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RESEARCH ARTICLE

EXPLORING THE INFLUENCE OF POWER DYNAMICS ON EVIDENCE-BASED PRACTICE IMPLEMENTATION IN CLINICAL NURSING: A CASE OF THE NIGERIAN ACUTE CARE SETTING

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ABSTRACT

Background: Evidence-based practice is an important aspect of healthcare delivery as its principles are internationally recognised to have instigated quality improvement initiatives. However, available evidence suggests that complexities surrounding its implementation largely exist in healthcare settings. **Aim:** This study aimed to explore impact power dynamics on evidence-based practice implementation in nursing in the Nigerian acute care setting. **Method**: A qualitative case study approach was utilised to study two hospitals drawing on interviews. Data was generated from staff nurses (n=12), ward managers (n=21), nurse managers (n=2), and physicians (n=2). Data was inductively, iteratively and thematically analysed through cross-case synthesis. **Findings:** Limited decision-making power deprived nurses of their autonomy, leading to non-delivery of evidence-based practice. These findings have significant implications for policy and practice as there is imminent danger for clinical outcomes in this context. **Conclusions:** Power dynamics impacts implementation of evidence-based practice in nursing. However, resistance can trigger emancipatory behaviours and can enable nurses to develop agency for challenging malpractices

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INTRODUCTION

Nursing practice is increasingly being subjected to public scrutiny due to perceived scandals within the healthcare industry. This has resulted in a culture where nurses are required to be able to justify the decisions they make in practice. Understandably, having the knowledge and skills required for implementing evidence is not enough since it requires the involvement of individuals, teams and organisational change to translate research into practice (Seers *et al.,* 2012). Several healthcare systems have in the past decade, acknowledged that evidence-based healthcare is essential, yet, there is a concern that what is known to be the best practice is not currently reflected in healthcare delivery (Seers *et al.,* 2012). Heater, Becker, & Olson (1988) reported that about 28% better patient outcome is achievable if nursing care is based on sound evidence rather than common sense. Graham *et al.,* (2006) estimates that over 40% of patients do not receive care that is consistent with scientific evidence and over 20% of patients is at risk of being provided with potentially harmful care. However, there is no guarantee for its use in healthcare practice (Thompson & Stapley, 2011). There are inconsistencies in utilisation of knowledge in nursing practice (Grove, Clarke, & Currie 2015; Ominyi & Nwodom, 2014). This slow pace of EBP implementation is due to the complex multifaceted factors present in practice settings (Estabrook *et al.,* 2007; Melnyk *et al.,* 2016; Rycroft-Malone *et al.,* 2013).There is no evidence indicating that nurses are unable to implement evidence, rather it is reported that nurse's ability to implement evidence relies on the support available within the practice setting (Estabrooks*et al.,* 2007).

Theoretical framework: This study draws on Foucault's notions of power and resistance as well as subjugated knowledge. Foucault (1977, 1980) argued that power is relational and does not exist in isolation. However, there is resistance in power relationships which may benefit the less powerful people (Foucault, 1980). Less powerful individuals could resist oppression as power relation is defined by their very presence (Foucault, 1977). The resistive nature of power makes it possible for less powerful individuals to take risks that may lead them to establishing identities capable of generating agency encouraging risk-taking.

MATERIALS AND METHODS

This study aimed at exploring impact of power dynamics on evidence-based practice implementation in nursing in the Nigerian acute care setting.

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Design: A collective case study design is utilised to generate wider understanding within the acute care Nigerian context. Collective case study involves more than one case and may be carried out at one or more sites (Stake, 1995). It is used to examine cases that share similar problems or characteristics (Stake, 2005). It must be conducted in settings where boundaries between activities being studied and their contexts are non-separable (Hamel, Dufour, & Fortin, 1993).

Sampling: Two large acute care settings that were considered meeting the criteria for a collective case study were purposively selected. It was our desire to explore EBP in a large, complex and challenging clinical environment where rich information was likely available. Different participants groups were required to provide different source of data and pparticipants were selected based on their job titles. All staff nurses and ward managers who worked in medical and surgical units as at the time of this study, were autonomically eligible to participate, except for those who did not consent. Nurse managers and hospital managers were automatically eligible to participate due to their roles. All participants were physically approached and invited to participate in the study.

Ethical consideration: Ethical approval was duly obtained through the Research Ethics Committee of the two hospitals. Participants were provided with participants information sheet outlining the study's purpose, their involvement as well as strategies for maintaining confidentiality and anonymity. Participants were issued with written consent which they signed prior to data collection.

Data collection: In-depth semi-structured interviews were utilised to gather data from participants between 2016 and 2017. First round of interviews involved ward managers as well as staff nurses while second round of fieldwork captured data from nurse managers and physicians.

Data analysis: Data for this study was transcribed verbatim and was analysed through cross-case (Stake, 1995; Yin, 2014), and thematically (Miles & Huberman, 1994). Interviews extracts were labelled to generate codes, which were revised where necessary. The second level coding yielded categories. Individual case analysis was conducted, that is, case 1 data was first analysed, and themes were generated, and were utilised as a frame of reference to analyse case 2 data. Then, through a cross-case analytic approach, case 1 and 2 data were integrated to establish similarities. To achieve rigour, this study utilises a theoretical framework, multiple perspectives (four participants group) and prolonged engagement in the field (9months).

FINDINGS

Data analysis yielded four overarching themes which include decision-making power; nurse-doctor relationship; resistance: challenging with expertise; possibility of change: implementing practice changes.

Decision-making power: Findings show that professional power bases in hierarchy in this setting existed leading to absolute maintenance of professional boundaries. Nursing was perceived to be ranked low within this hierarchy, thereby, limiting their autonomy. Consequently, nurses had to surrender ownership and clinical decision-making to more powerful professionals. Precisely, physicians were perceived as more powerful professionals who were meant to determine how practice decisions were made.

…it's all about who does what…I mean I don't have the power to decide what needs to be changed or not, but the doctors do, because the power to decide belongs to the them and I have the feeling that some of them joined the profession so that they can dictate what happens…for me it's about hierarchy… (**interview ward manager, case 1**)

As seen in the quotes above, the differences in professional power bases appeared problematic. Seemingly, clinical decision-making processes was characterised by the traditional hierarchical nurse-doctor role relationship. The low position of nursing in the hierarchy of healthcare professional appears to have placed them in a situation where their roles were defined by physicians, resulting in deprivation of professional autonomy. As seen in the quotes below, nurses suggest that they were constantly denied the opportunity to influence practice, even in cases where they felt they had the expertise to introduce relevant initiative for practice change.

Last year the HNS [nurse manager] brought an idea that we should adhere to the World Health Organisation's hand hygiene checklist in our unit and she passed a circular that all managers should ensure this happened and we all complied, but I tell you, the doctors didn't want to comply simply because it's nurses' idea and it didn't hold…few months later, after we had Lassa fever incidence in the hospital with which two doctors and one nurse died and the checklist was brought up again by a doctor and it was implemented even the doctors because it was a doctor that brought it up this time (**interview staff nurse, case 2**)

This suggest that physicians determined what form of evidence that should be implemented in the settings. Although the guideline was later implemented, it was initially turned down when it was raised by the nurse manager. Evidence that was neglected when raised by the nurse manager was appreciated and subsequently implemented when it was the physician's idea. As seen in the quotes below, nurses' sense of selves suggests an acceptance of their subordinate position within the context. For nurse managers in executive positions to share such hegemonic conceptualisation is an indication of the danger befalling nursing in the Nigerian context.

…yeah, that's the way it is here…when I joined this hospital in fourteen years ago I was made to feel that doctors are owners of patients and not the nurses so whatever they want to be done for the patients is what we do…even if I bring in the latest piece of evidence whether it's from research or anyway the doctors will have to decide whether we can use it or not…as long as it's a nurse they [doctors] don't want to hear about it… (**interview staff nurse, case 1**)

The apparent hesitations to describe what appears to have become part of the norm as doctors are held superior to nurses may indicate that she [nurse manager] holds the same view. From the perspective of staff nurses as seen inthe second quote above, it seems normal that doctors are not only held in hierarchy but that patients are legitimately owned by doctors who then decide what treatments, interventions or evidence are applicable and by whom.

Nurse-doctor relationship: Professional inter-dependence in healthcare practice requires that considerable aspects of nursing practices be delivered in collaboration with other professionals. In this study, findings show that clinical

decision-making generated significant conflicts within the healthcare team. This is particularly between nurses and physicians as nurses were required to adhere to doctors' orders without questioning. As seen in the quotes below, physicians, were the perceived highest authority in overall clinical decision-making.

…It has always been like that…the doctors take the lead and when they give orders they demand that we follow it immediately and absolutely…personally I feel that as members of the healthcare team we should discuss about certain things before decisions are made but this is not the case…the only time we get to meet is during ward rounds and even during ward round we don't talk much because they normally come with a lot of medical students that are on placement… (interview ward manager, case 2)

As seen in the quotes above, nurses suggest that domineering attitudes of physicians affected nurses' participation in care delivery activities, for example, ward rounds. From the nurses' point of view, all members of healthcare team, including nurses and doctors should normally engage in clinical discussion about patients' conditions before decisions are made for patients, but this was not happening. Lack of nurse-doctor discussion about clinical scenarios was viewed in relation to traditional practice of domination over nurses by physicians. Therefore, lack of collaboration between nurses and doctors, and possibly other members of the healthcare team was considered problematic. Nurse-doctor relation in this context was characterised by power relations generating feelings of marginalisation among nurses as seen in the quote below.

…when the doctors finish ward round, they review patients' plan and may be prescribe medication for the patients in their folder and because the nurses didn't go for round with them, they are not even aware of what the doctors have written in the patients' folder…the nurses won't even know whether the patient's medication has been changed, whether the dosage has increased or decreased and the nurses will continue with the previous medication…the patient's condition becomes worse and the patients will spend more money and sometimes it results in death…so, this has caused a lot of problems and it's still causing problem even today…(interview wardmanager, case 1)

Changes in patients' prescriptions require nurses' awareness to update patients' medication list and ensure that medications are administered as required. Since nurses were not aware of these changes, it would imply that patients' medication will not be made available to them, and might not have been administered as required, which again might lead to deterioration of patients' conditions. Nurses have also viewed their non-involvement in clinical discussions and decision-making in relation to self-image. There is an indication that nurses in these settings were not proud of their professional image.

Doctors look down on us and some of us [nurses] too like bringing ourselves down…we [nurse] don't want us to be equal members of the team because they want to be super people…so even though we give them the best suggestion they will never be proud to say that we suggested this or that except unless it's on the negative side…who are you to suggest for me, I'm the doctor…so they will always show us that they higher than us… (interview ward manager, case 1)

As expressed in the quotes above, nurses appear to construct their professional identity as inferior in relation to that of doctors. There seems to be a controversy about the origin of this low sense of professional identity. Nurses perceived that doctors view nurses as inferior.

Resistance: Challenging with expertise

Frustrations experienced by nurses stimulated them to challenge with their professional knowledge through utilisation of various strategies of resistance. This is particularly, when there were clinical scenarios that significantly required nurses to confront physicians in defence of poor clinical decisions. Nurses utilised their formal professional advocacy to challenge doctors' decisions when they perceived that diagnoses were inaccurate and could potentially harm patients.

…we are not allowed to set IV lines on patients but after we lost a patient I decided that my nurses will be setting IV lines whenever the doctors are not available in the ward and the doctors disagreed but I insisted...so one day there was an accident patient who was on blood transfusion and all of a sudden she went into crisis and was struggling so when I checked I observed that the line was no longer patent and both the blood and infusion has stopped and there was no doctor in the ward so I quickly rallied round and managed to set another line and commenced transfusion all over again…later on the doctor who supposed to be on call came and after seeing what happened he was so happy with me and in the end thanked me for it because he would have landed himself in trouble if the patient had died because he was not at his duty post…so the point I'm trying to make is that we need to have the skill as nurses so that we can have the power to act and make decisions on our own and not just rely on the doctors (interview ward manager, case 1)

As seen in the quote above, self-confidence and professional identity appeared to have played a role on how nurses felt about power, particularly, those who felt they were confident enough to challenge clinical decisions. Nurses recognised that although they may not have the formal power to physically engage doctors in some clinical encounters, they have professional knowledge to detect malpractices. These nurses drew on their professional advocacy to ensure that patients got the right treatment. However, nurses recognised relevance of knowledge whilst negotiating inter-professional relationship as they suggest that it heightened their competence which enabled initiation of changes in practice. The confidence to act while making clinical decisions and ability to defend it may have generated the feeling of powerfulness. The 'brilliant' nurse in the extract below could advocate for patient against what could have resulted in medication error.

…I have some brilliant nurses who have always risen to speak up whenever things go wrong…they have the skills and experience and understand what they are talking about and the doctors finds out that they really understand what they are talking about, they back off... doctors are not even good at research except that they belief in their medical doctrines so much that whatever any of says is not real…there is this doctor that prescribed cipro [ciprofloxacin] for one of our patients simply because he has fever and he [doctor] claims it is infection without any lab investigation yet…unfortunately, there was one of my staff who have undertaken a programme in pharmacology who argued with the doctor and refused that

the medication will not be given unless there is a laboratory result and a diagnosis showing that the he [patient] has infection…the doctor simply walked out but came back later with a lab result which was negative for inflection… (**interview ward manager, case 1**)

The quote above suggests that nurses are active knowledgeable agents who can resist medical domination in the face of malpractices. Actions of the nurse who has undertaken specialist training in pharmacology as seen above, demonstrates that nurses have relevant expertise necessary to trigger emancipation. By being in regular contact with patients, nurses may have perceived themselves as being in better positions to understand patient problems. Nurses appeared to suggest that the amount of time they spend with patients gives nurses the opportunity to know the likely needs and conditions of patients unlike doctors who occasionally meet them. Spending more time with patients affords nurses the opportunity of studying patients and their potential responses, which might enable uncovering of patients' psychosocial needs. This insider knowledge would inspire the nurse to draw on their personal and informal power to influence clinical decisions where necessary by engaging the doctors in discussions.

Possibility of change: implementing practice changes

Findings suggest that nurses were conscious of practice changes as well as use of sound evidence in guiding practice. Therefore, nurses' perceptions were explored to generate insights into how they construct evidence, EBP and practice change. Nurses commonly perceived that EBP was a way to achieving changes in practice and to ensure patient safety. Generally, nurses framed EBP as utilisation of research evidence, in form of clinical practice guidelines, professional knowledge or expertise and patient choices in determining required care. In both cases, there were indications depicting practice changes as nurses' perceptions suggest that they have made reasonable efforts towards underpinning their practice with sound evidence.

...we have to keep making changes in our approach no matter how little…the way we attend to patients, you know, those little things are very important and can make a difference for our patients…the assessment that we normally carry out on patients during admission is not enough and can't be enough so what we do is a continuous assessment which in most cases result in other changes in the patients' care plan but whatever adjustment we do the plan depends on what the patient presents…although it normally difficult to keep switching we have recognised that it makes us much more organised now (**interview ward manager, case 1**)

As seen in the quotes above, minor daily reforms appeared to be the most common changes in this unit. These modifications were mainly targeted at meeting patients' needs but appeared to have been made based on personal interests in delivering evidence-base care rather than wide organisational policy. These ward managers appeared curious about the level of practice changes that they have made, perhaps, due to their desires to improve the quality of care. Further, '*being much more organised now than before and seeing the benefits"* (**interview, ward manager, case 2**) appeared to reinforce the belief about benefits of implementing EBP and all actions applied in implementing change in practice. Achieving positive outcomes might include seeing the benefits, feeling safer, saving time and ensuring that patients are satisfied. The possibility of change appeared to have necessitated the need for nurses to explore different training options available with the intention of achieving certain level of knowledge and expertise required in EBP implementation. As seen in the quotes below, attaining a high level of knowledge and skill would enable nurses to question current practice or confront malpractices, leading to potentially increased visibility within the setting.

I personally choose to go for workshops to refresh my skills…there should improvement in knowledge and skills so that staff should be able to assess patents and determine the kind of care they need…for instance, nurses should be able assess patients to determine whether they have pressure sore that may require treatment or not, staff should embrace seminars and workshops to improve their knowledge and skills and people should also know what seminars and workshops have added into nursing profession without entering the university…and that's what continuous education unit should do so that continued nursing training will be ensured because there are a lot new trends in nursing but so many nurses are not aware and this can only be noted when nurses start attending seminars and workshops (interview ward manager, case 1)

Nurses acknowledged that it was crucial to gain additional skills capable of enabling independent planning or initiation of ideas that can foster practice changes. Recently registered nurses were aware that they required additional education and experiences to increase their knowledge base. Changes in practice created opportunities for further education and self-development. This resonated the nurses' needs to acquire relevant research knowledge and skills that could underpin clinical nursing practice.

DISCUSSION

Findings show that nurses in this context lacked autonomy to drive EBP implementation. Hierarchy and power constituted conditions impeding implementation of knowledge in nursing practice. Inter-professional relationship between nurses and doctors created hierarchies due to existing power structures. There were both explicit and implicit power relations in the inter-professional clinical encounter, generating complex micro-political tensions. Nurses may have conceded to status quo, thereby normalising the existing hierarchy of power in these settings. Foucault (1980) whilst examining normalisation processes defined discursive practice as a way of determining acceptable norms within the organisation. These discursive practices may be constraining to organisational functioning since it can privilege certain groups or individuals (Cheek, 2000). In this study settings, the privileged position of medicine was not challenged to any significant extent as physicians consistently defined evidence that was acceptable for use. Thus, the rights to clinical decision-making was reserved with the physicians. Consequently, nurses were conspicuously deprived of clinical autonomy and were limited in what they could do to change practice. Nursing practices were constantly determined by the medical discourse as physicians dominated daily processes, and in most cases prescribed limits for nurses in their roles. It was a context in which medical supremacy is promoted while downplaying nursing and nurses' interests. Consequently, the professional relationship between nurses and physicians was one that did

not permit exchange and sharing of knowledge rather it created ethical dilemmas for nurses, typifying the counterproductive nature of power and hierarchy. Previous study report that cultures endorsing hierarchy of professions and individualism generate barriers for efficient care as well as patient safety (Leape& Berwick, 2005). Inherently, nurses were made victims of both historically and socially constructed stereotypes. Medical impediment on EBP in nursing has previously been reported as there are indications suggesting that medical professionals may not allow nurses implement practice changes (Cheng *et al.,* 2017; Wilkinson, Nutley, & Davies, 2011).

Nurses were being socialised to develop ideology that normalises nurses' acceptance of medical dominance which has in turn affected nurses' professional identity. Previous study reports that medical professionals derive power from their socio-political position and are afraid of losing it to other professions (Alubo& Hunduh, 2017). Nurses in this context appeared to have been completely deprived of their nursing clinical autonomy. Clinical autonomy is a prerequisite for nurses to be able to implement EBP and utilise research-based knowledge in practice. This would enable nurses to make clinical decisions that are underpinned by not only sound research evidence, but also based on due considerations of patient preferences and nurses' clinical experiences. As seen in the findings, a few nurses challenged with expertise and implemented EBPs. These actions seem to be part of nurses' advocacy aiming to protect patients. In the view of participants, these actions were focused on delivering evidence-based care, thereby establishing an alternative conception of knowledge. However, these were nurses who felt they have the knowledge, skills, and experience to resist or negotiate hierarchical constraints. These nurses made a few evidence-based changes, for example, reduction in the number of times that catheter bags were changed and decrease in the fasting time prior to surgery. Nurses' ability to navigate their ways to deliver evidence-based initiatives demonstrates the productive and resistive possibilities of power. Questioning malpractices demonstrates the possibility of resistance in power relations reflecting the relationship between power and resistance as Foucault's (1978) argued.

Limitations: The findings of this study can be considered to have cast light on the impact of power dynamics on EBP implementation in nursing practice. However, this is a small qualitative study which is not intended to achieve generalisability in a quantitative sense. Therefore, findings of this study may be judged in relation to the context of Nigerian acute care setting. It may be a limitation that this study has only explored perspectives of nurses, ward managers, nurse managers and hospital managers, and have not necessarily involved patients and physicians. Involving patients may not have necessarily changed the information as they are not experts in EBP implementation.

Conclusion

This study makes a unique contribution to a body of nursing knowledge in some areas. As far as I'm aware, there is no existing study investigating the impact of power dynamics on knowledge implementation in nursing practice. This study highlights the complexity surrounding EBP implementation and further adds to the literature around influence of power on knowledge implementation. These findings emphasise roles of, and interactions among key individuals within practice context further demonstrating the interplay between actors and context. Roles as well as decision-making authority of professionals are crucial in knowledge implementation. Healthcare managers must consider the implications of power dynamics in policy and practice.

Key issues

- Decision-making power impacts evidence-based practice implementation in nursing
- Limited power diminishes nurses' professional autonomy and leads to unsuccessful implementation of practice changes in nursing
- Power dynamics endorses inter-professional relationships which in turn impedes successful evidence-based practice in nursing
- Resistance can trigger emancipatory behaviours which can create agency for challenging malpractices
- Nurse managers and nurses must be empowered in order to implement evidence-based practice

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