفيات

التاريخ: ٢٠١٠/١٢/٢٠

الرقم: عام

المحترمون

الأخوة / مدراء المستشفيات

السلام عليكم ورحمة الله وبركاته

الموضوع / إجراء بحث

بالإشارة لكتاب السيد مدير عام تنمية القوى البشرية بخصوص الموضوع أعلاه يرجى تسهيل مهمة الطالب/ خليل شقفة والذي يعمل مدير وحدة التمريض بوزارة الصحة والمتعلق ببرنامج ماجستير الصحة العامة- إدارة صحة- جامعة القدس لإجراء بحث بعنوان-

"Job Autonomy as Perceived by Nursing Managers in Governmental Hospitals in the MOH Gaza Governorates "

حيث سيقيم الباحث بتعبئة استجائه من مدراء التمريض ومشرفي التمريض ورؤساء أقسام التمريض في مستشفيات قطاع غزة الحكومية، وذلك بما لا يتعارض مع مصلحة العمل وضمن ضوابط وأخلاقيات البحث العلمي، دون تحمل الوزارة أي أعباء مع موافقة خطية من المشاركين في البحث. ولا مانع لدينا من إجراء الاستبيان.

آملين حسن تعاونكم،،،

د. محمد الكاشف
مدير عام المستشفيات

محمد الكاشف

المحترم
المحترمون

مسورة السيد مدير عام تنمية القوى البشرية
مسورة السيدة مدراء المستشفيات



تأريخ: ٢٠١٠/١٢/٢٤

فدق الأمل - وزارة الصحة

Annex (13): statistical Nursing in MOH hospital - Gaza Government

Palestinian National
Authority
Ministry Of Health
Nursing Unit



السلطة الوطنية الفلسطينية
وزارة الصحة
وحدة التمريض

**Comprehensive statistical Nursing in MOH hospital - Gaza
Government**

Name of the hospital	actual number of nursing	Number of beds in hospital	nurse per bed
El-Emiraty Hospital	72	54	1.3
Abu Yousef Al Najjar Hospital	84	76	1.1
European Gaza Hospital	234	263	0.9
Nasser Medical Complex	282	386	0.73
Aqsa Martyrs Hospital	139	136	1
Al-Shifa Hospital	531	704	0,75
El-Nasser Children's Hospital	106	159	0.66
Eye Hospital	35	44	0.8
Durra Hospital for Children	62	90	0.7
Beit Hanoun Hospital	50	46	1.1
Kamal Adwan Hospital	105	98	1.1
Specialized pediatric hospital	68	56	1.2
Psychiatric Hospital	33	35	0.95
Grand Final	1789 nurse	2147	0.8
One nurse for each 873.1 citizen in Gaza strip			

مفهوم الاستقلال الوظيفي لدى مسؤلي التمريض العاملين بالمستشفيات الحكومية - محافظات غزة

الباحث: خليل مصطفى شقفة

المشرف : د. يوسف إبراهيم الجيش

ملخص الدراسة

تم اختيار موضوع الدراسة لأن الاستقلال الوظيفي له تأثير كبير على حالة الرضا الوظيفي و الانتماء وتحقيق الذات لدى المسؤولين في الحقل الصحي عامة وفي حقل التمريض خاصة و الذي بدوره سوف يؤثر بشكل كبير على مستوى الخدمات التمريضية ونجاعتها مما قد يساعد صانعي القرار على اتخاذ ما يلزم لتحسين حالة الاستقلال الوظيفي التي ينتابها كثير من الغموض والضبابية في وقتنا الحاضر وتعتبر أحد مصادر الصراعات التي قد تحدث بين المسؤولين من مختلف فئات العاملين بالحقل الصحي وهذه الأسباب مجتمعة حدت بالباحث للقيام بهذه الدراسة.

أهداف الدراسة

تهدف هذه الدراسة إلى تقييم حالة الاستقلال الوظيفي لدى مسؤلي التمريض بالمستشفيات الحكومية بمختلف مستوياتهم الإدارية، وكذلك التعرف على العوامل التي تؤثر في حالة الاستقلال الوظيفي واستكشاف الطرق التي قد تساعد على تحسين الوضع القائم هذا بالإضافة إلى معرفة ماهية العلاقة الموجودة بين الاستقلال الوظيفي و الصفات الشخصية و المهنية لمسؤلي التمريض.

منهجية الدراسة

هذه الدراسة هي دراسة وصفية تحليلية مقطعية لمسؤلي التمريض بالمستشفيات الحكومية التابعة لوزارة الصحة الفلسطينية.

الفئة المستهدفة

جميع مسؤولي التمريض العاملين بالمستشفيات الحكومية التابعة لوزارة الصحة (رؤساء أقسام - مشرفي تمريض - مدراء مباني - مدراء تمريض مستشفى) باستثناء الذين لم يمضى على تكليفهم بالمسؤولية مدة عام

عينة الدراسة

تكونت العينة من جميع مسؤولي التمريض العاملين بالمستشفيات الحكومية بقطاع غزة بجميع مستوياتهم الإدارية وعددهم 301 موظف وموظفة.

جمع البيانات

تم جمع البيانات من خلال استبانته تحتوي على مجموعة من المعطيات الشخصية و الإدارية و المهنية التي تؤثر في حالة الاستقلال الوظيفي وتم إعطاء المشاركين الفرصة الكافية لتعبئة هذه الاستبانته و إبداء رأيهم لأي درجة يتفقون مع العوامل المؤثرة في حالة الاستقلال الوظيفي. لقد تم توزيع 301 استبانته على مسؤولي التمريض بالمستشفيات وقد استجاب منهم 238 موظفاً أي ما نسبته 83.0%

تحليل البيانات

تم استخدام البرنامج الإحصائي "SPSS" وتم اختيار النتائج باستخدام اختبارات إحصائية مثل اختبار T. test واختبار ANOVA ، Mean ... الخ.

نتائج الدراسة

لقد سجلت الدراسة أن هناك توجهات متباينة من قبل المشاركين نحو حالة الاستقلال الوظيفي لمسؤولي التمريض و العوامل و المفاهيم التي تؤثر بها وما يشار إليه بالبنان أن الغالبية من مسؤولي التمريض عبروا عن شعورهم بالاستقلال الوظيفي داخل أقسامهم بنسب متفاوتة، ولكنها أوضحت أيضاً الغموض والضبابية حول مستوى الاستقلال الوظيفي في وزارة الصحة بشكل عام وذلك يرجع من وجهة نظرهم إلى النمط الإداري المعمول به في الوزارة وعدم وضوح أو تجديد الوصف الوظيفي أو عدم وجوده على

حد قول البعض الآخر ، ولقد أوضحت الدراسة أن هناك بعض المتغيرات الشخصية (الجنس - العمر - مدة الخبرة الكلية - المؤهل العلمي) لها علاقة بالإدراك و المشاعر المواكبة لحالة الاستقلال الوظيفي فعلى سبيل المثال وجد وبدلالة إحصائية أن مسؤولي التمريض الأقل سناً و الأقل خبرة و الذكور منهم أكثر إدراكاً وأكثر شعوراً بالاستقلال الوظيفي، كما بينت الدراسة أن هناك بعض المتغيرات المؤسساتية والإدارية التي لها تأثير أو علاقة بحالة الاستقلال الوظيفي، فوجد أن كافة أفراد العينة يعتبرون أن مدير التمريض بالمستشفى الأفضل من حيث الاستقلال الوظيفي يليه في ذلك مشرف التمريض، كما أفادت الدراسة أن العمل في المكان المرغوب به له أثر إيجابي عن الرضا الوظيفي المرتبط بالاستقلال الوظيفي.

أما المتغيرات التي ليس لها تأثير بدلالة إحصائية فهي

(مكان العمل - المؤهل العلمي - مدة الخبرة في المنصب - العمل في المكان المرغوب فيه) وهذا قد يعود سببه إلى أن الجميع واقع تحت ظروف عمل ونمط إداري وأنظمة وقوانين واحدة في حين أن بعض الدراسات بينت أن هناك علاقة إيجابية وطيدة بين المؤهل العلمي و حالة الاستقلال الوظيفي أما بالنسبة للعوامل التي تؤثر في الاستقلال الوظيفي ولها علاقة به فقد كانت النتائج إيجابية لكن بنسب متفاوتة حيث تبين أن الرضا الوظيفي له أكبر الأثر في حالة الاستقلال الوظيفي $M= 4.04$ يليه على التوالي النمط الإداري المعمول به الوزارة / المؤسسة والوصف الوظيفي وطبيعة المهنة بنفس النسبة وأخيراً مكان العمل ومحاولة من الباحث لاستكشاف الوسائل التي يمكن أن تحسن حالة الاستقلال الوظيفي لدى مسؤولي التمريض فقد اتفقت الغالبية العظمى منهم على أن يكون مدير وحدة التمريض بالوزارة مسئولاً بشكل كامل عن كافة العاملين من التمريض بالمؤسسات الصحية الحكومية وأن يكون المسئول المباشر من نفس المهنة / التخصص " تمريض "

صفات مجتمع الدراسة كانت على النحو التالي

غالبية مسؤولي التمريض " مجتمع الدراسة " من الذكور (76.1%) والغالبية لم تتجاوز أعمارهم الـ 45 عاماً (77.5%) معظم المسئولين يعملون بمجمع الشفاء الطبي والنسبة الأكبر حاصلين على شهادة البكالوريوس في التمريض (72.7%) والغالبية العظمى متزوجون (93.7%) كما شكل رؤساء الأقسام الأكثر عدداً (56.3%) يليهم مشرفو التمريض (37.4%)

التوصيات

خلص الباحث إلى التوصيات و الاقتراحات الآتية من أجل تحسين حالة الاستقلال الوظيفي و الذي سوف ينعكس بشكل إيجابي على مستوى الخدمات الصحية

§ توفير ثقافة مؤسساتية مبنية على العمل بروح الفريق الواحدة ، العدل ، الإخلاص و الثقة و الاستفادة من الخبرات و الكفاءات الموجودة.

§ تحسين حالة الاستقلال الوظيفي والرضا الوظيفي للعاملين في حقل التمريض.

§ وضع الأنظمة و القوانين و الوصف الوظيفي وتعريف مجال الممارسة المهنية و التي سوف يكون لها دور في الحد من الصراعات التي تحدث في المؤسسات وإزالة الضبابية التي تضي على العمل المهني.

§ ممارسة مزيج من الأنماط الإدارية التي تكفل المزيد من المشاركة في صنع القرار ومشاركة الكوادر التمريضية في وضع السياسات و الإستراتيجيات ذات العلاقة بالخدمات الصحية ككل.

§ تحسين صورة التمريض على الصعيدين الرسمي و الشخصي.

إن هذه الدراسة قد تكون حافزا لمزيد من الدراسات تشمل كافة المؤسسات الصحية حكومية وغير حكومية وفي كافة أنحاء الوطن حتى يمكن إيجاد العوامل المؤثرة في حالة الاستقلال الوظيفي بشكل شمولي و محدد ومقارن وكذلك إجراء المزيد من الدراسات لتحديد علاقة الاستقلال الوظيفي بالإنجاز و الإنتاج ومؤشرات أخرى لها علاقة بالاستقلال الوظيفي.