10.6: Power and Advocacy

What is Power?

Academics from many disciplines have studied the elusive concept of power. Hokanson Hawks (1991) provided two different meanings for power: (1) power to, or the ability to get things done, and (2) power over, or the ability to influence the behaviour or decisions of others. The definition of power, commonly found in leadership research, is “the ability to get things done, to mobilize resources, to get and use whatever it is that a person needs for the goals he or she is attempting to meet” (Kanter, 1993, p. 166). Power is a force that is inherent and personal and it comes into play when clinicians are influencing the health care decision making of others (Milton, 2016). When power is defined as the ability to get things done, it is a significant resource for nurses, and as such, warrants further in-depth discussion.

Sullivan (2013) adapted the classical description of social power to fit the nursing perspective. The five types of nursing social power, as described by MacPhee (2015) are: (1) “personal power based on one’s reputation and credibility; (2) expert power [referring to the possession of skills and knowledge] that are needed by others” (p. 188); (3) position power that is a result of your position in the organization or group; (4) perceived power resulting from your status as a powerful person; and (5) connection power ensuing from your association with, or links to, powerful people. Understanding these versions of social power, which have been adapted for nursing, will provide the nurse leader with a basic understanding of the power dynamics that influence decision making within the workplace.

However, the increasing complexity of our health care organizations requires the nurse leader to look at power from additional perspectives. Some authors look at power as situated within a relationship (Davidson, 2015). Davidson states that, by the very nature of being human, people are always in relationships where power dynamics are at play. Stacey (2006, as cited in Davidson, 2015) stresses the importance of relationships as both an enabling and a constraining power.
In order to form and stay in a relationship with someone else, one cannot do whatever one wants. As soon as we enter into relationships, therefore we constrain and are constrained by others . . . we also enable and are enabled by others. (p. 134)

Udod (2008) uses the work of Michel Foucault in her research exploring empowerment for staff nurses. Foucault’s work also emphasizes that power is not owned, but rather is a “relation or situation. . . . When power is exercised in relation to others, it causes reactions and effects” (cited in Udod, p. 81). Power is regarded as a strategy, suggesting that nurses develop tactics on how to comply with power, rather than fight it. Finally, power is not present solely in the actions of leaders; it is also present in the actions of people who resist (e.g., whistle-blowers). In summary,

nurses need to work with power rather than against it, recognizing that their task is not to overcome more powerful others . . . but to understand how power and its effects operate in order to enhance their sense of empowerment and hence, their practice. (Udod, 2008, p. 88)

Essential Learning Activity 10.5.1

Read the following article to learn more about power, then answer the following questions.


1. What are three assumptions that the rationalist/positivist makes about power?
2. What are the limitations of studying power from the rationalist/positivist approach?
3. What is the main assumption about power in using the complex responsive process analysis?
4. Why should we examine and call attention to patterns of power relations within organizations?

Power and Health Care for Indigenous People

Recognition of the impact of colonization and residential schools on the health and well-being of Indigenous people requires the nurse leader to take a closer look at the relationship between power and diverse populations and, more specifically, at the relationship between power and the Indigenous population. Foucault’s work demands that we acknowledge “how power relations shape the production of truth” (Macias, 2015, p. 225) and how “discourse defines and limits the subject’s freedom” (p. 231). Foucault also suggests that changing discourse can produce freedom.

Madeleine Dion Stout (2015), a Cree speaker from Alberta who became an RN approximately 46 years ago, worked to improve the health of Indigenous people by changing the discourse of power in just such a way. She addressed the need for Indigenous people to develop their own determinants of health, rather than accept the values of the colonizer society. She stated very eloquently in both Cree and English how the Indigenous people will move forward to reclaim their health and well-being. In her words:
kaskitamasowin miýw-āyāwín is health and wellness we have conjured up and created for ourselves. kaskitamasowin miýw-āyāwín means achieving health status that we wish upon ourselves and for our families, communities and nations. We achieve kaskitamasowin miýw-āyāwín with our own will and abilities and with the resources we have at our immediate disposal. kaskitamasowin miýw-āyāwín comes from our inner strength, inner forces, and inner voices. (p. 145)

Changes in ownership of Indigenous health and well-being are rapidly becoming evident in the relationship between Health Canada and the Indigenous population. In accordance with the wishes of the Canadian Indigenous people for a health plan that meets their needs, the Government of Canada developed the First Nations and Inuit Home and Community Care (FNIHCC) 10-Year Plan (2013–2023) (Health Canada, 2015). This plan provides a template for collaboration with First Nations and Inuit partners in health care. It will be updated yearly or as needed. The plan is envisioned as responsive to the unique needs of the Indigenous people, representing “a continuum of home and community care services that are comprehensive, culturally safe, accessible, effective, and equitable to that of other Canadians and which respond to the unique health and social needs of First Nations and Inuit” (Health Canada, 2015, p. 1).

Figure 10.5.1 First Indigenous Nurse in Northern Saskatchewan

[January 1958], photo courtesy of the Provincial Archives of Saskatchewan. Photographic Services Branch Collection, collection number R-B6805, is used with permission. All rights reserved. About this photo: Jean (Cuthand) Goodwill was the first Indigenous nurse in Northern Saskatchewan. This photo was taken at the Indian Health Nursing Station in La Ronge, Saskatchewan. Jean Goodwill and her colleague Jocelyn Bruyere went on to develop a registry of Indigenous nurses, which eventually became the Registered Nurses of Canadian Indian Ancestry, laying the foundation for the formation of the Canadian Indigenous Nurses Association in 1975.