

**An exploration of empowerment from the  
perspective of Irish nurses and midwives**

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perspective of Irish nurses and midwives

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the degree of Master of Science (Research)

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I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of Master of Science (Research), is entirely my own work and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work.

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## **Abstract**

Empowerment is a complex and multifaceted construct. It is understood to be a perception of ability that can be influenced by numerous factors. Due to the subjective nature of human perception, there is a potential for empowerment to mean different things to different people. Empowerment theory is also equally diverse. Several research approaches have attempted to measure empowerment. Most of these have assumed its meaning which is problematic given the fact that empowerment is interpreted at the level of the individual. Zimmerman (1995) asserts that empowerment is contextually determined. Because nurses and midwives, practice in complex environments, it is also possible that these contexts impact on their perceptions of empowerment.

This study aimed to explore perceptions of empowerment amongst ninety-three nurses and midwives. Ten focus groups were held across Ireland with representation sought from five branches of nursing and of midwifery. In total, ten themes emerged from the data, one antecedent theme, three empowerment themes and six impacting themes. Empowerment was found to consist of inherent beliefs of control, personal power and professional respect. Education for practice was found to be antecedent to inherent empowerment beliefs. Six impacting factors were also identified which determine empowerment beliefs. These are organisational factors, management, professional issues, interpersonal issues, individual factors and historical legacy.

The findings, while reflecting aspects of empowerment theory and research, suggest that empowerment is conceptualised more broadly by Irish nurses and midwives than previously thought. Education for practice as antecedent and professional respect as an inherent empowerment belief are new findings as is having a clearly defined role and willingness for empowerment. This study supports the view that empowerment is complex and contextually determined and as such, contributes to current understanding surrounding the meaning of empowerment amongst practising nurses and midwives in Ireland.

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# 1 CHAPTER ONE - LITERATURE REVIEW

## 1.1 Introduction

*“ There is much talk of “empowerment” as the vehicle for bettering personal lives. This [empowerment] is a badly misused construct that has become heavily infused with promotional hype, naive grandiosity and virtually every brand of political rhetoric”*

*Bandura 1997, p 476*

There is clear evidence to suggest that there is an official mandate to empower nurses and midwives in Ireland, particularly in the last decade. (Department of Health and Children 2000). Indeed Chavasse (1992) argues that patients cannot be empowered unless nurses (and midwives) are empowered first. However, as Bandura suggests, empowerment is a complex concept and remarkably few attempts have been made to enhance clarity of understanding surrounding this term despite its prevalence in the literature. Indeed, some authors state that empowerment is more identifiable by its absence (Kieffer 1984). There is evidence to suggest that there is a diversity of conceptualisations surrounding empowerment. This is broadly attributable to the differing perspectives in which empowerment is viewed. The multiplicity of definitions has served also to contribute to the ambiguity of understanding regarding empowerment (Nytanga and Dann 2002). Reference to a “one-size-fits-all empowerment” and highlighting how organisations can ‘manage it better’ suggests that many clearly do not appreciate the interpretative nature of the empowering experience (Forrester 2000). Another feature of the empowerment literature is its inherent positive bias. This is perhaps due to an assumption that empowerment, in the main, is viewed as a positive entity (Kuokkanen and Leino Kilpi 2000).

The following review seeks to provide some clarity regarding current conceptualisations of empowerment in the literature. This review begins by exploring related concepts of power and control.

### **1.1.1 Perspectives of power/control**

It seems near impossible to speak of empowerment without raising issues about power and control (Conger and Kanungo 1988, Ryles 1999). According to the Oxford English Dictionary (1989), empowerment involves an investment of power. Whilst this definition suggests that power to act is inextricably linked with empowerment, it fails to clarify (a) what power consists of, (b) who is the 'investor' of such power. There are two main perspectives from which power can be conceptualised. These are further expounded below.

More commonly, power (in relation to empowerment) and its investor are viewed as external to the person. Most of the organisational literature suggests that empowering power comes in the form of legitimate authority to make decisions in the workplace (Huczynski and Buchanan 2001). This means that the power (as it is understood from an organisational standpoint) is something that is invested (usually by a manager) in their employees. Empowerment by delegation in this manner assumes that giving employees decision-making power is empowering them. This form of empowerment is clearly evident in literature that conceptualises power in this way (O' Conaill, 2000, Forrester, 2000, Department of Health and Children 2000). Viewing power in this way could be viewed as a somewhat narrow perspective as it negates the individual's desire or abilities regarding decision-making power.

It is possible to use a monetary analogy to explain the relationship between power and control. If power is viewed as a currency, control is perhaps what can be 'bought' due to the possession of

this currency. From an organisational perspective, authorisation is viewed as power from which decision-making (control) can result. Perhaps, like currency, it is commonly assumed that power in this way is desired, and that those who have more are better off.

In contrast to the view of power outlined above, it is also possible to suggest that the locus of power can come from within the person. In this way, the individual is the 'investor' of power by investing a sense of efficacy in themselves enabling them for example, to believe that they can make decisions in a workplace. This is done primarily through interpretation (Thomas and Velthouse 1990). This view of empowerment by self-enablement is primarily evident in the psychology literature (Spreitzer 1996). The individual could solely generate this interpretation of power although it is more plausible to suggest that the social environment plays a crucial role in the individual's interpretation of power or otherwise (Berger and Luckman 1966). This acknowledgement of external sources impacting on individuals' interpretation of power within a workplace setting is reflected in some management strategies which, unlike delegating power down to employees, seek to enable workers by motivational strategies, thus encouraging a positive perception of ability and control (Conger and Kanungo 1988, Huczynski and Buchanan 2001). Considering power from this perspective, its relationship to control seems dependent on the perceptions of the individual. Perception, involves the interpretation of situations, and is somewhat subjective (Sperling 1980). Whilst Thomas and Velthouse (1990) some years ago, identified the subjectivity of individual interpretation in relation to empowerment, little attention has been paid to the subjectivity of the empowering experience.

Lukes (1974) highlights that the ultimate exercise of power is the ability to cause others to have the beliefs and desires of the more powerful. Lukes interpretation of power reflects Bandura's

(1997) skepticism of using empowerment as a vehicle under the guise of improving peoples situations yet potentially infused with alternative agendas. Powers (2003) also reflects this viewpoint.

Considering the above perspectives from which to view power and its product – control, it is posited that it is necessary to consider both perspectives of power (i.e. internal and external) in order to achieve a clearer understanding of the meaning of empowerment. The following section explores current theories and research on empowerment using the perspectives on power outlined above.

## **1.2 Theoretical and empirical literature**

Several theories of empowerment are identifiable from the literature. As indicated above, power and control are related features of empowerment apparent in all of the theoretical literature (Freire 1972, Kanter 1993, Conger and Kanungo 1988, Thomas and Velthouse 1990, Gibson 1991, Ryles, 1999). How each theory defines the locus of such power and control are where the differences become evident. This also reflects their origin (from organisational theory, psychology and critical social theory). Four main theoretical perspectives are reviewed in this section. Relevant empirical research is reviewed also.

### **1.2.1 Organisational theory perspectives**

The view of empowerment from an organisational theory perspective views empowerment as external to the person and emphasises the importance of organisational structures on the

empowering experience of the individual employee. Most of the literature views empowerment in this fashion. Organisational structure refers to the processes controlling employees work relationships and productivity (Huczynski and Buchanan 2001). Traditionally, organisational structures have been characterised by a hierarchical, highly centralized decision making processes (Huczynski and Buchanan 2001). Many Irish hospitals functioned using this method of operation. It is interesting that this form of structure was dominant in hospitals as there is a need, for example, for doctors to make medical judgements etc about patients. The potential for conflict in this area seems apparent. However, this form of organisation is currently being reformed in an effort to increase productivity and efficiency. This is evident in the new Irish Health Strategy, which seeks to promote more autonomous groups of professionals by devolving decision making downwards (Department of Health and Children 2001).

Kanter's theory of structural power defines empowerment as "control over conditions that make actions possible" (Kanter 1993, p.166). This control is solely facilitated by organisational structures. This theory also formed the framework for the largest body of research exploring empowerment amongst nurses. Whilst her definition of empowerment is similar to the tentative definition offered in the abstract, Kanter (1993) in her theory of structural power suggests that power and control are solely located within organisational structures. Kanter's theory is based on an ethnographic study of a large profit oriented organisation in the United States, which she conducted in the late 1970s. This will be reflected upon in the review of the empirical work stemming from this theory, which was extensively tested on nurses. Kanter (1993) defines empowerment as "Control over conditions that make...actions possible" p.166. Three main determinants impact on the degree of structural power an individual achieves within an organisation; power, opportunity and proportions.

Two main sources of power are evident – formal and informal power. Formal power relates to the individuals actual rank within an organisation and is found in jobs, which are visible, central to the purpose of the organisation, and as a result, allows for some discretion in decision-making. Informal power relates to informal structures (such as goodwill), which enables employees to carry out their jobs effectively. Other structural determinants (opportunity and proportions) are also thought to affect an employee's capacity for effectiveness. Opportunity relates to promotional opportunities, where employees could advance within their own organisation. The future orientatedness of opportunity is distinct from job satisfaction, which relates to the employees' current opinion. Proportions refer to the ratio of men and women working in an organisation. The minority gender group is thought to be advantaged in relation to structural power.

The fact that this model is theory based is useful in providing a view of empowerment from an organisational perspective. Critique of this theory lies with its unilateral assumption that environmental or organisational factors alone are responsible for bringing about 'empowerment' of employees.

As highlighted earlier, a body of work exists which can be traced to Kanter's theory of structural power. Heather K. Spence Laschinger, principal investigator at the University of Western Ontario, Workplace Empowerment Research Program (WERP)(1992-2001) conducted over thirty studies utilising Kanter's theory of structural power on nurses in exploring empowering factors within the organisation. Most of these studies were conducted on Canadian nurses. Building from the work of Chandler (1991), who originated a conditions for work effectiveness questionnaire (CWEQ) based on Kanter's theory, Laschinger and her team added two more

scales to measure formal and informal power. The job activities scale (JAS) measures formal power and the organisational relationships scale (ORS) measures informal power (Laschinger 1996). According to Laschinger (1996), the higher the scores rated on these scales, the higher the person has access to work empowerment structures. A global empowerment measure has also been developed (GE). This consists of two questions in which the mean score of the factors within the CWEQ (opportunity, information, support and resources) represents the measure of empowerment amongst respondents Laschinger and Wong (1999).

It is notable that almost all of the research studies, which utilize the questionnaires devised from Kanter's model, indicate that their samples are 'moderately empowered' (e.g. Wilson and Laschinger 1994, Laschinger et al 1997, Laschinger et al 2000a, Laschinger et al 2001). This remains despite variations in samples selected. It has not been possible to isolate any research, which has found a population to be empowered or not empowered. For example, Laschinger and Wong (1999) surveyed 672 randomly selected nurses from a Canadian medical centre. Recognising the high response rate from this survey (71%), which may suggest a very enthusiastic respondent population, it was found that respondents were moderately empowered. Similarly, another study by Laschinger et al (1997) consisted of a two-phase survey of practitioners in two separate hospitals. Both sets of participants were reported to be 'moderately empowered' i.e. having moderate access to work empowerment structures; resources, information, support and opportunity. The possibility of gender bias response from this tool has also been explored and disproved. Laschinger et al (2001a) tested a sample of equal weighting of male and female nurses (300 of each) that had similar findings.



This trend of 'moderate empowerment' is not isolated to work undertaken by the WERP in Canada either. As measured by the CWEQ, 75 physical therapists were surveyed and also found to have a moderate degree of empowerment (Miller et al 2001). Although the majority of research studies were conducted in Canada, the trend of moderate empowerment using the CWEQ and its associated tools does not seem to be culturally bound either. In Ireland, Scott et al (2003) surveyed 3,854 nurses and midwives utilising the CWEQ, ORS and JAS from six different branches of nursing and midwifery. They found that nurses and midwives were also moderately empowered. A correlation comparative study between the United States and Norway also found both groups to have scores suggesting 'moderate empowerment' (Ellefsen and Hamilton 2000). Although worthwhile in establishing a large body of work surrounding organisational characteristics and empowerment, it is reasonable to question the general trend of similar results across multiple studies and populations. Although generalisability is a desirable trait, particularly in quantitative studies, caution should be exercised when interpreting findings from a tool, which perhaps, does not adequately measure a complex phenomenon such as empowerment. According to Kanter, a third determinant of 'numbers' or proportions between men and women in an organisation impact on the individual's access to structural power and empowerment in the organisation. It is notable that this is absent from the CWEQ questionnaire. Haugh and Laschinger (1996) state that "As nursing is a predominantly female profession, the latter structure is not relevant to the study" p.43. This is questionable as there are clear indicators that minority genders in nursing occupy a disproportionate amount of managerial positions in nursing (Department of Health and Children 2002, Scott et al 2003).

Nurses seem to have higher levels of informal power than formal power in the work place setting (Laschinger et al 2000a, Scott et al 2003). This may suggest that nurses rely on informal

structures and collaboration with others rather than being overtly visible and having discretionary decision-making latitude. In one study comparing Norwegian and American nurses (n=825), those with higher educational levels had higher levels of formal power (Ellefsen and Hamilton 2000). This may suggest that education plays a part in having formal authority within an organisation.

### **1.2.2 Management/psychological theory perspectives**

The seminal work of Conger and Kanungo (1988) sought to merge current opinion between management and psychological theory perspectives on empowerment. Conger and Kanungo (1988) define empowerment as

*“A process of enhancing feelings of self-efficacy among organisational members through the identification of conditions that foster powerlessness and through their removal by both formal organisational practices and informal techniques of providing efficacy information” (p. 474)*

Conger and Kanungo preferred to view empowerment more as a motivational construct initiated by management intervention. They devised a five stage process model of empowerment. The first stage of this process places the onus on a manager to identify conditions, which they determine to be powerless. They highlight a number of areas where this potential powerlessness could arise. These are represented below.

<i>Context factors leading to potential lowering of self-efficacy belief</i>		
<b>Organisational factors</b>	<b>Supervisory style</b>	<b>Job design</b>
Significant organisational changes/transitions	Authoritarian (high control)	Lack of role clarity
Start-up ventures	Negativism (emphasis on failures)	Lack of training and technical support
Competitive pressures	Lack of reason for actions/consequences	Limited participations in programs, meetings and decisions that have a direct impact on job performance
Impersonal bureaucratic climate	Reward systems	Lack of appropriate/necessary resources
Poor communications/network forming systems	Noncontingency (arbitrary reward allocations)	Highly established work routines
Highly centralised organisational resources	Low incentive value of rewards	Lack of meaningful goals/tasks
	Lack of competence based rewards	
	Lack of innovation based rewards	

**Table 1. Contextual sources of powerlessness as highlighted by Conger and Kanungo**

*(1988, p 477)*

The second stage of Conger and Kanungo's process model of empowerment involves the manager using various management strategies (participative management, goal setting, feedback system, modeling, contingent/competence based rewards and job enrichment). Effective use of these strategies, coupled with the removal of the predetermined conditions of powerlessness (as perceived by the manager) is expected to result in an empowering experience on behalf of the employee. The expected outcome of this process is behaviour change characterised by enhanced productivity. However, it is possible to assert that removing factors to prevent job dissatisfaction do not necessarily promote growth and motivation (Bowditch and Buono 1997, p. 90).

Unlike the previous theory, Conger and Kanungo acknowledge the importance of the individual's perception of their own power and self efficacy. However, their theory defines empowerment as a process in which beliefs in self efficacy are enhanced, not as the actual individual's belief. One could question their assumption that managers have the capacity to detect sources of employee powerlessness. The empowering experience of the individual (enhanced self-efficacy) is one of the stages in their process view of empowerment. It is also notable that the final stage in this theory represents a desired outcome (for the manager).

This view of improved productivity as an outcome of empowerment is an interesting trend, which is evident predominantly amongst the management literature. The manager must make use of the employees full potential, to encourage participation at all times (Steers et al. 1996). It is commonly assumed that 'empowered' employees result in a more productive (and potentially profitable) workplace (Forrester 2000). Delegation of decision-making power is the most commonly used strategy to 'empower' staff (Huczynski and Buchanan 2001). The recent Irish Health Strategy (Department of Health and Children 2001) plans to use this method to empower their workforce (who are predominantly nurses and midwives). The aim of the competency framework for nursing management is also comparable (Office for Health Management 2002). There are several fundamental difficulties inherent with this method. The perspective of inducing empowerment simply through delegation is a somewhat narrow view (Conger and Kanungo 1988). This is due to the lack of clarity surrounding what is delegated. Secondly, assuming that employees desire decision-making power and will be productive following its implementation is also problematic. Powers (2003) asserts that it is possible to view empowerment as a strategy for coercion. Although it is not suggested that any of the literature sources contain coercive strategies, it is suggested that inducing empowerment through

implementation of pre determined management methods should be viewed with caution. This is primarily because most management methods assume the meaning of empowerment (as delegated decision making power) and thus fail to recognise that this view of empowerment may not be shared by all.

### **1.2.3 Constructivist approaches to empowerment**

Unlike the previous theoretical approaches outlined, constructivist approaches accept that reality is socially constructed by the perceiver (Berger and Luckman 1966, O'Dowd, 2003). A discussion of empirical work that ascertains constructions of empowerment from the view of the person experiencing empowerment (employee perspective) is also presented. It is notable that empowerment conceptualisations from constructivist approaches illustrate multidimensional and complex elements of empowerment from the individual's perspective supporting the notion that empowerment is not a simple concept. Thomas and Velthouse (1990) highlighted the element of individual interpretation and judgment of events as central to empowerment theory. A sense of meaningfulness, competence, self-determination and impact are judged as perceived empowerment. Their "alternative theoretical perspective" uses the terms evaluation, attribution and envisioning, illustrating that individuals (employees) perceive situations considering past, present and future events within a work setting.

It is interesting that the underestimation of the complexity of empowerment from the constructivist perspective is acknowledged by those who attempt to utilise qualitative methodologies to explore empowerment perceptions (Shields, 1995, Foster Fishman et al 1998, Kuokkanen and Leino Kilpi 2001). Kuokkanen and Leino Kilpi (2001) explored the ideal

qualities of an empowered nurse using interviews with nurses who considered themselves empowered practitioners. Five categories emerged; moral principles, expertise, personal integrity, future orientation and sociability from interviewing nurses (n=30) who considered themselves 'empowered' practitioners. The category moral principles reflected the rhetoric of nursing and midwifery practice which is based on enabling patients to have involvement in or control over aspects of their care. Expertise was associated closely with being educated appropriately and having the skills to practice effectively. This is comparable with the notion of competence (Thomas and Velthouse 1990, Spreitzer 1996). Autonomy and the ability to make decisions were also felt to be part of the expertise category of an empowered nurse. Future orientatedness refers to the ability of the nurse to be innovative and think about the future impact of one's work. This links somewhat with envisioning outlined by Thomas and Velthouse (1990). Having social skills were also found to be qualities of empowered nurses. The category of personal integrity was felt to represent personal qualities such as courage and self-esteem, which were also felt by participants to be important constituents of an empowered nurse. What was interesting about this study was that the authors reported that the nature of the data and subsequent themes which emerged resulted in the original thematic framework being abandoned. Kuokkanen and Leino Kilpi initially sought to explore beliefs about what an empowered nurse is like, how an empowered nurse acts along with highlighting preventing and promoting factors. They found that the five themes (moral principles, personal integrity, expertise, future orientatedness, and sociability) embodied all of their research questions and as such, could not be attributable to any one research objective. For example, their theme personal integrity was conceptualised by nurses as an empowering quality, a facet of empowered behaviour, and aspects relating to personal integrity were evident as promoting and inhibiting factors for empowerment. The discovery of this mirroring effect suggests that perhaps no one factor

'promotes' or 'prevents' empowerment. It is the application or emphasis of such factors in given contexts, which could potentially determine empowering experiences.

It is also notable that in the only two qualitative studies exploring empowerment from a nurses' perspective, the confounding effects of the environment have been highlighted (Fulton 1997, Kuokkanen and Leino Kilpi 2001). This is further illustrated in quantitative approaches that cross tabulate job satisfaction and organisational commitment with perceptions of empowerment (Scott et al 2003, Kuokkanen et al 2003). Triangulating with their previous exploratory approach, Kuokkanen et al (2003) also found that 51% of their population surveyed felt empowered (n=416) and 15% felt that they were not empowered. These findings are of note as they differentiate between nurses who say that they are empowered (or not) when compared with other tools devised from a non-participant definition of empowerment (Chandler 1991, Laschinger 1996).

#### **1.2.4 Social psychology perspectives**

Some research has been conducted testing the theoretically derived tenets of meaning, competence, self-determination and impact as determined by Thomas and Velthouse (1990). The sum of these tenets is referred to as a psychological empowerment (Spreitzer 1995). Significant relationships between these tenets and psychological empowerment have been tested and validated using survey methodology developed from Thomas and Velthouse's work (Spreitzer 1995, Spreitzer 1996, Mok and Au Yeung 2002). Spreitzer's research (1995) also found that self-esteem was positively related to empowerment. Whilst her sample was constituted of employees from two profit oriented organisations (n=521), her findings could be

potentially generalisable to a nursing population due to the nature of the tenets studied. This is evident in recent research amongst a nursing population which has combined measures of psychological empowerment with structural empowerment (Laschinger et al 2001).

Rappaport (1987) and Zimmerman (1995) assert that empowerment is a multilevel construct which means that each level impacts on and is impacted by each other (interdependent). Zimmerman (1995) stated that people, contexts and times impact on empowerment perceptions. He also argues that psychological empowerment has domain specific limitations. From a nursing/midwifery perspective, this means that the control beliefs and efficacy beliefs necessary to empower nurses and midwives are clearly different from say, control beliefs for empowered bank clerks. As a result, Zimmerman (1995) asserts that it is not feasible to develop a universal measure of empowerment given these limiting factors. This may explain some potential difficulties in utilising tools to measure empowerment, which do not originate from a nursing and/or midwifery context (see section 1.2.1 above). Zimmerman's (1995) view strengthens the thesis that empowerment research is best conducted from the perspective of the person experiencing it.

### **1.2.5 Critical social theory perspective**

Critical social theory asserts that phenomena cannot be understood without considering the history and structure within which it is found (Freire 1972, Fay 1996, O' Dowd 2003). This theory suggests that oppressed groups behave in a particular fashion. Whilst communication is key to the basis of this theory (Habermas 1987), it is the awareness of the (oppressive) situation which is crucial to the liberation of oppressed persons (Freire 1972, Porter 2003). Freire (1972)



posits that oppressed people's perceptions of reality are clouded by their submersion in the contextual reality of the oppressive situation. Fulton (1997) utilised this theory to conduct two focus group discussions to unearth nurses' conceptualisations of empowerment from a critical social theory perspective (n=16). Whilst it must be noted that this research was undertaken with students undertaking a postgraduate education programme, the findings offer interesting insights into conceptualisations of empowerment from nurses when viewed as an oppressed group. Four categories emerged from the data; empowerment, having personal power, relationships with the multidisciplinary team and feeling right about one's self. Nurses in this study conceptualised empowerment as freedom to make autonomous decisions, and having choice. It is interesting to note that power was conceptualised as internal and external to the person. As highlighted in section 1.1.1 above, it is difficult to consider power and indeed empowerment from one perspective. A lot of negative examples of powerlessness were unearthed, particularly in relation to unequal power relationships with doctors. Factors such as lacking confidence, self esteem and being fearful were voiced by participants as disempowering. This also suggests that environmental factors can clearly impact on individual perceptions. Fulton found that the participants in her study did not seem to have an insight or critical awareness of powerless situations. This is an important finding in her study, as liberation is deemed impossible without awareness of an oppressive situation (Freire 1972).

### **1.3 Irish nursing and midwifery**

In Ireland, the impetus for nurses and midwives to be empowered and achieve their 'full potential' has gained momentum particularly in the last decade. This has, in the main, been perpetuated by the Report of the Commission on Nursing (1998) which, while commissioned to avert national strike action, resulted in the production of a document that was to radically change the shape of nursing and midwifery. From this document, new and sweeping changes were signaled. These changes were primarily geared towards changing current practice and future nurse and midwife education. In current practice, new pathways of progression emerged which were previously non-existent. The roles of Clinical Nurse Specialists and Advanced Nurse Practitioners emerged. New management structures were operationalised, which introduced three levels of unit managers. Long service for nurses and midwives was recognised by remuneration. Future nurse education was also signaled to move to degree level, a move completed in 2003. All of the structural changes highlighted above have been supported and funded by the Government. This suggests that the Government is in favour of empowering the profession through improving its structures and educational status (with the current exception of midwifery, which has yet to progress). In relation to the perspectives of power and control highlighted earlier in this chapter, it seems that a somewhat external view of empowerment is evident (empowerment by delegation) in relation to nurses and midwives.

It is suggested that the nature of nursing practice and its supporting legislation, policies and professional bodies potentially impact on nurses' and midwives' perceptions of empowerment. Nurses and midwives practice in complex institutions and what they are authorised to do clearly varies depending on the type of organisation and the health status of the patient/client (An Bord

Altranais 2000a). An Bord Altranais (the Irish nursing board) has attempted to address this by developing documentation to clarify the scope of nursing and midwifery practice (An Bord Altranais 2000a). Using a consultative approach An Bord Altranais surveyed every nurse and midwife on the Irish register (59,010 - The Nursing and Midwifery Resource 2000 p.73). This resulted in the creation of a framework that should enable nurses and midwives practice more effectively.

It is clear that nursing and midwifery has undergone substantial change particularly in the last ten years. Empowering the profession through career restructuring, educational advancement, role clarity and devolution of decision making are clearly evident from a policy perspective (Report of the Commission on Nursing 1998, Department of Health and Children 2001). This perspective of power and indeed empowerment is viewed primarily as external to the person. The overlooking of the interpretative nature of empowerment, according to the author, provides a somewhat prescriptive view of empowerment that runs the risk of, in Bandura's words being "heavily infused with promotional hype" (Bandura 1997). The quality of nursing and midwifery practice rests on gaining a 'narrative understanding' of patients (Edwards 2000). This means it is necessary to understand and appreciate things from a patient's perspective in order to clarify meaning and effectively work together. It is probable that in relation to nurses and midwives, a 'narrative understanding' of the concept of empowerment has yet to be achieved.

## 1.4 Conclusion

From this review of the literature, the main conclusion to be reached in relation to empowerment is that the concept is clearly complex and multifaceted. This has been demonstrated through multiple conceptual analyses and research studies. It does not seem possible to have an understanding of the notion of empowerment without considering two closely related concepts of power and control. Empowerment appears to involve the investment of power to act and is predominantly assumed to be a positive entity. Those who view empowerment from an organisational theory perspective view power as something external to the person, which can be delegated. The most common form of power, which is delegated, seems to be decision-making power. The organisational theory perspective is felt to be a rather narrow view as it is impossible to separate the individual's perceptions from the social environment (which in this case, is the workplace). Similarly the opinion and desire of the individual worker seem to be overlooked using this approach. Much research has been conducted on nurses using this perspective. The consistent scoring of moderate empowerment is a concern with this measurement tool. The view of empowerment from a management/psychological perspective begins to acknowledge the capacity of the individual to interpret situations. However, the focus of this theory is a management strategy, to motivate individuals to believe in their own self-efficacy along with removing conditions of powerlessness. This strategy is felt to be quite management orientated and is not research based. Constructivist approaches attempt to explore empowerment from the individual's perspective. Consensus regarding empowerment being more complex than previously thought was evident which supports the thesis that empowerment is a complex entity. One study explored nurses' perceptions using exploratory methods. Critical social theory perspectives emphasise the impact of history and structure on empowerment conceptualisations.

One study utilised this framework, asserting that nurses are an oppressed group. The fact that participants lacked critical awareness of their situation was particularly interesting. What seems clear is that there is a paucity of research exploring empowerment from the perspective of nurses. No research to date has used a generic approach including all branches of nursing (and midwives) to elicit a common understanding of empowerment.

A brief overview of recent attempts to empower the nursing and midwifery profession illustrates that there are concerted efforts from a policymaker's perspective to improve nursing and midwifery practice. However, the fact that the majority of these efforts have lacked a participatory process illustrate that there is a potential for empowerment assumptions (on behalf of the policymakers) and empowerment beliefs (on behalf of nurses and midwives) to be different.

The purpose of this study aims to address this potential gap by eliciting practising nurses' and midwives' conceptualisations of empowerment in the Irish practice setting. Factors, which may contribute to or mitigate against empowerment, according to nurses and midwives will also be explored.

## **CHAPTER 2**

### **EXPLORING EMPOWERMENT**

## 2 CHAPTER 2 - EXPLORING EMPOWERMENT

### 2.1 Methodology

*“Thinking about...empowerment suggests that we need to research the phenomena by studying how empowerment is actually experienced by those individual people who express the sense that they are, and are not, in control...and by studying the mediating structures in which they reside”*  
Rappaport (1987), pp135

As previously highlighted in the literature, it appears that the construct of empowerment has multiple definitions and conceptualisations. In the majority of empirical studies conducted, the organisations or researcher’s construction and subsequent definition of empowerment seem to have been utilised (Foster-Fishman et al 1998). As a result, there is a potential for the empowerment experiences and definitions to differ between participants and researcher thus potentially affecting the authenticity of the findings. Due to the variations in the literature in what is understood as empowerment, it was felt that utilising a qualitative exploratory approach to explore empowerment would result in a more, in-depth understanding of the phenomenon, whilst providing a realistic framework from which to base possible further study. Qualitative approaches are concerned with unearthing meaning in context (Denzin and Lincoln 2000, Daly 2003). This study is primarily concerned with nurses’ and midwives’ understanding of the meaning of empowerment in practice. Given the fact that empowerment has not previously been researched from the perspective of nurses and midwives in the Republic of Ireland, would also make this study somewhat exploratory in nature, as there is a dearth of comparative studies. It is hoped that the findings of this study, using an interpretive research method, would result in a

greater understanding of empowerment from participants' perspective (Gantley et al 1999, Morgan and Spanish, 1984).

Secondly, as outlined in the literature reviewed, there appears to be a tendency for researchers to define empowerment as a singular entity, tailored to suit the paradigm for which the research is intended. It has been highlighted that power and control can be viewed as internal or external to the person, affecting the individual's experience of empowerment (section 1.1.1 above).

Exploring the relationship between these aspects, from the perspective of practising nurses and midwives proves a potentially interesting study. Similarly, from a methodological perspective, building a theoretical framework which is one-dimensional and not tailored to reflect multiple and individual perceptions of the concept would be poor research practice, particularly in relation to this subject area (Foster-Fishman et al 1998). An advantage of qualitative research is that it can provide a means to view phenomena in a different way, challenging traditional views (Burns and Grove 2001).

Qualitative research appreciates the potential for multiple perceptions of reality along with acknowledging contextual influences on such perceptions (Burns and Grove 2001). Given the fact that perceptions of empowerment are contextually embedded (Zimmerman 1995), it would seem that a qualitative approach would best fit a study which aims to explore what Irish nurses and midwives believe empowerment to mean.

Qualitative research approaches use a variety of methods to collect data (Denzin and Lincoln 2000). This study utilised focus groups as a method of data collection. Krueger (1994) argues that focus group discussions are the method of choice when there appears to be a difficulty in



understanding a phenomenon amongst particular groups. Rappaport (1987) suggests that exploring the individuals understanding and experiences of empowerment is a vital first step in contributing to empowerment theory. It is with consideration to Rappaport's and Krueger's arguments that the choice of method emerged from a need to gain a broader spectrum of understanding relating to the concept through an appropriate methodology. It is felt that the use of focus group discussions would enable practising nurses and midwives to express freely their understanding and experience of empowerment from an 'emic' or insider perspective (Lane et al 2001).

## **2.2 Aim of study**

The aim of the study was to explore practising nurses' and midwives' understanding and experiences of empowerment. It was hoped that the findings of this study would unearth possible factors that affect empowerment unique to the practice of nursing and midwifery. This study also formed the first phase in a larger two-phase research project exploring empowerment amongst nurses and midwives in Ireland.

Currently, there are 6 divisions on the Irish Register of nursing/midwifery practice. These are: general nursing, psychiatric nursing, midwifery, mental handicap nursing, sick children's nursing and public health nursing. Nurses and midwives practice in a wide range of environments throughout the country. Each of these environments, whilst somewhat unique, is influenced by current legislation, health policy and the ever-changing demographic profile of patients/clients

(An Bord Altranais 2000a). The primary research objectives using the medium of focus group methodology were as follows:

- To explore nurses' and midwives' conceptualisations of empowerment.
- To explore nurses' and midwives' experiences of empowerment.
- To identify factors which enhance nurses' and midwives' experiences of empowerment.
- To identify factors which inhibit nurses' and midwives' experiences of empowerment.

## **2.3 Method**

### **2.3.1 Focus Group Discussions.**

Within the social sciences, the use of focus groups date back to the mid 1920s when a published description of group interview technique was made (Morgan 1997). Focus group discussions are primarily used as a unique method where in-depth exploration and understanding about a particular topic can be realised using group interaction (Morgan 1996, Asbury, 1994, Krueger 1994). According to Wilkinson (1998a):

*"Focus groups are a particularly good choice of method when the purpose of the research is to elicit people's understandings, opinions and views, or to explore how these are advanced, elaborated and negotiated in the social context".*

*Wilkinson (1998a) pp 185.*

This is particularly useful given the multiplicity of factors (both external and internal), which are thought to affect conceptualisations of empowerment. The decision to use focus group discussions, as opposed to individual interviews was made for a number of reasons. Firstly, within a focus group discussion, clarification and validation of opinions and experiences can

occur amongst the participants (Morgan 1996). This has the potential to encourage more articulate accounts of empowering experiences and also increase the credibility of the findings (Wilkinson 1998a Wilkinson 1998b, Kidd and Parshall, 2000).

Secondly, reduced researcher influence (a facet of the focus group method) was felt to be more advantageous than individual interviews where the potential for a researcher to influence the participants is greater (Wilkinson 1998a). Given the topic under exploration, it was felt to be the best method of choice. The focus group discussion method has been viewed as potentially empowering for the participants for this reason (Lane et al. 2002, Parahoo, 1997, Wilkinson 1998b). Focus group discussions have been articulated as ‘egalitarian’ according to Wilkinson (1998b). This is due to the fact that participants speak to each other as opposed to through a moderator. Apart from keeping the group ‘focussed’ on the topic, a moderator aims to exert relatively little control (or power) in this situation. Being more than the sum of its participants, having a ‘voice’ within a focus group discussion can also provide the individual with a degree of personal incentive to contribute freely (Morgan 1995). An asset of focus group discussions is the fact that they can address contemporary issues such as “empowerment and diversity” (Morgan 1996).

As highlighted earlier, empowerment can be viewed as a socially constructed entity (section 1.2.3 above). In a focus group discussion, participants are offered an opportunity to make “collective sense” of their individual perceptions and experiences, within a social setting (Wilkinson 1998). This would not be possible in one to one interviews. Whilst it is possible to explore empowerment from the perspective of the individual, the social world in which these perceptions are based cannot be ignored. This perspective, while grounded in a somewhat

artificial social environment of a focus group discussion, was felt to have merit in enhancing the validity of the findings.

According to Lane et al (2002), who utilised focus group discussions with carers of older people in Ireland, it has also been argued that the focus group approach is culturally sensitive. This is echoed by Kitzinger (1995) who highlights the value of exploring dimensions of understanding, which may involve a degree of cultural variation. This is an important consideration, given the fact that there is a dearth of previous research exploring empowerment perceptions in the Republic of Ireland.

Focus groups also have the capacity to provide qualitative data from which to frame a quantitative phase of study thus adding depth to such triangulation of method (Morgan 1997, Parahoo 1997, Krueger 1994, Asbury 1995, Bender and Ewbank, 1994). It is hoped that the findings of this research will result in a deeper understanding of factors which could impact on empowerment amongst Irish nurses and midwives and provide a strong basis for future research.

#### ***2.3.1.1 Selection of Sample***

Because the study aimed to encompass representation from all 6 divisions of the nursing and midwifery register, it was necessary to utilise a combination of purposive and quota sampling in order to recruit participants. In an effort to obtain a national distribution, the country was divided by Health Board regions. At the time of the study, there were 10 Health Board Regions in the Republic of Ireland. Participants included staff employed in Health Board hospitals and services, voluntary hospitals and appropriate voluntary services in each region. All of the

appropriate services in each region were identified as potential sources of participants. The location for each focus group discussion was selected with a view to providing equity and ease of access for participants.

#### *2.3.1.1.1 Homogeneity versus Heterogeneity in focus groups*

There is much debate regarding the necessity for homogenous groups in focus group research. What is considered homogenous relates to the common foundation or 'ancestry' individuals have to one another (Collins Compact English Dictionary 2000). Some authors suggest that segmenting a group to enable them to be as homogenous as possible allows for a quality discussion (Kidd and Parshall 2000, Morgan 1996). On the other hand other authors suggest that there is added advantage in bringing together heterogeneous individuals from differing backgrounds (Kitzinger 1995, Bender and Ewbank 1994). Asbury (1995) concludes that the most important aspect of homogeneity is the common experiences held by participants. In this study, it could be argued that participants from six different divisions of nursing/midwifery recruited in ten different regions of Ireland are in effect a heterogeneous group of individuals who share little but for a name on a national register of practitioners. On the other hand, if the participants are delineated according to their scope of practice in caring for the individual (Henderson 1966), there is a case to be made regarding the homogeneity of the groups researched. Similarly, if the participants in the study are classified by their position within the Irish healthcare system, affected by national legislation (Nurses Act 1985) and Health Policy (Department of Health and Children 2001), then the research participants recruited for this study were, in effect, a homogeneous group.

#### *2.3.1.1.2 Focus Group Size*

Traditionally, between 6 and 10 participants have been considered as an ideal amount for focus group discussions (Tipping 2001, Morgan 1996, Krueger 1994). Whilst Parahoo (1997) suggests that it is the purpose for which the sample is required which should direct the number of participants, it is important not to ignore the suggestions in the literature to over-recruit (Lane et al 2002, Morgan 1996). In order to achieve a balance of recruiting a group, which represented all 6 divisions of nursing/midwifery, a decision to recruit 14 individuals to attend each group discussion was made. A more detailed breakdown of this strategy can be viewed in Appendix 1

The decision to over-recruit stemmed from the variety of literature that highlighted clear difficulties that can occur as a result of under-recruitment (Lane et al 2002, Morgan 1995, Kitzinger, 1995, Krueger 1994). This strategy was successful in obtaining a range of between 5 and 13 participants and is further outlined in table 2 below. This table also highlights the number of representatives from each branch of nursing which attended the focus group discussions.

**Table 2. Attendance at focus group discussions by region and nursing branch.**

<b>Geographical Area</b>	<b>General Nurses</b>	<b>Midwives</b>	<b>Sick Children's Nurses</b>	<b>Public Health Nurses</b>	<b>Psychiatric Nurses</b>	<b>Mental Handicap Nurses</b>	<b>Total</b>
MWHB Area	4	2	1	1	3	2	13
SWAHB Area	3	-	1	1	2	2	9
NAHB Area	3	2	-	2	2	2	11
NEHB Area	4	2	1	2	2	2	13
NWHB Area	1	1	1	2	3	2	10
WHB Area	2	1	1	2	-	-	6
ECAHB Area	4	1	-	2	3	-	10
MHB Area	2	1	1	2	2	1	9
SWHB Area	1	-	-	2	2	-	5
SEHB Area	1	1	1	2	2	-	7
Total	25	11	7	18	21	11	93

### **2.3.2 Ethical considerations**

Central to the conduct of rigorous research is close adherence to ethical considerations such as voluntary consent, informed consent, confidentiality, and non-maleficence (McAuley 2003).

Consideration was given to uphold these as much as possible throughout the study. Ethical approval from a research ethics committee was not required, as it is protocol in Irish health services to gain permission from the Directors of Nursing and Midwifery in order to access a

sample of nurses and midwives. The Directors of Nursing and Midwifery in the relevant healthcare settings granted permission for the study.

Directors of Nursing / Midwifery and other relevant managers also nominated participants for the study. Mac Dougall and Fudge (2001) identify that quite often; 'gatekeepers' can impact on the recruitment process, preventing access to a sample population. This was indeed a concern given the nature of the concept under exploration. However, Krueger (1994) asserts that due to the nature of the topic under exploration, non-researchers (such as Directors of Nursing / Midwifery in this case) may be the only realistic method of participant recruitment. Using this approach to identify a sample may have caused some problems in relation to freedom to participate as some participants were asked to attend the discussions at short notice. Others stated that they were told to go to the focus group discussion, which they found ironic given the topic under exploration. Although it did not appear to affect the nature of the data that was collected, this should be considered as a potential limitation of the study and is further discussed in section 4.2 below.

Upon receiving contact details from the Director of Nursing / Midwifery, the participants were subsequently contacted in writing and by telephone by the researcher in order to explain the nature of the focus group discussion, and to answer any queries that they may have. Verbally, they were informed of the location and duration of the discussion. They were informed that the discussion would be taped and transcribed and also assured that any identifiable information (such as names or hospitals) would be removed and replaced with pseudonyms. Traveling expenses and time off in lieu were secured with the participants' employers and they were informed to this extent by the researcher. They were also verbally informed that they were under



no obligation to participate (although it is acknowledged that the selection process could have affected the participants perception of the right to withdraw from the study). All of the participants were then sent the equivalent information in writing also (see Appendix 2 and 3). Due to the fact that participants reveal their views in the presence of others in the group setting, it is possible that disclosing information in a situation such as a focus group may be stressful (Smith 1995). In an effort to compensate for this, the researcher also allowed some time for the participants to debrief informally at the end of each discussion. Similarly, there is also the potential that issues and individuals who were mentioned in the group discussion may be known to other participants. In an attempt to uphold confidentiality, all participants were asked not to discuss the content of the discussion with others.

### **2.3.3 Conduct of Focus Group Discussions**

Many of the difficulties which arise in conducting focus group discussions frequently result from bad planning in the initial stages (Tipping 2001, Morgan 1995). Bearing this in mind, the researcher carefully considered the practical aspects of conducting focus groups effectively. Careful planning of the interview schedule was also conducted. The factors which were considered in the planning and implementation of the discussions are elaborated below.

In each of the areas, a location that was felt to be relatively equidistant and easily accessible for participants was chosen to hold the discussions. The following section outlines of the considerations made before, during and after the focus group discussions.

### ***2.3.3.1 Prior to the focus group discussions:***

The room was visited by the researcher and the assistant moderator one hour prior to each of the discussions. During this time, the seating arrangement was prepared (a circular seating arrangement was utilised with the recording equipment placed on a table in the middle of the circle). The recording equipment was prepared and tested. Signs were prepared and placed strategically to make the location easy to find for participants. The participants' first names were placed in front of chairs. This was to enable participants' refer to each other more easily. According to Lane et al (2002) and Tipping (2001), it is important that the researcher/moderator creates a relaxed and comfortable atmosphere prior to the discussion. The researcher and assistant moderator upon arrival greeted all participants. The focus group discussions were organised so that lunch was provided prior to the discussion. This was with a view to 'breaking the ice' amongst participants. This proved to be quite successful as many participants introduced themselves informally and discussed their practice backgrounds at that time.

#### ***2.3.3.1.1 Moderator considerations***

The skill of the moderator has been highlighted as an important factor affecting the outcome of focus group discussions (Tipping 2001, Morgan, 1996, Smith 1995). Throughout all of the discussions, the moderator aimed to have a minimal role in the discussions. The participants were instructed at the beginning of each session to direct their responses to the group. This process was felt to have contributed to the liveliness of the group discussions (Tipping 2001). The moderator was conscious only to intervene to clarify points made by participants using the pre-arranged probe questions. Also some intervention was used when a dominant speaker took over the discussion allowing for less vocal individuals to participate (Smithson 2000).

Morgan (1995) suggests that it is useful if the moderator is from a similar background to the prospective participants. This is thought to allow participants to identify more closely with them and feel comfortable in disclosing information. This view is contradicted by Krueger (1994) who feels that this is not always necessary. All participants including the moderator stated their background of practice (general, psychiatry etc). The fact that the moderator as a nurse and therefore from a similar background was felt to be helpful as it was possible to understand the medical and nursing terminologies used by the participants. The knock-on effect of this was that transcription was eased also due to familiarity with the language used in the discussions.

#### *2.3.3.1.2 Recruitment of assistant moderator*

Stewart and Shamdasani (1990) highlight the importance of having an assistant who can capture accurate data along with noting data which may not necessarily be discernable by tape recording (i.e. non-verbal communication). An individual was recruited to assist in conducting the focus group discussions who also operated as assistant moderator. The assistant moderator was invaluable in ensuring the smooth operation of the discussions along with making sure that the data were collected appropriately (Kreuger 1998). Although it was not a pre-requisite, the assistant moderator was a registered nurse, public health nurse and midwife. This proved to be very useful as this individual was familiar with the terminologies used by three of the six divisions of nursing/midwifery and as a result could document the discussion easily. In this study, data were collected using a cross section of data acquisition techniques (dictaphone with microphone and utilisation of assistant moderator notes). Use of both methods proved to be valuable in clarifying the participants' meaning during data transcription and analysis and was particularly helpful in discerning aspects of the audiotape, which were difficult to hear. Given the advantages highlighted above, it is suggested that using an assistant moderator was beneficial in

enhancing the focus group validity (Kidd and Parshall 2000). This is further expounded upon in section 2.3.5.1 below.

### **2.3.3.2 *During the focus group discussion:***

At the beginning of the discussion, the purpose of the interview, rationale for recruitment and length of discussion was explained clearly to the participants. The fact that the interview was being recorded both electronically and by hand was reiterated to them (they had also received written information about the conduct of the group in advance). Tipping (2001) asserts the value in providing a neutral opportunity for participants to begin speaking. This was done by asking all participants to state their first name and area of practice. Many authors highlight the importance of moderator skill in ensuring successful data acquisition during focus group discussions (Lane et al. 2002, Kidd and Parshall 2000, Wilkinson 1998b). However, according to Morgan (1995), careful planning along with appropriate questioning is of equal if not more importance to obtaining high quality data. Given the fact that the researcher was moderating focus group discussions for the first time, careful attention was given to both of these aspects. One difficulty which can arise during focus group discussions is that of an individual dominating the discussion (Smithson 2000, Kreuger 1998). This materialised in one of the discussions and was dealt with by encouraging the quieter individuals to contribute more often.

It was possible within the timeframe allowed (one hour) to ask the allotted questions outlined in the interview guide (Appendix 4). Very little effort was required to keep the group discussion 'focussed' on the topic of empowerment. This mirrors Wilkinson's view of the egalitarianism of this method of data collection (Wilkinson 1998b). However, the lack of deviation from the

subject under discussion could also be attributable to the knowledge and professional status of the participants. In the main, asking participants to speak one at a time seemed to be the only active intervention made by the moderator. The assistant moderator took detailed notes throughout the discussions and clarified all of the notes taken with the participants near the end of the discussion (Tipping 2001). At that time, the participants were offered the opportunity to confirm or refute the notes taken. This assisted in augmenting the reliability of the data collected.

#### ***2.3.3.3 Following the focus group discussions:***

At the end of each of the discussions, the moderator thanked the participants for attending and remained available should any participants wish to discuss or debrief about anything that was stated in the discussions. After each session, the moderator and assistant moderator discussed and reviewed the documentation and subsequently added any additional observational data. In general, the conduct of the focus group discussions was relatively smooth.

#### **2.3.4 Interview guide**

As stated by Morgan (1995), formulation of an appropriate interview guide is an essential element in successful data acquisition in focus group discussions. In order to elicit nurses' and midwives' understanding and experience of empowerment, careful planning of predetermined questions were created by considering the literature and arranging a number of brainstorming sessions amongst representatives from all branches of nursing and midwifery. A psychologist also participated in these sessions. The questions were intentionally broad and open ended. This aimed to generate maximum discussion amongst the participants (Morgan 1995). The final

interview guide consisted of eight questions in total (see Appendix 4). The categories and sequencing of questions was prepared using Krueger's (1994) suggested format. This meant that the sequence of questioning involved: opening questions, introductory questions, transition questions, key questions and ending questions (Krueger 1994). Pre-testing of the interview guide was conducted in conjunction with the same individuals consulted in the formation of the interview guide. The same interview guide was utilised throughout the ten focus group discussions to ensure continuity of approach and comparability of the data obtained.

### **2.3.5 Ensuring rigour throughout the research process**

One of the main critiques of the qualitative research process is that there is often a lack of a documented strategy outlining steps taken to ensure rigour throughout the research process in research reports (Webb and Kevern, 2001). The need for a rigorous approach to ensure best research practice was echoed in the recent Research Strategy for Nursing and Midwifery in Ireland (Department of Health and Children 2003). This research aims to uphold the principles outlined by the Research Strategy for Nursing and Midwifery in Ireland. Numerous steps were taken in order to ensure that all stages in the research process were as clear and methodical as possible. Some of the steps taken have already been described i.e. planning of the interview guide, conduct of the group discussion, transcription and analysis of the focus group discussions. The following is a description of added steps taken to ensure the integrity of this process.

#### **2.3.5.1 *Validity/Credibility***

In general, validity refers to the extent to which the data collection appropriately records the phenomenon of enquiry (Parahoo 1997). This term has been primarily applied to quantitative methods of enquiry with some arguing that 'credibility' is a more accurate explanation of the

strategies used to ensure a valid qualitative approach. I suggest that these arguments over semantics overlook the importance of ensuring a rigorous approach to the qualitative research process. As Krueger (1994) points out

*“Focus groups are valid if they are used carefully for a problem that is suitable for focus group enquiry”*

*Krueger 1994, p. 31*

As highlighted previously, the decision to use focus group discussions was made in order to explore a complex and multifaceted concept from the perspective of nurses and midwives. It was decided that the support available from other participants within the group discussion would be helpful due to the fact that they all were employees of a health service and may have similar experiences to share. Similarly, focus group discussions offer the advantage of participants being able to internally co-validate the content of the discussion with one another. Clarification or disagreement of opinions occurred frequently during each of the discussions, which also contributed to the validity of the data collected.

Nearing the end of the discussion, a summary of the discussion made by the assistant moderator was read out to the group. The participants were asked if this was a fair synopsis and were also offered the opportunity to contribute further or clarify their opinions. The final question in the interview schedule (*“Now that you have heard the summary of the discussion, is there anything you would like to add?”*) was asked at all of the discussions. Participants who responded to this question often clarified the contributions they had made previously. This feedback opportunity was considered useful in enhancing content validity.

Tissier's (1999) strategy for data analysis was methodically adhered to. This strategy consists of five stages and is listed as follows.

1. Familiarisation
2. Identification of a thematic framework
3. Indexing
4. Charting
5. Mapping and interpretation

The fact that this process was methodically adhered to further contributes to the validity of the research process. Having a co-researcher simultaneously analyse and check the transcripts was also helpful. The co-researcher although operating independently, came up with similar findings. This resulted in strengthening of the credibility of the findings.

In relation to validity, it could be suggested that the contributions made by the participants must be considered as accurate and valid as they represent participant perceived reality (Carey 1995). On the contrary, Kidd and Parshall (2000) identified that the experience and education of participants should be recognised also. In this research study, participants had a broad spectrum of experience of nursing and midwifery practice. Some participants had up to 40 years of experience in practice.

#### **2.3.5.2 Reliability/Transferability**

Reliability in general, refers to the consistency of a method in exploring particular phenomena (Parahoo 1997). This is often performed through re-testing of a method in a separate study with a view to generating similar results. Although it could be argued that it is not possible to



replicate the study due to the nature of the approach and uniqueness of each of the focus group discussions, it is also possible to argue that moderate reliability was achieved through several methods outlined below.

A standardised approach to focus group discussions was upheld which meant that some comparability was possible across groups as identical questions were asked throughout all ten group discussions. This is viewed as a clear advantage according to Morgan (1996) in increasing the reliability of the discussions. Another aspect of ensuring reliability through a standardised approach was that the same individual moderated all ten discussions. This was advantageous as the researcher was familiar with the interview guide along with previous discussions. Equally, reliability through consistency in transcription and analysis was also possible due to consistent researcher involvement. It will also become apparent in the discussion of the findings (see section 3 below) that although some issues emerged which were unique to each group, a clear resurgence of similar themes (ten in total) were identifiable through all ten focus group discussions. This indicates that although part of the same study, a reliable pattern of themes emerged at each discussion. This is felt to have contributed to a moderate degree of transferrability in this discussion (Kidd and Parshall 2000).

### ***2.3.5.3 Generalisability/Applicability***

It is frequently argued that the findings of qualitative research are not generalisable due to the nature of the phenomenon under investigation and the number of participants (usually a very small amount), which constitute the total population. Carey (1995) argues that if data saturation occurs from similar themes which seem to continuously emerge following several focus group

discussions, then it is possible to cautiously generalise the findings to similar groups of individuals. Due to the recurrent themes, which emerged in this study, the findings of this study may be applicable to the larger population of Irish nurses and midwives and their experiences of empowerment in practice.

## **2.4 Data analysis**

The primary aim of qualitative data analysis is to gain an enriched insight into a phenomenon (Parahoo 1997). It is also essential to ensure that the process utilised in analysing the data obtained is as methodical and verifiable as possible (Krueger 1994). Each of the discussions were transcribed verbatim. Audible deviations were also documented. These included pauses in the conversation, laughter and group consensus using terms such as 'Hmmm' and 'Ahh'. Nonverbal communication such as gestures and behaviours were documented as observations separately in an effort to capture the overall character of each discussion (Stewart and Shamdasani 1990). Both of these types of data were analysed simultaneously for each focus group discussion and then combined to produce the overall findings. A lot of rich and interesting data were collected which presented a clear challenge for analysis. Two main methods were employed to analyse the content of the data obtained: computer assisted qualitative data analysis followed by manual data analysis and is further discussed below.

### **2.4.1 Computer assisted qualitative data analysis**

Preliminary data analysis involved a transcript based, systematic content analysis using ATLAS ti (a computer assisted qualitative data analysis package). It has been argued that the advantage of a computer-assisted approach maintains the rigour of traditional analysis yet greatly reduces

researcher cost and time (Stewart and Shamdasani 1990). Using this method, it was possible to ascertain emergent themes through a primarily quantitative method, counting the incidence and frequency of codes that emerge (Wilkinson 1998a). Codes were identified and the incidence and frequency of these codes was recorded simultaneously. A sentence formed the minimum requirement for inclusion into a code. However, it was felt that use of the computer-assisted method was not sufficient to honour the data which was obtained in this study. This is further expounded upon below.

The strength of the computer assisted data analysis was evident in identifying both the frequency and incidence density of the codes that emerged from the data. A total of 412 codes were identified. Some of these codes were mentioned a lot in particular conversations whilst others mentioned less frequently, spanned all of the discussions. According to Bender and Ewbank (1994), analysis of codes and themes should use the group as the unit of analysis. In total, 27 of the 412 codes assigned were mentioned across all 10 focus group discussions and are presented in Appendix 10. Although some authors state that the group is the unit of analysis (Asbury 1995, Bender and Ewbank 1994), one could question the appropriateness of applying equal weighting to a theme, which is mentioned across all of the categories but with significantly less frequency compared with another. However, because the purpose of this study sought to unearth a generic understanding of empowerment as it is experienced by nurses and midwives, it was felt that codes, which emerged in each discussion would more appropriately capture the study objectives. It is not surprising that in the table outlining the frequency of codes across all ten focus group discussions (Appendix 10), the most popular code related to aspects of actual practice. This could be attributed to the research questions asked in the study, which aimed to reflect nurses' and midwives' experiences of empowerment in practice.

Following the creation of this table (Appendix 10), the codes were further categorised into broad themes. The broad themes which emerged (from computer assisted analysis) were Practice, Management, Organisational, Education, Interpersonal, Personal and Professional and are outlined in Appendix 11. However, on further inspection of the data analysed using this method, several inconsistencies became apparent. It was not possible to discern which categories the following codes belonged: Change, Negative experience, Positive experience, Power, Empowering, and Control. Power, for example, could have been attributable to the person, the organisation or to one's manager. Similarly, it was not possible to identify whether control reflected personal control or professional control. The value of negative and positive experiences is also questionable without consideration of the context of the conversation. Whilst independently interesting, it became obvious that the data was much more complex and that the analysis method was not compatible with appreciating the true depth and complexity of the data which was collected (Bender and Ewbank 1994). It is also important to acknowledge the limitations of researcher understanding and experience with using such computer packages. Krueger (1994) asserts that the intensity and depth of data analysis is determinable by the purpose of the study. It became clear that a more comprehensive method was necessary, which appropriately reflected nurses', and midwives' understanding and experiences of empowerment. As a result, manual analysis was undertaken to address this shortfall and appreciate both the context and the content of the discussions (Carey 1995, Morgan 1995).

#### **2.4.2 Manual Data Analysis**

*"The unanticipated volume of data is sobering...more often, it is the complexity of the analysis that stops the researcher cold"*

*Krueger 1994, p.141*

Given the nature and content of the data obtained and the concept under exploration, it was felt that manual analysis was necessary in order to capture the nature and complexity of the data. This process aimed to result in a summary of themes that emerged in the data through paying attention to the meaning of the narratives constructed by the participants in the group discussion (Bender and Ewbank 1994). The advantage of utilising this kind analysis is that it is both situationally responsive and allows for a more detailed account of participants' responses (Wilkinson 1998a). It is also important to keep sight of the analysis of the group interactions, an often-neglected aspect within focus group analysis (Webb and Kevern, 2001, Kitzinger, 1995, Krueger 1994). Appreciation of all aspects of the group interactions were observed and analysed in order to recognise the ethnographic context in which it was collected.

#### ***2.4.2.1 Analytical Approach***

According to Tissier (1999), there are five main stages in qualitative data analysis. Tissier asserts that although the approach is disciplined and systematic, creativity on behalf of the researcher is also necessary. These stages are: familiarisation, identification of a thematic framework, indexing, charting and mapping. It is important to stress that these stages were not sequential during data analysis. The following outlines how this method was applied to analyse the data relating to nurses' and midwives' understanding and experience of empowerment.

##### ***2.4.2.1.1 Familiarisation***

This involved re-reading of the initial transcripts and a secondary tape-based analysis. Each of the focus group discussions was carefully listened to and an abridged summary of each of the discussions was formulated. Thorough consideration was given to the language used by the participants, the intensity of their responses, the frequency and context of group agreement/

disagreement, and consistency of individual responses (Krueger 1994). The context in which participants framed their experiences was also noted. Again, nonverbal communication was incorporated in the analysis coupled with important audible findings e.g. pauses in the conversation, laughter and group consensus using terms such as 'Hmmm' and 'Ahh' (Stewart and Shamdasani 1990).

#### *2.4.2.1.2 Identification of a thematic framework*

Following re-familiarisation with the data and consultation with the original and tape based transcripts, it seemed that two different types of themes emerged. The first themes to be identified were initially termed '**key themes**' and emerged clearly from the data. These are comparable with the 'sought themes' mentioned by Bender and Ewbank (1994), which are to some extent, expected due to the knowledge of the literature and current research available. These themes were then named impacting factors because the data which emerged within these themes was concurrent with nurses' and midwives' articulations of factors which impact on empowerment. In congruence with Bender and Ewbank, more subtle themes emerged across all ten of the discussions which permeated through all of the data. These more elusive themes were somewhat unexpected, and offered an added dimension of understanding into the phenomenon of empowerment as the participants experience it. These, more subtle themes were initially termed '**interweaving themes**' due to the interweaving nature of their occurrence within the data. These themes were renamed inherent empowerment beliefs. Both sets of themes will be discussed in detail later in the next chapter.

#### *2.4.2.1.3 Indexing*

All aspects of the data obtained through focus group discussions (issues, themes, nonverbal communication) were documented and indexed clearly throughout the analysis of the data. This

ensured that each of the issues, which emerged, could easily be tracked to each of the themes that emerged (Gantley 1999). A diagrammatic representation (analytical framework) of the key and interweaving themes was produced which assisted in highlighting the complexity of the data that was obtained. This is presented in the following chapter.

#### *2.4.2.1.4 Charting*

According to Tissier (1999) charting refers to the reassembling of the appropriate data to the appropriate theme. This occurred simultaneously during the identification of a thematic framework. Issues and narratives, which were found in the data during tape-based analysis, were placed within the category of the relevant theme. This was subsequently documented and repeated for each of the focus group discussions. This resulted in ten separate preliminary analysis documents.

#### *2.4.2.1.5 Mapping and interpretation*

It must be stressed that aspects of the final stage of mapping and interpretation of the data obtained did not occur in isolation but in conjunction with all of the other stages identified by Tissier (1999). The data set as a whole was interpreted by reviewing the ten preliminary analysis documents seeking out common characteristics and themes. It has already been highlighted that nine themes in total were identified. The six key themes (or impacting factors) were additionally mapped out onto a chart and the accompanying issues pertaining to each of the themes in the focus group discussions was included. This assisted in visually comparing and contrasting issues that emerged specific to the themes and to the focus group discussions.

### **2.4.3 Summary**

The methodology chosen for this study was based on the assertions of Rappaport (1987) and Zimmerman (1995) who highlight that empowerment experiences are contextually determined. A qualitative approach was chosen as the most appropriate methodology for this study in order to elicit nurses' and midwives' understanding and experiences of empowerment as it related to their practice setting. Because of the lack of comparable research from an Irish perspective, it is suggested that this study is exploratory. Focus groups were chosen as a method of data collection due to their capacity to capture a group consensus about empowerment experiences. This is because of possible advantages of group interaction in relation to the subject under exploration. Ninety-three individuals participated in the study who were recruited through nomination from Directors of nursing. Ten focus group discussions held in locations dispersed nationally yielded a large amount of rich data. This data was initially coded using a computer assisted method and subsequently analysed manually using Tissier's (1999) 5 stage approach. The findings, which emerged from the data analysis process, give an interesting insight into how empowerment is experienced by Irish nurses and midwives. These findings are presented in the following chapter.



## **CHAPTER 3**

### **FINDINGS**

## 3 CHAPTER 3 - FINDINGS

### 3.1 Introduction

In all ten discussions, all participants contributed enthusiastically and gave in depth examples of what they understood empowerment to be, along with describing numerous factors that they felt contributed (or not) to their experience of empowerment. All of the participants stated that although anonymity was assured, they actually would not mind being identified as they felt very strongly about the subject under exploration. In general, the group dynamics were positive. Anecdotally, most participants said they enjoyed the discussion and were interested to hear about the similarities in empowering (and non empowering) situations experienced by colleagues from other disciplines. The purpose of this study aimed to produce a generic view of empowerment. However, some branches of nursing/midwifery experienced unique issues, which are briefly highlighted also.

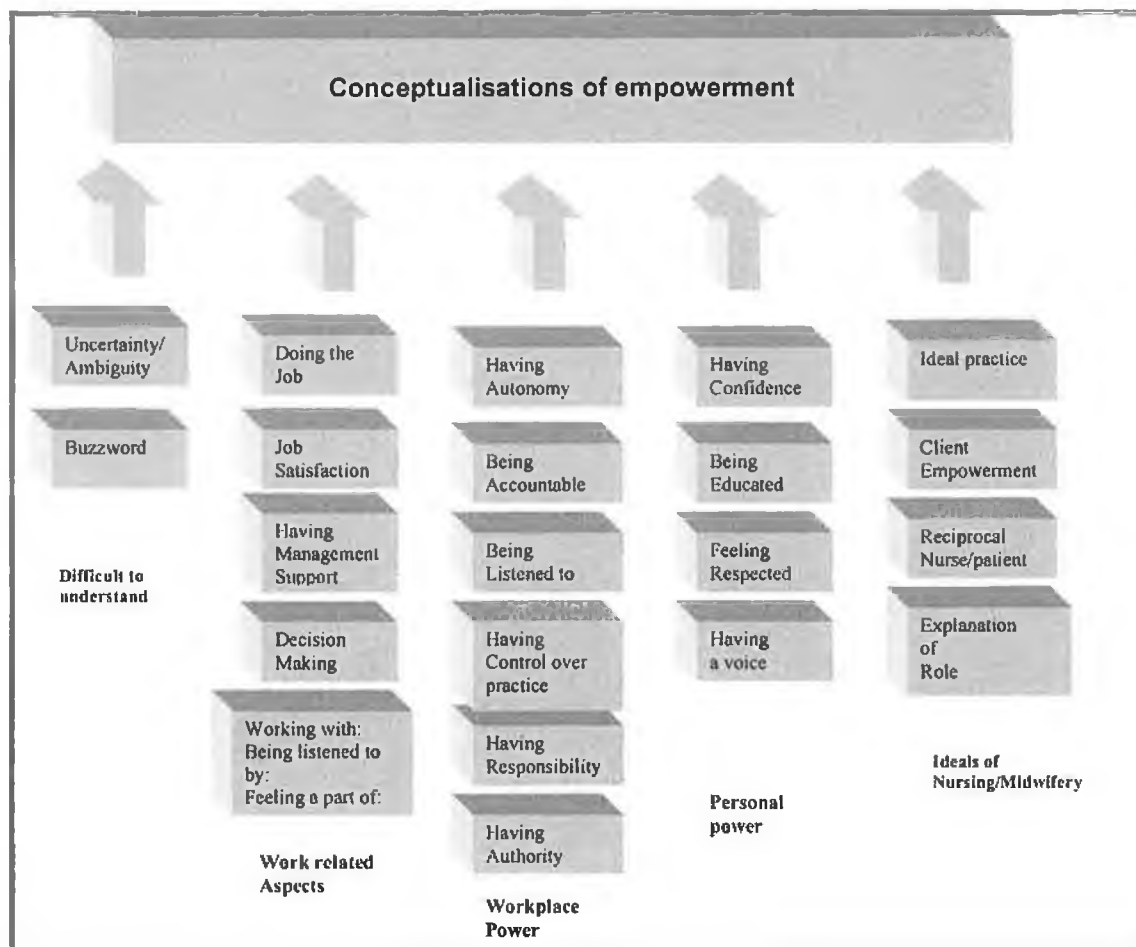
As stated previously, the research objectives aimed to explore the meaning of empowerment, to identify related experiences of empowerment and unearth factors, which may impact on empowerment amongst nurses and midwives. Apart from the first research question, which aimed to ascertain what nurses' and midwives' immediate responses to what they understood as empowerment, it was not possible to analyse the data according to each of the research questions. This was due to the fact that the same issues seemed to impact on an individual's experience whether positive or negative in relation to empowerment in practice. For example: *involvement in decision-making* was one of the issues, which emerged under the key theme of

organisational factors. This theme will be discussed in further detail in the relevant section. Nurses and midwives articulated *involvement in decision making* as what they understood as empowerment. Similarly, their experiences of empowerment included descriptions of *involvement in decision-making*. Positive and negative aspects of this issue were articulated as either empowering or disempowering. The degree of *involvement in decision-making* within the organisation was a marker for how empowerment could be enhanced or inhibited also. This phenomenon of mirroring of findings across research objectives is not unique to the study of empowerment amongst nurses (Kuokkanen and Leino Kilpi 2001). It was felt that the interpretation of the data as factors, which affect the experience of empowerment, would more appropriately reflect the interactive nature of the data (Smithson 2000). These impacting factors appeared to determine what nurses and midwives inherent empowerment beliefs (control, professional respect, and personal power). Being educated for practice emerged from the data as something, which was antecedent to nurses' and midwives' inherent empowerment beliefs. All of these themes are further illustrated in section 3.3 below.

What was notable was that the majority of examples given by participants were of negative experiences; where participants stated they were not empowered or were disempowered due to certain factors. As highlighted earlier, nurses' and midwives' understanding of empowerment was the only aspect that could be isolated from the data. This is further expounded upon in the following section.

### **3.2 Nurses' and midwives' understanding of empowerment**

A multiplicity of responses were made in relation to the question "What do you understand by the term empowerment?" In total, 20 different items emerged as nurses' and midwives' immediate responses as to what they understood as empowerment. The contributions made by the participants seem to echo the literature, which states that empowerment is an ambiguous, and multifaceted concept (Ryles 1999, Lewis and Urmston 2000). The items were broadly categorised into five elements; relating to the ambiguous nature of empowerment, relating to work aspects, related to possessing legitimate power in the workplace, related to perceiving personal power and lastly ideal conceptualisations of how nursing and midwifery practice should be viewed. The following figure is a representation of a group conceptualisation regarding the meaning of empowerment. Gaining a group conceptualisation was possible due to the nature of focus group methodology, which whilst encouraging individual participation, enabled participants to agree through consensus. In relation to this question, no participant disagreed with any conceptualisation made by another. From this, it is possible to assume that a broad group consensus of empowerment conceptualisations was achieved.



**Figure 1. Nurses' and midwives' conceptualisations of empowerment**

### **3.2.1.1 Difficulty understanding empowerment**

Several participants expressed views regarding their opinion of empowerment.

*"I'm not quite sure if I understand empowerment" (Focus group discussion (FGD) 3)*

*"[Empowerment] wasn't something I thought about last year or that, it meant nothing to me". FGD 10*

*"I think I'd have a certain amount of suspicion... it's a lot of buzz...FGD 7*

*“ Empowerment...I think it’s very ambiguous” FGD 10*

*“Empowerment...is everything really” FGD 5*

#### **3.2.1.2 Work related aspects**

Some participants mentioned just practising as nurses and midwives was empowering. Having management support, and working effectively with the multidisciplinary team were understood to be empowering.

#### **3.2.1.3 Ideals of nursing/midwifery practice**

Some participants stated that they understood empowerment to be primarily related to patients. Some participants highlighted that empowerment was reciprocal in nature. This meant that practitioners who empower patients are in turn empowered by them.

*“ I think it really should be more of an issue about the clients” FGD 3*

*“Its a two way thing really” FGD 5*

#### **3.2.1.4 Workplace power**

Having authority in decision-making, being supported on making decisions and having autonomy in practice was mentioned in a number of focus group discussions by several participants. Accepting responsibility for the decisions that one makes along with being confident and comfortable in making such decisions was verbalised as empowering also.

*“My perceptions of empowerment would be giving nurses a sense of autonomy, having a greater involvement in patient care, being able to make decisions, professional decisions, and stand by those decisions” FGD 8*

*“I do think that empowerment does come from responsibility, and accountability...I think respect is what is involved” FGD 3*

### **3.2.1.5 Individual aspects**

Participants seemed to be able to differentiate between individual aspects of empowerment and external (workplace) aspects of empowerment. This is illustrated in the following quotation.

*“You can be in a very powerful position...but you can be very disempowered...somebody in a lower position could feel very empowered as a person” FGD 10*

Individual aspects such as being respected and having confidence emerged as empowering also.

*“I think empowerment begins with respect for the position that you’ve got” FGD 4*

*“ To me, it’s having the self confidence...” FGD 9*

## **3.3 Introduction to themes of empowerment**

The following section outlines the themes that emerged from the focus group discussions. On analysing the data, six themes initially emerged which represented aspects, which clearly seemed to impact on how they experienced empowerment in practice. These themes, initially termed key themes as they were felt to be key to how empowerment is experienced, were: organisational factors, management, professional issues, interpersonal issues, individual factors and historical legacy. What is notable about these themes is that they represent nurses’ and midwives’ views

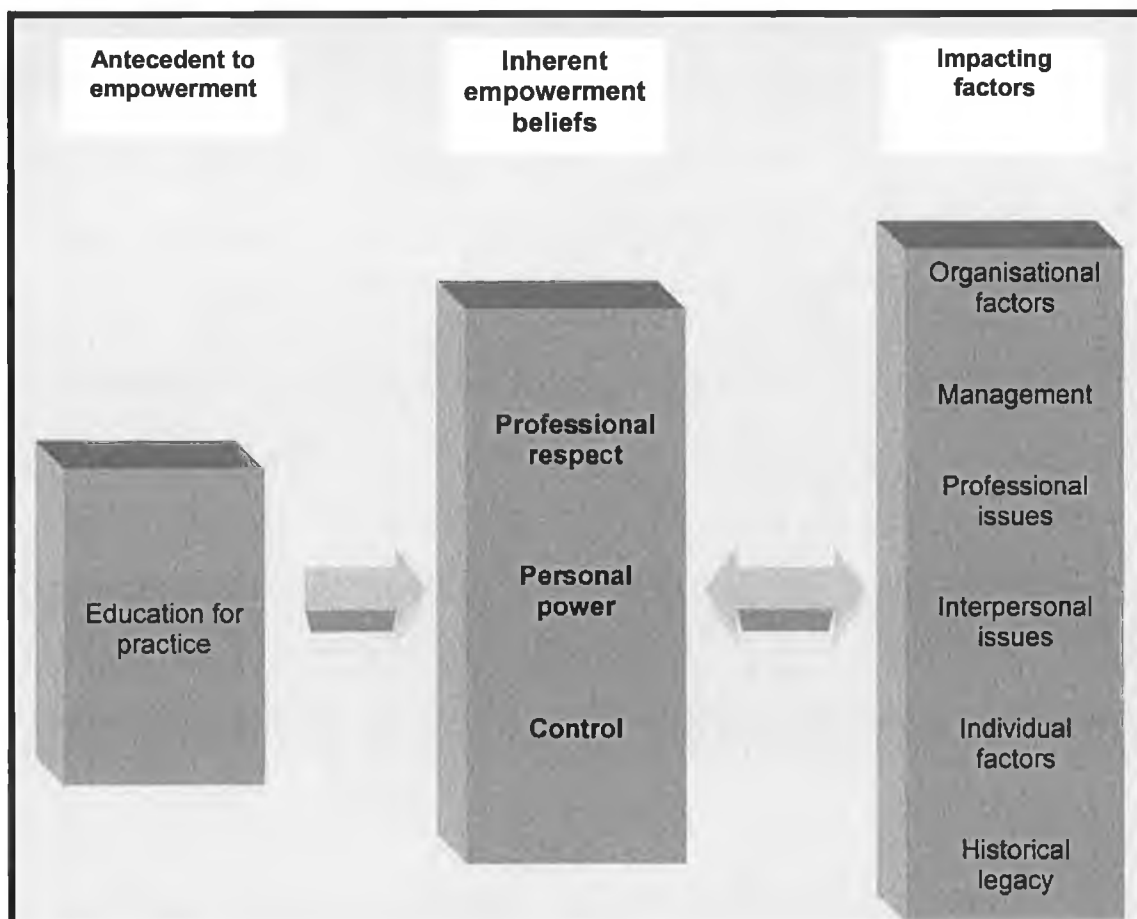
of factors, which potentially impacted on their experiences of empowerment either positively or negatively. This suggests that these factors have the capacity to strengthen or determine empowering experiences. This group of themes were renamed impacting factors due to their potential to impact on empowerment experiences. What is also notable about these themes is that the six themes were easily identifiable in the data through clear exemplars provided by participants. Aspects of these six themes are also easily identifiable through the computer-assisted process of data analysis (see section 2.4.1)

Moreover, during the analysis process, more subtle themes emerged which were somewhat elusive yet permeated through all of the more obvious themes. These themes were 'interweaved' through all of the data. To clarify, sometimes when participants were clearly describing factors which impacted on their empowering experiences, subtle comments made briefly through that narrative suggested the presence of another phenomenon, something more akin to perceptions of empowerment. Voice intonation, and group agreement (e.g. Hmm ahhh) also signalled the presence of something more elusive, which described empowerment. It was the intuitive detection of the presence of these themes that prompted a move to a manual analysis strategy (see section 2.4.2). The presence of the more elusive themes was also identified through exemplars of empowering practice, which were voiced by the participants. These three themes (initially called interweaving due to the nature of their presence in the data) were felt to relate to nurses and midwives inherent empowerment beliefs. What is notable is that the themes relating to empowerment beliefs are as such, not as tangible as the key themes described above despite the fact that these themes are felt to represent empowerment beliefs. It is also suggested that the presence of these aspects are necessary for empowerment to occur as opposed to the six impacting factors (themes) described above which have the capacity to influence empowering



experiences. The three themes of professional respect, personal power and control were renamed inherent empowerment beliefs. It is interesting to note that the inherent empowerment beliefs had the potential to affect the impacting factors also. For example, a person who believed they had professional respect could be less affected by interpersonal issues.

On further exploration, it seemed that education for practice, was found to be a key antecedent influencing nurses' and midwives' inherent empowerment beliefs. Numerous examples of education 'bringing about' confidence, control and respect from others were evident in the data. The following conceptual representation illustrates the themes that emerged from the data.

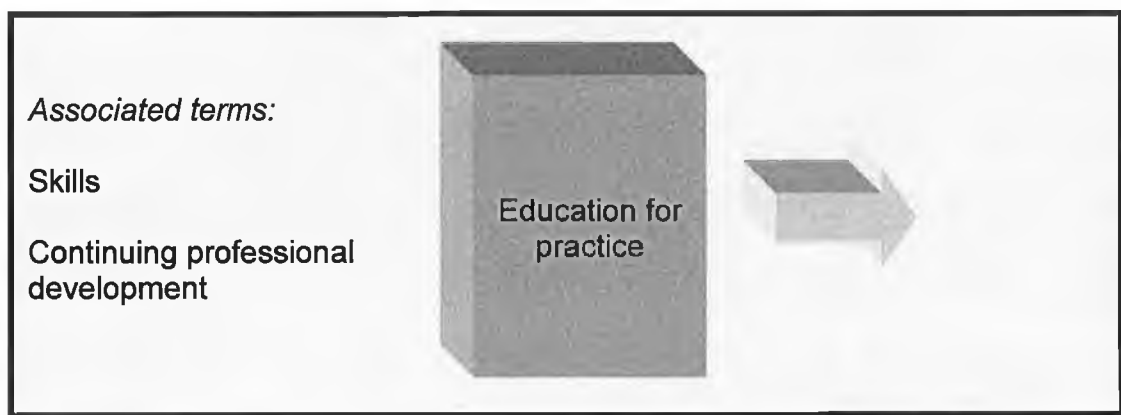


**Figure 2.** Conceptual representation of emergent themes of empowerment

From the diagram above, it is evident that there are three distinct areas which relate to empowerment. These are : antecedent to empowerment (education for practice), inherent empowerment beliefs (professional respect, personal power, control) and impacting factors (organisational factors, management, professional issues, interpersonal issues, individual factors, historical legacy). Each of these areas, and the associated themes that emerged are further discussed in the following sections.

### 3.4 Education for practice

**Figure 3. Education for practice**



It seemed that being educated for practice, was antecedent to nurses' and midwives' perceptions of empowerment and underpinned the three aspects of professional respect, control and personal power. Unanimously, it was felt that education was vitally important for empowerment. Being educated in order to practice effectively was voiced as necessary for empowerment according to nurses and midwives. The knowledge gained from being educated to practice underpinned nurses' and midwives' perceptions of control, personal power and professional respect. These

are further expounded below. It could also be suggested that knowledge gained also enhanced participants' critical awareness of empowering (or disempowering) situations.

*Participant 1 "I mean to be empowered you need knowledge,".*

*Participant 2 "Ongoing education".*

*Participant 3 "Knowledge is the base, like that's the foundation".*

*Moderator "Right".*

*Participant 3 " If you don't have the knowledge you can't be in the confidence, then you know, empowering, giving information, delivering, empowerment ....[the patients] know, you know what you're talking about, to give them confidence then"*

*FGD 8*

*"I think education is empowerment" FGD 1*

*" I think it is important to keep involved in ongoing education....say of the current research, and in that way your knowledge builds and you can feel empowered"*  
*FGD 3*

*"[People who are educated for practice] They're more empowered to carry out their day to day...there's certain types of training that people can use so they're more able to deal with those issues and therefore you're more confident and you're more empowered to work within those areas...with proper skills you're not as afraid, so you're more inclined to go to work and do your job." FGD 4*

Professionally, it was felt that being educated was good for the profession. It was felt that education and the professionalisation of nursing and midwifery will enable nursing and midwifery to be a powerful and respected entity. Internal recognition of the power of nursing and midwifery amongst colleagues was also identified as important. This suggests that nurses and midwives have a degree of critical awareness of their context (Freire 1972).

Acknowledgement of the pre-requisite of education and its resultant knowledge in order to be respected, have increased control and personal power beliefs were raised. Possessing up to date skills, was also voiced as an essential element to empowerment. Examples of the impact education has on being respected as a professional were also illustrated:

*"I think people [nurses and midwives] are realising you do have a voice and it's a very powerful voice and people will respect you just as long as you do have the knowledge and are able to use your experience and have the background knowledge. There is nothing worse when someone says they can't back it up,"* FGD 7

*"I think, you know, education and bringing us up to professional standards gives us that power and then when you can say, 'no this isn't right, this is the reasons why', then you'll be heard... I think that's changing now, people have seen that more and more."* FGD 7

*"For those who have developed skills, I mean our colleagues, Nursing sisters, doctors, you, they would all listen to our opinions when we have done these courses and that in itself is an empowerment".* FGD 10

The work of Clinical Nurse Specialists (CNS) exemplified the effect education for practice had on control over practice. Most participants felt that because they had developed specialist knowledge and skills through education, they were perceived to be more empowered and had more decision-making authority. This was confirmed by the participants who were practising as clinical nurse specialists. It is notable that CNS voiced that their roles were visible and they had clearer roles and more formal authority compared with non-CNS. The following example illustrates the CNS

*"It's a day unit opened just Monday to Friday and hone'stly now we feel very empowered... We would work very much from protocols...we can make decisions according to a protocol, so we can ring and get an answer straight away instead of maybe bleeping a doctor in the morning here in the wards and you haven't got a decision until the next day...moving to the specialist area I think... money isn't a problem at the minute... that's just the way I feel, I feel empowered... we've been recognised as a clinical nurse specialist recently... that helps too."* FGD 3

*"Well you're just asked to... you can fill in, you know the gap between the nurse and the doctor... you can fill in that more so at times when we have to go outside the ward. So it just makes you feel that you are doing that little bit more. It's, it's kind of challenges you...you are doing more than just coming in, going through the motions... you get more satisfaction from doing that extra little bit".* FGD 10

The changing face of nursing education was discussed in a number of groups and felt to be empowering for the profession as a whole. There was a clear link made on numerous occasions between education and its direct impact on confidence.

Participant 1 *"The new training now. They won't do non-nursing duties"*

Participant 2 *"[agreement – nodding head]"*.

Moderator *"So is that the new training?"*

Participant 2 *"I think it's going to be a huge advantage to the nursing profession."*

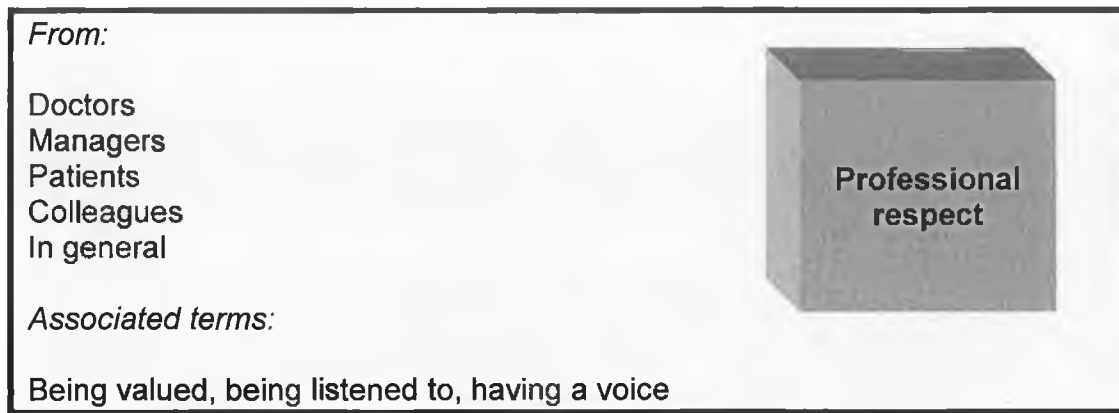
Participant 3 *"So confidence now, education brings confidence and you stand back and you say 'well it is not a nursing duty', you can make a decision. It empowers people". (FGD 4)*

*"I think it's great now to see the younger nurses coming out, and I suppose it's research...that's the way they're being trained... I think it's very valuable... they ask a lot of questions and that and they want the answers as well. So I think it's good to see them moving from the ritualistic approach to nursing." FGD 8*

In summary, it seems that education for practice is something which Irish nurses and midwives perceive as an important antecedent to their empowerment in practice. As highlighted previously, empowerment was found to consist of three inherent empowerment beliefs. These are presented in the following section.

## 3.5 Inherent empowerment beliefs

### 3.5.1 Professional respect



**Figure 4. Professional respect**

Throughout all of the discussions, it emerged that the perception of being respected as a professional directly affected the individual's experience of empowerment. The numerous statements made about being valued, respected and listened to in the workplace illustrated this. Whilst connecting with all of the key themes, being respected as a professional links closely with the key theme of interpersonal factors (section 3.10 below). Perceptions of how nurses and midwives were actually respected as professionals emerged throughout all of the focus group discussions. Such perceptions included expressions of being valued, listened to and respected. Related to these issues, participants gave examples of how they were treated from organisational, management, interpersonal and personal perspectives. Deficiencies in professional respect were identifiable from five sources; generally, from doctors, from managers, from patients, and from fellow nurses. Being respected as a professional was felt also to impact on nurses' and midwives' beliefs in their own capabilities. Some general examples included:

*"Why do nurses have to fight so hard you know, to be valued?" FGD 9*

*"That constant, that constant battle of trying to get as you say other professionals that you're working with, not so much their approval but just their assistance and just their respect." FGD 9*

*"We have a lot to offer... you know, we have lots of experience to put forward and all that sometimes maybe we feel that we're not being listened to as much as we should be listened to" FGD 5*

*"I don't think our input is as valued".* When probed further, the participant continued:

*"By senior management in the sense that the psychiatrists and psychologists or occupational therapists have an input their input is possibly more valued because of the structure in the hospital, you know, the way things work".*

*"We are now bringing overseas nurses into our country...which is wonderful from a cultural point of view but where are the nurses in Ireland? So you have to look at how they are being treated. Nurses are being treated appallingly FGD 4*

One participant compared how nurses are respected in Ireland compared to abroad. Her experience of being respected was also voiced as being currently beneficial in Irish nursing practice.

*"I trained here, left and I nearly choked when someone asked me my opinion...in Australia. Within the few years that I was there I got totally changed...how I acted and...my whole level of confidence because I suppose how nursing is perceived there and how nursing was I suppose respected really and we were seen as professionals so then when we came back here then you kind of kept on with that, it stayed with you and I suppose that has helped all along". FGD 3*

Areas where professional respect were highlighted included dealing with the medical profession who sometimes did not listen to the staff views in relation to their patients.

*"When I feel they're ready for discharge... go to meetings and we discuss with the consultant and all he does is turn around and say 'ah no we'll keep him for another few days'... We're the one's who look after them twenty four hours a day, not for five minutes a day...now you do respect their judgement at times, but I think also we should be equally respected... with the consultants that's one negative" FGD 5*

Linking closely with the public perception of nurses' and midwives' roles, examples of patients asking participants to do 'non professional' duties showed that nurses and midwives felt that lack of respect from patients about their role as professionals was not conducive to empowerment.

*"It's just nurse, you know she's always there at everybody's beck and call, whether it's a patient, or it's a doctor or the relatives or whoever I think it's just they've no recognition" FGD 2*

*"I was going into a house one day and a man said to me 'did you see the cow, was the cow out there'... he said 'I mean the milk, is it at the gate? And I did see the milk at the gate and I said 'Oh I didn't see it'. And he said 'I thought you could have brought it in'. You know that's the public's perception of sometimes what you are". FGD 4*

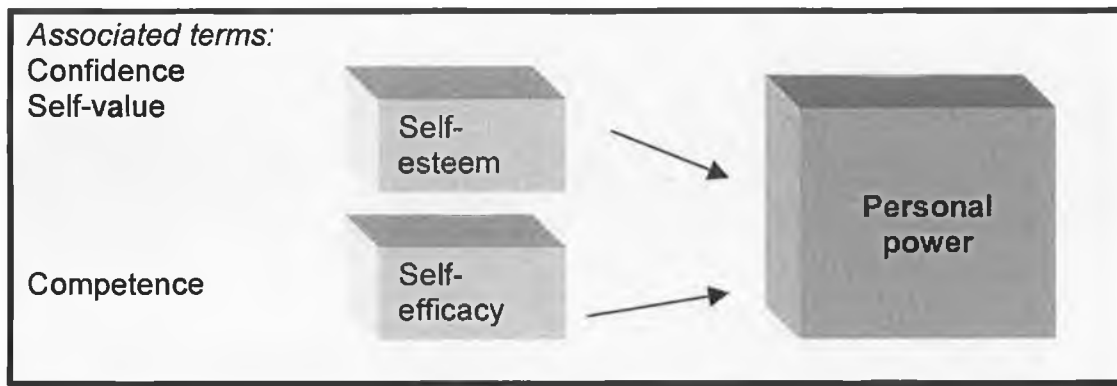
There was some negativity expressed in relation to collegial respect. Although there was reference to the need for nurses and midwives to support each other, most of the emphasis was spent giving examples of how nurses and midwives did not experience large amounts of collegial support.

*"I think nurses ourselves are their own worst enemies very often because of their ranking system". FGD 3*

The hierarchy of traditional nursing appears also to have been a restricting factor for one participant. It appeared to strike a chord with several others. The actual statement of nurses and midwives being their own worst enemy was raised at varying points within the focus group discussion and agreed with by different participants.



### 3.5.2 Personal power



**Figure 5. Personal power**

Whereas self-efficacy refers to beliefs in one's abilities, to execute action, self-esteem relates to belief in one's worth (Bandura 1997). Both of these features seemed to be inherent factors for empowerment according to the participants. Having the confidence (which was usually as a result of being educated for practice) was felt by nurses and midwives to be essential for empowerment to occur. This could be associated with self-respect as distinct from professional respect. Believing in one's ability to act appropriately also emerged as an inherent feature of empowerment.

*"Working as an independent practitioner, I certainly would experience... a feeling of having the confidence to make decisions... I would feel ... empowered in that way." FGD 7*

*"confidence has a lot to do with empowerment and if your confidence is knocked so far down you just don't feel you can empower yourself" FGD 3*

*"I feel that nurses sometimes lack in confidence and assertiveness to give their opinions and it is important particularly as the fact that they're 24 hours they are giving the care that they are able to speak their minds you know at the relevant times, as either advocates or as nurses again they can assess things their opinions and very often they don't they might sit there they know the patients better than anyone else and yet..." FGD 2*

*"And I do think we need to be a little more confident in our own knowledge and say yes we do have these skills and knowledge and we can share some of the pressure" FGD 2*

*"I have to say if you haven't got confidence in yourself... it takes a long time... its very hard to build up confidence... you could be a very quiet person sitting in the back row and it takes an awful lot of courage for you to come forward to kind of give your point of view as to what way work should go ahead or for your own words to be listened to, but communication and confidence are important issues for empowerment" FGD 3*

Valuing one's self also seemed to impact on beliefs of professional respect

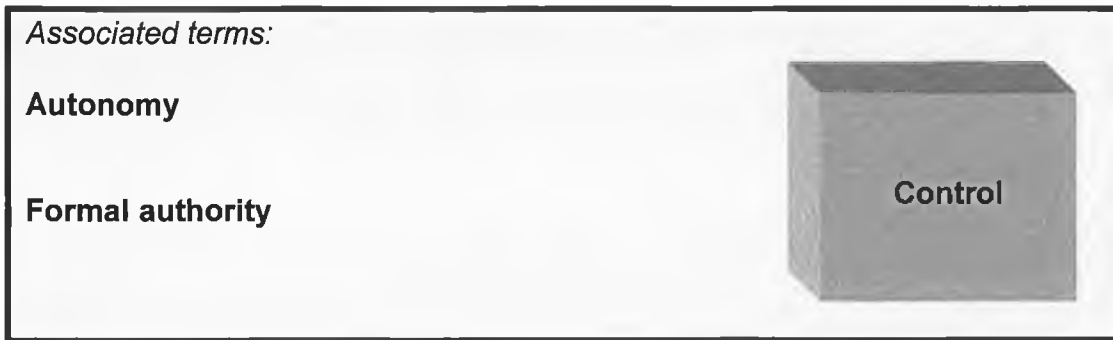
*"I think that's very important that really if you feel valued in yourself if you are valued by peers by your other members of the team and your manager and by the public in general" FGD 3*

The aspect of self efficacy (belief in one's ability) was evident from the data. What was interesting was that nurses and midwives stated clearly that they believed they had ability in numerous ways. This was most evident in participants' articulations of their potential to be involved in strategic decision making. Impacting factors (such as organisational issues and management) clearly seemed to be determinants of nurses' and midwives' self-efficacy belief.

*"[Managers] are almost checking up on you still to see if you are doing it right and that and you know you're like well look it I'm well able to do it like,... you just feel that they're still they're trying to hold on to it and they're trying to let it go but they're not quite willing to let you take that on yet because I don't know it's taking from them they feel its taken from their power or whatever" FGD 2*

*"I've been battling here... my energy has gone...if I express an opinion or have an idea about something that you expect to be listened to and its very wearing battling all the time" FGD 3.*

### 3.5.3 Control



**Figure 6. Control**

*"In relation to myself, I suppose the autonomy that we're given within our job description to develop... within certain latitudes...having the knowledge and skills and the experience to do that... I think that's a huge part of empowerment for me personally" FGD 7.*

It was detectable from the data that individuals who have a sense of control (or possibly perceived that they have control) experienced a greater sense of empowerment. Numerous examples were given throughout all of the focus group discussions, which illustrated the importance participants placed on having a sense of control. The most obvious examples of having control were illustrated through practitioners' experiences of being able to make independent decisions relating to current patient care and future planning. In nursing and midwifery practice, autonomy is defined as having a degree of freedom within one's scope of practice, to make decisions (An Bord Altranais 2000a). Having such autonomy in practice was predominantly voiced as making decisions based on nursing experience.

*"I suppose my perception of empowerment would be giving nurses a sense of autonomy... being able to make decisions, professional decisions, and stand by those decisions". FGD 6*

*"I would find that you have the responsibility without all of the authority or the autonomy" FGD 2*

Closely linked to nurses' and midwives' control beliefs was the aspect of formal authority. Formal authority, unlike autonomy, refers to the actual legitimate power of the person within the organisation. There is a distinction to be made between making autonomous decisions in practice (autonomy) and having clear authorisation to make such decisions within the organisation (formal power). However, this distinction was blurred by some participants who equated autonomy with formal power. According to the majority of the focus group participants, having both seemed essential for control, which contributed to empowerment.

The view of empowerment as decision-making power (and subsequent control) has been highlighted previously (see section 1.1.1 above). Exemplars of not being in control, and not being able to make decisions afforded a sense of frustration and subsequent disempowerment on the part of nurses and midwives were numerous in the data. Most of the negative contributions made in relation to this interweaving theme included situations where the individual practitioner had no control and where managers or indeed the organisation held the control and power over those experiences. This sense of control is found throughout all of the impacting themes also.

*"Its difficult being empowered if you don't have control and power yourself"*  
FGD 3

*"You need to feel, you know, you need to feel the autonomy to make decisions..."*  
FGD 2

*" [Having] total control over the normal ante natal care, that would be empowerment from a midwife point of view"* FGD3

It is notable that this participant continued in saying that her 'control' of antenatal care was determined by others.

*"The nursing decisions that we make, they have to be within agreed parameters, according to our managers" FGD 3*

However, perceived control was deemed to be essential for empowerment

*"I suppose empowerment means...being confident in what you do, in your practice you know, and I suppose really having control." FGD 8*

*"I would find that you have the responsibility without all of the authority or the autonomy" FGD 2*

The aspect of having control over, or in some cases access to resources to practice effectively was deemed as an essential element for empowerment. This can be equated with the supply line of resources deemed necessary for control over practice conditions (Kanter 1993). Availability of resources such as equipment, money and human resources are highlighted as impacting factors. (See section 3.7.4.2 below).

### **3.6 Key themes - Impacting factors**

As highlighted earlier, six themes emerged from the data which illustrated factors which had the capacity to impact on nurses' and midwives' inherent beliefs about empowerment. The fact that these impacting factors were easily identifiable in the data in comparison to the inherent empowerment beliefs described above, suggests that perhaps nurses and midwives are able to clearly identify impacting factors more so than actually defining the term. Downie (1994) outlines that ostensive definitions often highlight attributes of something in an attempt to explain it as opposed to nominally defining it. This phenomenon of identifying associated factors of empowerment was identified by Kuokkanen and Leino Kilpi (2001) who explored qualities of

empowered nurses. It is of note that Kuokkanen and Leino Kilpi found that aspects of their themes; moral principles, personal integrity, expertise, future orientatedness and sociability could be detected either positively or negatively in relation to empowerment. The labile nature of the impacting themes which emerged in this study somewhat reflects Kuokkanen and Leino Kilpi's findings insofar as they could be applied positively or negatively and the application of these factors determined empowerment experiences amongst nurses and midwives. In order to maintain consistency, sub themes arising from the impacting factors are presented as neutrally worded as possible. Experiences that arose from positive (empowering) or negative (disempowering) application of such sub themes are also presented where they arose in the data. It is worth noting that whilst participants identified the potentially positive impact of these factors, the majority of contributions made by nurses and midwives reflected experiences resulting from their negative application.

### 3.7 Organisational factors

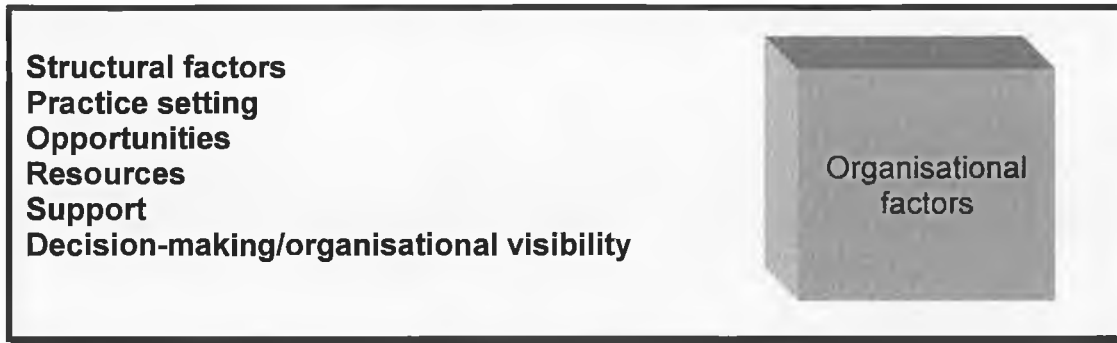


Figure 7. Organisational factors

#### 3.7.1 Structural factors

##### 3.7.1.1 Size of the organisation

It appeared that the actual size of the organisation could potentially affect an individual's experience of empowerment. It seems that a smaller organisation, according to the participants, is potentially more empowering than a larger one. The following examples illustrate experiences of working in organisations of differing size.

*"I would say...[practitioners were] ...a lot more empowered within the smaller working unit. We were busy, but at the same time we kept, we seemed to have more control on what was going on, we seem to be able to have a better rapport with the doctors, and we certainly worked a lot more independently". FGD 4*

A comparison to working in a bigger organisation was also made.

*In a "bigger unit...[one has the potential to be] disempowered...it was bigger...busier...[the practitioners] couldn't seem to get to grips and they became extremely disillusioned because they had lost their empowerment... they were being swallowed up within this busy system...the doctor seemed to have more control...this is the way things are done in a busy unit type of thing". FGD 4*

One participant, however, said the following in relation to working in a smaller organisation.

*"I suppose my thoughts are... a small organisation can be very empowering and ours is a very small organisation. But the one thing you have to careful about, that every day is they don't abuse that empowerment that they give you, and they can have a tendency... then that's the time you need to say, no".*  
FGD 7

One participant made a reference to the healthcare "system" restricting empowerment.

*"It's the system has got a lot to do with how people feel...the system knocks against empowerment" FGD 1*

#### **3.7.1.2 Flattened structures**

Working in a service with a 'flattened structure' within the community was felt to be an empowering environment as follows:

*" We probably have a fairly empowered kind of working place but its only sometimes when you speak to your friends who work in a hospital setting you kind of then realise sometimes there are quite vast differences in the areas in which you work". FGD 1*

#### **3.7.1.3 Statutory versus voluntary organisations**

There was some interesting debate in one of the focus group discussions regarding voluntary organisations excelling in performance compared with state-funded organisations. Taking the initiative, being led by the service user and being highly organised were aspects of voluntary organisations which the participants felt made them stand out compared to state organisations. It was also felt that the voluntary organisations were taking the lead in relation to general developments and innovations.



### 3.7.2 Practice setting

According to the participants, particular settings seemed to offer more potential for empowerment than others. Some participants gave examples of their experiences of practising overseas and compared their experiences to the Irish context. Within the country of Ireland in general, the hospital setting appeared to be the least amenable to empowerment and the community setting was verbalised as the most empowering practice setting as it was felt that there was more scope for independent practice. However, a paradox was expressed by practitioners in the community setting. Working independently appeared to bring a feeling of isolation also. The following are some quotations made in relation to this area.

*"I think the structure particularly in the hospital setting we are at times disempowered". FGD 3*

*"I think it's easier if you work in the community to be more empowered than it is to be working in a hospital- there are too many people around who are disempowering, watching everything you are doing so its easier in the community to do what you want to do". FGD 3*

A participant working in the community outlined what she felt was a difference between practising in a rural versus an urban setting.

*"I worked for ... years in Dublin and just moved... last year and I must say (the new rural area of practice would) be a more positive culture as regards decision making independent practice, just small things that would be annoying in Dublin. For example, if we were changing something in the health centre, we could not make that decision on our own, somebody else would have to approve it before a penny would be spent...(in the rural area of practice) at the moment...nobody has ever questioned anything in the ordering I've ever done... it's automatic if it's me who is working in it, it's taken that I'm the one, that will know what I need in my own area you know". FGD 5*

Some participants felt that political influences also affected the practice setting.

*"I think there's a difference too in the community and we'll probably be experiencing that. I mean money will be poured into hospitals because they're buildings and they're vote catching I suppose for the politicians and the community...isn't seen that way". FGD 10*

### **3.7.2.1 Working environment**

One interesting contribution made asserted the importance of having the appropriate facilities to deal with patients/clients, as a factor that affects empowerment. Another participant felt that looking after patients on corridors was disempowering.

### **3.7.2.2 Clinical audits**

There was some discussion about the increasing demand by the organisation and management alike towards "showing numbers", with a lot of negative comments about this. Clinical audits appeared to have worked well for some individuals, others mentioned the fact that it is impossible to document all of the things that nurses and midwives actually do. In relation to clinical audits, one discussion ensued as follows:

Participant 1	<i>"I've been a public health...for... years and I've been filling in all those blooming forms for that length of time...I think why I'm a little bit cynical about empowerment as such".</i>
Participant 2	<i>"Well...yeah".</i>
Participant 3	<i>"You can have the figures for somebody, if but you need somebody to follow those on and look at them and take them on board".</i>

*FGD 7*

Being able to see the results of work performed and documenting this work was felt to be empowering. However, there was also the negative aspect of clinical audit mentioned and this

emerged in the form of excessive paperwork. The increased volume of paperwork and subsequent time needed to complete audits were felt to be disempowering.

### **3.7.2.3 *The six monthly rotation of doctors***

In Irish healthcare organisations, non-consultant hospital doctors rotate every six months. There was much discussion in the focus group discussions regarding the medical profession and the six monthly changeover of staff. The irony of having new medical staff coming in with no experience and the nurses being expected to train the staff and yet receive no overt recognition of this. This was felt to be disempowering and was verbalised by a number of participants as they felt that they had more experience and had unique knowledge of their patients than the doctors in some circumstances. This led to conflict in relation to dealing with members of the medical profession due to differing power relations between doctors and nurses. These issues are discussed later in interpersonal issues (3.10 below).

*"We have a changeover of medical staff ... junior doctors come in you have to start handling different things if you're doing procedures and that, it's sort of expected of us because we're not in our own right specialists as such, it's expected of us to teach them how to do it" FGD 2*

*"Every six months new people coming in to paediatrics who wouldn't know which end to put the nappy on and you start off and you start teaching you know and it goes on, something happens while they're only here for six months and you're the one who is here all the time you should have it should be down to you" FGD 7*

One participant verbalised the difference between nursing knowledge and medical knowledge and the power issues between junior house officers and nursing staff on initial rotation to the wards.

*"We have junior House Officers coming down for six months and they've never been in a Psychiatric Hospital in their life. And they're trying to tell us what drugs to prescribe patients and how to deal with this, that and the other, they haven't got a clue, we teach them for six months and they go away feeling better. So that in itself is a form of empowerment. It's great actually". FGD 5*

### **3.7.3 Opportunities**

#### **3.7.3.1 Opportunity to access continuing education**

It appeared that there were regional differences also in relation to this issue. Broadly speaking, there seemed to be clear educational opportunities offered to nurses and midwives. It was the organisational support for staff to attend such courses was lacking (see section 3.7.5.1 below). However, some participants felt that the opportunities for continuing education were problematic because they were either at an inappropriate time or difficult location to get to. Most of the participants in the West of Ireland felt that because most courses were held in Dublin, this was a problem. The inopportune timing of educational courses was mentioned as a barrier to empowerment.

*"They're still only offering two courses for nurses...and two of the courses are two nights a week between 7 and 10 o'clock. I mean if you work a long day, and you're on, you just can't get to them. There isn't the opportunity, there, the course might be there but because you have to work, you're either on nights or days you'd be lucky to get some, or if you do you're there for three weeks and you're missing week four. I mean there isn't the services there or the facilities...for nurses because of the work that they do and the times they work". FGD 5*

The fact that in some cases, managers placed an onus on staff to find their own cover to attend continuing education courses mitigated against nurses and midwives opportunity to attend continuation courses.

### 3.7.4 Resources

#### 3.7.4.1 Staffing levels

It is not surprising given the current climate in the Irish healthcare system that there was a lot of discussion and frustrations voiced in all of the focus group discussions at situations arising from inadequate staffing levels in the workplace. It is indeed difficult to articulate the frustration and emotion expressed within the discussions relating to this theme. *When asked directly about what would enhance empowerment in the focus group discussions, most of the immediate responses were "more staff"*. Having appropriate resources has been highlighted as an essential element in the capacity for empowerment from a structural power perspective (Kanter 1993). Human resources are essential for an effective organisation. The knock-on experience of increased workload resulting from inadequate staffing levels was also discussed at length and quite emotionally. It is important therefore to acknowledge that the contributions made in relation to staffing levels intrinsically link with the comments made in relation to having an increased workload.

*".... People on the ground feel very disempowered...you have... again not enough staff and then you look around at the papers and you have directors of this, that and the other and you wonder what they're doing or what they're directing because there's so few people on the ground". FGD 7*

*"Really you have a task to be done and very little time to do it and fewer people to help you with it, you have to have maybe in this day and age it is considered a luxury to allow yourself to be empowered." FGD 2*

*"In relation to the short staff ...you do some treatment or therapy with a patient but you realise that because you are carrying such large case loads you can't give that time or that service isn't available because there isn't enough personnel there to carry it out, nurses are doing that every day of the week in all settings you know not carrying out full things because there is not enough staff". FGD 2*

The current crisis of not having enough staff seemed to have a ripple effect on numerous practical issues that clearly seems to impact on nurses' and midwives' capacity to experience empowerment. It could be suggested that the current staffing crisis is a confounding variable impacting on empowerment experiences of nurses and midwives.

#### *3.7.4.1.1 Increased workload*

The amount, ferocity and emotion expressed about having an increased workload in all of the focus group discussions cannot be underestimated. Again, this is not surprising given the current staffing crisis in the health services. Closely linked with staffing levels, almost all of the participants felt that having an increased workload was independently disempowering. There was much frustration expressed at being unable to provide appropriate care for one's patients, in particular, the public health nurses who expressed particular exasperation regarding their workloads. The following comments made speak for themselves in relation to the disempowerment felt by practitioners who all seem to have an increased workload.

- |               |   |
|---------------|---|
| Participant 1 | <i>" They are being killed. They're going up from twenty five to thirty one patients, not one person goes up and says 'look it, you're just killed'"</i>  |
| Participant 2 | <i>" Yeah"</i>  |
| Participant 1 | <i>" There's your week on that you've given up three times over because there's no staff. I don't know what they're going to do. It's a completely serious issue, and the fact that they are leaving constantly all the time"</i> |
| Moderator     | <i>"So increasing the work load - there's less staff"</i>   |
| Participant 1 | <i>" Oh, Mmmm"</i>  |
| Participant 2 | <i>" Mmmm"</i>  |
| Participant 1 | <i>"And increasing the pressure. And all these wonderful jobs saying 'we're here to equip you[to work] in the ward'. Nobody can do it in the ward I think, because they're killed." FGD 4</i>                                     |

*"you feel that you're carrying the can for everybody, it can actually have the opposite affect, alright it might make you feel kind of important on the day but it turns you into an awful short-tempered little person for a couple of hours. You'd want to work where I work for an odd day." FGD 2*

*"You may have... ideas...but getting time to sit around and discuss it with your colleagues and getting, getting something up and running like, it's just got so busy". FGD 4*

#### 3.7.4.1.1.1 Increased workload and public health nurses

Participants who were public health nurses expressed particular distress with regard to their increased workload. Having an ever-increasing caseload, and dealing with patients through the lifespan both was not conducive to empowerment. The following represent some of the disempowering experiences felt by these participants.

*"it's the enlargement of our work at the moment as a public health nurse that, how can I?, I sometimes, I feel, I'm, I'm like a fire brigade service, that I'm trying to put out all the fires and I can't focus in on a manageable area". FGD 10*

*"The amount of work...there are days you'd wonder; are you going to spread yourself so thin that you are just going to vapourise and disappear, DISAPPEAR". FGD 10*

*" there is only three[public health nurses] in our catchment area covering 90,000 and when you're trying to develop a role or develop service you just can't with those numbers". FGD 2*

*" I know more and more public health nurses are being burnt out and losing interest and are getting out of the role. I know one girl who's recently left public health nursing because she couldn't take it anymore". FGD 4*

#### **3.7.4.1.2 Administration**

It was also felt that there was an increasing amount of paperwork to contend with which undoubtedly increased the nursing workload. There was a felt need to comply with the added paperwork because of an awareness of litigation.

*"I feel computers are chucking out an awful lot of work to us as well and we're still doing Mr. Plod on the ground". FGD 10*

#### **3.7.4.2 Access to monetary resources**

The theme of having access to resources provoked considerable amount of discussion and debate across all of the focus group discussions. It emerged through these discussions that Mental Handicap nurses appeared to have experienced the most difficulty with regard to accessing resources for their clients. The issue of needing access to resources emerged through a number of different guises. These are discussed further below.

##### **3.7.4.2.1 Budgetary control**

Some participants mentioned the fact that clinical directorates were being set up in their areas. Generally this was felt to be positive as departments had control over their budgets. One participant however stated that some managers had refused to become involved in clinical directorate budget management.

*"When your patient care is suffering you're suffering and it's really disempowers, because you cannot provide with the resources out there you cannot provide an optimum patient care and you feel you are the one that's feels bad about that and I think that's very disempowering". FGD 2*



*"That's the difficulty with us because we're not involved at a financial level with a budgetary level, we might see better ways of spending the same budget...to provide a better service to clients because there's really nobody who's more in touch with the client than the nurses who are day to day dealing with them". FGD 7*

Particularly, mental handicap nurses articulated the bureaucratic difficulties experienced in trying to source money for clients. The frustration expressed at not having control of budgets could be attributable to the nature of their nursing practice.

*"In the field of learning disability working with empowerment for me, it's providing a standard of living for those clients ... and again it's down to resources and funding, and like something as simple as to have a birthday party...you need go through the channels to get it funded you know...because the...client you work with is removed from it...it feels that you're the one that wants it...that's where apathy comes in". FGD 2*

Given the contributions made by all of the participants representing mental handicap nursing, there appear to be real difficulties within this area, which seem to be affecting their experiences of empowerment in practice.

### **3.7.5 Support**

#### **3.7.5.1 Support for continuing education**

Being educated for practice emerged as a base factor which impacted on the inherent empowerment beliefs of nurses and midwives (see section 3.4 above). The positive impact of having opportunities to undertake continuing education was evident from the data.

*"[an individual's] true self comes out you have an opportunity if it's drawn out of you...to improve yourself". FGD 1*

It emerged that staff working in healthcare organisations were clearly provided with opportunities for further educational development. Lack of support and relief to attend courses were clearly disempowering issues. Quite often participants felt disempowered by being unable to access continuing education courses. Some participants from the East of Ireland stated that they had difficulties with accessing monetary resources for continuing education. In general, there did not seem to be a problem in accessing resources for continuing education in the West, North West and South of the country. The irony of this is that a lack of staff mitigated against accessing continuing education in these areas. In one discussion, it was stated that continuing education courses were cancelled in one particular institution due to a lack of staff. Some participants, stated that the actual location of educational courses was not suitable.

*" We're only a small hospital...you're away from Dublin, you've nowhere to go to do any courses".*

*FGD 5*

### **3.7.5.2 Remuneration**

On a more practical level, not being remunerated appropriately for petrol and car maintenance was mentioned as disempowering by public health nurses.

*"[Public health nurses have been remunerated at] the same rate for 20 years for petrol and car maintenance though these have gone up. They are little things but yet they can be very important if you want to empower people". FGD 2*

### 3.7.6 Decision making /Organisational visibility

It seems that being involved in decision making was a determinant of how empowered nurses and midwives are. Examples of involvement were directly linked as empowering and conversely, not being involved in decision making processes, was not empowering.

*"I find that the majority in the health service are nursing professionals and when it comes to say making critical and strategic decisions they are actually a very small number that have that particular input". FGD 2*

A highlighted need to be involved in decision-making was enthusiastically discussed throughout all of the focus group discussions. Participants recognised the value and perhaps the power of being able to make decisions. The identification of a need to be involved in decision-making occurred at 3 different levels. The first level related to clinical practice (clinical autonomy), the second related to development of new services, and the third level relating to strategic representation. These are discussed in further detail in sections below. What was interesting about the contributions of the participants was that frustrations voiced by nurses and midwives about not being involved, particularly in strategic decision making, stemmed from their assertion that they had unique knowledge of the patient. Due to the fact that they had unique knowledge, they felt they could contribute effectively in the decision making process as they felt they would be able to represent the patients best. Kanter (1993) posited that formal power was achievable through jobs which are visible (see section 1.2.1 above). The fact that nurses and midwives stated that they were not involved in decision making could suggest that they do not possess enough formal power particularly at a strategic level.

*It is "supposed to be devolved including like you know staff levels equipment and everything but you know somebody decides that it's more important to paint the kitchen than to get in a couple of cardiac monitors and things like that, the priorities are completely different to what they should be" FGD 2*

### 3.7.6.1 Decision making in relation to clinical practice – clinical autonomy

The participants appeared to be acutely aware of their potential (and ability) to make decisions in the best interest of the patient/client. It emerged from the discussions that decisions relating to patient/client care were sometimes made by persons not in direct patient/client care.

*“We’re experts in our fields in nursing, and I think we’re best placed to make decisions in relation to nursing care for patients, and sometimes that might be expensive or it might cost, but at the same time we’re making it from an area of expertise that we’re trained in”. FGD 4*

*“Staff working on the ground have no say whatsoever, whatever policy the Health Board brings out you have to more or less, whether its sensible or not try to work within that. And I feel that when there is policies being brought out that maybe we don’t agree with, it’s very hard to be empowered or deliver a good service”. FGD 4*

*“We make the decisions, triage decisions, about which patients would be in which category and then... like the minor treatment and things like that we would take on as well but when it would come to making the decisions about who’d get the bed and stuff like that that’s way out of our control”. FGD 2*

Issues arising from limited clinical autonomy are felt to be disempowering. However, these issues are not new (Wilkinson and Miers 1999). It seems that from the last quote, nurses and midwives seem to have autonomy in practice yet acknowledge that they are limited in particular circumstances. An Bord Altranais (2000b) state that nurses need to define the parameters of their clinical autonomy. This data suggests that the parameters of autonomy remain a somewhat grey area. The fact that strategic decisions were being made without consulting them was felt to be an inhibiting factor for empowerment. Practising within an institution was also identified as being restrictive in relation to clinical autonomy:

*“Because I work as part of an institution, I’m not one hundred percent autonomous”. (FGD 7)*

This identification of limited autonomy within an organisation may serve to illustrate a restriction to autonomous nursing and midwifery practice. This is in comparison to the practice setting of the community which was felt to offer a more autonomous (and empowering) way of working.

### **3.7.6.2 Decision making and the development of new services**

Most of the contributions, which were made in relation to this issue, were predominantly negative. The participants illustrated numerous examples highlighting an apparent lack of invitation on behalf of the organisation towards nurses/midwives working in direct patient care in relation to planning or implementation of new services. Again, because participants stated they had unique knowledge of their patients, and worked at such a close level with their patients, they had an understanding of the potentiality of service development. The fact that this was being overlooked by service developers, brought frustration as it impacted on nurses' and midwives' ability to care effectively for their patients.

*"When services are being developed, when strategies are being put in place the nurse is the very last person to be consulted, the person who is out on the ground, the very first person who should be consulted...very often health services are being developed and the nurse has... they've had no input whatsoever and it's very disempowering". FGD 1*

*"The Health Board issues all these fancy leaflets and I don't think, well I know they don't consult us on the ground, as to what to put in that leaflet and what kind of care we could give or deliver". FGD 4*

There were some examples given of being involved in setting up new services. However, of the two individuals who gave examples, both had a similar experience that was initially positive and then became disempowering.

*"You're not really listened to very, very much. It's the people up the line, the managers and whatever and the medical people that at the end of the day have the power...we were asked to get involved in the service planning, we came along...contributed very well... about six months later a complete service plan came out from the Health Board saying this is what you're going to do from twelve months anyway. So I mean it was a wasted exercise, so that doesn't help".*  
FGD 5

From the perspective of participants who contributed to the focus group discussions, not being involved in decisions making regarding new services appears to be disempowering. It is ironic that the individuals who were invited to participate in new service development were eventually disempowered also. Nurses and midwives appear to be very aware of the value of the contribution they could potentially make in relation to developing new services for their patients and clients. Perhaps, service planners and key decision makers could observe and consult with nurses and midwives working within the service prior to developing new services.

### **3.7.6.3 Strategic decision making/ representation.**

Nurses and midwives recognised that they lacked representation in relation to strategic decision making. The appropriate representation of nurses and midwives in comparison to other members of the multidisciplinary team on committees was highlighted also.

*"Within an organisation...the representation of nursing...isn't really there."*  
FGD 1

This suggests that nurses are conscious that they are somewhat invisible in the organisation. In relation to the allocation of resources, some participants articulated examples of what they felt were misdirected resources. The following examples represent the issues that emerged relating to

not having control or consultation with regard to resource allocation. In relation to clinical directorates, one nurse said:

*it is "supposed to be devolved including like you know staff levels equipment and everything but you know somebody decides that it's more important to paint the kitchen than to get in a couple of cardiac monitors and things like that, the priorities are completely different to what they should be" FGD 2*

#### **3.7.6.3.1 Decision-making and centralisation**

In one of the focus group discussions, it was felt that centralisation of decision making was disempowering for nurses and midwives who worked in the community.

*"Health Boards have taken on this role of centralisation...they've disempowered communities...now if I want something... I inform my representative...they go in there and I think that they're going to be there working on behalf of me and they are. But they are powerless themselves because they're depending on the support and votes of their colleagues in the other counties. And that takes the whole community aspect out of it".*

*"It's very easy to make a decision... about things that are going to affect people far away. Cause you're not there at the coal face and you're not seeing the fallout or whatever".*

*FGD 4*

It is possible that the disempowerment felt by this participant relates to a lack of control or involvement in decision making in relation to allocation and access to resources.

#### **3.7.7 Information**

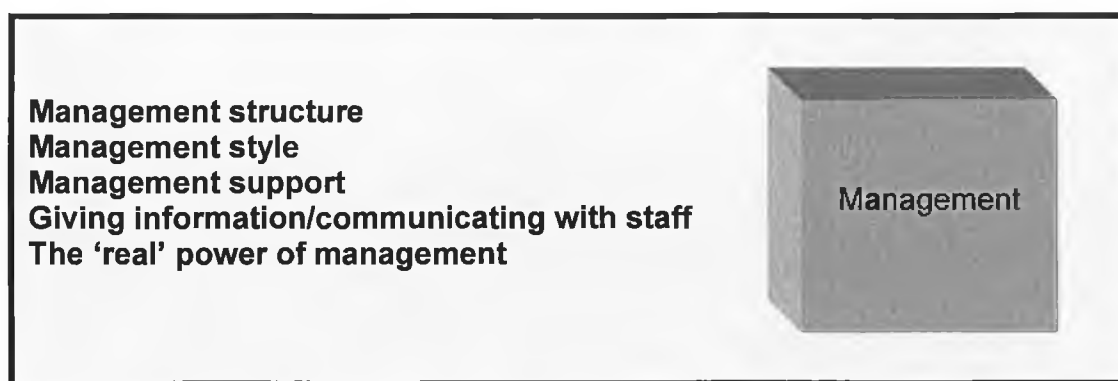
Communication of information, usually in the form of ward meetings was felt to be an important factor impacting on empowerment within an organisation. This became evident in the closing

comments of the focus group discussion, where the importance of and the need for communication was expressed by the majority of participants

*"Yeah, better round communication...I think it would be a good start" "Better communication, more openness, flexibility". FGD 6*

*" Going back to meetings. I'd love to have meetings in work but I can't, for the simple reason is that all our staff rotate on a daily basis...you never have the same ward staff, it's impossible to ward meetings, any continuity of care goes out the window." FGD 5*

### 3.8 Management



**Figure 8. Management**

Many contributions were made in relation to the effect managers have on the individual's experience of empowerment. It seems, from the focus group participants, that effective management is a key factor in promoting staff empowerment. The impact of management on nurses' and midwives' empowerment experiences could have been subsumed into organisational factors given the fact that managers form an integral part of an organisation. From the data, management emerged as a strong, distinct theme which could impact separately on



empowerment experiences. For example, it was possible to distinguish aspects of the negative impact of management within a positive organisation. As a result, the impacting theme of management is presented separately. The majority of participants gave examples of managers' negative impact on nurses and midwives. Some participants seemed to have a critical awareness of their manager and the disempowering (or empowering) effect of their actions. The following section highlights the impact management has on experiences of empowerment.

### **3.8.1 Management structure**

There were some interesting discussions relating to the current management structure relating to hospital management.

*"I suppose at the moment there is a feeling on the ground that it's a top down rather than a bottom up [approach]. FGD 7*

This contribution continued in indicating that people felt disempowered by this approach.

*"I think the nursing hierarchy disempowers an awful lot of people" FGD 3*

Several interesting points were made in relation to the impact the new Clinical Nurse Manager structure has had on the practice area. This links to the new management structure outlined by the Report of the Commission On Nursing (1998).

*"now it's too many bosses... whatever you kind of suggest has to be passed by each one... then it has to go up even higher again and you just feel like if you suggest anything you just say ah here forget it". FGD 3*

It is possible that an increase in the actual number of line managers has effectively resulted in an increase in the traditional nursing hierarchy.

### **3.8.2 Management style**

Throughout the focus group discussions, there were differing opinions and experiences given by participants relating to the style of their respective managers. Generally, it was felt that a helpful and supportive manager was empowering. Having an authoritarian manager who was regimental was felt to be counterproductive for empowerment. From the data, it appears that authoritarian, dictatorial methods of management had been what most participants stated they had experienced in their practice. This was felt to be very disempowering for the participants. The impact managers had on individual perceptions of personal power and control were evident.

*"I suppose the type of management, the style of management, if you work in an area where your manager involves the other members of the team and they'll feel empowered but if they are very autocratic this is the way we do it here it doesn't matter you can make decisions". FGD 6*

*"Where I work what you worked with in another situation this is it, em I think that would disempower me very much." FGD 2*

*" I remember one time standing in for somebody for a clinic and got literally an abusive phone call [from her manager] saying 'who told you should do it?' ... I was obliging you know... management feel they're after power and control of the situation...you're stepping out of your shoes if you decide the management would be very autocratic, 'my way and my way only'. I find that incredibly difficult to deal with on a personal and professional basis and I feel my past is totally gone. Not even disempowered, just gone. You might as well pack your bags and go". FGD 4*

#### **3.8.2.1 Management response to empowerment**

Another interesting issue arose whereby a person perceived by their manager as empowered appears to receive a greater workload.

*"You can be used because you're out there doing things or whatever and then it's kind of someone can turn that around and say 'well you're good at doing that you do this'... it's a contradiction in terms... you find you're landed with an awful lot of stuff...it is very manipulative really" FGD 3*

### **3.8.2.2 Participation versus instruction**

The participants felt that they would feel more empowered if they were asked by their managers to participate in decision making at ward level. This is because such decisions affected their practice and as a result, they felt it would be best if they were included. This links closely with decision making highlighted previously (section 3.7.6 above). Numerous examples of the converse of this, being instructed without consultation, were evident from the data.

*"I think it's very difficult to be empowered when the decisions are made for you in advance." FGD 3*

There was active input made by a number of participants in relation to the issue of being controlled to some extent by one's immediate manager. Several examples were voiced, outlining experiences of managers making decisions for staff without consultation.

*"the decision is already made, arrangements are made, you're going to be there".*

*"It's a very fine line between being asked and being told because sometimes you might feel you're being asked and if you agree that's fine but if you rebel against, if you say well I'm not interested or I don't want to well then that's when ha, ha, ha, you're putting the cat among the pigeons".*

*FGD3*

Some participants identified that non-compliance with managers could be detrimental to their success within the organisation.

#### 3.8.2.2.1 Rostering

Not having any say in or control of the roster was deemed as an inhibiting factor. Some nurses stated that they could not go home after a shift

*“if you’re needed you’ve to stay” FGD 5*

*“ If you want to do your best, you have to be able to do your best” FGD 2*

Having an input into rostering (as opposed to being told when they are to come in to work) would seem to be beneficial for nurses and midwives.

#### 3.8.3 Management support

The issue of being supported by one’s immediate manager occupied a great deal of the focus group discussions. This particularly related to being supported in clinical decisions made. Interpersonal support was also mentioned. Generally, feeling supported by one’s manager appeared to result in an increased experience of empowerment. Consequently, not having the support of one’s manager was felt to be an inhibiting factor which was disempowering for nurses and midwives resulting in reluctance to deal with particular situations occurring in the practice area. Support from one’s manager appears to be an important factor in enabling empowerment as it impacts on inherent beliefs of personal power, control and professional respect.

*“If you don't get support from your superiors you know to be able to go with confidence...this is the decision that should be made, you don't say intervene in something...you can only do it if you know you have the support of your superiors behind you”.*

*“I would know many skilled nurses who hold back they're wary because they won't have the support of people”*

*FGD 2*

The following contribution was made relating to community nursing:

*"You might feel empowered to do something but you're disempowered by a lot of conservatives... you're trying to call in to support you... your empowerment kind of gets a bit diluted because your hands are tied behind your back sometimes."*

FGD 3

### **3.8.3.1 Support for continuing education**

The theme of having to cover relates to participants' experiences of having the onus put on them by managers to arrange their own cover in order to attend continuing education courses. This emerged clearly as an inhibiting factor of empowerment and featured in all of the focus group discussions. This linked with the base theme of education for practice (3.4. above). Staff having to find their own relief found that although there was an opportunity to attend continuing education courses, lack of management support meant that they were as a result discouraged from undertaking continuing education courses. As highlighted earlier, the current staffing crisis means that many practitioners are currently overworked. Participants who wished to attend courses (but find their own relief) were conscious of the impact this would have on their already overworked colleagues. The following are a number of contributions, which express the participants' feelings in relation to this.

*"If someone within the team is doing a course then the other members of that team have to em, take over their work load and that can cause you know a lot of tension at times. It can put quite a large burden on their colleagues...you can feel very disempowered you know, if you're just trying to fit in so many calls during the day". FGD 7*

This onus of having to cover for colleagues who attend continuing educational courses appears to be indirectly disempowering because of the increased workload exerted on the remaining workers.

#### **3.8.4 Giving information/ communicating with staff**

Effective communication between management and staff was voiced consistently throughout the focus group discussions as an enhancing factor for empowerment in the workplace. All participants when speaking in relation to communication, unanimously felt that communication from one's manager was a very important factor. One participant voiced a need for managers to divulge information to staff members for empowerment to occur. This links with the need for information as necessary for empowerment in the workplace (Kanter 1993). Formal communication as performance appraisal was one of the methods suggested to positively impact on nurses' and midwives' empowerment experiences. According to the participants in this study, this method does not seem to be prevalent in nursing or midwifery management practices.

Communication from managers was empowering because nurses and midwives could gain a greater clarity of understanding from both perspectives (manager and employee alike). Giving information, either informally or formally, through appraisal mechanisms enabled nurses and midwives as it gave them a medium to evaluate their performance and potentially gain recognition for good performance also.

Participant 1      *" If you get positive feedback from your colleagues and manager that'll be enough sometimes".*

Participant 2      *" Yeah".*

Participant 3      *"I think that's very important...positive feedback I mean you could put that number one on top of the list. You don't need monetary, well everyone needs monetary ...but we're not asking for that. But positive feedback at ward level definitely". FGD 5*

*"Communication is a fundamental thing in empowerment...you have to go to your manager, you have to discuss your case with your manager and decide a strategy and in conjunction with them that you as a clinical expert I think is the way to go forward". FGD 3*

*"It's a matter of...getting these ideas across to your colleagues at a, you know, higher level of management or a lower level. But it's all to do with collaboration and communication across the way rather than up and down". FGD 4*

*"empowerment for me in my department would be staff meetings, that is one area that you know I am very keen to keep abreast with because when I came it wasn't a routine structure that was in place for meetings to take place". FGD 3*

Another viewpoint regarding the knowledge of the nurse's role of management and those in authority was made as follows:

*"When other people in authority accept you can be empowered... they're not sure of what we are supposed to be doing and what we are covered as it were, to do, then they can't trust us". (FGD 2)*

Perhaps there is a symbiotic benefit to communication in clarifying role expectations and building trust between managers and employees alike.

### **3.6.5 Recognising performance**

It was felt in general that being recognised for one's contribution in the workplace was a positively empowering factor. Having a formal staff appraisal was perceived by participants as potentially empowering also. This links with the theme of communication and management

feedback to staff. There were also some examples of negative experiences about being not acknowledged for the work that one is performing. In most cases, informal recognition through positive feedback strategy was felt to be empowering. Others alluded to the need for more tangible rewards.

*“I had been staffing on this unit for three years and one of the nurse managers she called me and said God you're really doing a great job, great like, you know, you do really feel high up, you do feel like you have empowerment and then someone turns around and says 'what did you do that for' and then you're back down to stage one, so staff appraisals, formally and informally, are so important, within in a unit”. FGD 3*

*“ Just [the manager would say] 'can you come in' and I mean if you don't come in then sister is saying 'well God we're really stuck, we've nobody to come in'. And you might have been (working for) five nights like, but you still have to come in to work....because they're stuck.....and no thanks for it no appreciation and not even the word thanks”. FGD 5*

*“I would see it as a problem from senior management down... thank you is not enough to me anymore, I'm sick listening to this, you're doing a great job, you're wonderful, I'm now going to tell them to take it off somewhere else and come to me with something constructive i.e. money and resources and to get this up and running. I think all too often if you keep the show going everything's ok, you know. Staff then at the end of the day just get fed up keeping the show on the road all the time and just get thank you sent down to you every now and again, any old person can send down thank you to you, someone out in the street can say thank you” FGD 3*

#### **3.8.4.1 Listening to staff views**

The need to be listened to by management in relation to suggestions and ideas closely links with the inherent belief of being respected as a professional (see section 3.5.1 above). Some participants mentioned that they felt that in relation to management, they were not listened to either.



*"Being listened to by our superiors... we have lots of experience to put forward and all that sometimes maybe we feel that we're not being listened to as much as we should be listened to". FGD 5*

### **3.6.6 The 'real' power of management?**

This theme interestingly emerged from the participants recognising a discrepancy between supposed and real influential power. The abilities of managers in their positions were questioned also. This theme featured in the majority of the discussions. There were intensive contributions made by several participants in relation to the actual power, and understanding of higher management about issues relating to ground level practice. Kanter (1979) highlighted that middle managers are often in a difficult situation as they are 'piggy in the middle' sandwiched between their subordinates and higher managers. It seems that nurses and midwives possess a critical awareness of the 'real' power of management. The following are some contributions made in relation to this theme

*"Our director of nursing would be very willing to empower her nurses but the CEO is a different, has a different opinion and that's where the buck stops I mean that's where the big decisions on finance and on everything else". FGD 2*

*"[in relation to expanding practice] I didn't get the support that I felt I should have got from management. Now, I then began to wonder has management got the real power at all. Are they up against another bureaucracy...what I'm saying is where is the power?, I'm not blaming management or anything like that but I mean, there must be some blockage somewhere". FGD 10*

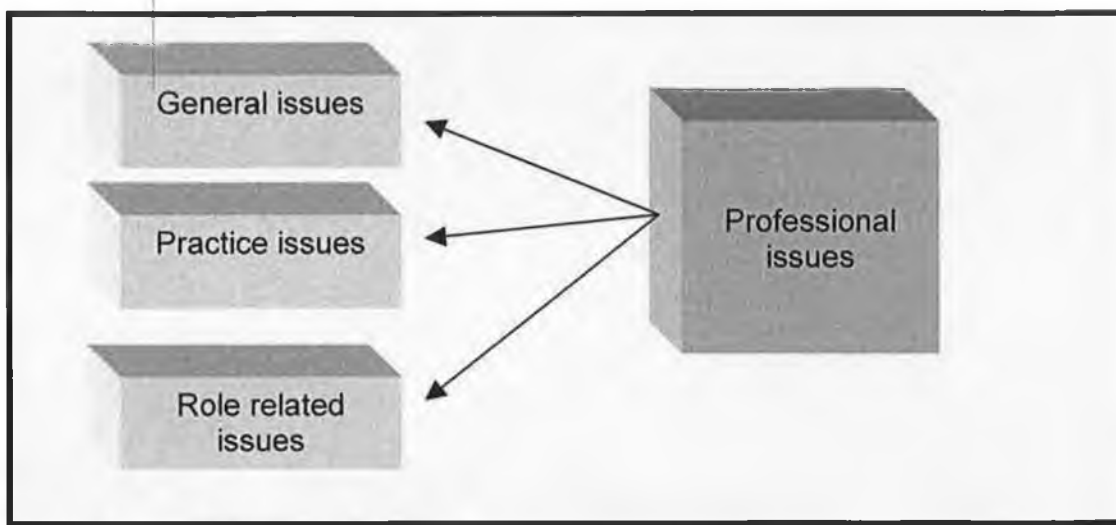
*"I think that the higher the manager is the more people he is answerable to and therefore you know he has to please everybody and therefore their ability to empower you as a clinical practitioner out there on the ground is reduced". FGD 3*

*"Those in authority, our seniors not always having the confidence and the competence to delegate and to question everything that you do...people that are core decision makers are not able to empower themselves...even in management...[managers] are afraid to make decisions in case they're making the wrong decision...I would have experienced a good bit of this". FGD 6*

One participant who was in a managerial position stated the following:

*"I would sometimes feel more disempowered than the staff that I work with because I think that the same support maybe isn't just there from senior nurse managers, you know they're a little bit more removed from the situation than say the support that I would give to the people that I work with, and sometimes when we make decisions it's not supported by senior nurse managers and then that's quite demotivating and disempowering". FGD 5*

### 3.9 Professional issues

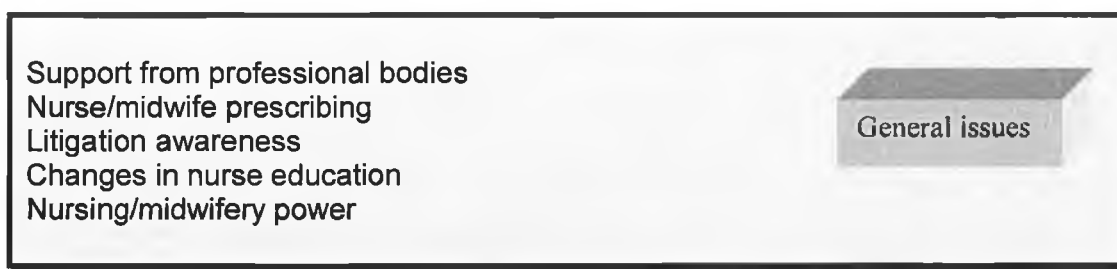


**Figure 9. Professional issues**

A large amount of issues directly relating to the professions of nursing and midwifery emerged as determinants of empowering experiences. This section also provides evidence to illustrate that there are factors unique to the practices of nursing and midwifery which impact on empowerment. The volume of data in this section is unsurprising given the recent changes in both professions (see section 1.3 above). Similarly, role related and practice issues continue to be fervorously discussed in many professional nursing and midwifery journals. This suggests that

although discussions of the nature of nursing and midwifery occur independently of their empowering (or not) impact on nurses and midwives, many have the potential to impact on nurses' and midwives' experiences of empowerment. The following section is further broken down into three areas; general issues, practice issues and role related issues.

### 3.9.1 General issues



**Figure 10. Professional issues – General issues**

#### 3.9.1.1 *Support from professional bodies*

An Bord Altranais (the Irish nursing board) featured on a number of occasions during the focus group discussions. It was generally felt that An Bord Altranais was restrictive in developing or expanding the role of the nurse and midwife. This was despite the recent release of the scope of practice document (An Bord Altranais 2000a)

*"I think the... organisation which doesn't at all empower us anyway as professionals is our own Bord Altranais". FGD 7*

Some direct references were also made in relation to the actual scope of practice document produced by An Bord Altranais. There seemed to be mixed responses, some felt that the document had empowered them, others felt it had limited their practice and was, as a result,

disempowering. Although actual reference to the scope of practice document featured in two of the ten discussions, the mixed responses were evident in both. There was some discussion relating to the need for more protocols and guidelines for practice that would enable individuals to be more confident in carrying out procedures in practice.

### **3.9.1.2 Nurse/midwife Prescribing**

In two of the discussions, it was felt that having the ability to perform some limited prescribing would be empowering. The current frustrations voiced by participants included being unable to prescribe IV fluids, Paracetamol and Pethedine (mentioned by a midwife for women in labour).

*"Just for an example, giving somebody Panadol...we might decide that definitely the person has, is complaining of a headache and they need Panadol, but unless it's written up on the prescription chart we don't have the power to do that".*  
FGD 8

### **3.9.1.3 Litigation awareness**

An awareness of position and legal vulnerability was voiced on a number of occasions. Many participants stated that they felt they were not protected and 'not covered' to perform tasks which they would have previously performed. The issue of 'being covered' to practice emerged from a discussion of the Scope of Practice document and continued into varying debates about what one would 'be covered' to do in an emergency. There appears to be no clear consensus as to what 'being covered' actually meant, although some references are made to a fear of litigation and its perceived restrictions in practice. The following contributions demonstrate the varying debates which took place in relation to this issue.

*"There is a Charter of Patients rights, there's no Charter for the nurses you know, and you're left very, very open to litigation". FGD 4*

*"You know, everything that you write...at the end of the day what you write down at a time of stress...where a patient's life is in danger, you don't have time to write, it's the aftermath when you're sitting shaking, 'thank God everything turned out right but it was by the skin of my teeth', how in the name of God do you sit down and write in detail you know, this is where there is such a weakness, we are just human beings, professionals...We're not protected, I feel we're not. And litigation is so high especially in Ireland. You know that the structures are not in place to help us". FGD 4*

*"I found that the legal aspect of things as well is disempowering too. There are a lot of forms to be filled, there's a lot more detail in the report, em in the institutional settings, in a hospital setting, people are afraid of their lives of litigation". FGD 1*

There appears to be a real need for clarity in relation to the legal framework for practice.

#### **3.9.1.4 Changes in nurse education**

The new training for nurses was generally felt to be a positive step globally for empowerment. Midwifery has yet to change its educational format. However, the perception that students were going to be more assertive and research orientated was felt to be an enhancing factor by both nurses and midwives in the study. This also impacts on nurses' and midwives' inherent empowerment beliefs (see section 3.4 above). Some participants expressed reservations about the selection and trends in the current education of nurses and midwives.

*" I trained in the 60s ... I think that the new training has to be good from that point of view, that they're going to question more." FGD 6*

Interestingly, there was acknowledgement from participants that there was some resistance in the clinical area to the current new method of training nurses and midwives. The following outlines the contribution made regarding this.

*"It's interesting because a lot of the new nurses coming through, you know a lot of the resistance they feel is from existing staff, because staff nurses who weren't empowered or didn't speak out themselves, you know they almost resented maybe the younger people coming in doing it and that'll take time to change really as well." FGD 6*

One experienced participant highlighted that because her status had changed (experienced staff to student midwife), expectations of her had also changed.

*"I was quite a senior staff nurse where I was working and I just felt when I went back to being a student again I was completely disempowered ... no one would trust me to make a decision... you're gone back down to the bottom of the ranking system again". FGD 3*

What this also suggests is as Kanter (1993) highlighted, there may be a link between formal role and empowerment.

### **3.9.1.5 Nursing/ midwifery power**

There were some contradicting issues discussed in relation to the power of nursing as a profession. Some participants felt that nursing and midwifery lacked power while others identified that nursing and midwifery were indeed very powerful entities. The areas where nursing and midwifery alleged powerlessness was evident was primarily in relation to decision making (see section 3.7.6 above) and were notably at a strategic level. Nurses and midwives did acknowledge that education was the key to gaining power at a strategic level. At a local level, it seemed that nurses and midwives possessed power in relation to their patients.

#### 3.9.1.5.1 Power over patients/clients

Several participants stated that nurses and midwives commanded a lot of power over patients and clients. Acknowledgment was also made towards the potential for abuse of that power in the clinical area.

*“A uniform alone gives us a lot of power what people see when we... in the clinic have to wear a white coat if we're taking bloods and it's amazing...I think there is a huge public image of what we're like and how they perceive us, and the amount of power that we actually have over them. People will give you everything when you sit down and tell them who you are as a clinician.” FGD 7*

#### 3.9.1.6 Governmental decisions

In two discussions, reference is also made to the Government and the impact that the decisions made in the past have had on the disciplines of nursing and midwifery.

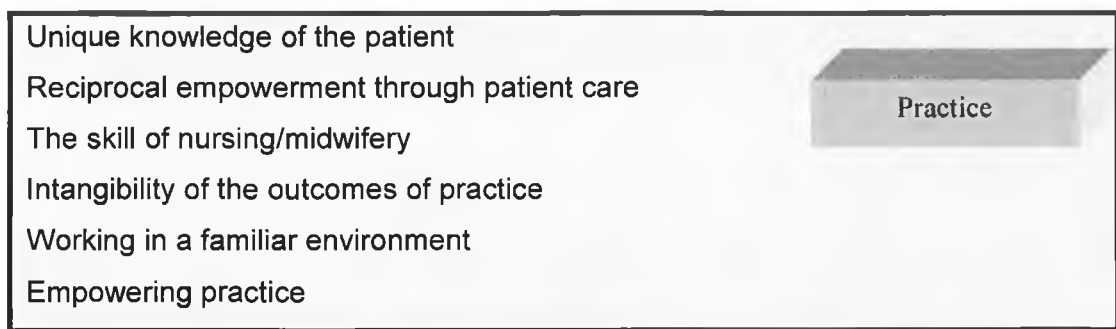
*“the Government are only realising what value a resource we are when they got rid of us all in the 1980s... we're very valuable to... the higher management structures and we are not being utilised to the fullest of our potential”. FGD 2*

*“One of the negative aspects would have come from back at the mid eighties...that is really the nub of the problem today...any of ...that were involved in it at that particular time could have and did say it like at the time that they would see down the road, and envisaged, knew exactly what was going to happen...where you are going to have massive staff shortages...it was as plain as the nose on your face”. FGD 10*

There appears to be a clear identification by the participants of a lack of foresight on behalf of the government of that time which appears to have had a knock-on effect towards the current healthcare situation.

### 3.9.2 Professional issues: Practice

The issues presented below represent aspects somewhat unique to nursing and midwifery practice which were felt to impact on experiences of empowerment.



**Figure 11. Professional issues – Practice**

#### 3.9.2.1 *Unique knowledge of the patient/client*

The phenomenon of knowing the patient best permeated throughout all of the focus group discussions and was passionately articulated by the majority of participants. Having unique knowledge of the patient formed the basis for most of the frustrations voiced by nurses and midwives in relation to factors which impact on empowering experiences. Most of the participants stated that they knew their patients/clients best due to length of time they spent with the patient in comparison to other members of the multidisciplinary team. References to having ‘24 hour’ exposure compared to medical doctors who would only see the patient for a short length of time were evident in the data. The nature of the actual relationship between nurse/midwife and patient/client was highlighted as another feature of this theme. Being ‘on the ground’ with the patients was also something which seemed crucial to this unique knowledge. This was echoed when discussing the need for involvement in decision making, because nurses and midwives felt they had unique knowledge of the patient/client, they felt they were uniquely



able to contribute effectively in making decisions in the best interest of the client. Perhaps this unique relationship is core to the art of nursing and midwifery and is independently empowering.

The following are some examples given by the participants, which illustrate their feelings.

*"[The nurse] is the person who is there on the ground all the time, who is seeing the patient or the client at their very worst or their very best" FGD 3*

*"Its like a cake with cream or something...we're there in every layer you know. We're like something that goes through the whole...through everything, you know, like the mesh, we'll say... others can come in and come out, and doctors come in and come out and do you know, experts come in and come out, but we're there through the whole system, we are there" FGD 10*

*"I feel empowered in the team and probably because of the knowledge that I would have of the client which would differ from a consultant or the registrar, the registrars train and change everything so they don't really know the core group of patients, they wouldn't attain a deep knowledge that I would have" FGD 1*

*"I feel... the fact that they're 24 hours they are giving the care...they know the patients better than anyone else and yet..." FGD 2*

*"The people on the ground are the one's that know what's going on... they're not listened to." FGD 2*

Having unique knowledge of patients or clients seemed to be viewed as a positive feature unique to nurses and midwives in practice. However, it is notable that this knowledge was not being 'tapped' and as a result, was counterproductive to nurses and midwives empowerment experiences. It is interesting to note that there were also negative connotations about having such long periods of contact with patients in comparison to other healthcare workers.

*"I think that another valuable thing to note is that twenty-four hour cover that is provided they're there continuously throughout the day ...you don't often see that with people who are empowered workers". FGD 2*

#### *3.9.2.1.1 Clinical experience*

Linked with having unique knowledge of the patient/client is the value placed by nurses and midwives on clinical experience. Some participants highlighted the fact that they had decades of experience in their particular field and knew more than the medical profession. Whether this was viewed as empowering seemed to depend on the confidence of the individual participant.

*"We shouldn't take a back seat when they come down, 'oh there's a doctor they must be best', they don't, we're the experts, a number of the staff... have twenty-five, thirty years experience, you know. And intuition has a lot to say for itself as well, you know, we all have evidence based care, it's coming in but we must never forget experience is also crucial." FGD 5*

The issue of standing by one's professional opinion arose on a number of occasions throughout the focus group discussion. This was initially mentioned in relation to the medical profession but branched out to encompass management also. Having the knowledge and confidence to stand by one's professional opinion were also felt to be vital factors in empowering the practitioner. This is also evident as an inherent empowerment belief (section 3.4 above).

#### *3.9.2.2 Reciprocal empowerment through patient/client care*

The theme of reciprocity of empowerment relates specifically to nurses and midwives stating that they experience empowerment from caring for their patients/clients. The reciprocity of empowerment was also a conceptualisation of empowerment also (section 3.2 above). Perhaps this feeling relates an intrinsic sense of meaning and impact similar to the view of empowerment as outlined by Thomas and Velthouse (1990). There were a number of interesting contributions made which demonstrate the reciprocal effect of empowerment for nurses as a result of empowering patients/clients.

*"The client, that what I've done has been important or the family or em you know ... where I've managed to get them to talk, that is something, I feel empowered myself". FGD 3*

*"If the people we're attending are satisfied, you get a certain empowerment from that". FGD 4*

*"empowerment to me would be like in the area of cancer care that I am hopefully giving patients and educating patients and their families" FGD 3*

### **3.9.2.3 The skill of nursing/midwifery**

In relation to the skill of nursing, one participant made the following comment.

*"I think sometimes we're so focused on education now that we forget that... nursing and midwifery is a skill. First and foremost I think it's a skill and I don't think everybody has in them to be a nurse or a midwife really. But, we're sort of, I think people have sort of gone away from being skill based. I'm not saying that that's good or bad but we're so focused on education now that we forget about mentioning the word skilled, it just isn't mentioned anymore." FGD 6*

### **3.9.2.4 Intangibility of the outcomes of practice**

The fact that the outcomes of nursing and midwifery were difficult to measure were raised as a difficulty in empowering nurses and midwives. Kanter (1993) asserted that formal power could be gained through activities which are extraordinary, visible and relevant. The care of ill and vulnerable humans could be viewed as extraordinary and clearly relevant. Whether it is visible within the healthcare setting remains unclear. This aspect links with performing clinical audits within the organisation (section 3.7.2.2 above).

*"Well there's never a cry about health unless there's ill health occurring any way do you know".*

*In the community, it's...more difficult you know. How do you quantify better health? How do you get investment because you can show [results]".*

*FGD 10*

### **3.9.2.5 Working in a familiar environment**

It seems that working in a familiar environment is a determinant of empowerment amongst nurses and midwives. This could be due to the fact that practitioners who practised in familiar environments ought to be more experienced and perhaps possess the relevant education to practice in that area. There were some detailed experiences given by the participants relating to being moved to different practice areas in the focus group discussions. It seems that being moved, negatively affected empowerment. The consensus from the experience of being moved included feeling out of control and extremely vulnerable. At the same time she felt a sense of responsibility for the patients and the staff working in that area.

*"It's some poor patient in the bed... I might be able to help them out... if it's only just give them a bedpan". FGD 6*

### **3.9.2.6 Empowering practice**

In the focus group discussions, participants gave examples of their current experiences of being empowered in their practice setting. These experiences are grouped together in order to illustrate the commonalities inherent in practices perceived to be empowering. It was notable that in many cases, inherent empowerment beliefs were realised as a result of the empowering practice that the participant was involved in.

What was very interesting was that in relation to the potential for empowering practice, midwifery offered the most potential for empowering practice. This acknowledgement was

made by midwives and non-midwives also. The following section highlights the exemplars of empowering practice provided by the participants.

#### *3.9.2.6.1 Performing effectively*

Some participants felt simply that being able to do one's job well was empowering. Having continuity of care with patients was also verbalised as an enhancing factor for empowerment. There is a notable comparison with Kanter (1993) definition of empowerment as 'getting things done' in this participant's example.

*"When things are getting done and you're giving service to the client and things are happening you feel more empowered". FGD 2*

#### *3.9.2.6.2 Working independently*

Closely linked with the above theme, several participants articulated that working independently was empowering. It could be suggested that working independently infers a greater potential for autonomous decision making thus enhancing inherent control beliefs. Similarly, it seems that personal power is enhanced as having the confidence and belief in one's own self-efficacy is voiced. Although not specified, it could be suggested that having the formal power through a clearly defined role could be a determinant also.

*"Working as an independent practitioner, I certainly would experience... a feeling of having the confidence to make decisions... regarding patient care... I would feel empowered to ... come up with the best plan for the patient and their family and so I would feel ... empowered in that way." FGD 7*

#### 3.9.2.6.3 Nurse/midwife led services

In all of the focus group discussions, nurse and midwife led services and clinics were felt to be empowering. The benefits to practitioners and patients/clients were clearly articulated. All of the examples gave illustrations of having a degree of control (decision making power), either formally or through autonomous nursing practice. The following examples represent the diversity of nurse and midwife led services which represent empowering practice.

*"as a midwife the fact that I would run a midwife clinic for ante-natal patients, where I would have total control of the normal ante-natal care that that would be empowerment from a midwife point of view". FGD 3*

Being able to administer care from home was also perceived as empowering. This was because nurses could assess and make decisions in the home care setting about patient care.

*"Recently... the home based nursing had been set up and that's where acute care is given at home by a set up of nurses. ....CPNs are now sent out to assess the home situation. That's a new thing and it has given us empowerment, and definitely makes you feel you're useful and you're doing a good job...that has empowered us now, I would find that rewarding." FGD 4*

From a general nursing perspective, being able to triage patients was highlighted as empowering.

*"I work in triage in A&E... this is where the patient is assessed on arrival and you decide what treatment they need for the presenting problem. So I would see the patient when he/she checks in and decide if they're urgent or non-urgent, so I'd be making the decision for the patient at that stage". FGD 2*

#### 3.7.3.5.1 Making decisions

Related to the theme of involvement in decision-making, participants who had experiences of being able to make decisions in practice felt that this was empowering. One participant stated the

fact that he worked in conjunction with a consultant and was able to make decisions about the admission and care of patients/clients was very empowering. The support this participant stated he received from this consultant was verbalised as very positive also.

*"I mean if I go into work tomorrow and I feel that something has to be done I know I can go ahead and do it... I then kind of say it to everyone... she wasn't feeling well and I got the doctor to look at her" FGD 3*

#### 3.9.2.6.4 Specialist nursing practice (including Clinical Nurse Specialists).

There was much interest and discussion surrounding specialist nurse practice and its potential for empowerment. Generally, it was felt that being able to practice as a specialist was empowering. This was felt to be due to clearly defined roles, formal authority, respect from other healthcare professionals and specialist education for practice that gave participants an enhanced sense of personal power. Again, the aspects voiced as positive features of practice are parallel with inherent empowerment beliefs (see section 3.4 above). Participants, who were not in specialist nursing practice or Clinical Nurse Specialists (CNS) mostly concurred with the view of specialist nursing practice as being potentially empowering.

*" It's a day unit, opened just Monday to Friday and hone 'stly now we feel very empowered... We would work very much from protocols, our consultant visits once a week and I find it great actually. We can make decisions according to a protocol, so we can ring and get an answer straight away instead of maybe bleeping a doctor in the morning here in the wards and you haven't got a decision until the next day. You know we can get decisions made like that... moving to the specialist area I think... money isn't a problem at the minute... that's just the way I feel, I feel empowered... we've been recognised as a clinical nurse specialist recently on that, that helps too." FGD 4*

Negative aspects of specialist practice or being a CNS were also voiced.

*"That's the difficulty with specialisation as well because very often isn't the educational support...there isn't any area that I can study as such that is specific to the area that I work in...then you become too specific...and you're cornered into it...there's no course in Ireland that you can actually do". FGD 7*

*"There's only one of me...There's a lot more things I could do...I could expand that if there was another person that could be there with me, or that could fill in for me when I go on holidays...I spend my two weeks before I go, trying to organise everybody in all the groups from the different disciplines...I suppose I'm given a certain amount and it's taken back in the next". FGD 4*

*"The negative bit can be is...this one is getting loads, this person is getting loads of empowerment so we'll just throw on more work". FGD 7*

In one discussion, a negative impact of specialist nurses was voiced. Note that the disempowering effect of specialist nurses related to participants' fears of losing their skills or education for practice.

- |               |   |
|---------------|---|
| Participant 1 | <i>"We have about eight or nine specialist nurses coming in. I think that general, on the ward we do feel a little bit disempowered because we have all of those people coming in advising us what to do".</i>                    |
| Participant 2 | <i>"Come Friday evening they have all gone off. So Saturday Sunday, we have to pick up the pieces, so I feel that they should give us maybe more education, the specialist nurses. We can't keep up with all of it you know."</i> |

*FGD 10*

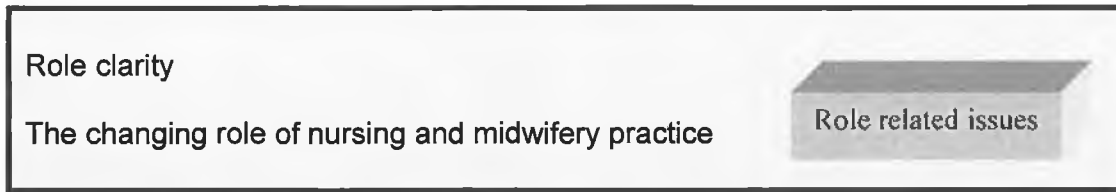
### *3.7.3.7 Experience overseas*

Participants who had worked overseas, clearly articulated that they felt more empowered in their practice compared to the Irish context. It was felt that having overseas experience was empowering as it gave the individual confidence to practice more effectively.

*"In England I think you're more empowered, you are the voice and you could do stuff..." FGD 2*



### 3.9.3 Professional issues: Role related issues



**Figure 12. Professional issues – Role Related Issues**

The role of the nurse and midwife was discussed at length in the majority of the focus group discussions. Generally speaking, having a clearly defined role equated with empowerment and contrary to empowerment was a poorly or non-defined role. Lack of role clarity was highlighted in the literature as a contextual factor detracting from empowerment (See section 1.2.2 above) Issues of consistency and awareness of what a nurse or midwife should be performing arose along with the long debated issue of performing non nursing duties were raised throughout the discussions.

#### **3.9.3.1 Role clarity**

It seems that having a clearly defined role impacts positively on empowerment experiences. What became evident from the data was that in the majority of cases, the role of the nurse or midwife is not clear. More often than not, the complex role of the nurse was identified.

*“with specialisation with I mean, nursing used to be nursing, now it's highly complex... if we don't know what each other are doing then how the hell can we explain the complexity of it or pass the complexity back.” FGD 10*

Difficulties in articulating the role of the nurse/midwife became apparent from the data. Many participants expressed a desire to have their roles clarified to enable empowerment to occur. This was echoed at a number of stages during the discussions. Not having a clearly defined role

resulted in differences in expectations between managers and participants which was problematic. The issue of having to perform non-nursing duties was voiced as being frustrating and disempowering. The origin of this seems to stem from nurses and midwives not having a sense of control over the boundaries of their role and subsequently, their practice.

*"We don't really have a very clear job description...one person's interpretation of what I should be doing could be different to mine. You know, particularly as regards prioritising work... I would have some difficulties with my management over decisions that I would have made and they would say 'you should be doing that', and I would say 'I just can't'". FGD 5*

*"A basic job description because our managers have different expectations in different health board areas as to what our jobs are. And sometimes that differs from the people that's working on the ground what they think what their jobs are" FGD 4*

*"I think a lot of people they don't really know what we do". FGD 3*

#### 3.7.4.4 Non-nursing duties

Having to perform non-nursing duties was felt to be disempowering and affecting the recognition of nursing as a profession. There was some discussion also about non-nursing duties adversely affecting the individuals experience of empowerment. It was also felt that delegating non-nursing duties to appropriate staff would "give us more time to do what we're trained for" FGD 4.

*"In a hospital setting as well, to be able to get away from doing non nursing duties... before we can start really to be empowered." FGD 5*

*"We've taken on every role. If something needs to be done and nobody else is going to do it I just think ' Jesus, I better do it because there will be trouble if I don't do it". FGD 4*

*"...it's only recently in our place that we've got a cleaner in the evenings from five to nine and no matter what staff is between five and nine you didn't have anybody actually to do it". FGD 9*

#### 3.7.4.6 Role misunderstanding

Many of the participants stated that their roles are frequently unknown or misunderstood by people with whom they have regular contact. This was felt to be disempowering as the expectations of others, in relation to the role, would not meet with practitioner perceptions.

*A "dietician or a psychologist or a doctor or whoever it is who very often sort of would have very few ideas about what a nurse would be and where the nurses role is, and I think where we realise that our role has expanded that people other health care professionals have no concept whatsoever of how our practice has expanded". FGD 3*

One participant gave an interesting example of her experience of her higher management's perception of her actual role.

*"We found our Director of Nursing had no idea what our job was. So we wrote it all down for her point by point and now she knows what we do and where our difficulties are coming from. We spent a long time doing it." FGD 7*

#### 3.9.3.1.1 Public perceptions

Some participants felt that the general public did not recognise the professionalism of nurses and midwives. It emerged in some of the focus group discussions that the public was cautious and uncertain about the authority of the practitioners. This was especially the case in relation to nurse and midwife led services. This is understandable given the newness of such innovations. Participants who were specialists, stated that a lot of their time is spent re-educating the public in relation to their role.

*"It's just nurse, you know she's always there at everybody's beck and call, whether it's a patient, or it's a doctor or the relatives or whoever I think it's just they've no recognition". FGD 2*

*"I was going into a house one day and a man said to me 'did you see the cow...he said 'I mean the milk, is it at the gate? And I did see the milk at the gate and I said 'Oh I didn't see it'. And he said 'I thought you could have brought it in'. You know that's the public's perception of sometimes what you are". FGD 4*

*"The image that [the public] give you as a midwife is quite funny... they all think that we're forty, spinsters, ride bicycles and we're absolute hags... God it's all batty you know. [The public think] We're power tripping, very powerful women who will tell you exactly what to do and don't even question it". FGD 7*

*"I would find that sometimes you know...families can have an idea that em, you know, as a nurse that you're literally going to you know, come in and camp in their house, and literally you know wave a magic wand and take over and fix everything". FGD 7*

*"I think that...the title nursing was disempowering, we almost should have changed it to something else because the historic thing ... it's got a very limited vision of, you know people have a limited vision of what a nurse is and reflect then the way its changed". FGD 3*

### **3.9.3.2 The changing role of nursing and midwifery practice**

Several aspects arose in relation to the changing role of nursing and midwifery. Some participants illustrated that what was previously part of their role is now not part of it at all.

*"We would be continually meeting new problems that we wouldn't have been meeting ten or fifteen years ago and an example of that probably, and you have come across it as well, is that we are meeting an awful lot of second and third generation mental handicapped, a lot of mothers with babies who have a learning disability and the grandparents who have as well". FGD 3*

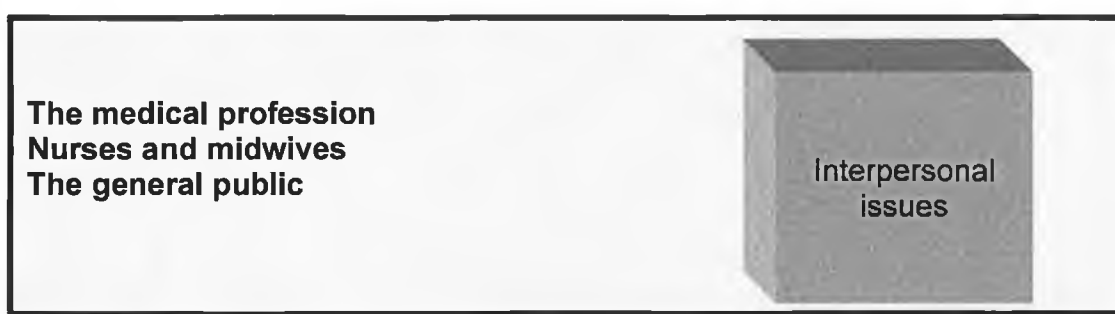
*"I think its important for us as nurses to help our colleagues and our other healthcare professionals to see how far we really have come... we're not mopping the brows anymore". FGD 3*

In relation to expanding the role of the nurse/midwife, some concerns were voiced.

*"I would have huge concerns for nursing as a profession if that's what we're going to take on, because we'll always run second best to medicals if we're going to do that...there's a very fine line and we have to be very careful".*

FGD 7

### 3.10 Interpersonal issues



**Figure 13. Interpersonal issues**

Interpersonal factors are categorised as such because they relate to interactions between individuals which in turn, impact on nurses' and midwives' empowerment experiences. This theme clearly links with the inherent empowerment belief of professional respect. This theme illustrates interpersonal issues which were articulated to impact on perceptions of being respected as a professional. Again, it is notable that most of the examples were negative, highlighting disempowering experiences resulting from interactions with other parties. The following section represents further elaboration about the groups of people which were felt to impact on nurses' and midwives' experiences of empowerment.

### 3.10.1 The medical profession

It is notable that mostly negative examples were made by the participants about their experiences with the medical profession. It is interesting to note also that the majority of contributions included giving examples of conflicts in practice. One participant described a situation where she was bullied by several members of the medical profession. The nub of frustration seems to result from their belief that they had unique knowledge of the patient yet this was not acknowledged at times. Participants clearly felt that they had knowledge and experience to make decisions yet the consultant always had the final authority. These conflicts of opinion are viewed negatively due to the fact that there is a perceived lack of respect for nursing judgement by doctors. Expressions of limited autonomy are also evident. This links with the inherent empowerment belief of control (see section 3.5.3 above)

*"If you come up with a lovely idea, you have the backup of management and they agree with you to go ahead and then you meet this brick wall with the obstetricians and em, like you're just floored... whatever empowerment that you had for your new ideas you've spoken to management, you've spoken to all the girls that work and everyone thinks it's a great idea and then, like, it stops. As I said with midwifery like, there's great scope for empowerment with both the midwife and for the mothers as well but there's that obstacle there". FGD 5*

*"We look after clients... we work together. When I feel...or one of my colleagues say they're ready for discharge, we go to meetings and we discuss with the consultant and all he does is turn around and say 'ah no we'll keep him for another few days'. When there's no clinical reason why he should be in that place. We're the one's who look after them twenty four hours a day, not for five minutes a day". FGD 5*

*"There are areas where I would be able to make a decision and I should be able to make a decision, but again, you're kind of shot down you know you have to sanction it with the medical profession before you can proceed with it". FGD 4*

*"You don't actually tell a doctor especially our one what you think is wrong...you're not really thanked for it". FGD 5*

*"You go to the doctors to check up this or to write up the medication but yet you're telling them what medication to write up". FGD 7*

*"Sometimes medical staff are not really open to what you have to say ". FGD 2*

One participant spoke initially of the power historically enjoyed by the medical profession and how that is affecting nurses and midwives today:

*"We...have to break down the barriers that the medical staff had over staff and still have...where they're constantly putting us down, and staff are actually afraid to make a decision without their consent. Closed medical models and that's where we have to go first before we talk about empowering...staff." FGD 5*

### **3.10.1.1 Lack of professional respect from the medical profession**

Numerous examples of not being respected by the medical profession were evident in the data.

This example relates to a procedure which was attempted without contact or collaboration with the nurse manager involved.

*"I was just so annoyed and so mad to think that he didn't have the courtesy to ring me, he organised all the other disciplines that would be needed for that case except without speaking with nursing and he probably... thought that he could walk over me". FGD 3*

Conflicts arising from doctors not believing the expanded role of the nurse/midwife were also evident. This example relates to mental health nursing.

*"I had referred a person to the clinic and (the doctor said) 'you cannot refer this person to the clinic you're a nurse', that's exactly how he said it to me and I said but I can and he said 'no I must have a GP's letter' and I had to explain to him that within the service that we provided that it was a nurse-led and it was as a result of the nursing diagnosis that I made... the psychiatric registrar found it very hard and went to the Consultant and went to the RMS, and who does this nurse think she is but fortunately I had the support of the RMS" FGD 7*

### 3.10.2 Nurses and midwives

*"I think we as midwives and nurses we need to empower each other a little bit better. I don't think we're very good at it, I don't think we're very good at telling each other we do a good job...I don't think as nurses and midwives we're very good at that, very good at seeing it from other perspectives, in doctors and other groups but not on our own front door. I think our first form is to empower each other, to say that we do a damn good job and start respecting each other... but respecting each other, respecting each others qualities, and actually acknowledging that...it doesn't have to come from management. Management aren't on the shop floor every day but I think if...as a team then you can come and say this is where the shortfall is and if you all agree... that's when you move on I think." FGD 4*

Having collegial support was felt to positively impact on empowerment experiences. One participant stated that it is important to be supported by colleagues as well as other members of the multidisciplinary team.

*"There is absolutely brilliant support, both from assistants and the staff in the other unit like. We all get on so well and, you know you'd never be stuck, everyone helps out and you know, you'd never have to go as far as management. If there was anything happening on the unit and everyone, just gets on great and there's great support there". FGD 5*

This was not always evident according to the participants.

*"I think it is very important that we as nurses would be supported by our colleagues and also by other members of the team and the team being a dietician or a psychologist or a doctor or whoever it is" FGD 7*

*"I think its important for us as nurses to help our colleagues and our other healthcare professionals...". FGD 3*

Freire (1972) illustrated that oppressed groups often engage in 'horizontal violence' amongst each other. This example could be viewed as an example of such behaviour in relation to deficiencies in professional respect amongst nurses and midwives.



*"I think that, you know, nurses who have specialist skills or who have done specialist courses or specialist education can be disempowered by their colleagues because there will be a bit of begrudgery there 'who does this one think she is' syndrome you know or she only got this because she worked on so and so or she did this for somebody else, and that you're not given credit or recognition by your colleagues for all the effort that you've put into your career you know, it's for your own personal benefit and the benefit of your client, it's not to get back, there's a lot of begrudgery out there I think" FGD 10.*

### **3.10.3 The general public**

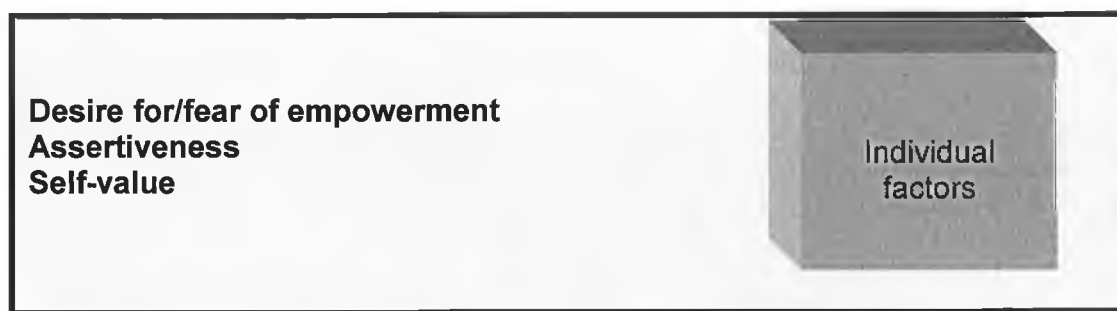
The perceptions and expectations of the general public featured a great deal in all of the focus group discussions. From the data analysed, it appears that there is a substantial amount of public expectation placed on the practising nurse or midwife. Examples of the public perceptions of the role of the nurse are highlighted in role clarity (see section 3.9.3.1 above). It was felt that the general public had increased expectations of the health service generally and also with nurses and midwives. This afforded much discussion and participant agreement. Better education, information and confidence were attributed to be factors which increased the public's expectations. The fact that public health nurses did not hold waiting lists also were expressed as a factor which increased public expectations. Being unable to meet the increasing public's expectations of healthcare was potentially disempowering due to the lack of resources available.

*"I think patients too nowadays have got such high expectations... we are trying to provide for these high expectations because we're so short staffed... We cannot provide the care that they expect". FGD 5*

*"You might be meeting what's available, but it may not be sufficient for the patient because of what they've read... they go looking for that extra, and they keep looking and they keep coming back to you... it's putting terrible pressure on you... you could have somebody else coming to you and saying 'well she got that, I didn't get that...I'm now going to my local politician' ... politics is a big issue". FGD 4*

*"[when the doctor comes] they're so glad to see him, it's all sweetness and light. ... he comes and they're so glad to see him oh here 'thank you doctor you're', and he is gone... we're the face that they see and then they're so glad when the person comes, they don't give out to them and then that person is gone, so they don't feel or hear all the complaints, do you know what I mean? ". FGD 3*

### 3.11 Individual factors



**Figure 14. Individual factors**

This key theme emerged from the participants' acknowledgements that an individual had indeed a significant part to play in impacting towards their own experiences of empowerment. There is a close link between this theme and the personal power beliefs (see section 3.5.2 above) The following is a breakdown of the factors which emerged and a discussion surrounding those factors. Participants clearly highlighted the equal importance of being empowered as a person with being empowered in the workplace. What was interesting was that the element of choice, or desire for empowerment emerged as an impacting factor. References that empowerment 'was up to the person' were evident in the data. Nearing the end of one focus group discussion, the moderator asked what factors need to change for empowerment to occur. An immediate response

of “*ourselves*” was made by a number of participants. This suggests an awareness of the potential for individuals to actively play a part in their own empowerment.

*“Something to go on yourself...It's not given to you”. FGD 6*

Confidence whilst felt as inherent to empowerment, was mentioned as an important impacting factor also.

### **3.11.1 Desire for/fear of empowerment**

- Participant 1 *"Attitude is the one thing that is ours "*.  
Participant 2 *" Yes, yeah. That's our own".*  
Participant 1 *" That's our own and we're the only people that have the absolute ability to change our attitude".*  
Participant 3 *"And not to be influenced by what others think "*.  
Participant 1 *" Exactly".*  
Participant 2 *"And by opening up our attitudes sometimes we're quite closed".*  
*FGD 6*

Two main elements emerged in relation to nurses' and midwives' attitudes towards empowerment. One relates to having the desire or to be willing to be empowered, the other relates to fearing empowerment. It seemed that there was a perception among participants that nurses and midwives have to be 'willing' to be empowered. This desire for empowerment featured in all of the focus group discussions. A lot of indications were made towards the individual being unwilling to 'take on' empowerment. As highlighted previously in the analysis, control (and its associated responsibility) was conceptualised as inherent to empowerment (section 3.5.3 above). There were also references made about the 'extra workload' or risks which could be associated with empowerment. More subtly, nurses' and midwives' unwillingness for empowerment seemed to stem from fears of repercussions and being

associated as disruptive. This apparent fear of empowerment could be linked to the traditional socialisation of nurses and midwives (section 3.12.1 below)

*"I think there's often an element of choice in a way... sometimes it can be safe to operate within... and not move beyond that... I think...(historical) training would be very much based on that very much you were in a box kind of thing, so it's about I suppose the choice whether we move out beyond that box". FGD 3*

*"Sometimes when you empower yourself and when you do challenge something, oh you're a trouble maker you know". FGD 6*

*"I think just with regard to people not willing to be empowered and the more that you're going to be afraid that you are going to get a reputation for being outspoken and whatever causing ripples or whatever, and the other is that if you show an interest in one particular thing suddenly you're inundated with extra on top of your... 12 hour day or whatever you've done, so you really want to pick and choose what you put your hand up for because you know you're going to get lumbered with it, so that might be part of not putting your hand up too often". FGD 2*

*"that are there they may be frightened that they might be laughed at or something if they did suggest something like that's what I would be thinking from the way I was trained and younger people, I was told to keep my mouth closed you know but now we don't, but I would find it myself, I would find it hard at times in multi-disciplinary to speak up at times if I wasn't really sure what I was talking about I think it depends on how many people are there and who it is" FGD 3*

*"I think too, it is fair to say that not everybody wants to be empowered wants to be responsible. I don't know whether it's a legal issue or they are unable due to lack of education or knowledge. Or maybe a certain person may not want any responsibilities" FGD 3.*

*"I feel that if you're willing and wanting to take on some more power people will allow you to do that but part of the problem is that people don't want to take it" FGD 2*

### **3.11.1.1 Resistance to change**

Some participants stated that some nurses and midwives own resistance to change and development, negatively impacted on their potential to be empowered.

*"What I would like to see happen is peoples attitude towards change, changing policy, updating, using all the valuable research that's right there instead of people adapting to the 'we've always done it this way' FGD 6*

*"its amazing how staff will become institutionalised in that they're not willing to change, or they're afraid to change a system or policy or anything and I mean for example a law changed, their views are so 'no, that's it, we did that once it worked, leave it that way'". FGD 3*

*"nursing needed to change its own attitude a wee bit. I think that there was quite a lot of us who were quite stuck in the mud and we don't want to change, we don't want to move on, we want to stick with the old habits and the old ways. The old definition I think where people you know that's not my job, I'm not doing that go and ask the doctor or whatever, you just don't want to be involved in it but I think that has to change I think that we accept a bit of responsibility ourselves for that." FGD 7*

### **3.11.2 Assertiveness**

*"The most empowering thing in the world is to be able to say no". FGD 7*

*"when you have the knowledge to back up what you saying, when you're able to say 'no we can't do this because...we can stand over what...what our decisions are, be it sometimes to say no...I think it empowers us as well that we don't feel that we have to be all things to all men"FGD 6*

In two of the discussions, nurses and midwives felt that being unable to refuse an increased workload despite feeling already overworked negatively impacted on experiences of empowerment. This also links with the historical legacy of nurses' and midwives' socialisation into traditionally not questioning the tasks which were delegated to them (historical legacy). It is

interesting to note that having knowledge for practice is raised here as antecedent for empowerment.

### **3.11.3 Self value**

Closely related to perceptions of personal power, lacking in self value was felt to determine beliefs about empowerment.

*"At times we don't know how to accept a thank you we say, no no that's alright, nothing" FGD 2*

*"Sometimes I feel very threatened you know oh she's newly qualified, she has a degree or a masters and I'm here I've been doing the work for how many years." FGD 2*

#### **3.11.3.1 Low morale**

There were some very emotional contributions made by the participant about this issue. Having a low morale was felt to be counterproductive to empowerment. Some participants gave examples of how their morale is knocked in practice.

*"I've been battling here... my energy has gone...if I express an opinion or have an idea about something that you expect to be listened to and its very wearing battling all the time". FGD 3*

One participant, who had several decades of clinical experience, voiced morale as a broader issue across the profession.

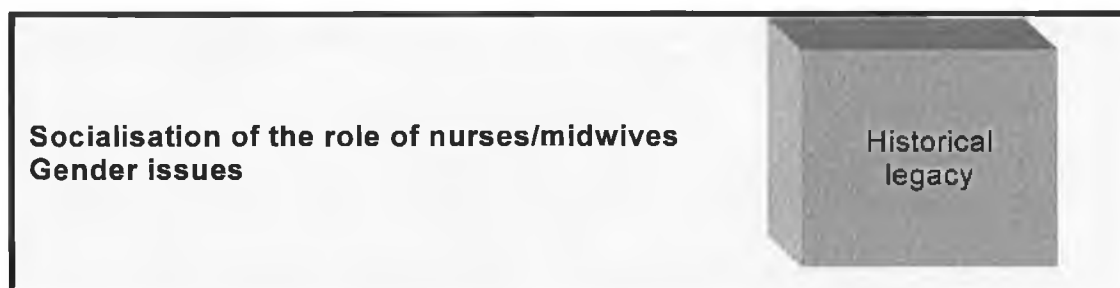
*"I think, nurses in general at the moment, I don't think I have ever seen them and I'm ... years now in the profession...I've NEVER seen them so demoralised. And I hone'stly... I fear for the future of Nursing". FGD 10*

### 3.11.3.2 Age

The issue of a person's age affecting their potential to be empowered was mentioned in one of the discussions. Note that the alleged deficiency (research orientation) links with education for practice (3.4 above)

*"I just find for myself, the age group. Because we're not research orientated and that has come with all the younger nurses", FGD 6*

## 3.12 Historical legacy



**Figure 15. Historical legacy**

What was notable about this theme related to the fact that events and socialisation processes which had occurred in the past were still felt by nurses and midwives to impact on their current potential to be empowered. References to 'baggage' in the data reflected experiences of the socialisation process (which was mostly through the traditional training of nurses and midwives) which indicate a difficulty in becoming empowered.

*"I think older nurses or people in carry a lot ...from the past.... that the young nurses... now won't have, which is a great thing...after years of working that way it's difficult"* FGD 6

### 3.12.1 Socialisation of the role of the nurse/midwife

All of the participants who talked about their training articulated the impact traditional training methods had on instilling subservience unquestioningness and obedience. This treatment was reinforced as it extended into the organisations in which they practiced. Vivid examples of oppression, and in one case, bullying, illustrated how nurses and midwives were traditionally trained and treated. It was felt that this treatment 'knocked confidence' and was counterproductive to empowerment.

Participant 1 *"I'm talking about, our training years ago".*

Participant 2 *"It was one of fear really wasn't it I think?"*

Participant 1 *"One of fear exactly".* FGD 6

*"I was trained in a system where it was do as you're told and if you don't like it there's the gates and out you go and we don't have jobs for the like of you around here".* FGD 3

*"We were told to scrub floors in the past literally... You could be expelled from the nursing... in my time anyway. After years of working that way, it's difficult [to be empowered]".* FGD 6

*"We need to break down the historical barriers that the charge nurse or the ward sister or the person who wrote the golden decision, you couldn't say 'boo' at her then. We also have to break down the barriers that the medical staff have over staff and still have".* FGD 5

The impact of traditional socialisation on the performing of non-nursing duties was also highlighted

*"You see the best nurse, you were trained that the best nurse was the one who gets the most done, you know"* FGD 10



- Participant 1      *" You see that's the history of the nursing background that we've come from "*
- Participant 2      *" It is " .....well I suppose traditional training ruined us. Because it made us believe that we had to do those things "*
- Participant 3      *"But we were subservient in these things."*

### **3.12.1.1 Lack of critical awareness**

Nurses and midwives highlighted that traditionally, they lacked education and critical awareness.

*" In the past, nurses would have done things ...because they were told maybe by a doctor or somebody to do it...and that was crazy, you know." FGD 6*

*"within nursing... I think you just kind of were told what you thought, you know what I mean you were told what you should and shouldn't do and you didn't argue with it at all." FGD 2*

Participant 1      *" we were never taught how to carry out research...down through the years of things that we did... a lot of them had very good outcomes, and that would have been a very important piece of research "*

Participant 2      *" We never wrote down what we did".*

Participant 1      *"Glorious opportunities passed, but because our whole training wasn't [research orientated] ". FGD 6*

### **3.12.2 Gender issues**

In one of the discussions, it was also perceived that the actual healthcare system had a bias against women. It is interesting to note that this was expressed in the only focus group which did not have any men present. This was further explicated through the marriage ban which traditionally prevented married nurses and midwives from working.

Participant 1      *"I think its just that, they just weren't, they weren't empowered at the time to do that because they took career breaks and they had to leave the job".*

Participant 2      *"Had to leave the job".*

Participant 3      *"Yeah".*

Participant 2      *"Got married "*

Participant 4      *"Yeah".*

Participant 5      *"All this thing against the wider bureaucracy that dictated. You had to leave your job".*

Participant 1      *"You were victimised".*

Participant 2      *"Yeah".*

Participant 1      *"You got married you used to leave within eighteen took your career breaks and you were, your focus was on child rearing and that's. It was expected of you". FGD 6*

It was felt that men in nursing and midwifery were more assertive and had a greater voice. This subject arose in two focus group discussions.

*"I think men coming into the nursing has empowered us a lot more in a sense...they've done a lot like for us as nursing even though you might appear to be a different organisation to the general thrust of general nursing". FGD 10*

### 3.13 Summary

This chapter illustrates the amount of rich data, which was obtained from the ninety three individuals who participated in this study. As highlighted earlier, all participants contributed enthusiastically giving detailed and in some cases, emotional exemplars of their experiences in practice. The following chapter attempts to critically discuss the findings of this study in relation to the literature.

## **CHAPTER 4**

### **DISCUSSION OF FINDINGS**

## **4 CHAPTER 4 - DISCUSSION OF FINDINGS**

Consistent with the bulk of the literature, it is evident from the findings presented that empowerment is something which seems to be clearly complex, subjective and multifaceted (Gibson 1991, Ryles, 1999, Foster Fishman et al 1998). This is due to the fact that the contributions made by participants were information dense, multidimensional and were in most cases, embedded in contextual examples of nursing and midwifery practice. As indicated in the review of the literature, there are a number of different perspectives from which empowerment can be viewed (i.e. Organisational theory, management/psychological theory, critical social theory, constructivist theory and social psychology theory). The fact that it was possible to identify aspects of all theoretical perspectives on empowerment, dispersed throughout the findings of this research, tentatively suggests that the current theoretical models may be somewhat one dimensional and not broad enough to illustrate completely, the broad spectrum of factors which have the potential to impact on the empowering experience of the individual nurse or midwife. Zimmerman (1995) asserts that a universal measure of empowerment may not be feasible due to the contextual and cultural elements, which are unique to each group. Perhaps Irish nursing and midwifery culture could be viewed as a culture in which, traditional theoretical perspectives (adapted from other disciplines) do not offer an appropriate appreciation of empowerment as this group of people experiences it. The close association between power, control and empowerment was also evident from the data. The fact that nurses and midwives acknowledged both external and internal sources of power as inherent to their empowerment

beliefs illustrates that viewing power, and indeed empowerment from a single foundation may not serve to appreciate the breadth of sources from which empowerment may arise from.

There are a number of interesting findings resulting from this research. The most notable finding is that education for practice seems to be a clear antecedent to inherent empowerment beliefs.

Whilst nursing expertise has been identified as a facet of an empowered nurse (Kuokkanen and Leino Kilpi 2001), the nature of being educated for practice and its proposed causative effects on perceptions of control, personal power and professional respect are new. Whilst empowerment has close associations with power and control in the reviewed literature (section 1.1.1 above), the inherent empowerment belief of professional respect is also an additional finding, which has not been highlighted in previous empowerment research. The emergence of confidence as an aspect of personal power is also notable. The conceptual map presented in section 3.3 was devised in an attempt to illustrate the distinct aspects that were found to relate to empowerment in this study.

The very fact that there are nine themes in this conceptual map which are inter related (not including one antecedent theme) pictorially illustrates a degree of complexity, which is reflective of the current literature on empowerment (Kuokkanen and Leino-Kilpi 2001).

The fact that determinants (or impacting factors) were found to impact on the empowerment of nurses and midwives (in contrast to isolating enhancing or inhibiting factors) suggests that it is the application of these factors (either positively or negatively) that determine empowerment beliefs. This represents a different way of viewing empowerment. A somewhat similar 'mirroring effect' of empowering attributes was also found by Kuokkanen and Leino Kilpi (2001). This illustrates a similar phenomenon, which compares favourably in demonstrating that empowering factors can have positive or negative applications.

A number of possible explanations could be offered concerning the fact that the examples given by nurses and midwives about empowerment were predominantly negative i.e. examples of disempowerment. Nurses and midwives may be experiencing a large amount of negative experiences due to organisational and management inadequacies. The Irish healthcare system is currently in the process of undergoing radical change. This, coupled with the current staffing crisis represents major organisational reformation and restructuring. According to Conger and Kanungo (1988) these contextual factors potentially impact (negatively) on perceptions of empowerment (section 1.2.2 above). It could be the case that the current contextual situation may explain the relative lack of positive examples of empowerment experiences.

In critical social theory, 'conscientization' or critical awareness is essential if empowerment is to occur (Freire 1972). Freire posited that critical consciousness of powerless situations is dependent on 'praxis' or reflection on action. Freire outlined that individuals who lacked critical consciousness give 'coded' responses that simply outline powerless situations. According to Freire, the liberating facet of praxis (which is enabled through education) allows for a critical appreciation of situations which express a 'decoded' or interpretative awareness of power relations in situations.

Although the examples of participants reflected negative experiences, nurses and midwives seemed to have 'conscientization' of their powerless situations. This phenomenon was also evident, particularly in relation to participants' questioning of the 'real' power of managers where nurses and midwives illustrated an awareness of the potential powerlessness of their supervisors within the organisation. The theme of involvement in decision-making emerged

through a process of nurses and midwives recognising their current disadvantages and prospective benefits. This would not have occurred if nurses and midwives did not have a critical consciousness about issues such as these.

Equally, the fact that education was articulated as an antecedent to empowerment suggests that nurses and midwives are clearly aware of the liberating potential of this characteristic. The liberating 'power' of education has been previously indicated as a supportive element in the development of nurses and midwives scope of practice (An Bord Altranais 1999). Nursing and midwifery practice is clearly skill based and governed by its code of conduct (An Bord Altranais 2000b) It is important also to note that this code places the responsibility for being educated, competent (and assessed as competent) on the shoulders of each individual nurse. Perhaps the emphasis of education for practice amongst nurses and midwives could be attributable to their binding code of conduct. Competence, according to An Bord Altranais (1999) incorporates education, knowledge, skill and clinical experience for practice. This has been identified as a component of psychological empowerment (Thomas and Velthouse 1990, Spreitzer 1995). Kuokkanen and Leino Kilpi (2001) found that competence was a facet of an empowered nurse. Kuokkanen and Leino Kilpi's finding is reflected in this study, which also found competence to be an integral part of empowerment. However the presence of the antecedent, education for practice, is a new finding.

Two separate diagrams were created to represent the findings of this study. The first represented initial conceptualisations made by nurses and midwives regarding their understanding of empowerment (see section 3.2). The second, is reflective of the findings resulting from the in depth analysis of the data obtained from the focus group discussions (section 3.3 ). The rationale

for creating two separate diagrams is primarily due to the fact that two different types of data emerged. The first responses given by the participants regarding what they initially understood as empowerment were straightforward and was not supported by examples in most cases. As a result, it was only possible to perform a grouping of items in the first diagram (Figure 1, Nurses' and midwives' conceptualizations of empowerment illustrated in section 3.2).

As the data were analysed more thoroughly, it was possible to look more closely at the nature of these themes and the possible relationships between these. This resulted in the more comprehensive diagram (Figure 2 - Conceptual representation of emergent themes of empowerment) which is illustrated in section 3.3. It is reassuring that aspects of these themes are present in both diagrams. This tentatively suggests that there is a degree of transferability between initial conceptualisations, inherent empowerment beliefs and impacting factors amongst nurses and midwives.

#### **4.1.1 Initial conceptualisations of empowerment**

As highlighted previously (section 3.2), it is notable that nurses' and midwives' initial responses to the question "What do you understand by the term empowerment?" were easily distinguishable from the data. This may be due to the fact that this was the first question asked in each focus group discussion. Twenty different items emerged as a collective response to what nurses and midwives initially understood empowerment to be. This supports Thomas and Velthouse's assertion that empowerment is subjective and as a result, has the capacity to evoke multiple meanings (Thomas and Velthouse 1990). The different responses given by the participants also illustrate a lack of consensus regarding the meaning of empowerment. However, due to the nature of this data (straightforward responses without supporting



exemplars), in depth analysis of this data was not possible and grouping of items mentioned by participants was performed instead. The fact that participants could conceptualise power and empowerment as external to and internal to the person within their initial responses was notable. Conceptualisations of work related aspects of empowerment (including workplace power) broadly reflected Kanter's theory of structural power (Kanter 1993) which associated having control over actions through formal authority, decision-making latitude and support as empowerment. Psychological empowerment perspectives of competence (through education), and confidence were also evident in nurses' and midwives' conceptualisations of empowerment. On the other hand, participants also articulated believing in one's self and perceiving one's worth (through feeling respected and having a voice) as empowering also. This can be linked with Thomas and Velthouse's (1990) notion of impact within the organisation. Self-esteem was conceptualised as empowerment, which links with previous studies (Spreitzer 1995, Fulton 1997).

It is interesting that the ideals of nursing and midwifery practice emerged as what nurses and midwives initially understood as empowering. Being able to empower patients is reflective of the rhetoric of caring practice and implies that participants may gain a sense of meaning and impact through caring for their patients. Caring, the essence of both practices is a powerful phenomenon in which nurses and midwives intend to 'do good' for their patients. By doing good for patients, "the highest part of the soul is enlivened" Murdoch (1991, p.102). This suggests that caring for others results in a positive feeling of achievement and satisfaction and may explain the inclusion of nursing and midwifery rhetoric as a conceptualisation of empowerment. This may also explain participants' statements about the reciprocal nature of empowerment which was said to occur between patient and nurse.

The fact that empowerment was conceptualised as a 'buzz word' suggests a degree of skepticism regarding its value as a term. Some participants stated that they did not understand the word, which illustrates a degree of honesty.

#### **4.1.2 Inherent empowerment beliefs**

Throughout the data, three themes emerged which were felt to represent inherent empowerment beliefs. Beliefs of professional respect, control and personal power were found to be sufficient conditions for empowerment according to nurses and midwives. While aspects of control and personal power feature the literature reviewed on empowerment, professional respect had not previously emerged. In this study, nurses' and midwives' inherent empowerment beliefs are a composite of beliefs of ability, respect and formal authority in the workplace. These are further outlined below.

Being respected has been recognised as an important antecedent to empowerment in the literature (Rodwell 1996). Respect has been raised as a determining factor for empowerment in recent research (Kuokkanen and Leino Kilpi 2001). Fulton (1997) found that nurses were often overpowered by doctors, which might be evidence to suggest that nurses are not respected and subsequently disempowered. This study highlights that being respected as a professional seems inherent to empowerment (as opposed to being an antecedent condition). The sources of professional respect include doctors, managers, patients, colleagues and in general. This represents a broader view of perceived respect than found in other studies (Kuokkanen and Leino Kilpi 2001). The medium by which persons are respected; by being given a voice and being listened to could be linked to perceptions of impact as highlighted by Spreitzer (1995).

The inherent feature of professional respect may also have association with issues of role clarity related to the evolving nature of Irish nursing and midwifery practice. As highlighted previously (section 1.3 above), Irish nursing and midwifery has recently undergone significant professional change not least to the scope of Irish nursing and midwifery practice (An Bord Altranais 2000a). It is possible that the role of Irish nurses and midwives may have evolved as a result. The advent of formal specialist pathways coupled with increased scope of practice means that nurses and midwives have the potential to expand their role (and status) in comparison to traditional nursing and midwifery practices. However, there is a potential for role conflict due to differences between the perceptions and expectations of others (e.g. patients and doctors) compared to nurses' and midwives' beliefs about their own role (Biddle 1979, Makay 1992). Beliefs about being valued as a professional could also be linked with nurses and midwives perceptions of their visibility and activity within their organisations. The theme, decision making (3.7.6 above) highlighted nurses' and midwives' views that they were not valued by their organisation because they were being excluded from decision-making processes. Historically, the work of nurses and midwives has included 'dirty work' of working with bodily functions such as defaecation and urination. Although work such as this is not performed exclusively by nurses or midwives, the value of this kind of work has traditionally been undervalued (Miers 1999).

The inherent empowerment belief of control is not a new finding. Much of the empowerment literature features control as central to empowerment (Conger and Kanungo 1988, Kanter 1993). Control is thought to originate from two main sources; internal to the person and externally, through an enabling practice environment (see section 1.1.1 above). Nurses and midwives seemed to articulate their sources of control as primarily external. It is notable that there is an

element of professional sanctioning coupled with organisational freedom in this theme. In the findings, there are two distinct aspects; clinical autonomy, and formal authority.

Autonomy within nursing and midwifery refers to having a degree of clinical judgment within one's scope of practice in caring for patients (An Bord Altranais 2000a). Fulton (1997) found that nurses in her study, equated empowerment with autonomy in relation to medical staff.

Nurses in her study also broadly equated empowerment with freedom to make autonomous decisions, and the right to choose. Acting autonomously has also featured as a characteristic of an empowered nurse (Kuokkanen and Leino Kilpi 2001). This facet also featured in the non-nursing literature. Having a degree of self-determination according to Thomas and Velthouse (1990) and Spreitzer (1995) is equated with being able to make independent judgments relating to work. From a nursing perspective, discussions about the need for nurses and midwives to be more autonomous are not new. Essentially there are a number of problems in relation to empowerment and perceptions of control through autonomy. All of these difficulties seem to stem from the difficulty in clearly delineating autonomous nursing practice.

Nurses and midwives have always had limited autonomy due to their status as 'semi professionals' in comparison with the medical profession (Wilkinson and Miers 1999). Turner (1995) argues that voicing apparent disempowerment through a lack of control in the hospital makes visible a deeper hiatus [sic] between nurses' (and potentially midwives') actual skills and knowledge and their lack of autonomy within the bureaucratic constraints of a hospital setting. If nurses and midwives are destined to have limited autonomy within the hospital setting, one could argue that nurses and midwives may not ever have the capacity to be empowered if autonomy is a critical feature of empowerment perceptions. According to Slevin (2003), society is required to

recognise autonomous practitioners. Given the numerous examples of the public's expectations of nurses and midwives to perform mundane tasks, it is questionable whether Irish society as a whole is prepared to recognise nurses and midwives as wholly autonomous practitioners. The recent scope of practice document (An Bord Altranais 2000a) provides a framework to enable nurses and midwives greater scope of autonomy within their realms of practice. However, this document places the onus of determining one's own scope of practice on the individual practitioner. This means that at a professional level, there could be difficulties in clearly differentiating the constituents of autonomy amongst nurses and midwives.

Control, in the form of having the power through legitimate authority has been recognised in previous research studies as being linked with empowerment (Sabiston and Laschinger 1995, Laschinger 1996) and links with the organisational theory perspective (Kanter 1993). It is notable that such studies identify lower scores in formal power (in comparison to informal power) (Laschinger, 2000, Scott et al 2003). This suggests that formal power is lacking amongst nurses (and in this study, midwives) within the organisation. Given the methodology utilised, it was not possible to determine the amount of formal or informal power experienced. Despite this, it seems that formal power is clearly perceived as essential for empowerment. As highlighted earlier, empowerment is often viewed as devolution of decision making power (section 1.1.1 above). The devolution of this 'power' results in enhanced control beliefs. The contributions made by nurses and midwives about not being involved in decision making at organisational and strategic levels, serves to illustrate some deficit in this area. Whilst a deficit was voiced, the centrality of this aspect to empowerment was evident also from the data. Because formal power is derived from legitimate authority in the form of rank, position and visibility, it would seem that seniority ought to result in enhanced empowerment (if formal power was a central feature to

empowerment). This supposition has found support (Laschinger and Shamian 1994, Scott et al 2003). This strengthens the link between formal power, ability to exercise autonomy and empowerment

As highlighted early in the literature review, the experience of empowerment is dependent on individual perception. Believing that one has the capacity and ability to be empowered featured clearly in the data as aspects of the inherent empowerment belief of personal power. Having confidence featured as central to empowerment. The aspect of having confidence has been found to be a feature of empowerment in previous studies (Fulton 1997, Kuokkanen and Leino Kilpi 2001), yet its centrality to empowerment is a new finding in this study. Similarly, links between self-esteem and a sense of meaning, impact, self-determination, and competence have been illustrated previously (Spreitzer 1995). Confidence in one's competence seemed vital for empowerment amongst the nurses and midwives in this study. From the data, nurses' and midwives' traditional social roles (as subservient and unquestioning workers) seem to have had an influence on their capacity to believe that they can be empowered.

#### **4.1.3 Impacting factors on empowerment**

##### *Organisational factors*

It seems that the structure of an organisation potentially determines perceptions of empowerment amongst nurses and midwives. Flattened structures with informal organisation of communicative activities appear to be more conducive to empowerment than those with a rigid hierarchical structure. Again, smaller organisations were felt to be more empowering due to the increased potential for nurses and midwives to retain some control over practice and have closer

relationships with other healthcare professionals. Both of these aspects directly relate to inherent empowerment beliefs. Larger hierarchical structures have previously been found to render workers relatively powerless (Kanter 1993). The desire for a move away from traditional bureaucratic structures (and centralised decision making processes) is interesting and reflects current decentralisation efforts (Department of Health and Children 2001). Practising in the community setting could be reflective of a more decentralised structure also. Perhaps this is why community practice was viewed as more potentially empowering than hospital or institutional practice as participants could experience enhanced control and professional respect.

It seems, from the focus group discussions, that nurses and midwives feel that they are under-utilised and not involved in decisions that affect, or have the potential to affect their patient/client care. This seemed due to the fact that nurses and midwives stated that they had a unique knowledge of their patients and as a result, would be best placed to make decisions on their behalf both directly and strategically. Nurses and midwives appeared to be very aware of the value of the contribution they could make, particularly in relation to developing new services for their patients and clients. This was due to the fact that their unique knowledge of the patient centered on their belief that they were most familiar with patients' needs and thus could incorporate their needs into new services that were being developed.

Nurses' and midwives' views about their unique knowledge of the patient also emerged in relation to dealing with the medical profession. The fact that nurses and midwives were exposed to new doctors every six months created tension, as the rank of the doctor (who lacked experience), often overruled experienced nurse and midwife practitioners who felt they 'knew their patients best'. This has been illustrated in Fulton's work, which identified similar conflicts

(Fulton 1997). However it is interesting that the basis of this conflict lies in 'knowing the patient' better than anyone else (see section 3.9.2.1 above). This is a facet of professional issues, and will be discussed shortly.

Having an influence over departmental decisions has been previously highlighted as a constituent of empowerment (Spreitzer 1995). In this study, it seems that this kind of impact is voiced as important for empowerment also. However, having a strategic impact was also voiced as an impacting factor for empowerment in this study. This has not been acknowledged in previous studies.

Kanter (1993) identified that workplace power is determined through lines of organisational resources, information and support. In this study, these factors were identified by nurses and midwives as important determinants of empowerment.

In relation to the structural determinant of resources, human resources seemed the most critical determinant. When asked directly about what would enhance empowerment in the focus group discussions, most of the immediate responses were "more staff". It could be suggested that having inadequate complements of staff reduces nurses' and midwives' ability to work effectively. This factor, and the resulting increasing workloads experienced by participants, impacts negatively on their empowerment beliefs. The determinant of accessing monetary resources was highlighted as the second main empowerment determinant in this section (particularly amongst mental handicap nurses). It is notable that accessing resources does not feature on previous empowerment research measurement tools (Laschinger 2000).



Whilst there were clear opportunities for continuing education, this seems to be a double edged sword due to the onus for replacement placed on the shoulders of the practitioners. This thwarted nurses and midwives incentive to undertake further education, as they would be potentially compromising patient care due to the lack of staff in their respective practice areas.

In this study, communication through meetings was voiced as the medium by which empowering information can be transmitted appropriately. A lack of communication about services, future planning and management strategies was detectable from the data. This links with Kanter's assertions that information at these levels is essential for empowerment.

#### *Management issues.*

It seems, from the focus group participants, that effective management is a key factor in promoting staff empowerment. It was interesting that the new management structures were viewed by some as less empowering than traditional management structures. This was due to the increase in numbers of managers in certain practice areas. From the data, it appears that authoritarian, dictatorial methods of management had been what most participants stated they had experienced in their practice. This is the antithesis of how Conger and Kanungo (1988) visualised an empowering manager.

Support from one's manager appears to be an important factor in enabling empowerment. This is acknowledged in recent nurse management development programmes, which have attempted to address this area (Office for Health Management 2002). However in this study, support from one's manager was not always evident in the practice setting, according to participants. The fact that nurses and midwives had an onus placed on them to find their own relief (replacement) was

voiced as disempowering. If nurse and midwifery managers are viewed as role models, according to Miers (1999), the apparent lack of support by current managers of nurses and midwives seems to impact negatively on empowerment. However, it is possible that the outcome of educational and supportive programmes for nurse (and midwife) managers could be beneficial and has yet to come to fruition. Traditionally, nurse and midwife managers in Ireland seemed to exercise authoritarian management practices. The fact that most emerged from the religious orders where obedience featured strongly may have precipitated this style of management (Robins 2000). Using a critical social theory perspective (viewing nurses and midwives as an oppressed group), it is possible to suggest that emerging midwife and nurse managers' role modelled themselves on their predecessors, thus precipitating a disabling management style. The impact nursing and midwifery managers have on the empowerment of their subordinates seems dependent on their relationship, which can cultivate or detract from personal empowerment beliefs of their staff.

Effective communication between management and staff was voiced consistently throughout the focus group discussions as an enhancing factor for empowerment in the workplace. Whilst lines of information are thought to be essential for empowerment from a structural perspective (Laschinger 1996), communication, the medium by which this information is passed featured as an enhancing and inhibiting factor. This was also echoed by Scott et al (2003). In this study, it emerged that management feedback to staff and formal appraisal would be appreciated and beneficial in empowering nurses and midwives. The providing of self-efficacy information through communicative strategies (Conger and Kanungo 1988) whilst already highlighted in the literature, seems find support in this study.

It is notable that the participants in this study seemed to have a critical awareness of powerless situations. This was most evident in the contributions they made about their managers, suggesting that they were constrained by organisational determinants.

### *Professional issues*

Given the nature of the population under study, it was not surprising that professional issues emerged as a determinant of empowerment. The two most notable features within this theme was that nurses and midwives asserted that they had unique knowledge of the patient and that issues surrounding role clarity impacted on empowerment.

Knowing the patient best resulted from the nature and duration of contact participants stated they had with their patients. Whilst not specified, it seems that this knowledge was somewhat prized by the participants, although not visible to others. The lack of value and attention given to this knowledge seemed to frame the basis for many articulations of discontent. This 'invisible' knowledge may be linked with a lack in formal power in the organisation (Kanter 1993). Clinical experience, which was closely linked with knowing the patient best was also felt to be something valued within nursing yet not so much externally. This was also echoed in other studies (Fulton 1997, Kuokkanen and Leino Kilpi 2001).

In a similar vein to conceptualisations of empowerment, some nurses and midwives felt that actual practice was empowering. The empowerment exemplars given by the participants illustrate clearly, aspects of control, professional respect and personal power backed up by education for practice. It was notable that nursing/midwifery led services were mentioned as

was the role of the clinical nurse/midwife specialist. In particular, clinical nurse and midwifery specialist roles also have education for practice as a central feature. The Report of the Commission on Nursing (1998) outlined the desirability for such practitioners to be educated to at least degree level with relevant specialist additional qualifications in their chosen area prior to them being considered to work as a clinical nurse/midwife specialist. Although there is no concrete evidence to support this claim, it could be the case that clinical nurse and midwife specialists may have felt more empowered than their other counterparts for this reason. Having appropriate support as highlighted above, coupled with having relevant educational preparation may explain the potentially empowering aspects of both types of practice.

What was also interesting was that, in relation to nursing and midwifery practice, there seemed to be a reciprocal nature to empowerment when applied to the care of patients. This meant that nurses and midwives were empowered by the patients they had cared for/ empowered. This has also featured in Kuokkanen and Leino Kilpi's (2001) work.

Role clarity was found to be a determinant of empowerment. This is a new finding in nursing and midwifery research. This finding echoes the assertions of Conger and Kanungo (1988) who identify the potential powerlessness which can result from unclear roles. Attempting to clarify the role of nurses and midwives is also problematic due to the complex nature of nursing and midwifery practice (Basford and Slevin 2003). Although role clarification presents a challenge for nursing and midwifery, performing non nursing/ midwifery duties seemed to be clearly voiced as a disempowering element.

Another closely related finding was that of discrepancies in role conceptualisation and, expectations. It seems that the general public, managers and the medical profession lack awareness of the actual role of the nurse or midwife. Again, given the fact that the role of the nurse or midwife is unclear in the nursing/midwifery literature, it is unsurprising that there is a potential for different understandings to occur amongst non-nurses and midwives (Biddle 1979). The discrepancy in role expectation could be mistaken for disrespecting the role of nurses and midwives. Also, differences in role expectation could affect interpersonal relations. Examples of this were evident in this study, and examples of conflicts resulting from these differences were littered throughout the data. The perceptions and expectations of the general public featured a great deal in all of the focus group discussions. From the data analysed, it appears that there is a substantial amount of public expectation placed on the practising nurse or midwife.

Interpersonally, good relationships with others were felt to determine empowerment. Nurses and midwives cited the medical profession as the source of most of their examples of negative experiences and indeed conflict. Fulton (1997) found this also within her study with medical power (and associated lack of nursing autonomy) rendered nurses and midwives powerless. It seemed that medical staff treated nurses and midwives disrespectfully according to the participants. The reasons for this could be manifold yet it is suggested that the discord may relate to limited autonomy and role perception. However, the fact that the medical profession dominated the exemplars of disempowerment amongst nurses and midwives may also be due to the fact that they are the group that nurses and midwives most frequently deal with.

It was clear from the participants that having collegial support is an important factor in empowerment and not having support is consequently disempowering. This is echoed in Fulton's

work also (Fulton 1997). Kanter (1993) also noted that the proportions of female to male workers affect how each group were viewed in an organisation. Peer solidarity was felt to be one way in which workers could generate support and reassurance. Kanter found that those in the minority proportion rose more quickly within the organisation due to their visibility. Perhaps collegial support is an important factor in empowerment amongst nurses and midwives due to the fact that nursing and midwifery are predominantly female professions.

### *Individual factors*

Although Kuokkanen and Leino Kilpi (2001) identified personal qualities of an empowered nurse which included courage, fearlessness and standing by one's decisions, an interesting finding of this study was the identification of desire or willingness for empowerment. The number of references made emphasising the need to 'want' or 'take on' empowerment is a new finding and raises many questions. Given the fact that twenty different initial conceptualisations were made about empowerment, pinpointing what part of empowerment nurses and midwives did not want to take on was not possible. However, the fact that a sense of willingness was necessary, contradicts the assumption that empowerment is desired by all (Conger and Kanungo 1988). When probed as to why people do not desire empowerment, responses usually reflected resistance to change or fear of repercussion by their managers if they chose to be empowered. In some cases, reference was made to the extra workload which may be associated with taking on empowerment. This suggests that empowerment was conceptualised as added effort and responsibility in the workplace. However, this finding illustrates that perhaps, the individual's attitude potentially determines their capacity to believe that they have personal power, control and professional respect.

### *Historical legacy*

All of the participants who talked about their training articulated the impact traditional training methods had on disempowering them as professionals. It was interesting to observe the existence of a continuing subservience amongst practitioners even after they qualified. This illustrates the impact of the social environment and its impact on the reality of the participants in this study (Berger and Luckman 1966). This impacting factor seemed to impact mostly on personal power beliefs such as confidence and self esteem. Traditionally and presently, nursing and midwifery is comprised of mostly women. It was interesting to note that men coming in to nursing was voiced as empowering. Kanter (1993) identified the power of 'tokens', those who are in a minority within the organisation. Kanter felt that these tokens had enhanced visibility and tended to rise quickly within the organisation. It could be suggested that token men in nursing and midwifery were viewed as empowering due to their visibility and potential to generally reach enhanced status within nursing and midwifery organisations (The Nursing and Midwifery Resource 2000).

In summary, it is clear that empowerment is by no means a straightforward entity. When asked about their understanding of empowerment, twenty different responses illustrate a concept which is clearly multifaceted. Problems with empowerment, or inhibitors of empowerment were the most readily identifiable from nurses and midwives articulations, with the resultant themes called impacting factors. Kieffer (1984) felt that empowerment is identifiable through its non-existence. This study suggests that empowerment is *initially* identifiable through examples of factors which impact positively or (mostly) negatively on empowerment. However, it is the author's view that empowerment *is* identifiable (in the form of inherent empowerment beliefs)

although not as easily so due to their interweaving presence in the data within exemplars of empowerment and disempowerment.

Zimmerman (1995) highlighted that empowerment was contextually determined. This contextual determinism may explain some of the new findings in this study. For example, it is interesting that education for practice seems to be antecedent to empowerment according to the participants in this study. This may be due to the context of Irish nursing and midwifery education, which traditionally was at certificate level and has only recently moved to degree level. Continuing education for nurses and midwives in Ireland was voiced as been problematic due to issues such as a lack of management support, and difficulties in accessing programmes. Nurses and midwives in other countries who already have graduate status and easily accessible continuing education programmes may not recognise education for practice as an antecedent to empowerment.

The fact that a clearly defined role was found to be a determinant of empowerment is potentially problematic. This is primarily due to the ongoing debate surrounding the role of nurses and midwives and its distinction from other health professionals or non-health professionals. This feature may be due to the context of Irish nursing and midwifery practice. It is also interesting that willingness to be empowered emerged as a determinant of empowerment amongst the participants in this study. Perhaps this could be due to the historical legacy of Irish nurse and midwife training which according to the participants “was one of fear” FGD 6.

## **4.2 Limitations of the study**



Some limitations of the study include the purposive sampling strategy, which relied on Directors of Nursing to nominate potential recruits for the focus group discussions (see section 2.3.1.1 above). This was felt not to be ideal as there was a clear potential for Directors of nursing to nominate participants who could give biased views due to possible close association with their director of nursing. Given the initial concern, this strategy did not seem to detract from all participants giving enthusiastic, detailed (and in many cases negative) exemplars of empowerment.

A potential limitation of the study could also have been the use of computer assisted data analysis in this instance. It is argued that continued use of this package would have missed large amounts of valuable data. Whilst this software has clear benefits in managing large amounts of data, the importance of extensive user training and proficiency in utilising the system effectively was underestimated. However, the change to a manual analysis strategy compensated for this shortfall.

The recruitment strategy aimed to ensure representation from all six branches of nursing and midwifery. While fourteen participants were invited, not all participants who were invited attended the discussions. This meant that in some discussions, representation across all six branches of nursing and midwifery was not obtained in some cases. The fact that the themes spanned all ten discussions despite incomplete attendance at the focus group discussions, suggests that this did not impact negatively on the findings. Given the recruitment strategy outlined above, it is also possible that the participants who did not attend the discussions may have felt too 'disempowered' to contribute. On the other hand, given the findings of the research, they could have exercised their empowerment through choosing not to attend.

## 5 CONCLUSION

The review of the current literature on empowerment found that there is a lack of consensus surrounding the meaning of empowerment. Five perspectives on empowerment were explored which had the concepts of power and control in common. It was found that power and control could be viewed as external or internal to the person. Each of the five perspectives presented an equally complex view of what were thought to be constituent elements of empowerment. The deduction that empowerment would best be explored from the perspective of practising nurses and midwives, was made due to the interpretative nature of the experience of empowerment.

The findings of this study supports the view that empowerment is a concept which is multifaceted and contextually determined. The experience of empowerment is effectively subjective. Education for practice was found to be antecedent to empowerment amongst the nurses and midwives in this study. Professional respect, personal power and control form the core elements of the empowering experience. Six determinants of these core elements were identified which could equally impact positively or negatively on the core empowerment elements listed above. These determinants included: organisational factors, management, professional issues, interpersonal issues, individual factors and historical legacy. These findings were incorporated into a conceptual model of empowerment based on an interpretative research approach (Figure 2, above). The implications of this study for future research, policy, practice, and education are also highlighted.

Education for practice, professional respect, role clarity, willingness for empowerment, involvement in strategic decision making and the historical legacy of nursing socialisation were

all new findings which emerged from this study. All of these aspects would benefit from further exploration. The findings of this study also suggest that nurses and midwives perceive that their impact in organisations is invisible. From a policy perspective, encouraging input into strategic planning and decision making along with implementing best practice in recognising (and rewarding) skilled practitioners would be helpful in addressing perceptions of organisational invisibility. Continued attention into workforce planning to meet service needs is suggested to address the staff shortages which the participants in this study found detracted from empowerment.

The phenomenon of knowing the patient best was an interesting adjunct, which emerged through nurses' and midwives' articulations of their practice exemplars. It is suggested that further research into this area would unearth some interesting findings relating to nurses' and midwives' assertions of their knowledge. Whilst clinical autonomy is not a new finding, there is a need for further exploration to clarify its scope amongst Irish practitioners. In this study, nurse /midwife led practice was empowering. From a practice development perspective, continued enhancement of existing initiatives would seem to be a factor in enhancing the empowerment of nurses and midwives involved in such practices. Equally, support for further education could potentially foster empowerment perceptions.

Some useful tools have been devised to test empowerment amongst nurses. The bulk of current research on empowerment of nurses is developed from a questionnaire, which stems from a theory derived from a profit-oriented corporation in the late 70s (Appendix 8). Equally, a questionnaire to measure aspects of psychological empowerment has been developed (Appendix 9). It is suggested that future research into empowerment should incorporate a broad

interpretative perspective in order to develop a more sensitive measure of empowerment amongst a nursing and midwifery population.

Little is known about the meaning of empowerment amongst healthcare workers such as nurses and midwives. This study attempts to enhance understanding about empowerment and how it relates to nurses and midwives as they care for their patients. It is hoped that the findings of this research will be beneficial to those who wish to empower the professions of nursing and midwifery, namely nurse and midwife managers. Nurse and midwife managers play a key role in impacting on self-efficacy beliefs of their employees. The findings of this study implies that managers should use a broad approach to improve nurses' and midwives' beliefs in their own ability, considering the many factors, which can influence these beliefs. Replication of this study amongst a population of nurse/midwife managers would provide interesting data from which empowerment perceptions could be compared. Whilst empowerment is complex and multifaceted, it is influential for Irish nurses and midwives. Irish nurses and midwives need to believe in their ability, and deserve to be enabled to deliver optimum patient care. It is hoped that the findings of this study will contribute to the achievement of this goal.

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## **7 APPENDICES**

## 7.1 Appendix 1 – Proposed numbers for recruiting participants

Branch of Nursing /Midwifery	Proposed number to recruit at each FGD.
General	4
Psychiatric	2
Midwives	2
Sick Children's	2
Mental handicap	2
Public health	2
Total number recruited for each FGD	14

## 7.2 Appendix 2 - Focus group invitation distributed to participants.

School of Nursing  
Faculty of Science & Health  
Dublin City University  
Dublin 9

DATE

ADDRESS  
ADDRESS  
ADDRESS

Dear XXX

Thank you for agreeing to participate in our research, exploring nurses' and midwives' understanding and experience of empowerment in practice. XXXXX has nominated you to participate in a discussion group of nurses and midwives from various disciplines working directly with patients/clients. From your discussion prior to nomination, you may have an idea what the purpose of the discussion group and research is about. However the information sheet over leaf may clarify this for you.

Your discussion group will take place in XXXXX on XXXXX between 13:00 and 15:00. We will provide you with a light lunch and refreshments during initial introductions between 13:00 and 13:30. The discussion itself will last approximately 1 hour.

We appreciate that some people have to travel some distance and expect that your time spent involved in this research is part of your working day and that remuneration for incurred travel expenses be paid by your employer.

We look forward to meeting you on the day and if you have any queries or are unable to attend, please contact either of us, below.

Yours sincerely

Melissa A. Corbally  
Research Assistant,  
Phone:01 7008432

### 7.3 Appendix 3 – Information sheet distributed to participants

#### *INFORMATION SHEET*

The research that we have asked you to take part in, through participation in a group discussion amongst other nurses and midwives, has been commissioned by the department of health and children. Similar groups will be held throughout the country as part of the first phase of this study.

The purpose of this research is to explore nurses' and midwives' understanding and experience of empowerment in practice and how this could be enhanced.

You have been asked to participate in a group discussion, which will be facilitated by 2 researchers from Dublin City University and where participants will be asked to discuss their understanding and experiences of empowerment in practice. They will also be asked to discuss some opportunities by which nurses/midwives could be empowered further.

The group discussion will be audio taped for typing up at a later date. The content of these interviews *will be strictly confidential and your name will not* appear on any reporting of this study, nor will you be identified anywhere in the results of the study. All names will be removed from the transcript of interviews and pseudo names will be used instead.

If there is anything you do not understand about the discussion at any time, please ask one of the researchers.

## **7.4 Appendix 4 – Interview guide**

Question 1. What do you understand by the term empowerment?

Question 2. How do you experience empowerment in your practice setting?

Question 2a. Can you give some examples?

Question 3. Are there any factors in your practice setting, which enhance your experience of empowerment?

Question 3a. Could you give some examples of these?

Question 4. Are there any factors in your practice setting, which inhibit your experience of empowerment in your practice setting?

Question 4a. Could you give some examples?

Question 5. What suggestions would you like to make to enhance your experience of empowerment in the future?

Question 6. Now that you have heard the summary of the discussion, is there anything you would like to add?

## 7.5 Appendix 5 - Thank you letter distributed to Directors of Nursing.

School Of Nursing  
Dublin City University,  
Glasnevin,  
Dublin 9

«Title» «First» «Surname»  
«Job\_Title»  
«Hospital»  
«Address\_1»  
«Address\_2»  
«Address\_3»

June 14, 2001

**Re: Empowerment study on Nurses and Midwives**

Dear «Title» «Surname»,  
The research team at Dublin City University conducting the above study on behalf of the Department of Health and Children, wish to thank you for your participation in nominating practising nurses for focus group discussions.

As you are aware, the aim of the focus groups was to explore the understanding and experience of empowerment among nurses and midwives. There was a good representation of the different disciplines within nursing and midwifery in each focus group. This facilitated the collection of valuable information that will be analysed and used to develop phase two of the research, a nationwide survey, in the near future.

Once again, we are most appreciative of your co-operation in nominating your staff and thank you for all your assistance in this research project.

Yours sincerely,

---

Melissa A. Corbally  
Research Assistant,  
Dublin City University,  
Dublin 9.  
Ph. 01 700 8432



## 7.6 Appendix 6 - Site confirmation

8/05/01

School of Nursing  
Faculty of Science & Health  
Dublin City University  
Dublin 9

Mrs. XXXX XXXX  
Director of Nursing/ Midwifery  
XXXX XXXX Hospital  
XXXX Health Board

Dear (Director of Nursing/Midwifery)

Thank you for your support of the research project, exploring nurses and midwives understanding and experience of empowerment in practice.

We are writing to confirm details of facilities you are providing, for hosting one of the research focus groups for this study. Classroom 1 on the ground floor of the nurses home has been allocated between 12:00 and 17:00 on Thursday 17<sup>th</sup> May. Light lunch and refreshments have been organised for 13:00 in this room, by (Name), who will invoice us here at the school for these.

We would be grateful if you would let us know if any of these details are incorrect and/or if you would like us to check in with a member of your organisation when we arrive on Thursday.

Thank you for providing these facilities.

Yours sincerely

Melissa A. Corbally  
Research Assistant,  
Dublin City University,  
Dublin 9.  
Ph. 01 700 8432

## **7.7 Appendix 7 - Thank you letter distributed to the participants**

School Of Nursing  
Dublin City University,  
Glasnevin,  
Dublin 9

«Title» «First» «Surname»  
«Work\_add\_1»  
«Work\_add\_2»  
«Work\_add\_3»

June 14, 2001

**Re: Empowerment study on Nurses and Midwives**

Dear «First»,

The research team at Dublin City University conducting the above study on behalf of the Department of Health and Children, would like to take this opportunity to thank you for participating in our focus group discussions.

As you are aware, the aim of the focus groups was to explore the understanding and experience of empowerment among nurses and midwives. There was a good representation of the different disciplines within nursing and midwifery within each focus group. This facilitated the collection of valuable information that will be analysed and used to develop phase two of the research, a nationwide survey, in the near future.

We appreciate your effort in attending the focus group and thank you for your contribution to the research.

Yours sincerely,

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Melissa A. Corbally  
Research Assistant,  
Dublin City University,  
Dublin 9.  
Ph. 01 700 8432

## 7.8 Appendix 8 – List of items from the structural empowerment questionnaire

Developed by the WERP programme – University of Western Ontario. Source : Scott, P.A., Matthews, A., Corbally, M., (2003b) *Nurses' and midwives' understanding and experiences of empowerment in Ireland*. Final Report. Department of Health and Children.

In this section, we are interested in your experience of empowerment in your current workplace. Please circle the number which best describes your response to the following.

*How much of the following do you have in your present job?*

1. Challenging work
2. The chance to gain new skills and knowledge on the job
3. Tasks that use all of your own skills and knowledge
4. Information about the current state of the organisation/service
5. Information about the goals of top management
6. Information about the values of top management
7. Specific information about the things you do well
8. Specific comments about things you could improve
9. Helpful hints or problem solving advice
10. Time available to do necessary paperwork
11. Time available to accomplish job requirements
12. Acquiring temporary help when needed

*In your work setting:*

1. The rewards for innovation on the job are
2. The amount of flexibility of your work-related activities within your organisation/service is

*In your present job, how much opportunity do you have for these activities?*

1. Collaborating on patient care with doctors
2. Being sought out by peers for information
3. Seeking out ideas from professionals other than doctors (e.g. physiotherapists, occupational therapists, dietitians)

*Please circle the number which best describes your response to the following:*

1. Overall, my current work environment empowers me to accomplish my work in an effective manner
2. Overall, I consider my workplace to be an empowering environment

## 7.9 Appendix 9 –Spreitzer (1995) texts of items measuring

### empowerment

Source: Spreitzer, G.M. (1995) Psychological empowerment in the workplace: Dimensions, measurement and validation. *Academy of Management Journal*. 38 (5), 1442 – 1465.

#### *Meaning*

The work I do is very important to me (meaning 1)  
The job activities are personally meaningful to me (meaning 2)  
The work I do is meaningful to me (meaning 3)

#### *Competence*

I am confident about my ability to do my job (competence 1)  
I am self-assured about my capabilities to perform my work activities (competence 2)  
I have mastered the skills necessary for my job (competence 3)

#### *Self-determination*

I have significant autonomy in determining how I do my job (self-determination 1)  
I can decide on my own how to go about doing my work (self-determination 2)  
I have considerable opportunity for independence and freedom in how I do my job (self-determination 3)

#### *Impact*

My impact on what happens in my department is large (impact 1)  
I have a great deal of control over what happens in my department (impact 2)  
I have significant influence over what happens in my department (impact 3)

### 7.10 Appendix 10 - Outline of codes which emerged from computer assisted analysis

Title of Code	1	2	3	4	5	6	7	8	9	10	Total Frequency
Relating to patient/client care/intervention	11	19	11	15	17	16	51	21	14	16	168
Relating to management/style/structure/role	12	9	14	12	13	14	11	3	36	17	141
Change	9	9	9	6	3	13	11	6	14	11	91
Education	4	6	4	4	11	3	16	7	15	14	84
Negative experience	9	11	12	16	8	3	4	6	4	9	82
Decision Making	4	10	6	17	9	9	11	5	6	2	79
Communication	4	2	11	11	12	1	8	10	8	8	75
Staffing levels	2	6	1	9	9	12	8	3	7	13	70
Resources	4	8	1	8	7	3	6	3	10	16	66
Knowledge	6	7	6	1	5	7	7	13	7	3	62
Workload	2	8	3	14	5	2	2	1	3	20	60
Positive experience	3	3	5	6	5	6	6	8	8	9	59
Structures	7	6	8	7	3	4	4	3	11	2	55
Responsibility	15	8	4	4	6	2	5	2	7	1	54
Public health	4	1	4	7	3	6	5	5	7	11	53
Confidence	6	6	6	3	3	6	10	4	4	1	49
History	1	3	5	4	1	8	6	5	12	4	49
Personal factors	3	16	6	2	4	2	3	1	6	5	48
Power	6	6	2	5	2	1	5	6	6	6	45
Empowering	2	3	13	2	1	1	11	1	7	3	44
Role	10	4	3	1	1	2	5	1	1	16	44
Community Setting	4	3	9	4	3	4	4	1	5	6	43
Hospital Setting	3	1	7	3	2	1	3	3	12	5	40
Doctors	1	2	4	9	4	7	5	2	1	3	38
Information	2	2	3	3	3	5	1	4	1	3	27
Control	2	4	1	5	1	4	1	2	2	2	24
Understanding of empowerment	1	1	4	2	2	2	1	2	1	2	18

### 7.11 Appendix 11 - Table of themes emerging from incidence density

<b>Practice</b>	<p>Relating to patient/client care/intervention</p> <p>Decision Making</p> <p>Workload</p> <p>Responsibility</p> <p>Public health</p> <p>Doctors</p> <p>Information</p>
<b>Management</b>	<p>Relating to management</p> <p>Management style</p> <p>Management structure</p> <p>Management role</p>
<b>Organisational</b>	<p>Staffing levels</p> <p>Resources</p> <p>Structures</p> <p>Community Setting</p> <p>Hospital Setting</p>
<b>Education</b>	<p>Education</p> <p>Knowledge</p>
<b>Interpersonal</b>	<p>Communication</p>
<b>Professional</b>	<p>History</p> <p>Role</p>
<b>Personal</b>	<p>Confidence</p> <p>Personal factors</p>