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NURSE PRACTITIONERS' PERCEPTIONS AND BEHAVIORAL INTENT TOWARD PRIVATE PRACTICE AND PROFESSIONAL AUTONOMY

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NURSE PRACTITIONERS' PERCEPTIONS AND BEHAVIORAL INTENT TOWARD PRIVATE PRACTICE AND PROFESSIONAL AUTONOMY

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Science at Virginia Commonwealth University.

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DEDICATION

This thesis is dedicated to my best friend, my loving wife Carol who has been a constant source of inspiration throughout my education.

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ABSTRACT

NURSE PRACTITIONERS' PERCEPTIONS AND BEHAVIORAL INTENT TOWARD PRIVATE PRACTICE AND PROFESSIONAL AUTONOMY

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The purpose of this study was to determine: 1) the perceptions of nurse practitioners toward private practice and professional autonomy, and 2) nurse practitioners' behavioral intent towards private practice and professional autonomy. Data were collected with a questionnaire designed by the researcher to measure demographic data, nurse practitioners' perceptions and behavioral intent toward private practice and professional autonomy, and knowledge of legal issues pertaining to private practice. Of 153 possible respondents, 100 (64%) nurse practitioners in the State of Maryland participated in the study.

Data were presented descriptively by number and percentage. The typical nurse practitioner was 31 to 40 years of age, attended a certificate program as an adult nurse practitioner, had a Master's Degree, worked full-time in a combination in-patient/out-patient setting, and

has been practicing for more then six years. Four nurse practitioners were in private practice. Results showed that almost all nurse practitioners' surveyed (97%) perceived private practice as appropriate, but most (83%) did not plan to work in that capacity during the next five years. Nurse practitioners' knowledge of legal issues (third party reimbursement, prescription writing privileges, and legality of owning and operating a private practice) were low with an average score of 55 percent. The autonomy section revealed that 1) nurse practitioners believed that nurse practitioner programs should teach and encourage private practice; and 2) that nurse practitioners are willing to make independent decisions and accept responsibility for them, but they were also inclined to accept limits established by the medical community.

CHAPTER ONE

Introduction

Background

The nurse practitioner in private practice has many characteristics in common with the private duty nurse, who represents the oldest form of nursing practice (Grippando, 1983). Both are self-employed, possess a high degree of control and autonomy over their practice, have minimal if any supervision, and bear complete risks and responsibility for their business.

During the early 20th century 70-80 percent (Grippando, 1983; Melosh, 1982) of the nurses worked as private duty nurses. They contracted directly with the patient or family to provide nursing services in either the home or the hospital. Post World War II hospitals became the largest employer of nurses with three hospital staff nurses for every one private duty nurse (Melosh, 1982).

Today, hospitals remain the largest employer of registered nurses with 68 percent of the 1.9 million active registered nurses. The number of self-employed nurses (9,214 or 0.6 percent of the nursing population) doubled between 1977-80, but decreased by 11 percent

between 1980-84 (American Nurses' Association, 1986). However, according to the U.S. Bureau of the Census (1985:521) there was an increase of business failures during this time period. Thus, the decreased number of self-employed nurses coincided directly with the overall increase in business failures.

The trend in society is toward entrepreneurship, an individual being independent and self employed, and the same holds true for nurses (Brown, 1986). Kinlein (1972), nurse practitioner, opened a private practice in 1971. This was the first recording of a nurse practitioner entering private practice (Agree, 1974; Lewis, 1980).

Numerous barriers have been present over the past century, which have inhibited nurses from offering their services as private practitioners. Some of these included lack of direct reimbursement for nursing services, minimal nursing autonomy, female socialization, lack of prescription writing privileges, and insufficient exposure to the concept of being self-employed.

The concept of private practice has been inspired by nurse practitioners who wish to gain and provide greater access to the community. Frustration over hospital bureaucracies (Rafferty, 1973; Greenidge, 1973), the desire to function in an expanded nursing role (Kinlein, 1972, 1977) with greater autonomy (Riccardi, 1982), the achievement of greater professional and personal fulfillment (Agree, 1974), and the belief that nurses have

more to contribute (Kerfoot, 1982) and furnish to the public then is being provided (Castiglia, 1979) are only some of the reasons for this conversion from the role of employee to entrepreneur. Nurse practitioners in private practice are offering a variety of direct nursing services to the public, including general nursing services (Greenidge, 1973), client counseling (Kerfoot, 1982), organizational consulting (Brathwaite, 1983), and health care education (Castiglia, 1979).

Significance

Professional autonomy is the "prize sought by virtually all occupational groups" (Freidson, 1970a). Though there are those in nursing who believe that nursing already has professional autonomy, others both inside and outside of nursing disagree. Bond (1986) describes nursing as a semi-profession while Freidson (1970b) claims it to be a paraprofession; but while nursing is not presently recognized as having full professional autonomy many agree this is changing (Riccardi, 1982; Mundinger, 1980; Dayani, 1982; Welch, 1985).

Private practice for the nurse practitioner offers both nurse practitioners and clients many advantages. For the nurse practitioner it offers a high degree of autonomy over nursing practice (Browning, 1982; Koltz, 1979), direct access to clients, and the chance to establish ones' own fee structure and work schedule. The client benefits by having a greater freedom of choice in

selecting a health care provider and by using a service which provides high quality care and cost effectiveness.

Nurse practitioners who are employed by an organization or a physician are accountable to that employer and may only have indirect contact with the client (Mundinger, 1980). The employed nurse practitioner therefore experiences the same problems that other employed nurses have. These include role ambiguity, hospital bureaucratic control of nursing practice (Simpson, 1979; Koltz, 1979), minimal control over patient care, institutional salary and benefit ranges limiting economic growth potential (Jacox, 1969), minimal flexibility in work schedule, and a high degree of supervision.

Research Question

What are the perceptions of nurse practitioners toward private practice and professional autonomy?

What are nurse practitioners' behavioral intent toward private practice and professional autonomy?

Conceptual Framework

Autonomy, a learned and on going process (Grissum, 1976) is a concept of identity, independence, and authority (Mundinger, 1980:1). Davis (1982) views autonomy as a form of personal liberty, an ethical principle which values an individual's right to self-direction. Thus, an individual with autonomy has the

ability to make decisions without constraints from others.

Professional autonomy, the control over the content and conditions of work, is composed of three elements: 1) a legal or political privilege protecting one occupation from encroaching upon another, licensure; 2) an occupations' control of production, application of knowledge, and skill in the work performed; and 3) a code of ethics (Freidson, 1970a:134).

An occupation is viewed as a profession if it can be characterized by the three elements of professional autonomy (Riccardi, 1982:10; Freidson, 1970b). These elements are the ability to determine who can legitimately do its work, how the work should be done, and to declare any outside evaluation of its work as improper and unqualified.

The degree of nurse practitioner autonomy depends upon who controls their licensure, education, and code of ethics. While the latter two are primarily controlled by nursing; the former, licensure, can be controlled by either a state medical board, or a state nursing board, or both.

Dachelet and Sullivan's (1979) "autonomy in practice" views professional autonomy as consisting of two "zones", job-content autonomy and job-context autonomy. Job-content autonomy is the technological or scientific aspects of the job, while job-context is the social and economic terms of the job. When job-content and job-

context autonomy increase so does the degree of professional autonomy. It is possible for a group to have a high degree of control over job-content while not having an equal amount over job-context (Bond, 1986).

Nurse practitioners can achieve professional autonomy through private practice. This method of employment would allow the nurse practitioner greater control over job-content and job-context. Thus, the nurse practitioner would have greater control over the client's management, the focus of the practice, and their own salary.

Operational Definitions

Nurse practitioner: a registered nurse who is prepared through a formal, organized educational program to provide primary health care, health promotion, health management, and health education in an independent fashion. Their services are available to all individuals, families, and communities. (Adapted from American Nurses' Association Scope of Practice, 1985b).

Private practice: is an enterprise owned and operated by a nurse practitioner which enables him/her to directly contract with a client (individual, group, or corporation). The client agrees to directly reimburse the nurse practitioner for professional nursing services rendered. The nurse practitioner also assumes all responsibilities that go along with owning and operating a business.

Professional autonomy: is based on a continuum of job-content and job-context, each at opposite ends of a scale. Job-content refers to a professions' ability to control their own technology and science. Job-context refers to a professions' ability to influence social and economic events (Freidson, 1970a:134; Dachelet, 1979).

Perception: the awareness of objects or other data through the senses (Webster's New World Dictionary, 1972:552).

Behavioral Intent: is an individuals' self propertied plan of action.

Assumptions

1) Nurse practitioners will answer the questions honestly and to the best of their ability.

2) Nurse practitioners have preconceived attitudes, values, and knowledge which influence the way they respond to the questionnaire.

3) Nurse practitioners have widely diverse and marketable skills for private practice.

Delimitation

The study was limited to a random sample of adult, family, OB/GYN, and pediatric nurse practitioners in the state of Maryland.

Limitations

1) The questionnaire had content validity and no preestablished reliability.

2) Nurse practitioners who do not feel that they should be in independent practice may not respond to the questionnaire thus altering the results.

3) Responses by nurse practitioners in Maryland may not represent responses of nurse practitioners practicing in other parts of the United States.

CHAPTER TWO

Review of the Literature

Introduction

An individual's perceptions and behavioral intent are influenced by previous life experiences. A nurse practitioner's perceptions and behavioral intent about private practice and professional autonomy are influenced by socialization factors and issues that can legally inhibit the scope of nursing practice. Socialization factors include degree of risk taking, influence of nursing schools (Koltz, 1979; Herman, 1978), female traits (Cohen, 1981; Gilbert, 1983), and the nurse practitioner role. Issues that can legally inhibit the nurses' scope of practice include restrictive nurse practice acts, limited third party reimbursement and prescription writing privileges, difficulty in obtaining hospital privileges, corporate laws limiting only physicians to own professional corporations, and restraint of trade which involves the limiting of nursing practice by another profession.

Only recently has the literature addressed the issues of nurse self-employment and the barriers to private practice. Few studies have been conducted to determine

how nurse practitioner perceptions and behavioral intent can influence their entry into private practice. In fact, more literature has been written in the past five years than the 20 years preceding.

This literature review will examine socialization factors and professional practice issues that can influence nurse practitioner's entry into private practice. These include: 1) female socialization; 2) degree of risk taking; 3) the role of the nurse practitioner; 4) nursing education; 5) nurse practice acts; 6) third party reimbursement; and 7) prescription writing privileges.

Socialization

Traditional female sex roles, risk-taking, nursing school socialization, and the nurse practitioner role are some of the factors which can influence nurse practitioners' perception and behavioral intent towards private practice. Resistance towards nurses' opening private practices is still present in the nursing profession (Koltz, 1979; Riccardi, 1982:6; Neal, 1982:8; Powell, 1984) because of a belief that private practice is not an acceptable way for nurses to work (Lewis, 1980). Some nurses believe that they cannot and should not assume independent responsibilities nor be held accountable for their decisions (Bullough, 1975; 1980) while others feel that it is illegal for nurses to work independently (Lewis, 1980). The following socialization factors are

being reviewed to determine how perceptions and behavioral intent can influence life experiences.

Female Sex Roles

The acquisition of sexual identification begins in early childhood and is reinforced throughout life. Traditionally, mothers were responsible for the development of their child's sex role and socialization while the father supported both of the processes. Girls were taught to identify with their mothers; rely upon others; encouraged to renounce their autonomy; and avoid independence, assertiveness, risk-taking, and taking pride in achieving goals (Grissum, 1976). For years, women were socialized to allow others to set goals for them, care for others before themselves, and not to expect financial rewards for services rendered (Ashley, 1976; Herman. 1978).

The traditional female role dictates a subordinate position which leads in many cases to role conflict and thus low self-esteem. Women had been lead to believe that only men could contribute the "important" things to society (Grissum, 1976). Thus, women viewed themselves as second class citizens because their role in society had caused them to lose sight of their individuality and prevented them from establishing goals of their choosing (Ashley, 1976; Herman, 1978). Gilbert (1983) states that two aspects of expectancy are prevalent, women either: a) believe that they cannot be as successful or as competent

as men in certain areas; or b) feel that they are performing less well then their male peers.

However, not all women conform to the traditional female role. Women who are raised differently from the one described above have different attitudes. Hennig (1977) interviewed 25 women, who held positions as presidents or vice-presidents in major U.S. business' to find out what was it about them as people (their experience, behavior and the environments in which they lived and worked) that allowed them to succeed in a "mans' world?" These women had uniquely different characteristics and upbringing than the traditional female. Each woman was a first-born in the family and shared interest and activities with her father that were traditionally regarded as more typical of a father and son relationship. Frequently the mothers were reported as "typical."

As adolescents the women accepted femininity on their own terms, but did not believe feminine inferiority applied to them. They rejected their mothers' traditional views and relied on their father's support and their own inner convictions. By college age all 25 women had rejected the "traditional feminine women" as someone to identify with. Many of them consciously choose their father as their role model. In summary, Hennig concluded:

> "From childhood on the 25 women in this study were taught, encouraged and supported by fathers, who expected them to aspire to and prepare for a career; who passed on to them

> their own view of a career as an integral part of a person's life' who dealt with them on the basis of an unquestioned assumption: that they would work, just as a man would do, for the greater part of their adult lives" (Hennig, 1977:118).

Sex role socialization can influence one's personality development, coping mechanisms, choice of life style, and occupation (Grissum, 1976). Female socialization is generally characterized as being passive, accommodating, submissive, helpless, emotional, noncompetitive, unadventurous, dependent, and security oriented (Neal, 1982; Herman, 1978; Grissum, 1976; Simmons, 1981). The nursing profession, 97 percent female, has been influenced, stereotyped, and constrained by traditional female sex roles (Ashley, 1976; Bullough, 1980; Hawkins, 1983:36; Rosenfeld, 1986).

Risk Taking

As mentioned previously, risk-taking is a characteristic of sex role development. Men associate risk with loss or gain; winning or losing; danger or opportunity; and positive or negative. Women view risk as being negative and relate it with loss, danger, injury, ruin, and hurt; it is something to be avoided. Men describe risk as affecting the future; while women regard risk as affecting the here and now (Hennig, 1977).

Risk-taking is defined by Webster's New World Dictionary (1972) as taking a chance. Each time an individual is willing to take a stand on an issue

(Stanton, 1974), accept responsibility and accountability for their decision (Henderson, 1985), try something new, or venture into uncharted areas they are taking a chance. Nurses make dozens of decisions that can effect a patient's outcome everyday. Yet there are those who say that nurses have not been socialized to take risks (Brown, 1986). Bullough (1975) says that nurses do not avoid decision making, but merely pretend to avoid it. This can be observed in two ways: 1) the decision-making nurse handles a situation by invoking the name of the doctor to the patient (Bullough, 1980); and 2) the nurse making a recommendation to the physician in such a way that the physician feels he initiated the idea, commonly referred to as the doctor-nurse game (Stein, 1967).

Accountability is the highest level of risk-taking (Mauksch, 1977). Assuming increased responsibility and accountability may be a nurse practitioner's greatest barrier (Jacobi, 1972). This is especially true during the transformation period from nurse to nurse practitioner when feelings of insecurities and anxieties exist (Sullivan, 1978).

Nursing School Socialization

Education reinforces the socialization process of childhood (Grissum, 1976:29). Early in the nursing students' education they learn about the health care power structure and their position within the system (Buckenham, 1983:104). The nursing education system does not

encourage independent practice; many nurse practitioner students learn their clinical skills in agencies, hospitals, public health departments, or physician offices where their perceptions of the health care power structure and position are reinforced (Simms, 1977). Though nurses graduate with knowledge and skills about health care they receive minimal if any exposure to private practice thus contributing much of the disinterest in independent practice (Neal, 1982:8; Koltz, 1979:21; Powell, 1984). Today nurses are asking for nursing schools to provide business courses that will allow them to succeed in private practice (Welch, 1985; Brathwaite, 1983; Simms, 1977; Koltz, 1979:21).

Little research evaluating nursing school's influence on nurse practitioner's perceptions of and entry into private practice has been conducted. Simms (1977) study of "Why nurses were reluctant to become entrepreneurs?" examined nursing school's contribution to the promotion of independent practice. One hundred associate degree, 100 baccalaureate degree, and all accredited master's degree programs were requested to have three students and three faculty complete a questionnaire. Twenty seven associate degree programs, 25 baccalaureate programs, and 20 master's programs returned the questionnaires for an overall return rate of 25 percent.

Statistically significant results ($p < 0.01$) indicated that respondents wanted more economic and management

courses. In addition no master's level family nurse practitioner program offered a minor in entrepreneurship. The author concluded "that both students and faculties in nursing programs prefer more courses that would help nurses to become entrepreneurs in the practice of nursing." However, caution should be used when interpreting these results because of the low return rate.

Women's Movement Influence

Simmons and Rosenthal (1981) interviewed 28 nurse practitioners (13 family planning, 15 pediatric) to see how the women's movement effected their views on new role attitudes, physician relationships, health care and change, and the women's movement. Because the sample population was small the results should not be considered as reflecting the total population of nurse practitioners.

Results showed that nurse practitioners: 1) abide by limits imposed by the medical profession in order to secure their jobs; 2) want a professional future with more independence, higher wages, and a greater acceptance by physicians as a peer, but are skeptical about these ideas coming about because of resistance by the medical community; 3) feel that they have little control in further actualizing their role and changing the nurse's traditional dependence on the medical community thus adjusting their individual work behavior to the demands of their medical colleagues.

The researchers conclude that nurse practitioners: 1) were satisfied with greater independence as primary care providers, but believe that they will have to wait until the medical profession changes its point of view before greater independence can attained; 2) have adopted the physician's definition of the nurse practitioners' professional territory and await for the medical profession to initiate change.

Nurse-Midwives and Private Practice

Beach, Fibich, and Paparo (1982) conducted an retrospective, exploratory study looking at factors to be considered when establishing a private nurse-midwifery practice. Four processes were investigated 1) commitment to the goal of establishing a private practice; 2) choosing a "birth setting"; 3) evolution of a partnership or solo practice; and 4) negotiation for physician backup. Twelve certified nurse-midwives in private practice participated in the study by responding to multiple choice questions and an interview. Content analysis was done jointly by the three researchers. They reported that the nurse-midwifes entered private practice for the following reasons: 50% reported political constraints at former jobs; 42% had a desire for autonomy; and 33% cited consumer demand. The nurse-midwives identified the most important characteristics to successfully opening a private practice were an independent spirit, commitment, and clinical competence.

Role of the Nurse Practitioner

The nurse practitioner coordinates and furnishes direct client care. They conduct health assessments, diagnose actual or potential health problems, plan therapeutic intervention, and evaluate the plan's effectiveness. Functioning in an independent and interdependent capacity the nurse practitioner has expanded the boundary of nursing practice (American Nurses' Association, 1985b).

Legal Nursing Issues

Nurse practice acts, third party reimbursement, and prescription writing privileges are legal issues that can influence a nurse practitioner's decision about whether or not to enter private practice. Restrictive nurse practice acts and limited prescription writing privileges can limit a nurse practitioners' ability to fully function in an independent role. In addition limited third party reimbursement can influence the nurse practitioners' financial livelihood.

Legislative acts have limited nurse's access to the client, and their autonomy and control over the profession, thereby restricting their influence over the health care system. Legislative activity in the past has restricted nursing practice, and hindered nurses from obtaining: 1) direct reimbursement, 2) prescription writing privileges, 3) hospital privileges, and 4) owning health care corporations. These barriers have made it

difficult for nurse practitioners to be successful in opening a private practice. Though recent legislation addressing these issues has been more liberal, barriers are still imposed.

Nurse Practice Acts

Nurse practice acts were one of the original barriers to private practice, due to a single passage in the original definition. In 1955, the American Nurses' Association House of Delegates (American Nurses' Association, 1955) approved a definition of nursing practice. The last line stated "...The foregoing shall not be deemed to include acts of diagnosis or prescription of therapeutic or corrective measures." By 1967, 15 states incorporated the definition into their state law and six states had used it with only slight modification (Bullough, 1976). The disclaimer was a distinct barrier to expanded practice (Mazey, 1986). Many individuals including the attorney generals of two states thought that the activities of nurse practitioners were illegal (Bullough, 1975).

More recent legislation updating nurse practice acts to accommodate nurses' expanded role began in 1971 in Idaho; near the end of 1974 20 states had joined the movement (Bullough, 1984b). By the summer of 1985, three states were left with the prohibitive language for diagnosing, treating, and prescribing (American Nurses' Association, 1985a). Restrictive rules and regulations in

amended nurse practice acts continue to impose barriers on nurse practitioners thus preventing them from totally asserting their expertise. These restrictions may include the requirement of written agreements between nurse practitioner and collaborating physician, pre-authorization of protocols before they can be implemented, or other restrictions to be discussed below.

Third Party Reimbursement

United States health care is greatly influenced by third party reimbursement. Unfortunately, health care reimbursement is actually illness care reimbursement since most insurance companies only reimburse providers for "medical services." Consumers' access to health care is limited by the fact that most insurers will only directly reimburse physicians and hospitals, thereby, giving physicians and hospitals control over the direction and economics of health care, and limiting competition from other provider practices and incomes (LaBar, 1985).

Lack of direct third party reimbursement has been the single most limiting factor for nurse practitioners in opening a private practice (Holmes, 1985; Goldwater, 1982; Sullivan, 1978), influencing health care delivery (Jennings, 1979), establishing professional autonomy (LaBar, 1985; American Nurses' Association, 1984), and attaining collaborative relationships with other health care professionals. In the late 1970's and early 1980's enacted reimbursement legislation for nurses continued to

contain many barriers. The Government Accounting Office considered restrictive reimbursement as an obstacle to wider use of nurse midwifes (Cohn, 1983).

Since the 1960's nurses have recognized direct reimbursement of nursing services (LaBar, 1986b) as a way to: 1) improve role development (American Nurses' Association, 1984), 2) increase recognition of services, 3) increase independence over practice (Baker, 1983), 4) increase professional autonomy (Pulcini, 1984; American Nurses' Association 1984; Lantanich, 1982), 5) enhance nursing authority (Jennings, 1979), and 6) improve the chance of economic success in private practice (Hershey, 1983).

The American Nurses' Association has a long standing history of recognizing and advocating third party reimbursement for nurses and nursing services. In 1984 they stated that direct reimbursement would enhance:

1. the development of innovative practice arrangements such as birthing centers, community nursing clinics, and independent practice associations;

2. the expansion of traditional nursing practice settings which nurses function in autonomously further develops the role of nurses.

3. the relationship with professional colleagues;

4. the image of nurses as revenue-generators in the system;

5. the degree of control over nursing practice.

Federal Government Health Insurance

Federal government health insurance includes Medicare, Medicaid, Federal Employee Health Benefits Program, Civilian Health and Medical Programs of the Uniformed Services, and the Rural Health Clinic Services Act. Nurse practitioners are eligible only for the later two.

Prescription Writing

Prescription writing is an integral part of assessment, diagnosis, and treatment in primary care (Batey, 1983:85). Thus, the limitation or absence of prescription writing can hinder a nurse practitioners' practice. The limitation or inability of nurse practitioners to prescribe medications enhances the barriers to becoming self-employed. Nurse practitioners who do not have full authority to exercise prescription privileges are hampered in their role to be independent and autonomous.

Part of a nurse practitioner's responsibility is to prescribe medications for their patients. When this is not possible, patients may be inconvenienced by having to make a second trip to the office to pick up a script. Nurse's and physician's time are interrupted and they are taken away from other patients.

Restrictive nurse practice acts or the lack of administrative rules by state boards of nursing prevented nurse practitioners from prescribing medication.

Legislation for prescription writing began in the early and mid 1970's shortly after the passage of laws which amended nurse practice acts to expand nursing practice. The initial nurse practice acts prohibited nurses from diagnosing, treating, or prescribing. Since then most nurse practice acts have been amended to eliminate the restrictive terminology. Many states did not include language permitting prescribing either because it was deemed to be a medical act (LaBar, 1984) or it was considered permissible by the amended practice act (Bullough, 1984a). Therefore nurses remain limited or prohibited from prescribing medications because of a lack of laws or regulations by boards of nursing and/or medicine.

Pharmacy Practice Acts are another barrier for nurses in prescription writing. Some states permit pharmacists to only accept prescriptions from physicians, dentists, and veterinarians. In other states medical acts are strongly worded and prohibit the nurse from prescribing (Bullough, 1984a).

Nurse practitioners have gained prescription writing privileges in 19 states (LaBar, 1986b), but not without severe limitations. Seven types of rules and regulations have been identified in the literature as barriers to prescribing. Fortunately more recent legislation has included fewer restrictions. Bullough (1984a), categorizes two ways states limit nurse's prescription

authority with the identified barriers following each category:

Category I "persons given prescribing authority are restricted"

1. only specific groups of nurses may be permitted to prescribe medications;

2. nurses may need to apply to the board of nursing or medicine for authorization to prescribe;

3. a) if authorization is not needed protocols and practice agreements between the nurse practitioner and the "supervising physician" may need to be on file with the respective board; b) some states must approve the written agreement and practice protocols before authorization is given;

4. the state may require the nurse to have specific courses in pharmacology or minimal practice time in the field;

5. nurse may need approval of prescription site

Category II "drugs that may be prescribed are limited"

1. a) a state may require the use of a drug formulary which would control the types and classes of drugs nurses may prescribe (one state limits the drugs nurse practitioner can prescribe to their specialty); b) some formularies include types of drugs that may not be prescribed and specify the number of refills or dosage units; c) combination formulary and protocols developed with a collaborating physician;

2) controlled substances have been restricted, nurses may not prescribe certain classes;

By viewing the barriers it is not difficult to see how nursing autonomy can be affected (LaBar, 1986a) and how it can inhibit a nurse practitioner from opening a private practice. A recent study (Pearson, 1986) has shown that nurse practitioners do find ways of obtaining needed prescriptions for their patients regardless of state laws. But, in states without legal prescriptive authority nurse practitioners frequently use a physician to obtain the prescription as opposed to nurse practitioners in states with prescriptive laws who use their own name.

State of Maryland Legal Nursing Issues

In the State of Maryland nurse practitioners became eligible for third party reimbursement in 1980 and prescription writing authority in 1981. However, third party reimbursement in Maryland only requires the insurer to offer nursing reimbursement as an option to the policies it sells (Cohn, 1983), rather then requiring the insurer to add nursing reimbursement to the policies. Thus, the policy holder must request that nursing reimbursement be added to the policy. For prescription writing privileges nurse practitioners must submit written protocols to the Maryland Board of Nursing and have a written agreement with a physician (Dunn, 1986).

Summary

Numerous social and legal factors can influence the nurse practitioners perceptions of and behavioral intent about private practice. Both socialization and legal constraints limit nurse practitioners from developing their own private practice.

CHAPTER THREE

Methodology

Introduction

A descriptive study was conducted to determine: 1) the perceptions of nurse practitioners toward private practice and professional autonomy, and 2) nurse practitioners' behavioral intent toward private practice and professional autonomy. The data were collected using a self-administered questionnaire designed by the researcher. The questionnaire included items of demographic data and nurse practitioners' perceptions, behavioral intent, and knowledge of private practice and professional autonomy. The advantages of a questionnaire include its economic efficiency, its ability to offer respondents complete anonymity, and its ability to gather and utilize large amounts of data for numerous purposes. Disadvantages include superficial data gathering, difficulty in relating cause and effect, and low a response rate which could result in a high bias response (Polit, 1983).

Sample and Setting

A list consisting of 547 adult, family, OB/GYN, and pediatric nurse practitioners was obtained from the

Maryland State Board of Nursing. The State of Maryland was selected because of its liberal nurse practice act and laws permitting nurse practitioners to prescribe medications and receive third party reimbursement.

One hundred seventy nine nurse practitioners were randomly selected to participate in the study. Of the 179 questionnaires mailed 22 were returned from the post office with no forwarding address, allowing for a potential response rate of 157. The actual response rate was 108 (69%), with 100 (64%) usable, three (2%) insufficiently uncompleted, and five (3%) returned after data analysis was completed.

Instrument

The data collection instrument was a questionnaire with two sections. The first section contained demographic data about nurse practitioners including sex, age, type of nurse practitioner, years of experience, highest level of education, and type of employment. The second section, nurse practitioners' perceptions, behaviors, and professional autonomy, was organized in a Likert scale, and knowledge of private practice was organized on a nominal scale (Appendix A).

Professional autonomy was measured by statements one to 16, in part two, and they were equally divided into job-content autonomy and job context autonomy. Job-content autonomy measured nurse practitioners' perceptions of technological or scientific aspects of private practice

(items 4, 5, 6, 7, 8, 12, 14, and 15). Job-context autonomy measured the social and economic perceptions of private practice (items 1, 2, 3, 9, 10, 11, 13, and 16). Autonomy items 9, 11, 14, 15, and 16 were phrased as negative statements. Scoring was based on the Likert scale with one equaling strongly agree to five equaling strongly disagree. A possible scoring range was from 16 to 80.

The knowledge section (items 17 to 23) assessed the nurse practitioners' awareness of state laws affecting their practice. These included knowledge of public and private third party reimbursement, prescription writing privileges, and the legality of nurse practitioners opening a private practice. Five points were awarded for each correct item and zero points for each incorrect or unknown item. A respondents score could range from zero to 35 points.

Item 24, used to answer research question one, assessed nurse practitioners' perceptions of appropriateness of owning and operating a private practice. While the nurse practitioners' behavioral intent of opening a private practice, item 25, was used to answer research question two. The responses on these two items separated the subjects into the two groups for data analysis.

The tool's content validity was established by drawing the items from the literature. A pilot-

questionnaire was given to 10 graduate nurse practitioner students to begin establishing construct validity. Each student was given a copy of the definition for job-content and job-context autonomy and asked to specify the type of each items' autonomy and review the questionnaire for clarity. Items in agreement 70 percent or greater were considered clear measures of job-content or job-context and were utilized in the study. Because research literature was scant, criterion-related validity cannot be determined. The tool had no preestablished reliability, however an expos facto reliability was calculated based upon 100 questionnaires. Utilizing coefficient alpha reliability the result was r = 0.64.

Procedure for Collecting Data

The goal of the study was to obtain 100 usable questionnaires. Permission for the study was granted by the Medical College of Virginia/Virginia Commonwealth University School of Nursing research committee. A list of nurse practitioners (excluding nurse midwives and nurse anesthetists) was obtained from the Maryland State Board of Nursing. By using a table of randomized numbers 179 nurse practitioners were selected for the study.

Each selected nurse practitioner was mailed a preliminary postcard to inform them that they were chosen to participate in the study (Appendix B). Then a cover letter (Appendix C), questionnaire (Appendix A), and self-addressed stamped envelope were mailed five days after the

postcards were sent. The cover letter explained the purpose of the study, time commitment, absence of risk, anonymity, and the statement that return of the questionnaire signified consent to participate in the study.

Each subject was instructed to spend 10-15 minutes answering all of the questions with a response that best reflected their perceptions and return the questionnaire in the self-addressed stamped envelope. The subjects were informed that no code was used on the questionnaire and their anonymity was guaranteed.

Summary

A questionnaire designed by the researcher was mailed to nurse practitioners in the State of Maryland. The list was obtained from the Maryland Board of Nursing. The questionnaire measured demographics, nurse practitioners' perceptions and behavioral intent and knowledge of private practice and professional autonomy. Each nurse practitioner received a postcard that briefly explained the study's purpose one week prior to receipt of the questionnaire. When they received the questionnaire a cover letter was enclosed with a further explanation about the study. The tool's reliability utilizing the coefficient alpha was $r = 0.64$. Of the possible response rate of 157, 100 questionnaires (64%) were returned usable and accepted for data analysis. Data were presented descriptively by number and percentage.

CHAPTER FOUR

Data Analysis and Interpretation

Introduction

The purpose of this study was to determine: 1) the perceptions of nurse practitioners toward private practice and professional autonomy, and 2) nurse practitioners' behavioral intent towards private practice and professional autonomy. An autonomy scale based on the work role and issues of private practice was designed by the researcher and used to measure the nurse practitioners' perceptions and behavioral intent related to private practice. One hundred nurse practitioners from the State of Maryland participated in the study. Data are presented descriptively by number and percentage.

Description of the Sample

Demographic data about nurse practitioners (N = 100) included age, type of nurse practitioner, type of education, years of experience, highest level of education, and type of employment. The subjects ranged in age from 26 to over 56 years; those between 31 to 40 years represented 48 percent of the sample. Fifty percent were adult nurse practitioners, 31 percent pediatric nurse practitioners, and 11 percent family nurse practitioners.

Certificate programs (57%) were the primary source of nurse practitioner education, Master's of Nursing programs contributing 38 percent, and the remaining five percent consisted of Bachelors of Nursing programs. However, 50 percent of the sample had a Master's degree or higher. Most nurse practitioners worked full-time (62%), in a nurse practitioner role (92%), at a hospital in a combination in-patient and out-patient basis (18%). Seventy percent of the sample were nurse practitioners for six years or longer (see Table 1).

Only four percent of the sample were in private practice, 93 percent were employees, and the remaining three percent were not working as a nurse. Nurse practitioners in private practice consisted of one having a partnership with a physician, one having a solo practice, and two who contracted their services with physicians. Income for nurse practitioner services included: 1) a guaranteed salary by the practice (N = 1); 2) a guaranteed salary plus a percentage of the profits (N = 1); and 3) income based upon the number of patients they saw (N = 2).

Data Analysis and Interpretation

One hundred subjects participated in the study. The plan was to use independent, two tail t-test, to test the difference between the mean of two independent groups. The number of subjects in each group were extremely uneven and t-test could not be used. Data are presented

descriptively.

Research Question I.

What are the perceptions of nurse practitioners toward private practice and professional autonomy?

Ninety seven percent (N = 97), believed that it was appropriate for them to own and operate a private practice. The mean on the professional autonomy scale for this group was 34.13, and a standard deviation of 5.59. While three percent (N = 3), disagreed. The mean on the professional autonomy scale for this group was 45.67, and a standard deviation of 2.08. The raw scores were similar between the three nurse practitioners. No test for statistical significance could be done difference between the perceptions of nurse practitioners who believed it appropriate to own and operate a private practice and those who did not. The mean scores of the two groups differ by 10 points and the range of possible scores was zero to 80. This could indicate that beliefs about professional autonomy are related to perceptions about the appropriateness of private practice. Further studies are needed to determine if there is a statistically significant difference between the two groups.

Research Question II.

What are nurse practitioners' behavioral intent toward private practice and professional autonomy?

A total of 98 nurse practitioners responded to this

Table 1

Demographic Characteristics of the Sample

Characteristic	N
Age (years)	
26-30	9
31-35	27
36-40	21
41-45	18
46-49	8
50-55	10
> 56	7
Total	100
Specialty	
Family	11
Adult	50
Pediatric	31
OB/GYN	6
Other	2
Total	100
Registered Nurse Education	
Diploma	17
AD	4
BSN	29
MSN	46
Ph.D	4
Total	100
Years Experience as NP	
<3	12
3-5	18
6-10	29
>10	41
Total	100

Table 1
continued

Demographic Characteristics of the Sample

Characteristic	N
Work Frequency	
Full Time	62
Part Time	30
UNK	8
Total	100
Current Practice Setting	
Hospital	
Inpatient	5
Outpatient	16
In & Out Patient	17
M.D. Office	9
HMO	8
Clinic	4
Occupational Health	6
Public Health	10
Other	20
Total	100
Job Status	
Employee	87
Self-Employed	4
Not presently working as a nurse	3
Total	94
Self-Employed Income	
Guaranteed Salary by Practice	2
Based on Number of Patients Seen	2
Total	4

item, two others reported that they were in private practice. Eighty-three percent (N = 83), said they do not intend to enter private practice with in the next five years. The mean on the professional autonomy scale for this group was 34.87, and a standard deviation of 5.90. Fifteen percent (N = 15), did have plans to enter private practice with in the next five years. The mean on the professional autonomy scale for this group was 33.33, and a standard deviation of 5.27. There was little difference between mean scores of the two groups indicating that the beliefs about professional practice were not influenced by intent to enter private practice. This was not determined by a statistical test of significance because of the unequal size of the two groups and the small number in one group.

Knowledge Section.

The knowledge section consisted of seven items, 17 to 36. Each item was awarded five points for a correct response and zero points for an incorrect or an unknown response. A total of 35 points could be earned with a possible range between zero and 35 points. Actual correct responses ranged from five to 35 points, with a mean of 19.35 (55%), and a SD = 7.37. Correct responses for each item were: number 17, nurse practitioners are eligible for third party reimbursement in Maryland, 78 percent; number 18, nurse practitioners are not eligible for Medicaid, 27 percent; number 19, nurse practitioners are not eligible

for Medicare, 33 percent; number 20, nurse practitioners are eligible for reimbursement by the Civilian Health and Medical Programs of the Uniformed Services, 35 percent; number 21, nurse practitioners are eligible for reimbursement by the Rural Health Clinic Services Act, 40 percent; number 22, nurse practitioners are permitted prescription writing privileges in Maryland, 97 percent; and number 23, nurse practitioners are legally permitted to own and operate a private practice, 77 percent (see Table 2).

Table 2

Knowledge of Legal Issues

Issues	Percent Correct
NPs are eligible for third party reimbursement in Maryland	78
NPs are not eligible to receive Medicaid reimbursement	27
NPs are not eligible to receive Medicare reimbursement	33
NPs are eligible to receive CHAMPUS	35
NPs are eligible to receive RHCSA	40
NPs are permitted to write prescriptions	97
NPs are legally permitted to own and operate a private practice	77

The knowledge section's low percentage of correct responses may be related to the lack of education that nurse practitioners received in their training program about private practice. Another factor could be that 70 percent of the nurse practitioners had been practicing for more then six years and did not keep abreast of the legal issues.

Autonomy.

The autonomy section consisted of 16 items, one to 16. Each item was scored utilizing the Likert scale with one equaling strongly agree and five equaling strongly disagree. A maximum strongly agree score could be 16 points and a maximum strongly disagree score could be 80 points. In other words a low raw score equaled a high autonomy and a high raw score equaled low autonomy. The raw score was 34.48, with a standard deviation of 5.86, and a range of 23 to 54.

Autonomy: Nurse Practitioner Education and Private Practice.

Item one asked nurse practitioners if nursing schools should incorporate courses promoting entrepreneurship and operating a private practice in the nurse practitioner curriculum. Eighty-two percent (N = 82) agreed or strongly agreed, while 18 percent gave no opinion or disagreed. Item two asked nurse practitioners if their program encouraged private practice as a viable

alternative to traditional nursing employment. Fifty-eight percent (N = 58) said their program did not encourage private practice, 16 percent had no opinion, and 26 percent said their program did encourage private practice.

Results were similar to Simms' (1977) findings that nurse practitioner programs have not promoted the concept of private practice. In addition, statements by Welch (1985), Brathwaite (1983), and Koltz (1979) that nurse practitioners want nursing schools to provide courses on private practice are supported by the study's results.

Autonomy: Risk Taking and Independence and Responsibility.

Item 15 asked nurse practitioners if they should abide by limits imposed by the medical profession in order to maintain their status. Sixty-eight percent (N = 68) agreed or strongly agreed, 14 percent had no opinion, and 16 percent disagreed or strongly disagreed. Item 16 asked nurse practitioners if they should wait for the medical profession to accept them as independent providers before greater independence and private practice can be attained. Ninety-four percent (N = 94) agreed or strongly agreed, three percent had no opinion, and two percent disagreed.

Nurse practitioners appear to accept limits established by the medical community. This may be related to female socialization characteristics such as passiveness and accommodation. This section tends to add support to Gilbert's (1983) statement that women believe

they cannot be as successful as or perform as well as their male peers. These results are similar to Simmons and Rosenthal's (1981) results about nurse practitioners' views on health care and physicians' relationships. Where they found that nurse practitioners believed that it was necessary for them to abide by limits imposed by the medical profession.

Item 5 asked nurse practitioners if they felt comfortable making independent decisions and taking responsibility for them. Ninety-five percent of the sample either agreed or strongly agreed, the remaining five percent either had no opinion or disagreed. The willingness of nurse practitioners to take responsibility for their decisions are supported by the literature review.

Item 8 asked if private practice provided more autonomy for nurse practitioners. Sixty-nine percent agreed or strongly agreed that it does, 16 percent had no opinion, and the rest disagreed. These perceptions are supported in the literature review by nurse practitioners who were in private practice.

Autonomy: Perception and Behavioral Intent of Private Practice.

Item 24 assessed nurse practitioners perceptions of appropriateness for owning and operating a private practice. Ninety seven percent believed it was appropriate for them to own and operate a private practice

and three percent did not. However, item 25 asked nurse practitioners if they planned to open a private practice within the next five years and only 15 percent said they did while 83 percent said they did not. Four percent (N = 4) claimed to be self-employed in item 12 of part one, but only two of those respondents acknowledged being in private practice in item 25. Thus, accounting for the altered percentage.

The results contradicted those of Koltz (1979), Riccardi (1982), Neal (1982), and Powell (1984) who found that there was resistance in the nursing profession towards opening a private practice. The discrepancy between the results and the statements may have reflected the perceptions of nurses at the time of the writing and not presently. Or, the author's statements reflect nursing at large, but not nurse practitioners.

According to responses to item 25 few nurse practitioners intend to open a private practice with in the next five years. Many reasons may contribute to this fact, without one being more influential then another, including female socialization, unwillingness to take risk and additional responsibility and accountability, lack of private practice instruction and encouragement by nursing schools, and legal issues which can inhibit a nurse practitioner's ability to operate a private practice. In addition, factors which were not explored by this study may contribute to the lack of interest by nurse

practitioners in entering private practice.

Summary

The typical nurse practitioner was 31 to 40 years of age, attended a certificate program as an adult nurse practitioner, had a Master's Degree, worked full-time in a combination in-patient and out-patient basis, and has been practicing for more then six years. Almost all nurse practitioners' surveyed perceive private practice as appropriate, but most do not plan to work in that capacity during the next five years. Nurse practitioners' knowledge of legal issues was low. This may be due to the lack of private practice education by nursing schools and/or the lack of nurse practitioners participating in their professional organizations. The autonomy section revealed that 1) nurse practitioners believed that nurse practitioner programs should teach and encourage private practice; and 2) that nurse practitioners are willing to make independent decisions and accept responsibility for them, but they were also inclined to accept limits established by the medical community.

CHAPTER FIVE

Summary, Conclusions, and Recommendations

Summary

The purpose of this study was to determine: 1) the perceptions of nurse practitioners toward private practice and professional autonomy, and 2) nurse practitioners' behavioral intent towards private practice and professional autonomy. The data collection was achieved with the use of a questionnaire designed by the researcher. The questionnaire divided into two parts elicited demographic data, nurse practitioners' perceptions and behavioral intent and knowledge of private practice and professional autonomy based upon the literature review. One hundred State of Maryland nurse practitioners participated in the study.

Ninety-seven percent of the nurse practitioners believed that it was appropriate for them to own and operate a private practice, but only 15 percent actually intended to enter private practice with in the next five years. The mean score for autonomy was 34.48, with a possible range of scores from zero to 80 (scores were inversely valued). The knowledge section score averaged 19.35 points or 55 percent correct out of a possible 35

points. Nurse practitioners believed (82%) that nurse practitioner programs should incorporate courses about private practice in the curriculum and 58 percent said that they were not encouraged to consider private practice as a viable alternative to traditional nursing employment. Seeking independence and accepting responsibility for decisions was rated very high (95%) for the group. However, they also believed that they must abide by the limits imposed by the medical community (68%) and wait for it to accept them as independent practitioners before more independence and private practice can be achieved (94%). The results cannot be generalized to nurse practitioner populations in other parts of the country because differing state laws may alter the outcome.

Conclusions

Nurse practitioners in the State of Maryland scored poorly on the knowledge section (average correct 55%). In addition only 78 percent knew that they were eligible for third party reimbursement and 77 percent knew that private practice for nurse practitioners in Maryland was not illegal. This lack of or incorrect understanding of legal issues may impact nurse practitioners' perception of practice options in the present or in the future.

Nurse practitioner programs should incorporate courses that promote entrepreneurship and private practice into their curriculum, according to 82 percent of the sample. In another item fifty eight percent of the sample

said their nurse practitioner program did not encourage private practice as an alternative to traditional nursing employment. These results support Welch's (1985), Brathwaite's (1983), and Koltz's (1979) statements that nurse practitioners do want nursing schools to provide courses on private practice. Additionally, Simms' (1977) research support this study's results that nurse practitioner programs do not have courses on private practice.

Sixty eight percent of nurse practitioners believe that they should abide by limits set by the medical community and 94 percent believe that the medical profession must accept nurse practitioners as independent providers before greater independence can be achieved. These results are similar to Simmons and Rosenthal's (1981) study on the women's movement affecting nurse practitioners. A variety of factors may contribute to these results including female socialization and supported by Gilbert's (1983) statement that women believe they cannot be as successful as or perform as well as their men.

A majority (95%) of nurse practitioners felt comfortable making decisions and taking responsibility for them. This perception of willing to take responsibility is supported by the literature review.

Nurse practitioners believe (69%) that private practice provides greater independence for them. These

perceptions are supported by nurse practitioners in private practice in the literature review.

Ninety seven percent of nurse practitioners believe that it is appropriate for them to own and operate a private practice. However, only 15 percent had any plans of actually entering private practice with in the next five years. These results may reflect that nurse practitioners are not educated to consider private practice for themselves, their lack of knowledge about legal and business issues that involve private practice, an unwillingness to take the risk and additional responsibility, or other factors which were not accounted for in this study.

Implications for Nursing

Nurse practitioner programs should include in their curricula those content that will encourage and expose their students to alternative forms of employment in addition to the traditional employment method. This can be accomplished by: 1) establishing a curriculum that includes course(s) and seminars about private practice, 2) providing an environment in the school that promotes private practice as an acceptable and viable method of providing services to the community, and 3) seeking nurse practitioners in private practice to be preceptors for student nurse practitioners.

Most nurse practitioners believe that it is appropriate for them to enter private practice, but do not

intend to enter this employment area themselves. However, they also believe that they should abide by limits imposed by the medical profession and wait for it to grant approval for greater independence and private practice. Nurse practitioners need to achieve greater independence and control over their practice. This will only occur once nurse practitioners mobilize their power base to enact change and achieve independence on their own terms and not allow others to impose limits on attaining greater independence.

Nurse practitioners need to improve their knowledge of issues that directly or indirectly affect them including business, marketing, third party reimbursement, prescription writing, and nurse practice acts. This could be accomplished by participating in professional organizations to change practice constraints, and attending conferences and reading articles that address the legal issues.

Nurse practitioner leaders must become more creative in effectively dispersing information that can affect a nurse practitioners future. If nurse practitioner leaders are successful in changing laws that support nurse practitioners, but unsuccessful in disseminating the information to nurse practitioners then much of the leader's time and effort will be wasted.

Nurse practitioners need to consider and enter private practice as a way to provide independent nursing

services to the community. This method of employment not only benefits nurse practitioners, but the community as well. The community's benefit would come in the form of improved access to health care, greater freedom of choice in choosing a health care provider, and improved cost effectiveness.

Recommendations

The investigator recommends the following for future study:

1) add an item in the questionnaire ascertaining if the nurse practitioner is an active member in their professional organization (local or national);

2) establish validity of the instrument, an alternate study format using interviews of nurse practitioners should be conducted to evaluate in greater depth the discrepancy between the perceptions and behavioral intent about private practice.

BIBLIOGRAPHY

BIBLIOGRAPHY

Agree, B. C. (1974). Beginning an independent nursing practice. American Journal of Nursing, 74(4), 636-642.

American Nurses Association (1955). ANA board approves a definition of nursing practice. American Journal of Nursing, 55(12), 1474.

American Nurses Association (1984). Obtaining third-party reimbursement: A nurses guide to methods & strategies. Kansas City: American Nurses Association.

American Nurses Association (1985a). State legislative report: A quarterly review of legislative activities of interest to the nursing profession. 3(2).

American Nurses Association (1985b). The scope of practice: Of the primary health care nurse practitioner. Kansas City: American Nurses Association.

American Nurses Association (1986). RN ranks grow to nearly 2 million, says HHS: New survey shows 20-percent employment rise. American Journal of Nursing, 86(5), 603-4, 13.

Ashley, J. (1976). Hospitals, paternalism, and the role of the nurse. New York: Teachers College Press, 75-76.

Baker, N. (1983). Reimbursement for nursing services: Issues and trends. In B. Bullough, V. Bullough, & M. Soukup (Ed.), Nursing issues and nursing stratigies for the eighties (pp. 305-311). New York: Spring Publishers Co.

Batey, M., and Holland, J. (1983). Impact of structural autonomy accorded through state regulatory policies on nurses' prescribing practices. Image: The Journal of Nursing Scholarship, 15(3), 84-89.

Beach, K., Fibich, S., & Paparo, D. (1984). The establishment of private nurse-midwifery practice in New York city. Journal of Nurse-Midwifery, 29, 377-385.

Bond, J. & Bond, S. (1986). Sociology and health care. New York: Churchill Livingstone.

Brathwaite, D. (1983). Development of a nursing practice... or so you want to go into private practice? Michigan Nurse, 56(2), 3-5.

Brown, J. (1986). Entrepreneur extraordinaire. Texas Nursing, 60(2), 25-29.

Browning, C. (1982). Private practice handbook: The tools, tactics, and techniques for sucessful practice (2nd ed.). Los Alamilos: Duncliff's International.

Buckenham, J. E. & McGrath, G. (1983). The social reality of nursing. Sydney Australia: Adis Health Science Press.

Bullough, B. (1975). Barriers to the nurse practitioner movement: Problems of women in a woman's field. International Journal of Health Services, 5(2), 225-233.

Bullough, B. (1976). Influences on role expansion. American Journal of Nursing, 76(9), 1476-81.

Bullough, B. (1980). Role expansion: The driving & restraining forces. In B. Bullough (Ed.). The law and the expanding nursing role(2nd ed.). New York: Appleton-Century-Crofts.

Bullough, B. (1983). Prescribing authority for nurses. Nursing Economics, 1(2), 122-125.

Bullough, B. (1984). Legal restrictions as a barrier to nurse practitioner role development. Pediatric Nursing, 10(6), 439-42.

Castiglia, P. T., Brook, M. J., Gorzka, P. A., McKaig, C. S. (1979). The development and operation of a professional nursing corporation. MCN, 4(4), 205-8.

Cohen, H. (1981). The nurses quest for a professional identity. Menlo Park: Addison-Wesley Publishing Co.

Cohn, S. (1983). Survey of legislation on third party reimbursement for nurses. Law, Medicine & Health Care, 11(6), 260-263.

Dachelet, C. Z., Sullivan, J. A. (1979). Autonomy in practice. Nurse Practitioner, 4(2), 15-22.

Davis, A. J. (1982). Ethical issues in nursing. In J. Lancaster & W. Lancaster (Ed.), Concepts for advanced nursing practice: The nurse as a change agent (pp. 216-226). St. Louis: C.V. Mosby Co.

Dayani, E. (1982). Autonomy for nurses through business. Kansas Nurse, 57(3), 18-19.

Dunn, B. H. (1986). Legal regulation of advanced nursing practice. NAACOG Update Serice, 4(8), 1-7.

Freidson, E. (1970a). Professional dominance. New York: Atherton Press, Inc.

Freidson, E. (1970b). Profession of medicine. New York: Dodd, Mead & Co.

Gilbert, L. (1983). Female development and achievement. Issues in Mental Health Nursing, 5(1-4), 5-17.

Goldwater, M. (1982). From a legislator: Views on third-party reimbursement for nurses. American Journal of Nursing, 82(3), 411-414.

Greenidge, J., Zimmern, A., & Kohnke, M. (1973). Community nurse practitioners-A partnership. Nursing Outlook, 21(4), 228-31.

Grippando, G. (1983). Nursing perspectives & issues (2nd ed.). Albany: Delmar Publishers inc.

Grissum, M., & Spengler, C. (1976). Womanpower & health care. Boston: Little, Brown & Co.

Hawkins, J., & Thibodeau, J. (1983). The nurse practitioner: Current practice issues. New York: The Tiresias Press inc.

Henderson, G. (1985). Nurses as risk takers. In J. C. McCloskey & H. K. Grace (Ed.), Current issues in nursing (2nd ed.) (pp. 842-848). Boston: Blackwell Scientific Publications.

Hennig, M., & Jardim, A. (1977). The managerial woman. Garden City: Anchor Press/Doubleday.

Herman, S. J. (1978). Becomming assertive: A guide for nurses. New York: D. Van Nostrand Co.

Hershey, N. (1983). Entrepreneurial practice for nurses: An assessment of the issues. Law Medicine & Health Care, 11(6), 253-256.

Holmes, B. (1985). Private practice in oncology nursing. Oncology Nursing Forum, 12(3), 65-67.

Jacobi, E. M. (1972). Accountability of the nurses: Are there barriers in licensing laws? Speeches Presented during the 48th Convention. Kansas: ANA.

Jacox, A. K. (1969). Who defines and controls nursing practice? American Journal of Nursing, 69(5), 977-982.

Jennings, C. (1979). Nursing's care for third party reimbursement. American Journal of Nursing, 79(1), 111-114.

Kerfoot, K. (1982). Hanging out a shingle: The joys and sorrows of private practice. In M. L. Lynch (Ed.), On your own: Professional growth through independent nursing practice (pp.116-125). Monterey: Wadsworth Health Services Division.

Kinlein, M. L. (1972). Independent nurse practitioner. Nursing Outlook, 20(1), 22-24.

Kinlein, M. L. (1977). Independent nursing practice with clients. Philadelphia: J. B. Lippincott Co.

Koltz, C. (1979). Development & management. Germantown: Aspen Publications.

LaBar, C. (1984). Prescribing privileges for nurses: A review of current law. Kansas City: American Nurses Assocaition.

LaBar, C. (1985). Third-party reimbursement: Status of legislation. Oncology Nursing Forum, 12(6), 53-58.

LaBar, C. (1986a). Filling in the blanks on prescription writing. American Journal of Nursing. 86(1), 30-33.

LaBar, C. (1986b). Third-party reimbursement for services of nurses. In M. Mezey & D. McGivern (Ed.), Nurses, nurse practitioners: The evolution of primary care (pp. 451-470). Boston: Little, Brown & Company.

Latanich, T. S., & Schultheiss, P. (1982). Competition and health manpower issues. In L. Aiken (Ed.), Nursing in the 1980s: Crisis, opportunities, challenges (pp. 419-445). Philadelphia: J.B. Lippincott.

Lewis P. J. (1980). Nurses in private practice. In B. Bullough (Ed.), The Law and the expanding role (2nd ed.) (pp. 156-163). New York: Appleton-Century-Crofts.

Mauksch, I. (1977). Paradox of risk takers. AORN, 25(7), 1289-1312.

Mazey, M. D., & McGivern, D. O. (Eds.). (1986). Nurses, nurse practitioners: The evolution of primary care. Boston: Little, Brown and Company.

Melosh, B. (1982). The physicans hand: Work culture & conflict in American nursing. Philadelphia: Temple University Press.

Mundinger, M. O. (1980). Autonomy in nursing. Germantown: Aspen Publication.

Neal, M. C. (1982). Nurses in business. Pacific Palisades: NURSCO, Inc.

Pearson, L. J. (1986). Nurse practitioners write prescriptions regardless of enabling legislation. Nurse Practitioner, 11(11), 6-7.

Polit, D. & Hungler, B. (1983). Nursing research: Principles and methods (2nd ed.). Philadeplhia: J.B. Lippincott Co.

Powell, D. (1984). Nurses-"High touch entrepreneurs". Nursing Economics, 2(1), 33-36.

Pulcini, J. (1984). Perspectives on level of reimbursement for nursing services. Nursing Economics, 2(2), 118-123.

Rafferty, R., & Carner, J. (1973). Nursing consultants, inc.-A corporation. Nursing Outlook, 21(4),232-35.

Riccardi, B., Dayani, E. (1982). The nurse entrepreneur Reston: Reston.

Rosenfeld, P. (1986). Nursing and professionalization: on the road to recovery. Nursing and Health Care. 7(9), 485-488.

Simmons, R. and Rosenthal, J. (1981). The women's movement and the nurse practitioner's sense of role. Nursing Outlook, 29(6), 371-375.

Simms, E. (1977). Preparation for independent practice. Nursing Outlook, 25, 114-118.

Simpson, I. H. (1979). From student to nurse: A longitudinal study of socialization. New York: Cambridge University Press.

Stanton, M. (1974). Political action and nursing. Nursing Clinics of North America. 9(3),

Stein, L. I. (1967). The doctor-nurse game. Archives of General Psychiatry, 16(6), 699-703.

Sullivan, J. A., Dachelet, C. Z., Sultz, H. A., Henry, M., & Carrol, H. D. (1978). Overcoming barriers to the employment and utilization of the nurse practitioner. Nurses, nurse practitioners: The evolution of primary care (pp. AJPH, 68(11), 1097-1103.

U.S. Bureau of the Census (1985). Statistical abstract of the U.S.: 1986 (106th ed.). Washington, D.C.: U.S. Government Printing Office.

Webster's New World Dictionary (1972). Nahsville: Southwestern Co.

Welch, C. A. (1985). Entrepreneurship in nursing. Oklahoma Nurse, 30(2), 7-9.

APPENDIX A

Questionnaire

NURSE PRACTITIONER'S PERCEPTIONS OF FACTORS RELATED TO PRIVATE PRACTICE

PART I

Please answer the following questions by circling the letter that best represents you.

1. Sex:
   A) FEMALE
   B) MALE

2. Which age group are you in. (CIRCLE ONE)
   A) Under 21
   B) 21-25
   C) 26-30
   D) 31-35
   E) 36-40
   F) 41-45
   G) 46-49
   H) 50-55
   I) 56-over

3. What is your nurse practitioner (NP) specialty?
   A) FAMILY
   B) ADULT
   C) PEDIATRIC
   D) OB/GYN-WOMEN'S HEALTH
   E) OTHER please explain_____

4. What type of nurse practitioner program did you graduate from?
   A) CERTIFICATE (Con't Education)
   B) BACHELOR'S DEGREE
   C) MASTER'S DEGREE
   Year graduated 19___

5. What is your highest level of nursing education completed?
   A) DIPLOMA
   B) ASSOCIATE DEGREE
   C) BACHELOR'S DEGREE
   D) MASTER'S DEGREE
   E) DOCTORATE
   Year graduated 19___

6. How many years have you been a registered nurse?
   A) Under 3
   B) 3-5
   C) 6-10
   D) 10 or more

7. How many years have you been a nurse practitioner?
   A) Under 3
   B) 3-5
   C) 6-10
   D) 10 or more

8. Are you presently practicing as a nurse practitioner?
   A) YES (please go to question 9)
   B) NO (please go to question 10)

9. As a working NP is your practice:
   A) FULL-TIME
   B) PART-TIME

10. How would you describe your job status as a nurse?
   A) EMPLOYEE (please go to question 11)
   B) SELF-EMPLOYED (please go to question 12)
   C) NOT PRESENTLY WORKING AS A NURSE

11. If you are employed, where do you work?
   A) HOSPITAL / IN PATIENT
   B) HOSPITAL / OUT PATIENT
   C) DOCTORS OFFICE
   D) HMO
   E) CLINIC / RURAL or URBAN
   F) OCCUPATIONAL HEALTH
   G) PUBLIC HEALTH / HOME HEALTH
   H) OTHER (PLEASE SPECIFY)_____

IF YOU ANSWERED QUESTION 11 THEN PLEASE GO TO PART II

12. If self-employed, what form of practice?
   A) PARTNERSHIP WITH DOCTOR
   B) PARTNERSHIP WITH NURSE
   C) SOLO PRACTICE
   D) OTHER (PLEASE SPECIFY)_____

13. If you are self-employed your income is based on:
   A) A SALARY GUARANTEED BY THE PRACTICE
   B) THE NUMBER OF PATIENTS I SEE
   C) MINIMUM SALARY GUARANTEE AND THE NUMBER OF PATIENTS I SEE

PLEASE CONTINUE TO
PART II

PART II: The following pages contain statements pertaining to private practice. Please circle the number that most closely matches your own belief regarding the statements below. When answering the questions refer to the following definition:

Private practice is an enterprise owned & operated (solo or joint) by a nurse practitioner which enables him/her to directly contract with a client (individual, group, or corporation). The client agrees to directly reimburse the nurse practitioner for professional nursing services rendered. The nurse practitioner assumes responsibilities that go along with owning & operating a business.

Key:
1-strongly agree(**SA**); **4**-disagree(**D**);
2-agree(**A**); **5**-strongly disagree(**SD**);
3-neutral/no opinion(**N**);

NP= nurse practitioner

	SA	A	N	D	SD
1) Nursing schools should incorporate courses which promote entrepreneurship and operating a private practice in NP curriculum.	1	2	3	4	5
2) My NP program encouraged me to consider entering private practice as a viable alternative to traditional nursing employment.	1	2	3	4	5
3) I would feel comfortable asking my clients for money if I was in private practice.	1	2	3	4	5
4) My clinical skills are good enough to enter private practice.	1	2	3	4	5
5) I feel comfortable making independent decisions and taking responsibility for them.	1	2	3	4	5
6) I would feel comfortable referring patients to a NP in private practice.	1	2	3	4	5
7) NPs in private practice can offer a greater variety of nursing services than the NP employed in the traditional way.	1	2	3	4	5
8) Private practice provides more autonomy for the NPs.	1	2	3	4	5
9) I do not know how to get a private practice started.	1	2	3	4	5
10) NPs in private practice receive more respect from other nurses and doctors then NPs employed in traditional ways.	1	2	3	4	5

	SA	A	N	D	SD
11) NPs should open private practices only where there is a shortage of physicians.	1	2	3	4	5
12) NPs and physicians are professional colleagues.	1	2	3	4	5
13) NPs should be eligible to receive third-party reimbursement.	1	2	3	4	5
14) Physicians should supervise NP prescription writing before they are given to the client.	1	2	3	4	5
15) NPs should abide by limits imposed by the medical profession in order to maintain their status.	1	2	3	4	5
16) NPs should wait for the medical profession to accept them as independent providers before greater independence and private practice can be attained.	1	2	3	4	5
17) NPs are eligible for private third party reimbursement in the state of Maryland.	YES		NO		UNK
18) NPs are eligible for Medicaid reimbursement in the state of Maryland.	YES		NO		UNK
19) NPs are eligible for Medicare reimbursement by the federal government.	YES		NO		UNK
20) NPs are eligible for reimbursement by the Civilian Health and Medical Programs of the Uniformed Services.	YES		NO		UNK
21) NPs are eligible for reimbursement by the Rural Health Clinic Services Act.	YES		NO		UNK
22) NPs are permitted to prescribe medications in the state of Maryland.	YES		NO		UNK
23) Maryland's nurse practice act make it illegal for NPs to open a private practice.	YES		NO		UNK
24) It is appropriate for NPs to own & operate their own private practice.	YES			NO	
25) I'm considering opening a private practice in the next five years. (place an "X" next to the question number if you are already in private practice)	YES			NO	

APPENDIX B

Preliminary Postcard

Dear Nurse Practitioner,

I am a nurse practitioner student at the Medical College of Virginia/Virginia Commonwealth University. In the next few days you will be receiving a questionnaire in the mail about nurse practitioners' perceptions of private practice. I am requesting that you complete the questionnaire and mail it as soon as possible. Further information will accompany the questionnaire.

Sincerely,

Steven Mitnick, R.N., BSN

APPENDIX C

Cover Letter

August 20, 1987

Dear Nurse Practitioner,

I am a registered nurse completing a master's degree as a nurse practitioner at the Medical College of Virginia/Virginia Commonwealth University. Presently, I am conducting a research project as part of my requirements for graduation. The purpose of the study is to determine nurse practitioners' perceptions of owning and operating a private practice and being directly reimbursed by the client.

Your name was chosen from a list of nurse practitioners supplied by the Maryland Board of Nursing. Enclosed is a questionnaire and self-addressed stamped envelope. I am asking that you spend 10-15 minutes filling out the questionnaire and mailing it back to me as soon as possible. The questionnaire is not coded nor does it contain your name thus all responses will be anonymous. By returning the questionnaire you are consenting to participate in the study and understand that there is no risk nor direct or immediate benefit to yourself. You may withdraw from the study at any time, without adverse effects, by supplying your own code number on the questionnaire and contacting me. All questionnaires will be destroyed at the end of the project.

The questionnaire is divided into two parts. Part one consists of demographic questions; part two covers your perceptions about private practice for nurse practitioners.

I would like to thank you ahead of time for spending a few minutes in answering the questionnaire. If you have any questions or comments please feel free to contact me at MCV/VCU School of Nursing [redacted]

Sincerely,

Steven Mitnick, RN, BSN

VITA