

Power and empowerment in nursing: a fourth theoretical approach

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Abstract

Title. Power and empowerment in nursing: a fourth theoretical approach.

Aim. This paper is a discussion of the use of poststructuralism as a means of exploring power and empowerment in nursing.

Background. Power and empowerment are well-researched areas of nursing practice, but the issue of how to empower nurses and patients continues to cause debate. Power and empowerment are complex issues and other researchers have provided some clarity by proposing three theoretical approaches: critical social theory, organizational theory and social psychological theory. We support their work and propose an additional poststructural approach as a means of analyzing power and empowerment in nursing.

Discussion. The concept of power in nursing may be critiqued by drawing on the work of Michel Foucault and paying particular attention to two areas: disciplinary power and knowledge/power relationships. Foucault's contention was that behaviour is standardized through disciplinary power and that power and knowledge are intertwined. Nurses who seek an understanding of empowerment must first grasp such workings as hierarchical observation, normalizing judgement, the examination, and power/knowledge relationships, and that cognizance of such issues can promote nursing practice that is empowering. They need to adopt a more critical stance to understanding power and empowerment in nursing, and one way of fostering such criticism is to view nursing practice through a poststructural lens.

Conclusion. A poststructural approach merits a place alongside other approaches to understanding power and empowerment in nursing.

Keywords: empowerment, Foucault, nursing, poststructuralism, power

Introduction

Power is an important issue in nursing practice but is a contested concept with a diversity of interpretations (Wilkinson 1999). Similarly, empowerment is ambiguous and difficult to define (Skelton 1994, Gilbert 1995, Ryles 1999, Kuokkanen & Leino-Kilpi 2000, Leyshon 2002, Menon 2002, Nyatanga & Dann 2002, Manojlovich 2007). Empowerment has become a widely used concept in nursing

(Hokanson Hawks 1992, Gilbert 1995, Rodwell 1996, Kuokkanen & Leino-Kilpi 2000) and there is a substantial body of knowledge on the subject (Fletcher 2006). However, the extent of its use risks it becoming a 'buzz word' (Chavasse 1992, p.1) or fashionable term (Hage & Lorensen 2005). Some have suggested that empowerment is easier to define in its absence (Kieffer 1984) and that, like obscenity, although we might not know what it is, we know it when we see it (Rappaport 1984). Difficulty in defining empowerment arises

because, like power, it takes on different forms in different contexts.

According to Chavasse (1992), no-one can value others unless they value themselves. Based on this premise, nurses need to be empowered before empowering others (Chavasse 1992, Rodwell 1996, Fulton 1997, Pearson 1998). The counterargument is that the idea of nurses empowering themselves in order to empower others is 'a little naïve' (Skelton 1994, p. 417), and empowered professionals will not necessarily extend an empowered hand to their patients and clients (Skelton 1994). Moreover, it could be argued that empowerment is about getting a patient to come round to a way of behaving that the nurse (as expert) knows is good for the patient, whilst encouraging the patient to think that it was their idea in the first place (Skelton 1994). The issue is also complicated from an organizational perspective, because sharing authority and resources with subordinates does not automatically empower them (Conger & Kanungo 1988). Although such discussions may appear somewhat negative or even cynical, they are an ideal starting point for this paper: power and empowerment are slippery issues.

It is apparent then, that empowerment in nursing is a complex issue but, notwithstanding its ambiguous, nebulous form, there is some consensus. For example, it is a positive concept (Gibson 1991, Ryles 1999, Kuokkanen & Leino-Kilpi 2000, Hage & Lorenzen 2005) and is intuitively appealing (Kieffer 1984, Gibson 1991, Menon 2002). There is also agreement that the concept of power is interwoven with empowerment (Gilbert 1995, Menon 2002, Kuokkanen *et al.* 2007), and that to understand the meaning of empowerment we also need to consider the concept of power (Gilbert 1995, Kuokkanen & Leino-Kilpi 2000).

Power can take three variations: power-from-within, power-over and power-with (Laverack 2005); at a simplified level these correspond to self-esteem, domination and shared power. Kuokkanen and Leino-Kilpi (2000) made a significant contribution to the body of knowledge on power and empowerment in nursing by proposing that they can be understood by drawing on three theoretical approaches: critical social theory, organizational and management theories and social psychological theories. In these differing approaches, empowerment is viewed as stemming respectively from: emancipation, organizational productivity or a process of personal growth. As researchers interested in the issue of empowerment, we have found their paper to be of immense benefit in helping to unravel this complex issue. Our aim is to support the work of Kuokkanen and Leino-Kilpi (2000) and develop their ideas because, while they discuss poststructuralism as a means of understanding power and empowerment, they do not propose it as a theoretical

approach *per se*. We suggest, however, that in terms of importance, poststructuralism warrants a position juxtaposed to critical social theory, organizational theory and social psychological theory. Our argument is that the three approaches are undoubtedly useful, but that the omission of poststructuralism as a way of understanding power and empowerment needs to be addressed.

We are not the first to suggest poststructuralism as a means to understanding power and empowerment, and other researchers before us have advocated its use (see, for example, Gilbert 1995, Ryles 1999). However, we argue that it remains under-used and our intention is to augment the existing knowledge base in nursing by proposing this additional approach.

Background

Nursing is still challenged by negative stereotypes and nurses are not empowered (Fletcher 2006). Manojlovich (2007) argues that powerless nurses are ineffective nurses and that they need power to be able to influence patients, physicians, other healthcare professionals and each other. If this is the case, then the issue of how they come to gain power is an interesting one. To add to the conundrum, some authors propose that the empowerment of patients requires nurses to relinquish professional power (Gibson 1991, Chavasse 1992, Rodwell 1996) and that, in essence, power is a zero-sum matter. In other words, someone can only possess a certain amount of power if another person loses an equivalent amount (Laverack 2005). But how are nurses to relinquish a power that they do not have in the first place? In a poststructural approach it is held that power is 'exercised rather than possessed' (Foucault 1995, p. 26). It is not a 'thing' and *ipso facto* cannot be relinquished. Instead, power is embedded in everyday practice and interaction (Leyshon 2002) and is exercised in relations which are not fixed (Wellard & Bethune 1996).

It is the exercise of power that forms the basis of our discussion in this paper but, before laying out suggestions for how a poststructural approach can be used to understand power and empowerment in nursing, we will revisit the three approaches put forward by Kuokkanen and Leino-Kilpi (2000) to facilitate discussion and critique later in the paper.

Critical social theory

Critical theory is concerned with enabling disenfranchised members to overcome domination (Appelbaum *et al.* 1999) and is based on the premise that certain groups in society are in a subordinated position. The controlling group has greater

prestige, power and status than the oppressed group (Fletcher 2006). In critical social theory, power is extra-personal, which means that an increase in power is compensated by someone else surrendering part of their power (Kuokkanen & Leino-Kilpi 2000). From this perspective, empowerment is equated with liberation (Fulton 1997) and involves a struggle because powerful people are not readily going to hand over resources, information or responsibility unless they see an advantage to doing so (Skelton 1994).

A great deal of critical social theory literature is based on the work of Freire (1996). In Freire's liberation pedagogy, members of the oppressed group internalize their oppressors' world view and make it their own (Hage & Lorensen 2005). They struggle to become similar to the oppressor (Hage & Lorensen 2005) in the belief that being like the oppressor will lead to power and control (Roberts 1983). The characteristics of the oppressor become more valuable and the tendency is for the oppressed group to absorb these values (Roberts 1983, Fletcher 2006). This marginalizes the oppressed group and leads to self-hatred and low self-esteem (Roberts 1983, Fletcher 2006), which in turn lead to horizontal violence (Fletcher 2006).

There is some argument that nurses are an oppressed group (Roberts 1983, Fulton 1997, Daiski 2004, Fletcher 2006) and that they conceptualize empowerment in terms of freedom (Fulton 1997). Relationships among nurses are often hierarchical and competitive and, consistent with oppressed groups, they exhibit subordination to those thought as more powerful (Daiski 2004). They also use manipulation (a common behaviour in oppressed groups) to get what they want from the oppressor (Fulton 1997). Bullying and horizontal violence are evident within nursing culture (Stevens 2002, Randle 2003), talking about each other and failure to support each other during conflict is widespread (Daiski 2004), and disrespect towards nursing students is evident (Bradbury-Jones *et al.* 2007a,b). Such studies point to the utility of critical social theory as a means of understanding empowerment in nursing but, as we will argue later, power is not always repressive and critical social theory may therefore be inadequate in capturing its complexity.

Organizational and management theories

The crucial difference between critical social theory and organizational theory is that the latter does not account for oppressed groups, but rather is concerned with the distribution of power in organizations and particularly how this occurs from the top-down (Kuokkanen & Leino-Kilpi 2000). Many nurses do not feel in control of their work environment (Attridge 1996), and power from this perspective is thus

defined as 'the ability to have control over my work situation such that I can successfully bring about more effective patient care or other work-related activity' (Attridge 1996, p. 50).

A great deal of research from an organizational perspective has been based on the work of Kanter (1993). Kanter's central argument is that structural factors within an organization are more important for empowerment than individual qualities. Kanter (1993) proposed four conditions for empowerment: opportunity for advancement; access to information; access to support; and access to resources. The environment provides relatively more or less empowerment, depending on how many of the four structures are present (Manojlovich 2007). From this perspective, power is the ability to get things performed and empowerment is the opportunity to execute a certain course of action successfully (Kuokkanen & Leino-Kilpi 2000, Suominen *et al.* 2006).

A significant volume of nursing research from an organizational perspective is attributable to Heather Laschinger and her colleagues in Canada. They have spent over a decade testing and expanding Kanter's model, amassing a considerable body of knowledge in relation to the effect of the work environment on nurses. Laschinger has studied factors such as trust in the work setting (Laschinger *et al.* 2000, Laschinger & Finegan 2005); job strain and burnout (Hatcher & Spence Laschinger 1996, Laschinger *et al.* 2001, 2006, Manojlovich & Laschinger 2007), the empowerment of managers (Laschinger *et al.* 2007) and the effect of leader behaviour on staff nurse empowerment (Laschinger *et al.* 1999, Greco *et al.* 2006). Such studies consistently point to the positive effect of empowering work environments on nurses' health (Laschinger *et al.* 2006). Considering power within organizations, then, is a useful way of understanding how to empower people. However, as will be examined later, the limitation from a poststructural perspective is that power is not solely distributed in a top-down manner: it also operates from bottom to top and laterally (Foucault 1995).

Social psychological theories

According to Manojlovich (2007), empowerment provided by the environment as in organizational empowerment 'only tells part of the story, but alone it is not enough' (p. 9). In an alternative theoretical perspective, empowerment is viewed from the point of view of the individual (Kuokkanen & Leino-Kilpi 2000) and this acknowledges that empowerment is also a psychological experience (Manojlovich 2007). Empowerment is seen as a process of personal growth and development, and an individual's beliefs, views, values and perceptions are key factors (Kuokkanen & Leino-Kilpi 2000). Psychological approaches to power focus on the individual

experience of power, and to be empowered is to be psychologically enabled (Menon 2002).

In the nursing literature, on one hand psychological empowerment can be an outcome, for example improved self-esteem as a consequence of empowerment (Hokanson Hawks 1992, Rodwell 1996, Bradbury-Jones *et al.* 2007a). On the other hand, it can be a process whereby self-efficacy is associated with adequately coping with situations (Conger & Kanungo 1988). Empowered nurses have been described as having personal integrity, marked by courage, tenacity and self-esteem (Kuokkanen & Leino-Kilpi 2001). It is this ability to capture the human perspective that gives psychological approaches to exploring empowerment appeal. The problem in privileging the individual viewpoint, however, is that cultural and political influences illuminated by poststructural explorations may be overlooked, potentially resulting in a naïve analysis.

Discussion

A fourth approach: poststructuralism

Poststructuralism is usually associated with the work of Michel Foucault, and it is his work that underpins the discussion in this paper. An important difference between a Foucauldian conceptualization of power and the three approaches discussed earlier is that power is not fixed. Knowledge production results in constant alteration of power relations (Wellard & Bethune 1996). Thus, although patients and healthcare professionals have different positions in the healthcare hierarchy by virtue of their status, *because* power is not fixed it is exercised in different forms by any of them, depending on the context.

Foucault's own words are helpful in capturing the nature of power from a poststructural perspective:

“Power is not exercised simply as an obligation or a prohibition on those who ‘do not have it’; it invests them, is transmitted by them and through them; it exerts pressure upon them, just as they themselves, in their struggle against it, resist the grip it has on them” (Foucault 1995, p. 27).

Foucault's conception of power is that it takes a capillary form and ‘reaches into the very grain of individuals, touches their bodies and inserts itself into their actions and attitudes, their discourses, learning processes and everyday lives’ (Foucault 1980, p. 39).

Importantly, rather than discussing power merely as a repressive force, as is the case in critical social theory, he argues that the notion of repression is inadequate for capturing the productive aspect of power because it is too

narrow and negative (Foucault 1980). Instead, he suggests that power is productive: ‘It induces pleasure, forms knowledge, produces discourse’ (Foucault 1980, p. 119). Power operates to create new ways of seeing and speaking and to produce what is considered to be the ‘truth’ in a particular society, its ‘regime of truth’ (Gilbert 1995). Later in the paper, we will take up this issue again, and discuss how the close association between power and knowledge has implications for nursing practice.

Foucault does not discuss empowerment as such; indeed, he may have questioned how empowerment can exist in a world where power (by virtue of its capillary form) is everywhere (Appelbaum *et al.* 1999). So does this mean that our attempt to use his approach to understand empowerment is on shaky ground? We argue that this is not the case and that, for nursing practice to be empowering, nurses need to identify the discursive practices through which they are formed as nurses (Gilbert 1995). Our aim then, is to show how a poststructural analysis of power can illuminate the potential for empowering nursing practice, for both nurses and patients.

Foucault's contention is that power should be studied from the bottom up rather than the top-down. Analysis of power needs to explore the way in which it penetrates the extremities of life (Gilbert 2003) and pay regard to its shifting nature. Therefore, although nurses may be relatively powerless in certain circumstances, they will be powerful in others. For example, Leyshon (2002) demonstrates how in nurse education both teachers and students bring elements of power to the relationship: a nurse teacher who is assessing students is exercising power by acting as a gatekeeper to the profession, yet students can use their power to disrupt a class. Similarly, patients and clients can exercise power, for example by choosing not to attend medical appointments or, in the case of community nursing, refusing nurses' entry to their homes. Understanding empowerment of nurses or patients, then, is not about liberation nor about power being distributed solely in pyramidal form; it is about understanding the ‘operations’ through which nurses and patients are situated and how power is exercised variously in different contexts.

Two core elements of Foucault's work – disciplinary power and knowledge/power relationships – are crucial in critiquing power and empowerment from a poststructural perspective and it is to these two elements that we now turn.

Disciplinary power

According to Foucault, ‘disciplines’ began to flourish from the 17th century onwards, for example in schools, hospitals

and military organizations. Disciplines standardize behaviour (Hardin 2001) and disciplinary power is marked by meticulous control of the body and subtle coercion, resulting in a relation of docility-utility (Foucault 1995). Docility-utility means that a person has hold over others so that they operate in a desired manner, with the techniques and efficiency that the person determines (Foucault 1995). The effect of *discipline* (as in '*disciplines*' such as nursing) is that individuals are in a sense robotic, as their docile bodies carry out useful action; in other words, they have been *disciplined*. Disciplinary power is exercised through three processes: hierarchical observation, normalizing judgement and the examination (Gilbert 1995, Ryles 1999). For the sake of clarity, we will examine each of these separately to show how they operate in nursing practice.

Hierarchical observation

Quite simply, hierarchical observation is about being watched: individuals are subject to a constant 'gaze' (Gilbert 1995). For Foucault, this observation (gaze) takes two main forms: indiscreet and discreet. The indiscreet form can be seen in overt recording and documentation by means of such mechanisms as medical records and registers of births and deaths (Ryles 1999). It is indiscreet because people are usually aware that the observation or recording has taken place.

Hierarchical observation is not always so obvious, however, and in discreet form 'it functions permanently and largely in silence' (Foucault 1995, p. 177), with people being largely unaware of the 'gaze'. According to Gilbert (2001), organizations are reflexive and technologies have changed, resulting in a move from direct observation to a lighter approach. In healthcare, for example, patients have increasingly been 'given' responsibility for their own care, and surveillance now relies on individuals' self-management (Gilbert 2001). This is reflected in the United Kingdom (UK) in policies such as 'The Expert Patient' (Department of Health 2004) and 'Self Care – A Real Choice' (Department of Health 2005), which ironically have underpinning philosophies of empowering patients to take control of their own lives (Department of Health 2005).

An important point is that, although patients may be 'self-managing', they still have to report to healthcare professionals for guidance, advice, monitoring and treatment. In poststructural terms, this is because for the gaze to be effective a degree of visibility has to be maintained. Individuals have to be aware of its presence (Gilbert 2001). In other words, patients may take some responsibility for their own

care, but the healthcare professional is always visible, albeit at times only metaphorically.

Nurses are not immune from this form of disciplinary power, and self-management is evident, for example, in UK postregistration education and practice standards. These 'encourage' nurses to think and reflect for themselves and they must keep a personal professional profile of their continuing professional development (Nursing and Midwifery Council (NMC) (2006). Discreet power operates through a system whereby an individual nurse may (or may not) be called upon to submit their personal professional profile to the NMC to audit how they have met the requirements. The *potential* to be required to undergo this audit disciplines nurses in a discreet manner to self-manage. In terms of empowerment, then, nurses need to be aware of the discourse of 'self-management' and alert to how this apparently benign concept operates for both patients and nurses.

A final point in relation to hierarchical observation is that, because power is not distributed from the top-down, neither is observation. Foucault noted that, historically, changes in education marked by increasing numbers of pupils and absence of methods for simultaneously monitoring a whole class necessitated a system of supervision. To help teachers, 'best' pupils were selected to become involved with surveillance and act as observers (Foucault 1995). Drawing parallels with nursing, surveillance operates through nurses being responsible not only for their own practice, but also for that of others. This calls for vigilance as to the extent to which colleagues are fit to practise (NMC 2004) and willingness to report concerns about their conduct, health or competence if necessary.

Normalizing judgement

The concept of normalizing judgement concerns being judged and compared with particular norms (Gilbert 1995, Hardin 2001). Different roles and responsibilities become ascribed and gradually they become the norm (Hui & Stickley 2007). A poststructural approach involves exploring how these norms have been constructed, for whom, and for what purpose (Hardin 2001).

Normalizing judgement is multi-directional and, in a similar vein to hierarchical observation, judgements are not only from the top-down (as might be expected in organizational theory, for example), but rather the observed and observer become victims of normalizing judgements (Ryles 1999). What this means in practice is that, while nurses may cast normalizing judgements over patients, at the same time those nurses will be under the gaze of managers, other nurses,

patients and, interestingly, themselves. Here, we introduce the notion of 'technologies of the self', which Foucault described as the way in which individuals transform themselves by a number of 'operations' on their own bodies, souls, thoughts and conduct (Foucault 1988). Simply expressed, technologies of the self are a form of self-monitoring and policing of ourselves. Thus, in relation to nursing, nurses learn to monitor, censor and regulate their own behaviour against normative standards (Hardin 2001). They take up discourses about what they should be like and compare themselves to these (Allen & Hardin 2001). Nurses are held in a discourse that describes them as, for example, caring and self-sacrificing (Ryles 1999), and they use images of an 'ideal' nurse as points of reference for their practice and engage in self-scrutiny, constantly comparing their performance to the ideal (Wellard & Bethune 1996). Although such comparisons may have the positive outcome of enhancing nursing practice by developing nurses' personal integrity, the ability to self-monitor is an enactment of power (Allen & Hardin 2001), and nurses need to be alert to this discreet form of disciplinary power.

A final point about normalizing judgement and technologies of the self is the notion of the 'confessional'. According to Ryles (1999), the modern individual is encouraged to seek self knowledge and then 'confess' this to an expert. The process of reflection and the associated bringing of private thoughts to the public sphere is one such example (Cotton 2001) and, along with clinical supervision, can be perceived in terms of the confessional (Gilbert 2001).

Patients have to 'confess' too, often to the very nurses who are tied up in their own confessionals. For example, Roberts (2005) argues that psychotherapy takes the form of the confessional, whereby the client is 'invited' to disclose their thoughts and feelings so that they can be monitored by the psychotherapist. The nurse is simultaneously confessor and judge – a position that captures the complexity of power from a poststructural perspective. The problem with the notion of the confessional is that, according to Foucault (1990, p.60), 'the obligation to confess is now relayed through so many different points, is so deeply ingrained in us, that we no longer see it as the effect of a power that constrains us.' In terms of empowerment, then, nurses might look beneath apparently benign practices such as reflection, clinical supervision and assessment of patients, and question the extent to which such practices might be forms of surveillance, albeit discreet in nature.

The examination

The examination combines the techniques of hierarchical observation and normalizing judgement and is a surveillance

(normalizing gaze) 'that makes it possible to qualify, to classify and to punish' (Foucault 1995, p. 184). 'Experts' are those called upon to make normalizing judgements, and the so-called caring professions maintain their surveillance of the population as judges of normality (Gilbert 2001) in order that the 'normal' can be restored (Cheek & Rudge 1994). In healthcare, qualification and classification can be seen with numerous client groups. For example, when a woman loses a significant amount of weight with no medical cause, her body becomes the focus of others' attention: the 'anorexic body' is weighed, measured and institutionalized (Hardin 2001).

In terms of punishment, when judgements are made there is a penalty for deviating from the norm and not measuring up to the rule (Foucault 1995), and a woman with anorexia is thus punished for her difference. Similarly, according to Ryles (1999), normalizing judgements of mental health patients have a major effect on the way users are viewed and, once categorized as mentally ill, they have difficulty escaping the implications of that category.

A feature of the examination is its permanency: the normalizing gaze is not merely a fleeting glance. Permanence arises from documentation associated with the examination and, according to Foucault (1995) this creates a 'meticulous archive'. The examination places individuals in a network of writing, and engages them in a web of documentation (Cheek & Rudge 1994) that captures and fixes them (Foucault 1995). Records, files and case notes thus ensure that the normalizing gaze is not lost. Another point about the examination is its positive form: it is not purely negative. For example, in relation to nurses, globally the qualification of Registered Nurse is preceded by various forms of examination, and 'examiners' are thus important gatekeepers to the profession. Without examination in some form, competency in nursing practice, and thus patient safety, would be jeopardized.

Power/knowledge

The complex relationship between power and knowledge was addressed extensively by Foucault, and his main idea was that knowledge and power are intertwined:

"Each society has its régime of truth, its 'general politics' of truth: that is, the types of discourse which it accepts and makes function as true...(and) the status of those who are charged with saying what counts as true" (Foucault 1980, p. 131).

For example, in nursing only recently have the discourses of holism and biopsychosocial approaches challenged the dominance of biomedicine. Similarly, in nursing research it is not until the past few decades that qualitative methods have been able to compete with the 'truth' of quantitative methods.

What is already known about this topic

- Empowerment and power are complex issues.
- Critical social theory, organizational theory and social psychological theory underpin most studies on empowerment.
- Poststructural approaches are used to research some areas of nursing practice, but not specifically empowerment and power.

What this paper adds

- Further understanding of power and empowerment in nursing can be achieved through adopting a poststructural approach.
- A poststructural approach to exploring power and empowerment has utility in revealing areas of nursing practice that other approaches fail to illuminate.
- Poststructuralism offers another lens through which nurse researchers can view power and empowerment.

As discussed, according to Foucault knowledge is produced through regular and identifiable procedures that determine what can be said and by whom (Björnsdóttir 2001). Those in powerful positions are able to exert their version of 'truth' (Hui & Stickley 2007), and discourses construct a particular version of something as if it were real (Carabine 2001). The role of nursing in this context is to develop new forms of knowledge and new ways forward (Ryles 1999). It is incumbent upon nurses to question the truths that hold sway within nursing and consider whose interests these best serve. We suggest that nurses should pay attention to issues that attract media attention, areas of nursing practice that have the greatest kudos and prestige, and issues that nurses are discussing and on which they are publishing. This kind of analysis might reveal the dominant discourses and current 'truths' within nursing and prompt nurses to be alert to the different – and no doubt competing – discourses in operation.

Foucault (1980) describes subjugated knowledge and popular knowledge, the former being that which becomes submerged under a veneer of functionalist order (Gilbert 1995) and the latter referring to the disqualified knowledge of people low in the hierarchy (Foucault 1980), such as healthcare users and nurses (Ryles 1999). Popular knowledge should not be confused with commonsense knowledge: popular knowledge is 'a particular, local, regional knowledge, a differential knowledge incapable of unanimity and which owes its force only to the harshness with which it is opposed by everything surrounding it' (Foucault 1980, p. 82).

Analysis of patients' knowledge reveals a paradox. As discussed earlier, patients are required to self-manage in the name of empowerment and by virtue of being 'expert' in their own care (Department of Health 2004). Empowered patients will ask questions and want to be actively involved in decision-making but if they do so, instead of maximizing their empowerment, they are likely to become disempowered and labelled as 'difficult' (Nyatanga & Dann 2002). In effect, their voice is silenced and their knowledge is disqualified. Overall, nurses need to pay attention to disqualified knowledge in relation to patients and themselves and be alert to the way in which they and service users are held within limiting and subjugating discourses (Ryles 1999). We propose that this kind of analytical stance adds another dimension to understanding empowerment in nursing.

Conclusion

Power is central to understanding nursing practice and, if claims of empowerment are to be credible, they need to be based on an understanding of the way power operates within certain social contexts. We agree with Skelton (1994) that it is important that nurses adopt a critical stance in relation to the notion of empowerment, and we argue that a useful means of fostering such criticism is to view nursing practice from a poststructural perspective.

A poststructural approach offers a means of challenging what is self-evident, and we argue that nurses need to consider hierarchical observation, normalizing judgement, the examination and knowledge/power relationships in order to illuminate taken-for-granted areas of nursing practice. We have revealed how empowerment in nursing can be facilitated by viewing practice critically and that a poststructural approach is an ideal means of achieving this critical perspective.

In conclusion, to empower others nurses have to develop an understanding of the way the hegemony of the present form of rationality is produced. In this paper, we have contributed to this endeavour. It is written from the UK, and we have made reference to some UK policy. However, power and empowerment in nursing are of global concern and we believe, therefore, that the paper has international relevance. A poststructural approach could be used to explore power and empowerment in a number of disciplines, not solely nursing. We have explicated its use in revealing taken-for-granted *nursing* practices and we suggest that such analysis can lead to the development of new practices, the corollary being the advancement of nursing knowledge.

A poststructural approach merits a place alongside other perspectives to understanding power and empowerment in nursing. Our aim is that this 'fourth approach' will offer

nurses another lens through which to understand this important issue in nursing practice.

Author contributions

CB-J was responsible for the study conception and design. CB-J was responsible drafting of the manuscript. CB-J, SS and FI made critical revisions to the paper for important intellectual content. SS and FI supervised the study.

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