

Nursing Practice Discussion Patient experience

Nurses inevitably occupy a position of power and should reflect on the issue of power, as well as the inherent challenges this poses within professional relationships

PATIENT NARRATIVES: PART 3 OF 7

Power inequality between patients and nurses

In this article...

- Why nurses occupy a powerful position in relation to patients
- Patient narrative illustrating power inequality
- Points for reflection on inequalities in power

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Abstract Corless L et al (2016) Patient narratives 3: Power inequalities between patients and nurses. *Nursing Times*; 112: 12, 20-21.

Many factors can result in an imbalance of power between patients and nurses. This can have a range of negative effects on patients' experience of care. This third article in a seven-part series on the use of patient narratives to reflect on care focuses on power inequalities and their effects, and suggests points that nurses can use to reflect on their own practice.

The patient narrative has become a core theme in nursing and nurse education and, in our experience, many students report profound learning from narratives. However, recent inquiries concerning bad practice have cited lack of listening to patients' voices as a core deficit in the services concerned. The third article in this seven-part series explores issues of power and the inherent challenges this poses within professional relationships. It draws on a story that develops previous themes in the series and focuses on the issue of how power manifests within healthcare.

Nurses may possess a number of attributes that place them in a powerful position in comparison with their patients. These include professional status, professional knowledge, being free of pain and fear, and being in a standing position rather than lying in bed. This article explores issues of

power and the inherent challenges this poses within professional relationships. The background to using patient narratives in nursing is discussed in detail in part one of this series (Buckley et al, 2016).

The narrative below comes from the field of mental health nursing and illustrates the effect on a service user of a power imbalance between her and the nurses caring for her. After reading the narrative, consider the reflection points that follow, and think about how your patients may be affected by a perceived imbalance of power and how you can minimise the negative effects.

Narrative: knocking on the door

Karen Sanders*, a mental health service user, describes her experiences of admission to a mental health unit.

"At times, when I've been in hospital, I haven't felt cared about by the nurses. One of the most difficult things to do when I am in hospital is to knock on the office door to ask for help. When I'm feeling vulnerable and need some support from a nurse, and the only option is to knock on the office door - it fills me with dread. Sometimes, I find that when I've knocked and everybody's busy on a computer or telephone, that they all turn around and it makes me feel like I'm bothering them. If a nurse gives me eye contact and a smile it makes me feel that I'm cared about and that I'm not a nuisance. I also think that nurses should spend as much time as possible out of the office, even if they're just sitting with service users."

"I've experienced a lot of nurses that have written my admission care plan

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• This article has been double-blind peer reviewed

5 talking points

1 How does power manifest in your relationship with your patients?

2 What environmental factors create a power imbalance with patients?

3 Do you create care plans with or for patients?

4 How does the patient narrative illustrate power inequalities?

5 How can you address these inequalities?



Are you presenting barriers to patients?

without talking to me. This leaves me feeling frustrated. I think 'how can you know what I need to help me get well without spending time with me or talking to me?' It's not as bad if they have started to do the plan but then give me some one-to-one time to read through it and then we discuss any changes I want to make. This is made easier if I have met the nurse before.

"When I've been admitted to a ward that I've never been to before, and then I'm presented with a finished care plan that I've had no input in, it can make me quite angry. Sometimes in this situation when I read the care plan it's just the same as the last one from a previous admission to another ward and all they've done is changed the ward names. This is really upsetting and then makes it even more difficult to approach the nurses to talk and ask for help. I feel that they don't really want to know how I feel and what I need.

"As a mental health service user I sometimes feel that I'm seen as somebody with problems first and as a woman who's intelligent and articulate second. The best nurses that I've met and worked with have been the ones that have made me feel cared about, important and not just somebody with mental health issues. They've been genuinely interested in every aspect of my life and personality."

Reflection points

In Ms Sanders' story, the door acted as a barrier. She felt intimidated to knock on it to ask for support and, as a result, she was made to feel worse.

Consider other environmental factors in this narrative that raised issues related to power and how our behaviour as nurses can actually disempower patients. Think about a patient you have nursed. What physical barriers to communicating with staff might the patient have experienced? How did they ask for help? Did you act as a barrier, albeit unintentionally?

Ms Sanders was concerned that she was "bothering" staff and being a nuisance. Patients often start conversations with "I know you are all so very busy but..."

Has a patient ever used this statement to you? What might this say about how the patient perceived you? Have you ever been busy typing notes and a patient has asked to speak with you? Were you tempted to finish what you were doing?

It could be argued that the nurse assessing Ms Sanders acted as a barrier in preventing her having access to her care plan. Ms Sanders could not "get to" the pen and paper, and so felt excluded from the

BOX 1. EXAMPLES OF POWER INEQUALITY

Barry Green has a learning disability and lives in a house with two other men, with staff support present 24 hours a day. He looks forward to regular evening phone calls from his mother. Staff have a policy of answering all phone calls in case they are from the service managers; Mr Green stands near the phone in the evenings just in case his mother rings. The staff have told him to "stop being such a nuisance" and said they will call him if his mother rings.

Karl Evans had recently had major surgery and takes anti-hypertensive drugs, which need to be taken an hour before food. The nurses have control and possession of this medication and, each morning, breakfast has already been served by the time Mr Evans receives it. He had asked if he could have control of his medication to ensure he takes it before food but was told that the nurses need to be in possession of all medication. As a result, Mr Evans had to eat a cold breakfast an hour after the other patients on the ward for the duration of his stay in hospital.

process. Power within healthcare often relates to exercising choice and the ability to make decisions regarding everyday life (Morgan, 1996).

What other barriers might impact on the development of a therapeutic relationship? In this scenario, the nurse was the sole author of the care plan; Ms Sanders was given no opportunity to contribute to what should be a person-centred process. This only reinforced the power differential between her and the nurse. This one experience affected Ms Sanders' perception of how she positioned herself as a patient within healthcare and may affect future engagement with professionals.

How often do you create a care plan with rather than for a patient? Do you ever do this before meeting the patient or do you always truly identify needs and plans of actions together? What happens if a patient wants to put something in a plan that you might disagree with? Do you leave it in or take it out?

Nurses' power may arise from their professional position and privileged access to private knowledge about their patients, which creates an imbalance in the distribution of power. As professionals, we "expect" patients to give us this information freely; however, we often refrain from sharing or disclosing information about our personal lives for fear of crossing "professional boundaries".

Think of a patient that you have worked with. What did you know about them? What did they know about you? How might that difference have made them feel? How do you feel when a stranger knows a lot about you?

Ms Sanders felt she was viewed by the nurses as a collection of symptoms rather than a person with thoughts, feelings and a life outside of hospital. Her sense of self was overshadowed by her diagnosis. While

some people may find a diagnosis helpful in understanding their condition, Ms Sanders felt that this was a barrier to nurses understanding who she really was.

Can you think of examples when you have viewed a patient's symptoms as the priority? What were the implications for that patient's care?

The theme of power applies to all fields of nursing, as highlighted by the examples in Box 1.

Conclusion

Nurses inevitably occupy a position of power in relation to their patients, whether conscious or unconscious. As the powerful person in this transaction, you have the means and the responsibility to do what you can to mitigate this difference. After reflecting on what barriers are presented by the physical environment, the different roles you occupy, your approach to caring processes and your understanding of how the patient might feel, think about what you can do to reduce these barriers. **NT**

* The patient's name has been changed

References

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ARTICLES IN THE SERIES

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- **Part 4** Communication: 6 April
- **Part 5** Empathy: 13 April
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