Issue of nursing powerlessness

Looking Back: Clinical Situation Description

In this paper, I will examine the concept of the nursing powerlessness as an issue between nurses and physicians. My examination will begin with a description of a clinical event that happen to me – describing environment, events and facts leading to the development of my experience with nursing powerlessness. I will then elaborate, analyse and revise how the issues of powerlessness, job satisfaction and psychological and physiological effects on my well-being manifested themselves during and after this experience, followed by providing some new perspective and identifying and elaborating recommendations for future revision of my practice. In order to support the detailed elaboration, discussion, analysis and revising of each of the issues I will provide evidence from existing literature.

A brief analysis of relevance of this issue to myself both personally and clinically will follow as well as a special section on how the critical reflection on the lessons learned from these events will influence my further practice as a registered nurse.

Elaborate

Not so long ago while working part-time in the surgical unit at one of the leading Toronto hospitals I was providing post-operative care for a 74 years old prostatic cancer patient. Usually, after each procedure one nurse assigned to the case will stay with the patient, and monitor until patient comes out of anaesthesia, as the surgeon would leave for other assignments. A charge nurse would remain at the floor in order to provide any support if needed. After coming back from the anesthesia the patient reported to have

experiencing severe pain, was constantly screaming, demanding to inject him with the “ strongest morphine” possible and to see his physician immediately. As an assigned nurse, I have pointed out to the patient that the strongest recommended painkillers, as prescribed by his doctor, had already been administered. However, my explanations seem not to solve the problem and I have decided to approach the physician, after consulting patient’s chart and history of pain medication.

After numerous unsuccessful attempts, I contacted the doctor via the phone and described the patient’s current condition. As I have started suggesting that patient’s pain medication may need to be revaluated I was labeled as unworthy, hinted that I was unable to perform my nursing duties and follow direct doctor’s orders. I was shocked by the level of hostility directed at me, felt degraded, and thought of being unjustly subjected to demeaning or rude remarks. I couldn’t even respond. As I mentioned before, in this paper I will attempt to shed the light on the issue of the powerlessness among nurses when dealing with higher in hierarchy physicians, charge nurses or management.

Shaken, I approached our charge nurse and asked to interfere, but was told that I should calm down and attempt to contact him again. Charge nurse hinted that it was not personal, that these things happen here frequently, and that I should learn to live a “ real RN life”. I hesitantly nodded and following the advice contacted the doctor again but received exactly same response. I ten approached my manager who after listening to me suggested that I might have been a part of the problem due to my communication style.

The circle was complete. I was stumbled and felt totally powerless or morally distressed.

Analyse

The critical issue to analyze here is powerlessness in a hierarchically structured organization, its links to performance, personal feelings and subsequent effect on patient safety. From research by Larsen and Lubkin (2009) it is clear that powerlessness is often associated with psychological, sometimes physical, and social lack of control. Fatigue, hopelessness and grief are therefore linked with the feeling of powerless. Later, when sharing this experience with other nurses, I came to realize that this was a so-called " normal" behavior portraying a physician-nurse relationships. The degrading remarks could manifest in doctor's body language, shrugs, sounds and even talking loudly about " some nurse" when that nurse was in the vicinity. Based on experience, these were " RN's 101 lessons in life" to be dealt with. I started to question my nursing approach to this situation.

While evaluating the usefulness of my then approach and behavior with patient and the physician I decided to make some research and to my surprise confirmed that according to Christie & Johnes, (2009) hierarchically, nurses are always located " at the bottom of the feeder" and should never advise or even suggest something different against doctor's orders. I understood that we, as RNs, though highly trained and respected by patients, were not in control, contrary to the learned knowledge acquired while studying at various courses or statements from the College of Nurses Practice Standards regarding nursing empowerment and maintaining

professional relationships (CNO, Professional Standards, 2002, p. 12). This new reality stressed me out. I felt unsafe, emotionally distressed, and powerless, unprotected and could not convince myself for making a right decision by choosing this department as a possible part-time future job. I have documented and reported these incidents to my nursing manager on the same day and also decided to consult our clinical educator and union rep to gain new perspective on what has just happened.

Revise

While reviewing the situation I learned the following lessons. Hospitals and health care facilities are highly hierarchical organizations where horizontal violence may result in creating a sense of powerlessness among those subjected to it. Based on a research conducted by the Emergency Nurses Association (ENA, 2010) it has been suggested that roughly 12% of day surgery/emergency department registered nurses are faced with at least one incident of professional or ethical misconduct that may or may not fall under the definition of a workplace violence per week. These incidents results in frequent sick days off on the very next day, as it was in my own case as well. Interestingly, 40-46% of all workplace violence incidents triggering time-off requests are requested by registered nurses citing inability to provide services required and moral distress (The U. S. Bureau of Labor Statistics). These morally stressful events often generate bad sleeping habits, non-regular heartbeat, being overtired, and developing headaches. According to a similar study (Moustaka & Constantinidis, 2010), such dramatic exposure to stress also lead to feelings of low self-esteem, post-traumatic stress

disorder, isolation, hypertension, migraines, insecurity, and even suicidal/homicidal thoughts.

According to Dodek et. al, moral distress was defined as a situation when nursing practitioners were unable to provide health care and comfort according to nursing standards and, moreover, as a distress arising from disagreements between members of the health care team as to direction of care. Dodek et al confirmed that a cardinal characteristic of moral distress was in fact powerlessness.

I strongly believe that as a human being and a highly trained registered nurse professional and health care provider, I deserve to be treated with respect and dignity. Based on my own values, assumptions, prior knowledge and throughout the analysis phase I concluded that in order to confront and overcome similar incidents I had to learn to accept the existence of the situation and be able to respond in a manner that will resolve the situation, prevent any further occurrences while maintaining my dignity. I realized that the first and foremost recommendation for future revision of my practice was not see myself as an oppressed individual and do not personalize the attacks (Becher & Visovsky, 2012). Secondly, I had to continue to remain proactive, prevent any attempts that would undermine my efforts as a medical professional (Roberts et al., 2009).

New Perspective

Notwithstanding the fact that at time I had no capacity to act and was lacking any authority or whatsoever and being subjected to the doctor’s dismissal of my proposals made me look incompetent and having no impact

of this patient’s care I gained some new perspective. Based on the research by Aditi (2012), nurses generally perceive their levels of empowerment depending on the previous circumstances that shape their individual capacity for empowerment. Aditi confirmed, that nurse’s own sense of meaning, self-reliance, expertise shapes nurse’s empowerment. Therefore, in order to be seen as empowered, I ought to free myself from socially oppressive forces, and affirm I am competent to provide relevant patient care autonomously (Aditi, 2012).

In a similar study approximately 33% of surveyed registered nurses confirmed feeling powerless facing unresolvable issues related to dominance exhibited by higher in hierarchy colleagues (Ulrich, 2010). I indeed sensed powerlessness due to dominant acts displayed by the physician. It is quite interesting that while learning that one’s nursing decisions are not even considered to start with how fast it generates a feeling of being out totally of control, hopeless, demoralized, pressured, isolated, and even invalidated.

Evidently, exercised physician’s bullying and aggressive control of the situation results in strong emotions of everyone involved according to Coursey et al., (2013).

In consonance with research by Dwyer (2011) this inattention to suggestions [made by lower in hierarchy nurses] is visible through power plays that gradually convert to horizontal violence cases. In his study, King-Johnes (2011) suggested that people who are constantly experiencing incidents of horizontal violence are often feeling oppressed.

In another research, there was also a strong evidence that based on hospital ranks as group wise, nurses are often faced with various types of oppression (Boykova, 2011). Statistically, approximately 47-51% of the time it were the members of the senior medical team who attempted to absorb lower status nurses into existing hospital hierarchies (Becher & Visovski, 2012). Reflecting back, I concluded that my own understanding of oppression was backed by both my own internalized sense of oppression and by the existing hierarchical structure of our health care facility. When my doctor completely rejected to reassess his orders and declined my suggestions, that act stopped me from providing better patient care and comfort for my patient. As a result I was feeling less compassionate toward my patient and less sensitive toward my job as a nurse. Several studies conducted by Dwyer (2011), Zerubavel & Wright (2012) and Coursey, Dieckmann, Austin & Rodriguez (2013) affirmed that lowered sensitivity had significant impacts on the nurse as victim, professional practice, and had serious implications for patient care since it caused moral distress in nurses.

Nurses were feeling less empathetic to the pain of their patients due to the frequent exposure to the effects of bullying, horizontal violence and power plays they were being subjected to (Zerubavel & Wright (2012). Coursey, et al., (2013) emphasized that is was essential for nurses to understand how to confront oppression and deal with experiences of powerlessness within the workplace since it was crucial for improvement in nursing practice and ultimately effective delivery of patient care. Another new perspective gained was the understanding that one of the tools to deal with cases of horizontal violence was proper documenting and reporting while not fearing

repercussions such as job loss. Violence is never an integral part of the health care profession and nurses need to demand to work in a safe working environment.

Statistically, approximately 15% of nurses would confront a colleague concerning unprofessional behaviors (Becher & Visovky, 2012). In related studies researchers from the University of Ljubljana, Slovenia (Nursing Standard, 2014) and Kvas et al. (2014) examined responses of a number of nurses and confirmed that fears over retaliation, job losses and strong belief that nothing will be done always prevents nurses from reporting these incidents, causing psychological trauma.

This critical analysis process helped me to be more informed about my feelings about my nursing practice and ways I understand safety, and react on ethical and moral issues arising from it. I consulted and studied various hospital policies, recommendations that regulated inter-professional conduct in the work environment. In a way the analysis of the event positively influenced my thinking about my nursing practice and my interactions in my future nursing practice as I have decided to take a leading role (Vessey et al., 2010) by empowering myself through confronting and active teambuilding (Becher & Visovsky, 2011), engaging in various mentorship programs (Latham, Hogan, & Ringl, 2008), and taking part in cognitive rehearsal processes organized by our clinical educators and union members for that purposes (Stagg et al., 2011) and taking up some leadership workshops. I have gained a new perspective that authentic leaders do not tolerate incivility and bullying, as they role model respectful treatment and

see the need for trust between leaders and followers within the organization (Read & Laschinger, 2013).

Finally, building self-assertiveness, avoiding emotional turmoil avoidance, understanding workplace violence policies, teambuilding exercising motivated me to be more knowledgeable and prepared to address these issues in positively affect my future practice.

References

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