Client–nurse relationships in home-based palliative care: a critical analysis of power relations

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Aim. To elicit an in-depth understanding of the sources of power and how power is exercised within client–nurse relationships in home-based palliative care.

Background. As in all social relations, power is present within client–nurse relationships. Although much research has focused on interpersonal relationships in nursing, the concept of power within the client–nurse relationship in palliative care settings has not been extensively investigated.

Methods. Applying a critical lens, secondary qualitative data analysis was conducted. Seventeen nurse and 16 client transcripts from a primary study were selected for secondary data analysis. These 33 transcripts afforded theme saturation, which allowed for both commonalities and differences to be identified. Data analysis involved analytic coding.

Results. Study findings help make explicit the underlying power present in the context of home-based palliative care and how this power is used and potentially abused. In analysing the sources and exercise of power, the linkage between macro and micro levels of power is made explicit, as nurses functioned within a hierarchy of power. The findings suggest that educational/occupational status continues to be a source of power for nurses within the relationship. However, nurses also experience powerlessness within the home care context. For clients, being able to control one’s own life is a source of power, but this power is overshadowed by the powerlessness experienced in relationships with nurses. The exercise of power by clients and nurses creates experiences of both liberation and domination.

Conclusions. Nurses who are willing to reflect on and change those disempowering aspects of the client-nurse relationship, including a harmful hierarchy, will ultimately be successful in the health promotion of clients in home-based palliative care.
Additionally, it should be recognized that nurses work within a specific health system context and, therefore, their practice is influenced by policies and funding models implemented at various levels of the health care system.

**Relevance to clinical practice.** The insights gained through this investigation may assist nurses and other health professionals in reflecting on and improving practices and policies within home-based palliative care and within home care in general.

**Key words:** community care, critical research approaches, nurse–patient relationships, palliative care, policy, therapeutic relationships

**Introduction**

The quality of nurse–client relationships has a direct affect on the quality of care provided and, therefore, is crucial to effective nursing practice (Eustis *et al.* 1993, Luker *et al.* 2000). Implicit in all social relations, including those between nurses and clients, is the presence of power (Giddens 1984), defined herein as ‘the use of resources, of whatever kind, to secure outcomes’ (Giddens 1977, p. 348) and expressed as control. However, power within the client-nurse relationship is not well understood. Power expressed through control is particularly important to clients receiving palliative care (Mesler 1995, Morgan 2001, Volker *et al.* 2004) and, therefore, there is a need for an in-depth understanding of power within these client–nurse relationships. As there also has been a lack of a critical perspective in palliative care research (Bottorff *et al.* 2005), the purpose of this study was to examine power critically within client–nurse relationships in the context of home-based palliative care.

Within the Canadian health care system, there has been a shift of care settings from hospitals to communities. Palliative care, defined as holistic, client-driven and end-of-life care aimed at achieving maximal quality of life of the client (Friedman & Bono-Snell 2004), also exhibits this trend. Moving such care to the home setting has an impact on the power balance between nurses and clients (Liaschenko 1994, Andrews 2002). Shifting caregiving to the home holds the potential to increase the focus on client-centred care, client involvement and empowerment (McWilliam *et al.* 2001). This intention fits well with the goals of most palliative care programs, where the focus is on providing holistic care as determined by the client rather than by the health professional (Randall & Downie 1999). However, studies of home care have shown that powerlessness may still be present among clients (Appelin & Bertero 2004). Furthermore, holistic care is not always realized (McGarry 2003) and empowerment may not occur (McWilliam *et al.* 2001).

**Literature review**

A large amount of research has been conducted exploring client–nurse relationships and has substantiated the importance of these relationships in a variety of settings (Forchuk 1995, Deeny & McGuigan 1999). For example, greater levels of attachment between nurses and clients are perceived by nurses to lead to positive health outcomes (Ramos 1992). More specifically, researchers have explored how to develop and maintain client-nurse relationships (Heifner 1993, McCann & Baker 2001, Castledine 2005). Although studies of the client-nurse relationship have focused on culture (Kleiman *et al.* 2004), humour (Greenberg 2003), collaboration (Paavilainen & Astedt-Kurki 1997), intimacy (Williams 2001), trust (Trojan & Yonge 1993, Lowenberg 2003), friendship (Geanellos 2002) and love (Stickley & Freshwater 2002), the examination of power within client–nurse relationships is lacking in this literature, particularly within the unique context of palliative care.

Some palliative care research studies have emphasized the importance of client–nurse relationships, but no discussion or analysis of power is present. For example, Davies and Oberle (1990) conducted a qualitative descriptive study of the nurse’s supportive role in palliative care and described six dimensions of this role: valuing, connecting, empowering, doing for, finding meaning and preserving one’s own integrity. The implicit power present in the relationship was not discussed, particularly as it might relate to the ‘empowering’ and ‘doing for’ roles of the nurse. Likewise, Mok and Chiu (2004) explored relationships in palliative care, but focused on nurses’ skills and did not address the concept of power. Raudonis (1995) also studied components that contribute to the development of positive relationships in palliative care, including attributes of nurses, but made no mention of power. The role of power was also overlooked in Clover *et al.*’s (2004) study of the ways clients negotiate their care with nurses. These authors found that clients often resorted to a passive role and suggested that
future research should explore how clients’ perceptions of lack of power may lead to this passivity. Luker et al. (2000) focused on one particular component of positive relationships, ‘knowing the client,’ but with no mention of power, either as existing within these relationships or as a hindrance to their development. In studying patient control in palliative care, Mesler (1995) offered insight into the potentially negative experiences within the client-nurse relationship, but did not include a critical examination of power.

Studies have been conducted that include an analysis of power in the client-nurse relationship, but these have been located outside of home-based palliative care or palliative care in general. For example, Henderson (2003) interviewed nurses and clients within four Australian hospitals and found that nurses saw the giving of power as sharing information and decision-making with clients. However, most of these nurses were unwilling to share decision-making, believing that they were the ones with health care expertise. This study offers a warning as to how nurses exercise power as ‘power over’ clients in some contexts, but does this occur in all health care contexts? Additionally, Hewison (1995), through participant observation, explored how nurses in a hospital setting exerted power over clients through language, ordering clients around, persuading clients who resisted nurses’ suggestions, using closed communication and using terms of endearment. Adding a discussion of context to these warnings of the misuse of power, Cohen (1998) questioned whether the ideal of shared power can be realized in an hierarchical health care system. By interviewing staff and clients in an in-patient psychiatric facility, she found that residential psychiatric nursing practice was not client-driven and most client participants had experienced authoritarian health care relationships with unequal control of resources. These studies provide a bleak outlook as to the exercise of power by health care providers, but is this the same in palliative care, which is based on an ideology of being client-driven?

The literature to date has focused on the importance of the client–nurse relationship, particularly examining how this relationship directly affects client care and how these relationships may be improved. The few studies that have explored power in client–nurse relationships have not examined this relational element in the context of palliative care in the home. Yet, the findings of these studies suggest the importance of critically examining the concept of power in client–nurse relationships so as to better understand the practice of nursing. To address this gap, the purpose of this study was to examine critically client–nurse relationships and power in the context of palliative care. The researchers questioned: (i) what are the sources of power within the client–nurse relationship; and (ii) how is this power exercised? The ultimate aim was to make visible the power present within home-based palliative care relationships and the implications this has for nursing practice.

Theoretical perspective

The study was conducted using a critical theoretical perspective. Within this perspective, it is understood that reality is socially and historically constructed through various social and political structures and is constantly changing (Ford-Gilboe et al. 1995). Critical researchers are encouraged to question dominant ideologies and taken-for-granted assumptions to give voice to alternative viewpoints (Eakin et al. 1996). According to Denzin and Lincoln (1994), this may be achieved through the raising of a critical consciousness and the uncovering of the realities of domination.

The specific theories of Anthony Giddens on class and power have been applied in conducting this investigation. Giddens’ conceptualization of a three-tiered class system includes a middle-class that exists through professional qualifications (1981), such as those possessed by nurses. Accordingly, nurses may have positional power in their relationships with clients. Giddens (1984) also explicates the duality of power, in as much as power can be used to both liberate and limit (or dominate). Extrapolating this duality into nursing practice, nurses may have the ability to facilitate client empowerment and challenge marginalization; however, nurses themselves may be guilty of perpetuating oppression (Hugman 1991, Wilkinson & Miers 1999).

Methodology

The study reported in this paper is a qualitative secondary analysis of data collected to explore client–family–nurse relationships in home-based palliative care. The objectives of the primary ethnographic, longitudinal study were to acquire information about these relationships, explore the context in which these relationships occurred, identify the conditions that strengthen the capacity of palliative clients and their family caregivers and identify needed program and policy changes in palliative care. The primary study, conducted in 2005, included four client–nurse–family member triads recruited through two community agencies in southwestern Ontario that provide home-based palliative care. Eligibility criteria included clients over 60 years of age and experiencing advanced cancer, family members identified by the clients as...
their caregivers and community health nurses identified as the primary nurse of the client. Clients averaged 70 years of age, had all been married and were all retired. Nurses averaged 50 years of age, had been in palliative care between five and 15 years, varied in family income and were all female. Data collection involved four to six in-depth, focused interviews with each member of the client-nurse-family member triad over a period of six to eight months. Interviews occurred on average every three to four weeks and were conducted at a location identified by the participant. Each interview and the related fieldnotes were transcribed verbatim and the transcripts were subsequently edited by a second individual (Lofland & Lofland 1995).

This secondary qualitative analysis used the analytic expansion approach (Thorne 1998), eliciting a more detailed exploration of the concept of power. New questions relating to power in palliative care relationships were asked in analysing the data, allowing for a different theoretical perspective to be applied. Although the primary study shed some light on the enactment of control between and among clients, family members and nurses within home-based palliative care, it was beyond the scope of the primary study to thoroughly examine power within client–nurse relationships.

Methods
From the 49 transcripts of the original study, all 17 nurse and 16 client transcripts were selected for secondary data analysis. Access to these transcripts was gained through the researcher’s position as a research trainee on the primary study. These 33 transcripts afforded theoretical saturation (Sandelowski 1995), at which point no new codes arose that fell outside of the proposed themes. Data analysis followed Lofland and Lofland’s (1995) guidelines for analytic coding. The first step involved initial, open coding of the transcripts. These codes, such as ‘taking control’ or ‘dismounting language’, were then organized and reorganized and the initial codes were pared down until themes such as ‘positional power’ and ‘the experience of powerlessness’ began to evolve. The primary author then went back to the transcripts to validate these themes and find exemplary quotes.

Trustworthiness
Throughout data analysis, Guba and Lincoln’s (1989) criteria for establishing credibility, transferability, dependability and confirmability were used. Credibility was promoted through the researcher’s involvement with the primary study, prolonged immersion in the data and by openly accommodating participants’ realities in refining the final interpretations of the findings. This meant refining codes and themes as new experiences were uncovered in later transcripts. Transferability was promoted by providing a rich description of the context and methods involved in generating the data. Dependability and confirmability of the data were promoted by maintaining an extensive audit trail of interview transcripts with open codes written directly on them, the various stages of analysis, initial drafts of the research findings and a reflective journal kept by the primary author throughout the process. In addition, findings from a critical analysis should illuminate power relations and harmful societal structures in order to create ways to confront injustices (Raphael 2000). To illuminate power relations, the authors continually questioned how power was being exercised in the relationships throughout the process of coding the data and refining the codes into themes. To illuminate harmful societal structures, the authors stayed attuned to the influence of context on the power relations being analysed.

Ethics approval for the primary study was obtained from the university with which the researchers are affiliated. Names have been excluded from quotes and identifying data have been removed to ensure participants’ confidentiality. Although pseudonyms are not applied to quotes to protect confidentiality, the quotes still represent a diversity of perspectives, with quotes being taken from each of the four client-nurse dyads.

Findings
Both the sources of power and the exercise of power within the client–nurse relationships of the participants of this study reflected a hierarchy of power within home-based palliative care. Within their larger, or macro-level, work context nurses experienced powerlessness. At the relational or meso level, nurses exercised professional power while clients exercised personal power. Ultimately, however, at the micro level the clients in this study experienced powerlessness. These macro, meso and micro level experiences are explicated in the following thematic subsections.

The macro level: nurses’ experiences of powerlessness
The nurses in this study often felt powerless within their work context. This powerlessness stemmed both from an implicit understanding of fiscal pressures and through the explicit rules and regulations under which the nurses worked. In Ontario, home care is managed by local Community Care Access Centres (CCACs) that receive their funding from the provincial government. These CCACs act as brokers of care, making contracts with private service provision agencies that
employ nurses providing in-home care. Nurses reported that they were aware of the fiscal pressures emanating from ‘higher up’ within the bureaucratized organizational structure of the home care system:

CCAC has had trouble with budgets and stuff too, eh; I mean cutting back and they’re trying to do things…budget wise and they don’t want to spend thousands…because of the government cut backs and the financial restraints and everybody trying to do things on a shoe string budget…. You know, there is only so much money.

These fiscal constraints contributed to the nurses’ perceptions of powerlessness, which ultimately shaped their practice:

VON [an in-home service provision agency employing the nurse]… does [care about the length of visits] because they want us to get in and, you know, get on with things, because we get paid [for] the amount of time it takes us.

For nurses, powerlessness within their work context also stemmed from more explicit rules and regulations that filtered down from their employers, with the intention of guiding their practice. One nurse explained:

You’ve got your guidelines, ‘This is what you’re supposed to do, go in and deal with this, this,’ and we’ve been told, ‘…if it’s not in that realm then we’re told you go get a…priest, go call in the social worker, you’re not supposed to deal with those kinds of things, you do your physical kinds of things.’

Sometimes I think that the VON doesn’t want us to be hanging around talking about [psychosocial] stuff like that. They want us to get in and get out.

As nurses were paid on an hourly basis, shorter visits achieved more efficient human resource allocation, which nurses did not challenge. The system power took precedence over any exercise of professional autonomy by study nurses.

The meso level: nurses’ exercise of professional power

Though nurses in this study often felt powerless in their work context, they were also in a position of exercising power in providing client care. Consistent with Giddens’ theory on class and power, this power was positional and originated from nurses’ occupational/educational status, which they used in assessing and monitoring and, ultimately, in controlling client care:

I’m a take charge kind of person. If I see something that needs to be done I will say, ‘This is what you need, this is what should be done, this is why,’ and then they usually say, ‘Okay,’ or, ‘Can you wait a day’ and I said, ‘Okay, I don’t mind waiting for a day, but if we haven’t got a conclusion or something hasn’t been changed or you haven’t got comfortable by then I have to do something.’

The position of nurses in their relationships with clients was well demonstrated through nurses using language of ownership of clients:

I’d love to see all my patients have nobody else see them, I get kind of possessive that way.

Nurses’ positional power was exercised as either dominating or liberating practice, two sub-themes of their positional power. The exercise of power through domination involved gaining assessment information about clients that the clients did not choose to disclose. Nurses had the power to go to family members to find out what they wanted to know:

We [nurses] always talk about the visit in the house and the visit out in the driveway…. That’s all right, as long as we get the story from somebody. I know a lot of times when I’m dealing with husbands and wives and I’ll say, ‘How well are you eating,’ and…let’s say the husband says, ‘I’m eating good.’ I look at the wife and [say], ‘What do you say?’

Nurses also exercised power as domination by ‘managing’ clients to whom they were assigned:

Like I have people on my list, two of them, I said, ‘I can’t come and see you today.’

This ‘managing’ of clients often included little negotiation with the client themselves. Examples of ‘managing’ clients without their input included shifting the client to another nurse or moving them to another time slot.

Conversely, nurses also exercised their power positively, affording clients more liberation. Liberating practice involved nurses being humble, providing comfort and doing caregiving tasks on request and taking clients seriously, as reported by one client:

Comforting, is the word, the very word and that’s a good word to describe [my] relationship [with the nurse].

Nurse participants talked about respecting clients as individuals, seeing them as experts in their own lives, accepting clients’ spiritual beliefs and making decisions mutually:

It wasn’t my decision, it was a negotiated decision…it wasn’t on my part only. We try to involve [clients] with the decision making…like, ‘What do you think, is once a month okay…do you think it needs to be a little more?’

They also gave examples of telling clients to call any time, doing a blood pressure check at the client’s request and helping the clients to meet their own goals:

I always say, you know, ‘You can call in between next visit if you need anything…’
One nurse made it clear that she constantly remembered what was most important to the client:

I just remembered the very first thing she told me was I’m not afraid to die, I’m afraid of having pain. So I’ve always got that in my head, to make sure her pain is well controlled.

By focusing on what was important to the client, this nurse practiced liberating care that was driven by the needs of the client rather than her own impressions. Some nurses’ exercised power positively to liberate clients by not imposing their expectations on clients:

There is no ‘shoulds’, …we always have a tendency to say, ‘Well, …I should do this, we should do this,’ and the minute I hear anyone saying ‘should’ I say, ‘Oh, let’s forget that word.’

Most meaningfully, despite the losses these palliative care clients were facing, nurses at times facilitated client empowerment, which is one of the goals of palliative care:

They lose everything, …it’s part of my role, …I feel, to make sure that they know that all those physical things and parts that get lost don’t matter…. It’s them [who matter], they’re a person and there’s a spirit and there’s an individual inside and it doesn’t matter what happens…with the disease and all the rest, there’s still that same person.

This nurse assisted clients in moving beyond their disempowerment of losses because of disease. Thus at the meso, or relational level, nurses had power, which they exercised either through domination or through liberation of the clients with whom they worked.

The meso level: clients’ exercise of personal power

According to Foucault (1980) whenever there is power, there is resistance. The clients in this study responded to nurses’ power or control by exercising power themselves. The nurses gave examples of clients resisting changes to their pain medications, demanding a change in nurse, resisting decreases in visits and cancelling visits. Nurse participants also described clients who did not follow the nurses’ care plans:

[The client says], ‘I’ve got pain,’ so you give her pain [pills], [and she says], ‘Oh, I don’t want to do that.’… Well, what are we supposed to do? She’ll say she’s not feeling well, so the doctor arranged all these tests at the hospital. I said, ‘You can go today, I’ll take you, get in my air conditioned car, I’ll take you.’ [She said], ‘No, I’m not.’

The client participants themselves described how they resisted their nurses’ power. One client told a story of having a nurse in whom he had no confidence:

I looked at her and said, ‘You know, your sequence is wrong, what you’re doing is wrong…. Go and ask somebody’…. She started the wrong thing. So I said to her, ‘You’re working in the wrong sequence.’

Unlike nurses, the clients in this study lacked positional power in the client-nurse relationship. Instead, power for the client participants appeared to originate primarily within the self as they attempted to gain control.

The micro level: clients’ experiences of powerlessness

Although clients appeared to exercise power, they also at times found themselves powerless within a home-care system that did not meet their expectations. The relationship between macro level systems and micro level relationships described by Eakin et al. (1996) was illustrated in the lack of continuity of care experienced by clients. Although nurses were responsible for clients to whom they were assigned, they were not always autonomous to practice as they saw fit. In the end, it was the clients who were left powerless to maintain the continuity of care they valued:

I haven’t seen or heard from [my primary home care nurse]. Somebody is coming today, I don’t know who is coming today but I haven’t heard or seen [the primary nurse].

Another example of the relationship between the macro and the micro is the time for visits that nurses had available. Again, it was up to the nurse to coordinate the care of their clients, but macro pressures had an impact on this. Most nurses made it clear to clients that they had limited time available for care, which directly impacted the relationship that clients were willing to or able to develop. As one client stated:

How much are you going to open up [to the nurse]?…She hasn’t got the time really.

Examples of clients’ personal experiences of powerlessness within their relationships with home care nurses abounded. One client was informed by the on-call nurse that this nurse did not want to go out at night. Another client had the frequency of their nursing visits decreased against their expressed desires. A third client experienced being admitted to hospital despite the fact that she had expressly stated her desire to stay at home. The nurse in this situation abandoned this client prior to a meeting with the physician, knowing that the physician wanted to admit her. Clients’ powerlessness was also perpetuated subtly by nurses using techniques such as letting the client know that the nurse was calling them on her own time, or by giving positive reinforcements only to decisions with which the nurse agreed.

The findings of this study help to illuminate the hierarchical structures of the sources and exercise of power between
nurses and clients within home-based palliative care. Nurses experienced powerlessness originating at the systems level, related to a home-care system that pressured them to decrease costs. This had an impact on their practice in a variety of ways, including decreasing visits and decreasing costs. Though they experienced powerlessness, nurses’ occupational/educational status was a source of positional power in their relationships with clients. Nurses exercised this power as either liberating or dominating practice. For clients, the self was the main source of power and this was exercised in their relationships with nurses as resistance. However, like nurses, clients were also facing powerlessness. This powerlessness, although very much related to what occurred at the macro level, was experienced in their relationships with nurses as they faced domination.

Discussion

The hierarchically structured power portrayed in the findings of this study allow for a deeper understanding of social power relations within home-based palliative care. The findings support the theories of Giddens (1981) in that the nurses in this study were found to have positional power. As well, similar to findings of a study that included clients in an acute care setting (Kettunen et al. 2002), clients in this home-based palliative care setting had access to power. In addition to existing knowledge, the findings in this study demonstrated that clients found power within themselves and expressed this power as control. It can also be seen how nurses’ power in this context was exercised as domination or liberation and how the power of clients was exercised as resistance. Additionally, nurses’ exercise of power must be understood within the context of a hierarchy of pressures and power. Most importantly, the findings as shown in Fig. 1 help in understanding the relationship between systems, at the macro level and relationships, at the meso level. For example, in the position of brokers of in-home services, the home care organizations mandated to allocate scarce resources are facing pressures in managing resources because of fiscal constraints. These constraints put pressure on the service provision agencies to decrease the length and frequency of visits so that they are economically competitive in vying for contracts. The Victorian Order of Nurses and other service provider agencies therefore must attempt to control nursing practice decisions by establishing rules and parameters limiting nursing services. Subsequently, within these rules and parameters, nurses are constrained in involving clients in decision-making related to their care. Therefore, the power structures of home-based care impact upon the client–nurse relationship.

It has been found that structural empowerment has a direct effect on work satisfaction (Laschinger et al. 2001). Therefore, that nurses in this study faced powerlessness originating from the systems level implies that there are changes required within the home care system. Firstly, the competitive bidding model of home care, wherein service provider agencies compete with each other to obtain contracts from the CCAC, should be challenged. As suggested by study findings, the current approach to home care leads to fiscal pressures that negatively influence nursing practice, such as nurses limiting their time with clients. Changing the competitive bidding model of home care has been previously suggested by the Registered Nurses’ Association of Ontario (RNAO 2005) and is further supported by these findings. As long as the CCAC is responsible for administering home care, contracts should be given to those service provision agencies that foster optimal client–nurse relationships rather than those who offer the cheapest care (Caplan 2005).

Although changes within the broader home care system are required, the service provision agencies must also establish a setting in which nurses may practice optimally. The findings from this study suggest that agencies need to consider how demands, such as cutting costs, cutting visits and appropriate reasons to make nursing visits, are limiting nurses from practicing in accordance with espoused principles of client-centred and empowering care. Service provision agencies could foster nurses’ power within their workplaces by involving them in decision-making processes about the length, content and reasons for nursing visits, all of which have an impact upon nursing practice. If nurses feel powerless within their workplaces, it is unlikely that they will enact liberation in their relationships with clients. For example, if a nurse is attempting to balance having enough clients with having too many, they are less likely to be flexible in arranging the timing of visits with clients. This may lead to clients experiencing domination and subsequently being passive or responding with resistance. However, if nurses are able to focus on developing liberating
relationships with clients rather than decreasing costs, clients are less likely to experience domination.

Although clients were found to have the ability to exercise power, at times they did not have the opportunity to use this power collaboratively with nurses. Rather, the positional power of nurses was often being used to dominate the client, such as when nurses managed client care without the input of clients. This fits with the findings of Henderson (2003) that decision-making is not necessarily being shared between nurses and clients and with those of McWilliam et al. (2001) that in home-based care, client empowerment is not always being realized.

As the findings of this study reveal, nurses have both the opportunity and the ability to confront unjust conditions rather than contribute to clients’ powerlessness. This may include challenging models of funding or policies that limit their power. As well, it may involve nurses altering their personal practices as caregivers. To do so, nurses must recognize the presence of power in their relationships with clients and also reflect on how they are using this power by exploring their personal way of relating with clients (Oudshoorn 2005). Collaborating with clients in determining care is a perfect example of health promoting practice, which, according to the Community Health Nurses’ Initiatives Group (Community Health Nurses Initiatives Group 2000), is one of the roles of community nurses. According to the World Health Organization (World Health Organization 1986, p. 3) ‘health promotion is the process of enabling people to increase control over their health and its determinants and thereby improve their health’. Therefore, community nurses are fulfilling their mandate and will assist palliative clients in improving their health, when they engage in wielding power positively as liberating practice.

Future research should be conducted to understand better whether clients are being given or are taking control of their care and what factors contribute to the disempowerment of clients. As well, research investigating the impact of systems design on nursing practice in home-based care needs to be undertaken. For example, how does a competitive bidding model or paying nurses hourly impact upon nursing practice? Lastly, researchers should explore power relations in other settings outside of palliative care or home-based care. This research may be used to build the critical consciousness of nurses and encourage reflective practice.

Conclusion

Although the exploration of power within home-based palliative care has led to the conceptualization of a hierarchy of power, this power is not necessarily wielded negatively. As power is the ability to secure desired outcomes, both the power of nurses and the power of clients may be enhanced by involving individuals in decision-making processes. Therefore, the powerlessness faced by clients in this study may be alleviated if they experience the liberating practice of nurses that involves client-centred care. Likewise, the powerlessness faced by nurses in this study may be alleviated if they are involved in decision-making processes with their employers around nursing practice. To this end, nurses who are willing to reflect on and change those disempowering aspects of the client–nurse relationship, including a harmful hierarchy, will ultimately be successful in the health promotion of clients in all care settings.

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Contributions

Study design: AO, CW, CM; data collection and analysis: AO, CW, CM and manuscript preparation: AO, CW, CM.

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