

**A qualitative study on:  
Iranian nurses' understanding and experiences of  
professional power**

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## **Abstract:**

### **Background:**

Nurses are expected to empower their clients, but they cannot do so if they feel powerless. They must become empowered before they can empower others. Some researchers have emphasized that understanding the concept of power is an important prerequisite of any empowerment program. While many authors have tried to define the concept of power there is no comprehensive definition. This paper is an attempt to clarify the concept of power in nursing. It also would present a model described the factors affecting nurse empowerment.

### **Methods:**

We choose the grounded theory approach for analysis of the participants' experiences and their viewpoints regarding the concept of professional power in nursing. Semi-structured interviews and participant observation methods were used to gather the data. Forty-four participants were interviewed and 12 sessions of observation were carried out. Constant comparative analysis method was used.

### **Results:**

Six main themes of: "Application of knowledge and skills," "Having authority," "Being Self-confident" "Unification and solidarity," "Being supported" and "Organizational culture and Structure" emerged from the data. According to the participants, nurses' power is influenced by these six variables. A theoretical model was designed to represent the inter-relationships between these six variables.

**Conclusions:**

Nurses' power depends on the gaining and application of professional knowledge and skills.

Delegating authority and enhancing self-confidence of the nurses also help them to apply their knowledge in practice. Unification of the nurses and supporting each other play the key roles in development of their collective power and provide a base for making a better working condition, professional independence and self-regulation.

## Background:

Nurses are the largest professional group within health service organizations [1]. They are expected to provide quality care by diagnosing and treating of human responses to health and illness [2] and empower their clients [3] by moving them toward an independent, self-regulated, healthy life. But whether and how nurses could provide such a proposed nursing care has been identified as being dependent on their professional power [4]. Tommy (2000) and Ellis and Hartley (1999) have also emphasized that no profession can provide suitable and qualified services unless its members feel power and have control over their own functions [5,6]. Thus, nurses need to be empowered themselves before embarking on a process of empowering others [7]. Considering the importance of nursing services in any health system, the 54<sup>th</sup> World Health Assembly has recommended its members to design programs for strengthening and promoting their nurses [8]. Some authors believe that success in empowerment programs depends on understanding the concept of power. They emphasized that to empower nurses, the first step in the process is to determine their definition of power [9,10].

Power is an essentially contested concept [11], in that its meaning and people's perception of it vary greatly from person to person depending on their values, situations and experiences. It has been defined and analyzed in several ways by authors from different disciplines including nursing [12].

The classical social psychologists have defined power interpersonally as influencing others' behavior by controlling the resources [13]. Lukes (1974) has considered power as an essentially unobservable force for controlling the others' decisions. Functionalists view power as a source held by individuals and groups in relation to the importance of their activities to society's goals. According to postmodernists, knowledge is power and these two do not exist

in isolation from one another. Feminists relate power to gender but there is little consensus among them about definition and dimensions of power [13,4].

A range of viewpoints concerning power also is discussed in health literature. Griffin (2001) has discussed the concept from three popular perspectives in the health literature including the trait approaches to professionalization, the medical dominance perspective and the view of health care work places as organizations [14]. Based on her results, the power of nursing as a profession is linked to a number of factors including its status as a profession, the fact that the majority of its members are women and the extent to which nurses have knowledge and skills necessary to working with other disciplines. While Leksell et al (2001) have defined power as conscious choosing and doing intentionally[15], some authors believe that the source of power in health system is the authority. However, Kokkanen (2001) has stipulated that power is more than controlling actions; it is the manipulation of thoughts, attitudes and social relations [16].

The concept of power generally is not associated with nursing. Many members of the public perceive nursing as powerless and this belief is reinforced by nurses' perceptions of themselves as powerless [17]. Some authors have identified characteristics in the nursing profession that reflect a powerless and oppressed group during the last two decades [10,18]. Some researchers have also reported the same distinctive characteristics in their studies on the Iranian nurses. They reported that Iranian nurses are not satisfied from their work setting. Nurses in these studies have expressed strong emotion concerning the lack of recognition in the workplace. They have also complained of lack of power and authority for controlling their practice and that the doctors and managers do not respect their decisions [19,20,21]. According to Watson (1999), though the nurses try to gain their power and status, but they don't uniformly agree on the concept and the ways of reaching power [22].

In the recent years, the public and the government have criticized Iranian nurses because of poor quality of patients care. They are searching for strategies to more appropriately utilize the workforce such as decentralization and privatization [1]. However, the nurses' views about the factors that affect their clinical functions have rarely been investigated. It appears that the critics have forgotten that nurses could not empower others if they feel powerless. Thus, an important area for research is to obtain nurses' perspectives on professional power. It could be the first essential step for administrators and educators, when designing programs for empowering nurses. To this end a qualitative study was conducted on "Iranian nurses' understanding and experiences of professional power." The purpose was to clarify how do Iranian nurses understand power as well as the process and factors affecting their professional power.

### **A brief history of nursing in Iran**

The development of nursing in Iran has been influenced by economical, historical, religious and cultural variables [23]. Until 70 years ago, nursing care of patients was carried out by household women at home or untrained personnel at hospitals [24]. In 1915 an American missionary endeavored to train a few nurses and after one year the same missionary established the first three-year nursing school in Tabriz, Iran. In 1935 the government obtained the services of 3 American nurse educators. They offered a two-year program in 3 nursing schools in 3 different cities. The graduates of these schools were called "doctors' assistant" because doctors always were respected in Iranian society [24]. After that, more western nurses, especially British nurses continued to educate nurses in Iran, in 2-3 years programs, therefore nursing in Iran has been strongly influenced by British nursing tradition [19].

Before Islamic revolution the most nurses were women, but after the revolution, the nursing curriculum was reconstructed and also more men entered the nursing profession. Now, nurses can study at universities from the level of a bachelor degree to a PhD degree. At present 184 centers for nursing education offer the BSc degree, 12 centers offer MSc degree [24] and six centers offer a PhD program in nursing. However, nursing in Iran still seen as a female occupation and nurses are seen as doctors hand maiden both in public and professional context [19].

## **Methods:**

Data were collected and analyzed using a grounded theory approach [25]. The term grounded theory reflects the concept that theory emerging from this type of work is grounded in the data [26]. The grounded theory approach has been used in nursing research since 1970. The studies have focused especially on nursing practice and nursing education [27]. Gaining and using power is clearly a process rather than static factors, which could suggest a grounded theory approach. This approach was also selected because nurses' practice takes place in a multidisciplinary team and grounded theory focuses on identification, description, and explanation of interactional process between and among individuals or groups within a given social context [25, 28]. Data were collected by individual interviews which were audiotaped and through observations recorded in field notes.

### **Sampling and data collection:**

We used purposeful sampling at first and continued with theoretical sampling according to the codes and categories as they emerged. All nurses with more than five years of nursing experience who were currently working full-time in four large hospitals covered by the 'Ministry of Health and Medical Education' in Tehran, Iran, were considered as potential participants. Sampling started from the surgical ward of the first hospital and was then extended to the other wards and hospitals. Data collection began with staff nurses. After interviewing three nurses and coding the transcripts, the codes and categories related to managerial support, organizational variables and nursing education led the researcher toward conducting interviews with head nurses, supervisors and a few key informants among, higher-level managers, doctors, and nurse educators for the purpose of filling the gaps.

A total number of 44 participants were interviewed including 12 nurses, 12 head nurses, two supervisors, three nursing managers (matrons), three nurse educators, three senior nursing directors, two doctors (who were the executives of two hospitals) and seven members of newly established “Iranian Nursing Organization” (INO) were interviewed. Each interview session lasted between 20 minutes to three hours, 115 minutes in average.

The participants were representative for all four hospitals. Because there is a centralized outline in nursing education in the country, all nurses presented with the same educational preparation. Also there is no system of recruitment in each hospital. Universities employ nurses and distribute them randomly to hospitals based on the number of nurses each hospital requires. Data collected and analyzed during a six-month period in year 2003.

#### **Interviews:**

One of the researchers contacted each of the potential participants to explain the objectives and the research questions of the study. If the participant agreed to take part in the research, an appointment was made for the time of interview. Based on the participants’ request, interviews were carried out two to three hours after starting their shifts because the workload was lower and nurses had the time to be interviewed.

Individual semi-structured interviews in a private room at the workplace were the main method applied for data collection. The interview guide was initially developed with the help of the two expert supervisors and was consisted of core open-ended questions to allow respondent to explain their own views and experiences as fully as possible.

At the beginning of each interview, the participants were asked to describe one of their own working shifts and then to explain their own experiences and perceptions on ‘professional power’ and the factors influencing it. For example, they were asked: “In your opinion, what is the meaning of ‘power’ in nursing? Explain some of your experiences in which you have felt

power as a nurse. What factors have made you feel power in these experiences? How, we as nurses could use or increase our power?”

Brief notes were made about the issues raised during the interview. Questions were asked later if these issues had not been spontaneously clarified. Some of the issues identified by the participants helped researchers to develop the interview guide over time. The interviews were conducted by the main researcher (MAH), were tape recorded, transcribed verbatim and analyzed consecutively.

### **Observation:**

The main researcher conducted twelve sessions of participant observation in all four hospitals. Observations were conducted during the different shifts in emergency, medical, surgical and intensive care units and involved not only the nurses interviewed but also the other nurses present in the shift. Observations were carried out on the days appointed for interviewing the participants. The researcher was present in the ward with permission of the head nurse from the beginning of the duty hours, so that in two to three hours time before starting the interview the researcher could observe the dealings and behaviors. Observation involved sitting in a corner of the ward and observing or following individual nurses around. The researcher was requested by the head nurses not to care formally for patients although at times assistance was given to the nurses on their request. The focus of participant observation was on nurses' interactions and dealings with their patients, colleagues, head nurses, supervisors and doctors with particular emphasis on nurses participation on decisions related to patient care and care setting. The researcher took notes during observations with detailed observations written up the same day. These detailed notes were used as data concurrently with the interviews.

**Data analysis:**

The collection and analysis of data were done simultaneously according to the grounded theory approach. The interviews and observation data were analyzed concurrently using constant comparative method. Each interview was transcribed verbatim and analyzed before the next interview took place. Therefore each interview provided the direction for the next. Open, axial and selective coding was applied to data [25]. During open coding, transcripts of each interview were reviewed multiple times and the data reduced to codes. The codes that were found to be conceptually similar in nature or related in meaning were grouped in categories. Codes and categories from each interview were compared with codes and categories from other interviews for common links. Axial coding was concentrated on the conditions and situations which cause a phenomenon to take place and the strategies applied to control the phenomenon. This process allowed links to be made between categories to their subcategories and then selective coding developed the main categories and their interrelations. Although a variety of different levels of personnel were interviewed, themes that arose were consistent across interviews. However, they used different words to refer to the same concept, for example while the managers used the word “authority,” some nurses used the word “permission” or “right to do” for referring to “authority.” Also all participants mentioned the insufficient salary of nurses, but the managers and doctors believed that the governmental rules don’t permit them to increase the nurses’ salary. Interviewing stopped when data saturation occurred. Data were considered “saturated” when no more code can be identified and the categories were “coherent” or made sense.

Credibility was established through participants’ revision as member check, prolonged engagement with participants and peer check. Maximum variation of sampling also confirmed the confirmability and credibility of data [29, 30]. The participants were contacted after analysis and were given a full transcript of their coded interviews with a summary of the

emergent themes to see whether the codes and themes are true to their experience. As a further validity check, two expert supervisors and three other faculty members did peer checking on about 45% of all transcripts. On this process the transcripts of interviews were given to them and they followed the same process as above to arrive at core themes. There was 90% or higher agreement between different raters.

Results were also checked with some of the nurses who did not participate in the research and confirmed the fitness of the results as well. These sampling strategies resulted in maximum variation sampling to occur and a vast range of views and experiences considered. The researcher tried to have precise documentation of the direction of research and the decisions made to save the “auditability” for the other researchers to follow the direction of the research. Prolonged engagement with participants and with the research environments helped the researcher to gain the participants’ trust and better understanding of the research environments.

**Ethical considerations:**

This study was carried out as part of a PhD thesis in Tehran University of Medical Sciences. The ethics committee of Tehran University of Medical Sciences gave permission for the study. Other ethical issues in this study involved the assurance of confidentiality and anonymity for the participants. All participants were informed of the purpose and design of the study and the voluntary nature of their participation. A written consent was sought from the participants for audiotaped interviews and the hospital directors and head nurses had also agreed to their participation and participant observation.

## **Results:**

The individual characteristics of the participants are presented in Table 1.

Data analysis resulted in the identification of six themes including “Application of knowledge and skills,” “Having authority,” “Being Self-confident,” “Unification and solidarity,” “Being supported” and “Organizational Culture and Structure.” Each theme will be discussed followed by the conceptual model of the interconnectedness of these six themes.

### **Application of knowledge and skills:**

The participants emphasized the role of professional knowledge of a nurse on his/her power and considered that as one of the critical factors in gaining power. According to one of the nurses: “a powerful nurse is the one who has rich knowledge and skill and is expert in his/her own job.” (Nurse five) One of the supervisors also said: “the ‘power’ as a whole means ‘ability’ ... the level of power a nurse has depends on the level of her/his professional knowledge and experiences. A powerful nurse is one who both has a good knowledge and can use it well.” (Supervisor two)

Though participants believed that having ‘professional knowledge and skills’ is the basic prerequisite for gaining power, they don’t consider it to be enough. They emphasized that: power is only gained when the nursing knowledge is “applied and implemented” by the nurse. They clearly stated that: “the power of a nurse would only be exhibited through application of knowledge and skills in the provision of care for their clients.”

Although power is not a visible and palpable thing, the nurses have experienced it when they have been able to take care for their clients based on their clinical judgment (which definitely has arisen from their professional knowledge and skills) and have observed effective outcomes for their clients.

One of the nurses described an experience in which she experienced power:

“When I was working in the neurological surgeries unit, a discopathic patient was brought from the operating room; one of his primary signs was leg pain. When he was brought I noticed the patient’s frequent complaining of leg pain. I went to his bedside and removed the blanket. Previously, he complained of pain in the right leg but now, he was complaining of the pain in the left leg. I felt the left leg’s temperature is lower than the right one. His pulse was slow. I immediately called the concerned doctor and also called and arranged for the operating room. The patient was taken to the operating room and an embolectomy was done. The doctor said that any delay in the operation would have led to the loss of the intact leg. Anyway, if my knowledge was poor, something would have happened. It was at that time when I felt power because I felt my proper knowledge and on time decision could have saved the patient.” (Nurse 11)

#### **Having authority:**

“Having authority” was a dominant theme in the participants' viewpoints. They frequently used such statements as “the right to do” or ‘the authority to do the duty without the necessity to get permission” to refer to the concept of ‘having authority.’ Although staff nurses and nursing managers pointed to different symbols of having authority, the relation between “power” (application of professional knowledge) and “authority” were so clear in their viewpoints that 36 participants referred to ‘authority’ in explaining their experiences about ‘power,’ and even considered them to be synonymous.

One of the senior nursing officers said: “Power means the ‘authority’ that one can have, and a man can be powerful only when he/she can decide on his/her own.” (Senior nursing officer one)

Head nurses also consider power as an outcome of having authority. To them: “power is the responsibility that is handed over to the man and is the right for him to do many tasks that even an ordinary nurse can do but he/ she has not been allowed to do.” (Head nurse four).

The staff nurses also considered power as having authority to decide in their own territory of duty. They believe in power and authority as the means for the better and faster care of the patients. One nurse commented: “we don’t want any more right than my real rights.” (Nurse four) Another nurse stated: “I must have the right to do nursing care based on my diagnosis.” (Nurse five)

From the participants’ points of view, some internal and external factors affect the feeling and using authority by nurses. The external dimension which considered as barrier to using their authority and power, covers organizational factors such as job description, official rules, unbalanced nurse-patient ratios and increase in non-nursing duties.

The internal dimension goes back to the nurses’ self-confidence in using their formal and informal authority. The following comments of two nurse educators describe this point: “The power depends on the individuals; some people have power with the same authorities, and some people do not,” (Nursing trainers two) “when I was designated as the head nurse of the neurosurgery unit, I made an agreement with the chief doctor that in cases we observe the signs and symptoms of infection, we don’t wait for them to come and order the culture. We also did many nursing interventions but now, many nurses wait for the doctor to order them.” (Nursing trainers one)

Many of the participants felt frustration because they felt that they had knowledge and experience to make decisions, yet the doctors always had the final authority. One nurse commented: “we look after clients ... we work together (with doctors), but they have the authority. When I or one of my colleagues feel the patients are ready for discharge, we say the doctor 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 ones who look after them twenty-four hours a day, not for five minutes a day.” (Nurse three)

**Being Self-confident:**

Self-confidence was another theme that emerged from data. Thirty-five participants emphasized the key role played by self-confidence in feeling and using power and authority, and majority of them considered that as a synonym or a necessary base for power. They also identified the different factors and dimensions in self-confidence of the nurses. They believed that: “self-confidence provides the nurse with the feeling of power and ability, and lacking of confidence causes the man to feel weak and unable to use him/her talents,” so that she/he would avoid independent actions.

According to a clear statement of one of the head nurses: “power depends on the individuals. Some people have the self-confidence to make use of him/her authorities in their duty limits as a nurse or a nurse manager while some are weak and unable to do so.” (Head nurses five)

Participants emphasized the mutual relationship between power and self-confidence. In other words, power gives the nurse self-confidence, and self-confidence brings the feeling of power with itself. One of the senior nurse managers commented in this regard: “Self-confidence brings power and vice versa; it is exactly mutual, and I have felt it many times. One day, they offered me the post of “deputy director” and asked whether I would accept it or not. I immediately said, “yes” because I had full confidence in doing it.” (Senior nurse manager one)

According to participants, although self-confidence is rooted in one’s personal characteristics and the social and work-related interactions, having adequate and job-related knowledge and information, together with the people’s feeling of confidence and self-efficacy in doing something, provide them with the feeling of power and ability.

While the participants considered self-confidence as one of the main pillars in feeling and application of power, the majority of them complained of the “lack of self-confidence in nurses and nurse managers” and considered it as the root factor in “powerlessness and feeling

of inferiority of nurses toward doctors.” This is why they do believe that the nurses’ self-confidence must be strengthened.

They also pointed out that self-confidence of nurses is negatively affected by the wrong methods of education, social culture, role ambiguity and frequent cross-questioning and under-questioning of the scientific and technical competence of nurses. These factors cause a feeling of inefficiency, powerlessness, role conflict and lack of self-confidence in nurses and make them believe that they are only mediums or means for doing the doctor’s orders. When the researcher was observing in a surgical ward he saw a patient who asked a nurse to inform him about his diet after the discharge. The nurse said: “you must wait until you doctor will come.” The researcher asked him why you did not educate the patient? The nurse said: “I don’t know what exactly I must to do. Am I allowed to give advice to a patient about his diet? Am I authorized to change the patient’s position? I have punished for such kind of works many times. This is why I am uncertain and I did so.”

#### **Unification and solidarity:**

The participants emphasized the importance of unity and its role in professional power. They considered the unity of nurses and coming together in nursing unions as an efficient way for increasing professional power. Although all participants focused on the necessity of unity among nurses and considered it as the most important factor in gaining collective power, most of them pointed out the disunion among the nurses and considered it as one of the reasons behind their weakness as a professional group. Two Participants stated: “if there is something lacking in nursing, it is the unity which is mostly not present.” (Trainer three) “The nurses do not support each other.” (Nurse one)

This condition has made nurses to accept the present situation as one nurse said: “we are weak because we are not with each other. So we could not use our power and obliged to obey every order. We try to adapt to the situation and avoid any disagreement.” (Nurse two)

According to the participants, the unsatisfied needs, heavy workloads, and lack of time are the main barriers in the unification and solidarity of nurses. One supervisor commented: “the pressure of work, overloading of responsibilities and working over time in other places just to fulfill their financial needs have made them extremely busy that they rarely have enough time to think over and find the root of this situation or find the ways to face it.” (Supervisor one)

However, many of the nurses have come to the conclusion that unification and collective actions are necessary steps in the development of their professional power. To them, coming together in legal and formal nursing organizations is the best solution in this regard. The following quotes of two supervisors confirm this: “this power must be created in these unions and organizations, and they must prove themselves at the social level.” (Supervisor two) “I believe in the strong power of nursing, but if this power is provided to a special organization the nursing status will definitely improve beyond the present position. It is also revealed in the holy Quran that: the destination of a society is measured by each one of its individuals.” (Supervisor one)

These statements not only indicate the necessity of unification and its role in the development of professional power, but to them, the presence of a talented leader in directing the existing energy is a must for it. One of the nurses also commented: “I wish nurses come together, to improve our condition and also could decide for our profession.” she was aware of the fact that collective power brings the possibility of reaching better working conditions and professional self-regulation. The latter would make it possible for them to develop standards and regulations for their profession and define the limits of authority, responsibility and accountability of each member within the profession. Afterward, they will be able to apply their personal power and provide quality care for their clients.

**Being supported:**

Nurses frequently emphasized the necessity of support. To them, support was mainly characterized as supportive management, and was considered as an important factor in the development of their professional power. One head nurse commented: “Powerful nursing owes support, it must be supported, and the “people in charge” should support it.” (Head nurse one)

The participants’ views and experiences on support were categorized under the three subheadings of: “provision of care facilities”, “provision of financial welfare,” and “provision of emotional support”. Nurses have emphasized that support would bring them the feeling of power and would result in the quality care.

However, a feeling of being unsupported was ruling over the nurses. They believe that they are not supported by both the nursing and non-nursing superiors; therefore, they considered the nursing managerial system as “deficient,” as two nurses said: “we don’t know what is this managerial system made for. They do nothing for us.” (Nurses three) “We have no professional, financial, emotional and life support at all, and these are the supports that can give us necessary power.” (Nurse 11)

According to the participants, managers have responsibility for the “provision of care facilities,” but they don’t do it properly. Shortage in nursing work force and lack of care facilities like sheets, dressing equipments, wheelchairs and so on, made nurses unable to apply their professional knowledge. Consequently, they feel unable to meet their clients’ needs, and giving them the feeling of inability and powerlessness. One of the participants said: “when we have only two nurses for 37 patients, certainly they cannot provide a good care. They can only monitor the blood pressure and give the drugs,” (supervisor one)

The participants mentioned the “insufficient income of nurses” frequently, but what made them suffered more was: witnessing of the unjust distribution of income in the health system.

All participants, (except two participating doctors) emphasized on the significant difference between doctors and nurses' income and considered it as a symbol of injustice, lack of support, and ignorance of the nursing services' value. "This made nurses preoccupied with financial difficulties and caused them not to be able to concentrate on their patients' problems." (Nurse educators two)

Nurses also emphasized the lack of "emotional support." They pointed out the cases, such as: "despising and suppression of nurses," "taking the side of doctors in their conflict with the nurses," "carelessness and inattention to nurses' problems" and considered them as symbols for the lack of "emotional support." The following statements contain clues to the unsupportive and oppressive behaviors of some of the nurse managers:

"There is no one listening to our tale of sufferings; we are complaining of our own colleagues, those who are in charge of us, because they never support us." (Head nurse one)

"Our matron shows off her power only before us, not others." (Nurse seven) "If something goes wrong in the hospital, the nursing office supports others rather than the nurses." (Head nurse six) Such experiences have taught nurses that any disagreement must be avoided.

Therefore they are reluctant to assume responsibility and this reluctance made them more powerless.

### **Organizational Culture and Structure:**

The structure and culture of the health care system was another important factor affecting nurses' power and also on their participation in clinical decisions. Many organizational issues have mentioned by the participants in this research. These include factors such as lack of nurses' visibility within the organization, dissatisfaction with the way the organization is managed, lack of involvement in decision-making, inadequate staffing, and lack of control on their practice setting.

As we mentioned earlier, nurses considered “authority” as an important pre-requisite for implementing professional knowledge and skills, but the majority of nurses believed that organizational related variables such as job description have limited them. Also some participants believed that there is a physician-centered culture in the health care system, that doesn’t regards nurses’ decisions and does not permit them to use their authorities. One of the supervisors stated: “Now, it is expected that nurses only obey the orders, give the drugs, do the injections, monitor the blood pressures and write the nursing notes, but not to intervene independently.” (Supervisor One) One nurse educator also commented: “I think the system forces the nurses to ignore their own authorities. For example every one who want to enter an ICU must change his her shoes. Nurses frequently have mentioned this rule, but most doctors did not do so, and the nurses were remonstrated. Finally nurses have ignored to do so.”

Many nurses mentioned that factors such as inadequate manpower, unbalanced nurse-patient ratios and increase in non-nursing duties have decreased their relationship with the patients and made them adopt a task-oriented working system that spontaneously acted as a barrier in the way of application of knowledge and skills. Thus, conflict has aroused between the professional roles and the roles that organization has imposed nurses. This conflict has produced a great deal of stress for nurses so that many nurses are searching a different job. One nurse said: “I don’t know what am I? I “I don’t know the meaning of my work, am I a nurse, nurse aid, worker, secretary or watchman? I am compelled to do the duties of all of them because there is not enough manpower for these duties. How can I be a good nurse with these difficulties?”

One head nurse also commented in this regard: “this ambiguity of the roles along with the heavy workloads and a poor socio-economical status made nurses depressed and angry and they wish to find another job.”

Nurses also identified management style as being an important influencing nurses’ power. But they believed that there was an autocratic management style in the hospitals they worked.

This management style has resulted to an unsupportive atmosphere in the hospitals that does not value nurses and nursing services.

Although there was consensus that being valued was an enhancing factor for empowerment, nurses felt disempowered by not being involved as professionals. As one nurse stated: “we as nurses not being valued by the top level managers. I think it is very important that you feel valued by other members of the team and specially by your manager.” (Nurse ten) Therefore nurses were not satisfied by their managers as one nurse said: “I think the nursing hierarchy disempowers many nurses.” (Nurse two)

Some of the participants believed that the “prolonged background of task-oriented,” “routine-centered work environment,” and “contentment in doing the doctor’s orders” have decreased the nurses’ self-confidence and have caused an internalized dependency in nurses so that many of them consider the “independent step” as prohibited and feel an internal compulsion in getting permission from the doctors.

## DISCUSSION:

From the participants' point of view, the concept of professional power had direct and mutual relationship with application of knowledge and skills in nursing practice (figure 1). In fact they conceptualized professional power as: "the ability of a nurse in application of his/her professional knowledge and skills and doing the nursing care based on the nurse's diagnosis, in response to the needs of their clients."

.....Place for figure 1.....

As presented in the figure 2, this ability has close relationship with having authority and being self-confident. Though nurses have felt power in implementing their own knowledge and skills in their caring practice as well as in participating in clinical decisions, but some other variables also affected their ability to exert their professional power in practice. Indeed, The Pooled effect of these variables negatively has been affected nurses' ability to make use of their professional power.

The theoretical model shown in the Figure 2 represents the major themes, as well as the relationships among those variables influencing nurses' power. These variables as a whole represent the process by which nurses have felt themselves powerful or powerless.

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Figure 2 shows that the six variables were grouped in three main inter-related **categories**. The first category was named as "personal power" (the inner three part circle in the model) which comes from the mutual effects of three processes i.e.: "application of knowledge and skills", "having authority" and "self-confidence." The second category was named as "collective power" (the second two part circle in the model) that comes from the interaction between two variables i.e.: "being supported" and "unification". "Organizational culture and structure" also emerged as the third category.

Data were examined to identify the core variable influencing the nurses' power. A precise review of the data and emerged themes proves that "organizational culture and structure" was the core variable affecting nurses' power. In fact it was the organizational structure and its physician centered and routine oriented culture that have made nurses to only obey doctors and managers, and carry out their orders. It became clear that the basic social psychological problem which nurses were encountered with was that of "Role conflict."

Indeed there was conflict between nurses' professional roles and the roles that organization imposed on the nurses. Patients need for care, and nurses have the knowledge and skills to care them, but they have not the authority, support and self-confidence for application of their own knowledge and skills. As a result, nurses feel tension and role conflict. Basic social psychological process that nurses were used to deal with the conflict and tension was that of "avoidance." in fact nurses were avoiding any independent caring intervention and only executed the doctors' orders. Actually they have come to the result that the hospital system does not tolerate their power and any attempt to exerting their own professional power would result in to tension and conflict to occur. Therefore they have ignored their own power and only obey. This made them more weak and powerless. Figure 3 has represented this process.

.....Place for figure 3.....

As presented in fig. 2, the participants in this research mentioned two aspects of professional power. According to the participants, personal power comes from the professional knowledge and skills, levels of authority, and self-confidence in applying them clinically. According to nurses, collective power also comes from unification and supporting each other. Piletier, et al (2000) and Sneed (2001) have also emphasized on the necessity of personal and collective power in nursing [31, 32].

Having a wide range of professional knowledge, making the right decisions on the basis of this knowledge, and exerting these decisions in responding to patients' needs are the most

important conditions which have created the experience of personal power in nurses participated in this study.

Knowledge is power [32], and those having knowledge can influence others. Nurses, who have professional knowledge and use it in the context of efficient human relations, gain credibility and a sense of power. In a qualitative content analysis of interviews of 30 nurses, they demonstrated that expertise; knowing how to do the job and possessing a wide range of knowledge were associated with the development of their professional power [33]. This also confirmed by Fulton (1997) [10] and Kubsch (1996) [34]. Benner, et al (1996) have also shown that nurses can take the situations at hand by acquisition of knowledge and skilled performance [35].

Although acquisition of knowledge is important, its application has close relationship with the level of nurses' authority and self-confidence. Precise review of data revealed the existence of bilateral relationship among these three variables. These interactive relations among the three variables are highlighted in fig. 2. This is the total effect of these variables that brings a nurse the sense of professional power.

The majority of participants in this research considered a close relationship between the power and the level of authority as well as self-confidence. Nurses frequently complained of lacking authority, however some participants implied that the nurses have the authority for application of their professional knowledge, but they do not use it due to some of organizational and individual barriers. Heavy workloads, staff shortage and unclear job description were among the organizational barriers that made them to become task oriented and overlook their authorities. Also participants in this study complained of the lack of self-confidence and internalized dependency in nurses and considered it as one of the leading causes of their powerless. To them, the wrong methods of education and frequent remonstrance and cross-questioning of the nurses have played important roles in this regard.

Laschinger et al. (2000), Nikbakht (2003) and Fulton (1997) also have reported that the nurses feel that they have little formal and informal power and authority [36, 19, 10]. It seems that nurses have acquiescence with doctors' domination and due to lacked self-confidence [37], the internalized beliefs about their own inferiority [18], low self-esteem, self-doubt and doubt in their own knowledge, ability [10], and competency [3], they have handed over the authority to those who are considered as superiors in the their mind, and therefore give rights to the doctors to have the last word. But, self-confident persons have an internal locus of control, and believe in their ability to influence results [38].

As fig. 2 indicates, there is interactive relationship between two variables of unification and being supported. According to participants in this research, these are the two variables that bring nurses the collective power. It is through this type of power that nurses could provide themselves a better working condition, professional independence and self-regulation. It is in such condition that they could apply their professional knowledge in their caring practice and feel power. As figure 2 indicates being supported has close relationship with professional self-confidence and also with perceived authority. The participants also confirmed this process. However they complained of the disunity and lack of group identity among nurses, as confirmed by Roberts (2000) [18]. It seems that some preoccupations of the nurses such as: salary, income and job insecurity have caused them to remain in the first and second category of basic needs as mentioned by Mazlo, so that they lack the required motivations and ability for professional co-operations and moving forward. This process has brought them the lack of political and professional power, so that, in spite of being the largest group in the health organization, they are considered the weakest discipline [1, 3]. Some authors criticized nursing for concentrating on the personal elements of power and overlooking the collective and political actions. However, as Gilbert (1995) and Cheek and Rudge (1994) argue, it seems that nurses have gained a better and brighter awareness of the structure of power now, and

have felt the need to change their socio-political actions [39,40]. As participants in this research implied, formation of professional unions and associations are the best strategies in strengthening nursing as a profession. Although these organizations can provide a powerful supportive system for the nurses and help them acquire better working conditions, but at the time of doing this research, the Iranian nurses lacked it. In fact they expected their managers, to support them. As Macphee and Scott (2002) argue, although all the factors and working conditions are not under control of the managers, but supporting the nurses can decrease the present pressure on nurses up to some considerable extent and increase the feeling of self-confidence, power and trust in them [41]. Nurses expect their managers to provide them with facilities for care, financial and emotional supports, so that they can take care of their patients with a peace of mind [5].

When nurses are not provided with these supports, they feel unable to control their working environment; therefore, they experience frustration, worthlessness and powerlessness. On the contrary, when they have the mentioned supports, they will feel power and authority [9, 42, 43] and have more confidence to act on their own diagnosis. It is here that Arai (1997) considers the existence of support and self-confidence as a must for the implementation of knowledge and skills [44].

Qualitative data such as emerged from this study need to be viewed from the immediate social and cultural milieu of the participants. It seems unlikely that only the work place has affect nurses power. There is a large amount of evidence that there are various power relationships in society that can have a negative effect on nurses' power and their effectiveness. Key areas such as childhood [45], gender [13, 46] and class [13, 47] are some of these factors. Iranian society has a traditional, paternal and masculine culture especially among the lower and middle classes, which emphasize on obedience from the power holders like fathers (at family), leaders and governors (in the society), and managers and physicians (in health system). Also the Iranian society traditionally has respected doctors and has seen nurses as doctors' assistants or handmaidens. Many physicians and hospital managers also regards

nurses as doctors helper and do not consider them as specialists in art of caring [19]. These socio-cultural factors also have played important roles in nurses' power less and have decreased their self-esteem and prevent nurses' from using their innate power and self-reliance [10].

Also Iranian nurses lack a culture of team work and although the participants in the study did emphasized on the importance of unity and teamwork, the value of participative decision-making have not been realized yet. In Iranian culture the person with the highest status makes the decisions and if the superiors wishes are clear, subordinates act in accordance with those wishes.

**Recommendations:** As data in this research indicated, organizational culture and its structure is the core variable that inhibits the nurses' power. Review of existing organizational structure and communication strategies could help in balancing medical, nursing and administration input to strategic planning and decision-making. Managerial supports, recognizing the value of nurses' services, mutual respect, implementing effective workforce planning, developing a system to ensure appropriate access to the resources required to meet client needs, providing staff with appropriate preparation including continuing education in order to deal effectively with increased public demands can foster the professional and personal confidence and self-esteem of nurses. Management training and development programs to meet these needs are recommended.

Nurses appear to have some concerns and uncertainties about their scope of practice and legal issues that are involved in their practice. Reviewing the nurses' job descriptive and providing continuing and accessible education about the scope of practice and practitioner accountability could decrease these concerns and encourage them to more empowered and independent practice.

## **CONCLUSIONS:**

The results of this study helped us to clarify the nurses' concept of power and its effective factors and strategies. Participants in this research considered power as the "ability of a nurse

to apply his/her knowledge and skills in the offering of nursing care based on his/her own judgment, in response to the needs of the clients.”

Understanding this concept and removing the present barriers in the way of nurses can improve their power in offering quality care, and the effectiveness of the health system will be enhanced. The experiences of the participants proved the need for enhancing nurses’ “personal” and “collective” powers. Development of these powers depends on the gaining and application of professional knowledge and skills. Delegating authority and enhancing self-confidence of nurses also help them apply their knowledge in practice.

The nurse managers can play an important role in supporting the nurses. Nurses have the highest expectation from them. This support can undertake any facilitating activity, such as provision of facilities, means and equipments, information, education, rewards, and even some symbolic behaviors that nurses perceive to be facilitating.

Although an extensive range of participants’ views and experiences has studied in this research, the small number of participants may limit the generalizability of the findings. Also this study was conducted when nurses’ morale was perhaps low because the government has started privatization of nursing and Iranian nurses were not pleased with the privatization project. Additional research conducted with other populations of nurses will help us to document nursing practice patterns and eventually to provide a pool of accumulated data related to factors affecting their professional power. This study was done in the some of the biggest hospitals and only in Tehran (the capital of Iran). Further research in other areas can give more information and deepen our knowledge in this regard. Also further research is necessary to test hypotheses suggested by the model such as the effect of unification and support on nurses’ self-confidence and authority, as well as the interaction of the organizational structure and nurses’ self-confidence in application of their professional knowledge.

Other research questions that might be helpful include the followings:

- How do different types of organizational structures and administrative strategies influence nurses' professional power?
- What types of strategies could enhance nurses' self-confidence in their clinical practice?
- What type of changes in our educational system might be helpful in enhancing nurses' self-confidence in their clinical practice?

Answering these research questions would help us to design strategies for empowering nurses to participate effectively in clinical practice by application their professional knowledge and skills.

## Competing interests

None declared.

## Authors' contributions

MAH: Initiation and design of the research, collection and analysis of the data and writing the paper.

MS: Main Supervisor of the project and co-analysis of the data and editorial revision of draft papers.

FA: Supervision of the project and editorial revision of draft papers.

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**Table 1: Individual characteristics of the participants**

	Level of education				Sex		Years of	Age
	Total	BS	MS	PhD	Female	Male	service	
							$\bar{X} \pm SD$	$\bar{X} \pm SD$
Staff nurse	12	9	3	-	9	3	12/4±5/7	32/7±5/3
Head nurse	12	10	2	-	11	1	22/6±6/2	52/8±5/2
Supervisor & matron	5	4	1	-	3	2	19±7/3	42/2±7/4
Senior nurse manager	3	-	2	1	2	1	24/3±7/8	47/5±7/6
Educator	3	-	3	-	2	1	28±1/5	50±1
Physician	2	-	-	2	-	2	19±12/7	48±11/3
Members of INO	7	2	3	2	1	6	23±11/4	42±10/1
<b>Total</b>	<b>44</b>	<b>25</b>	<b>14</b>	<b>5</b>	<b>28</b>	<b>16</b>	<b>19/3±8/1</b>	<b>40/8±8/3</b>

**Figure 1- Interaction between power and application of knowledge and skills.**

**Figure 2- Interactive relationships between variables affecting nurses' power**

**Figure 3- the process inhibiting nurses' power.**

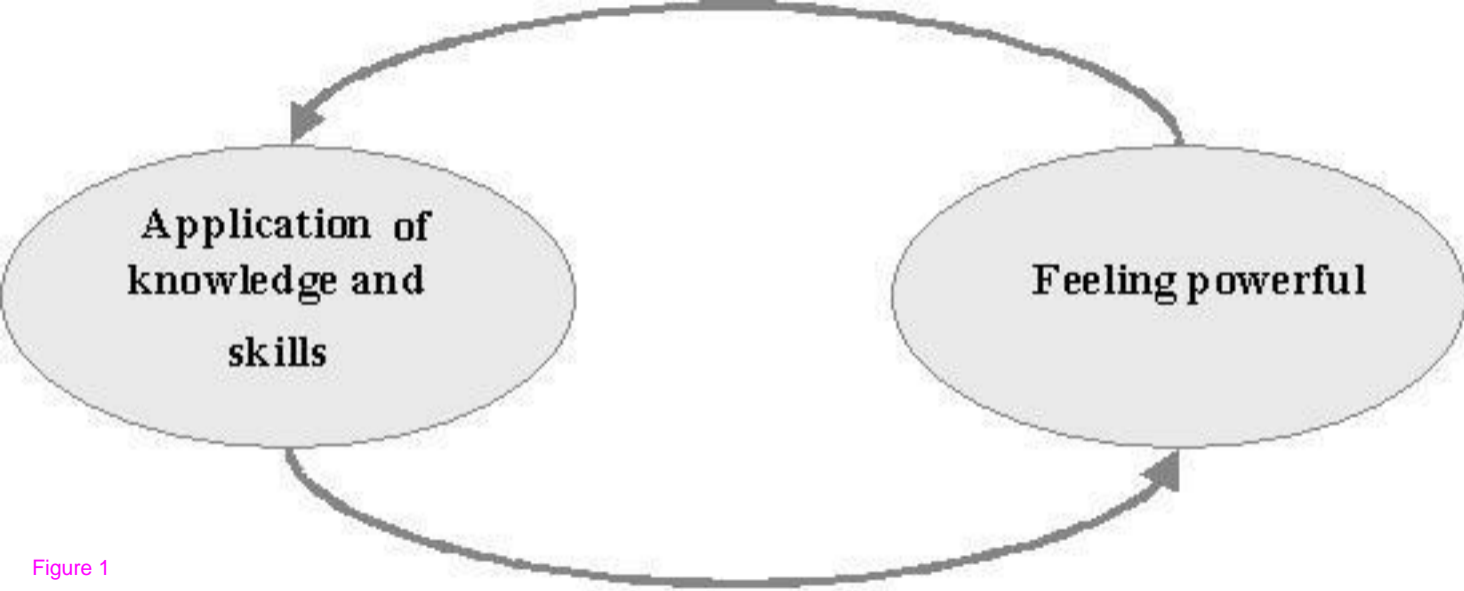


Figure 1

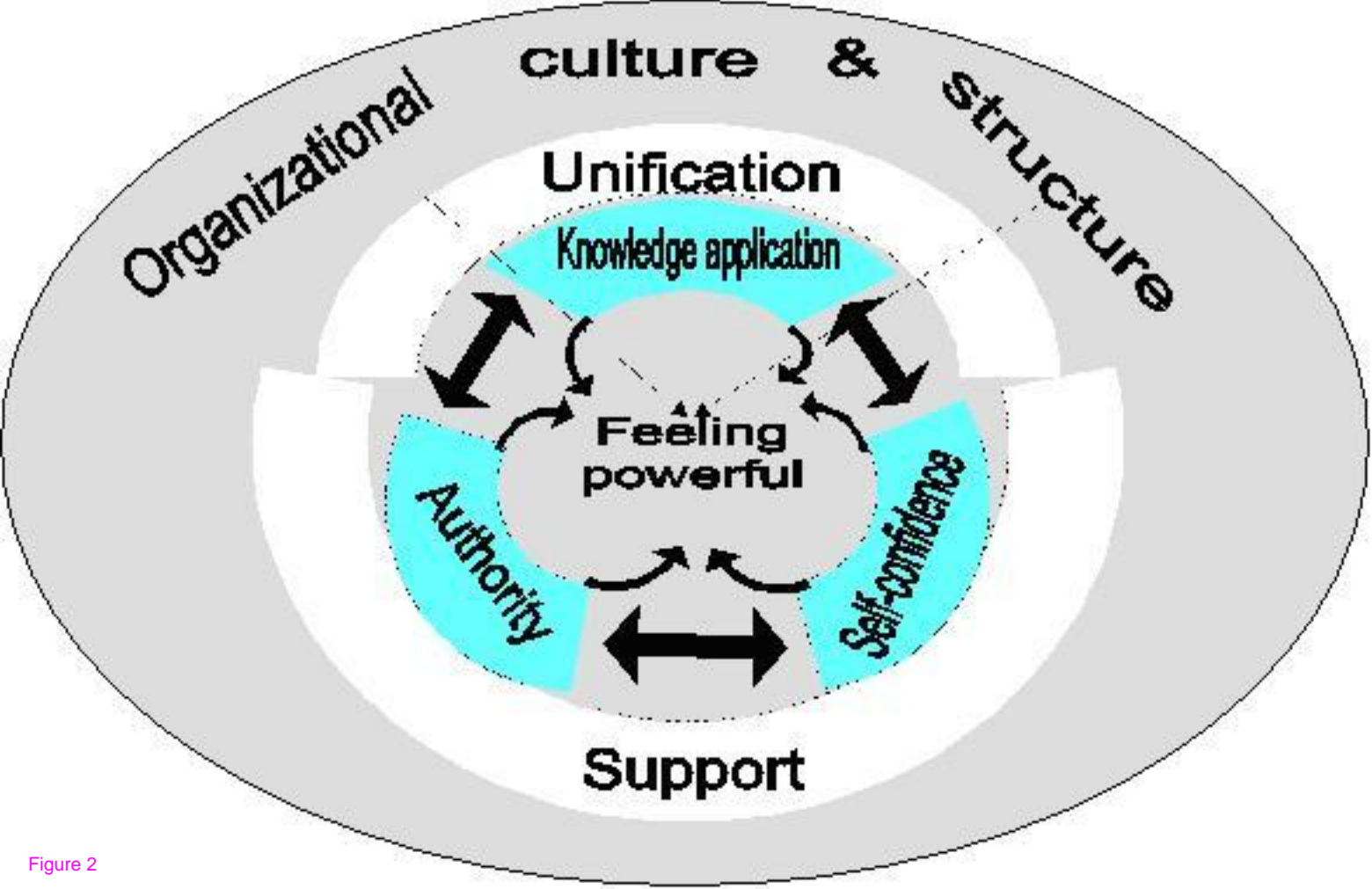


Figure 2

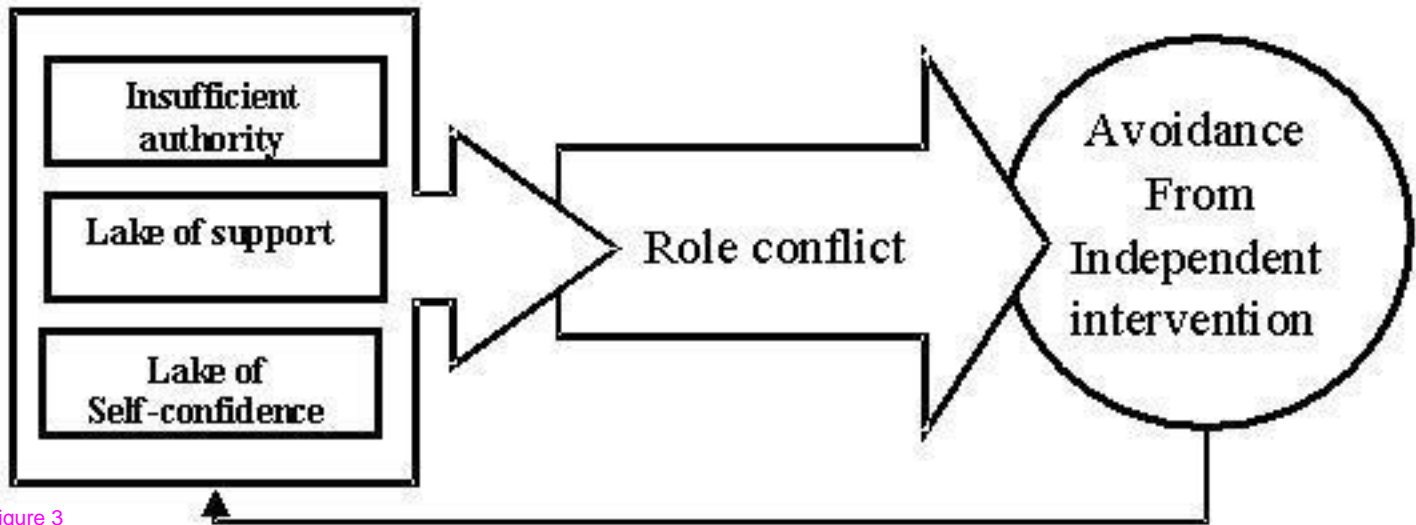


Figure 3