ENFERMEIRAS SUBMISSAS SÃO ÉTICAS? REFLETINDO SOBRE ANOREXIA DE PODER[1]

ARE SUBMISSIVE NURSES ETHICAL?: REFLECTING ON POWER ANOREXIA

¿ES ÉTICA LA SUMISIÓN DE LAS ENFERMERAS? REFLEXIONANDO SOBRE LA ANOREXIA DE PODER

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RESUMO: Acreditamos que a noção de anorexia de poder, que definimos como a falta de desejo de exercer poder, é central para a reflexão de questões éticas em enfermagem. Questionando o pressuposto de que enfermeiras são *powerless (nao têm poder)*, argumentamos que as enfermeiras podem e exercem poder e que suas ações e omissões têm conseqüências não apenas para elas mesmas, mas também para quem elas cuidam. Propomos a ética feminista como uma perspectiva tanto para entender quanto para superar a anorexia de poder das enfermeiras. Intelectuais feministas destacam o impacto psicológico da opressão e que percepções estereotipadas sobre a mulher são socialmente construídas, portanto podem ser mudadas. Propomos que as enfermeiras, utilizando esta orientação teórica, devem explorar as implicações da centralidade da noção de cuidado para as maneiras como nós concebemos relações de poder em saúde. Talvez, a desconstrução do conceito de cuidado focalizando em como as enfermeiras exercem poder, possa ajudar-nos a reconceptualizar enfermagem e promover novas agendas para a saúde e os cuidados em saúde.
PALAVRAS-CHAVE: enfermagem, ética, cuidado, poder, governabilidade, ética feminista

ABSTRACT:We believe that the notion of power anorexia, which we define as a lack of desire to exercise power, is central to reflections about nursing ethical concerns. Questioning the assumption that nurses are powerless, we argue that nurses can and do exercise power and that their actions and inactions have consequences not only for themselves, but also for those for whom they care. We propose that a feminist ethics perspective be used both to understand and to overcome nurses' power anorexia. Feminist thinkers remind us not only of oppression's psychological impact, but that stereotypical views about women are socially constructed and, therefore, can be changed. Nurses using this framework should explore the implications of a centralized notion of caring to the way we conceive of power relations in health care. Perhaps deconstructing caring by focusing on how nurses exercise power could help us to re-conceptualize nursing and promote new agendas for health and health care.
KEYWORDS: nursing, ethics, caring, power, governmentality, feminist ethics

RESUMEN: Creemos que la noción de anorexia de poder, que definimos aquí como una falta de deseo de ejercer poder, es una idea central para la reflexión sobre cuestiones éticas en enfermería. Al plantear la premisa de que las enfermeras son *powerless* (no tienen poder), argumentamos que las enfermeras pueden y ejercen poder, y que sus acciones u omisiones tienen consecuencias no sólo para ellas mismas, sino también para aquellos a los que cuidan. Proponemos usar una perspectiva de la ética feminista para comprender y para superar esta anorexia de poder de las enfermeras. Las intelectuales feministas destacan no solo el impacto psicológico de la opresión, sino también que las imágenes estereotipadas sobre las mujeres son construcciones sociales y, por tanto, se pueden cambiar. Proponemos que las enfermeras, utilizando esta orientación teórica, exploren las implicaciones de la centralidad de la noción de cuidado en la forma en que conciben las relaciones de poder en salud. Tal vez, la desconstrucción del concepto de cuidado al focalizarse en cómo las enfermeras ejercen el poder, pueda ayudarnos a reconceptualizar la enfermería y a promover una nueva planificación para la salud y los cuidados en salud.
PALABRAS-CLAVE: enfermería, ética, cuidado, poder, gobernabilidad, ética feminista

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During the past 20 years, many authors (MURPHY, 1983, ROBERTS 1983, YARLING; MCELMURRY, 1986, LOYOLA, 1987,COLLIERE, 1989, GASTALDO; MEYER, 1989, CONDOM, 1992, GERMANO, 1993, JAMETON, 1993, LUNARDI, 1993, LUNARDI FILHO, 1995, WOLF, 1996, LIPP, 1998, BOWDEN, 2000, HAMRIC, 2000, PETER, 2000[a], SOARES, 2000, TUCK; HARRIS; BALIKO, 2000, HOLMES; GASTALDO, 2002) have described nurses' powerlessness or, at least, perceived powerlessness. Erlen, Frost (1991, p. 397), for example, most emphatically stated that nurses "perceive themselves to be powerless to effect ethical decisions involving patient care."

In this paper, we question the assumption that nurses are powerless. Instead we argue that nurses can and do exercise power and that their actions and inactions have consequences not only for them, but also for those for whom they care. In formulating our arguments, we recognize that there are legitimate constraints to nurses' agency[5] and that, as for all persons, nurses' autonomy is situated in their practice contexts (SHERWIN, 1998). Nevertheless, we maintain that nurses do not recognize, or perhaps they underestimate, their power in ways that render them unnecessarily powerless. When nurses frequently deny themselves the power to resist others in their professional lives, they might be denying their patients the best care possible. Therefore, reflecting on how nurses exercise power and nurses' apparent lack of appetite for power, that is, power anorexia is crucial to general considerations of ethical concerns in nursing.

NURSES EXERCISING POWER

In contrast to the prevailing notion that nurses are powerless, Holmes, Gastaldo (2002) maintained that nurses exercise power in different ways and that they are a powerful group who govern individuals, groups, and populations, and create policies and knowledge. Power is understood in this paper as a relational exercise, "a productive web which goes through all the social body more than a negative instance functioning to repress" (FOUCAULT, 1990a, p. 8). For example, Mckeever (1996) and Stewart (2000) emphasized that Canadian nurses are important agents who further advances in home care and health promotion. As health care professionals who are in direct communication with care recipients both individually and collectively, nurses are a group of experts that can represent individuals, institutions, and the state. In fact, "nursing research provides knowledge about the population and helps to decide priorities in funding" (HOLMES, GASTALDO, 2002, p. 10). Nurses are "an important group that helps the state to govern at a distance" (HOLMES, GASTALDO, 2002, p. 17), according to Foucault's concept of governmentality[6] (FOUCAULT, 1990b). Through power relations, this professional group, like others, promotes and restores health, gathers and disseminates knowledge, and also constructs people's subjectivities and ways of life. Yet in spite of being the largest health professional group within the Western world's health care systems, nurses are frequently perceived as invisible. Holmes, Gastaldo (2002) underscored nurses' feelings of being unimportant and victims of the institutions and organizations they helped to construct, support, and administer. Arguably, they may be experiencing an ambivalence associated with participating in their own oppression. Or, perhaps, many nurses are not aware that they exercise power in numerous ways and that they have the potential to exercise power in unaccustomed ways. Indeed, "they seldom reflect about their own ways of exercising power or rarely perceive health care as political care" (HOLMES; GASTALDO, 2002, p. 18).

Lunardi Filho (1995) identified nurses' experiences of feeling impotent, unimportant, unrecognized, devalued, and blamed for bad outcomes and mistakes. He also established that nurses perceive themselves as being responsible not only for organizing the work environment, maintaining working conditions, and ensuring the professional fulfillment of other health professionals, but also for accomplishing everyday caregiving activities through the implementation, management, and control of these different activities. According to a perspective from DEJOURS (1997), Lunardi Filho (2000, p. 14) affirmed that "the organization of work is nothing else but the expression of the will of those who organize it. When others accomplish their work according to those who have organized it, they are enacting the power that comes from these organizing activities. Thus, when nurses occupy organizational, coordination, and management roles, they are exercising power in ways that these roles make possible"[7]. These roles are circumscribed and lead into particular modes of power relations due to their structure and the particularities of a given setting.

When Lunardi Filho (2000) also observed nurses' work in hospitals, he concluded that nurses are (a) the ones who hold almost all the information of the hospital, (b) the organizers of the care environment, (c) the keepers of institutional norms and routines, and (d) the organizers of caregiving. According to him, "Such capacities seemingly give the nurse the necessary and sufficient capacity to act as the global caregiving administrator within his/her area of influence in the micro space where he/she practices and develops such activities" (p. 197). However, as Lunardi Filho

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[5] Liashenko (1994, p.17) defined *agency* as "the capacity to initiate meaningful action." and as "a mix of motivation and physical action directed toward some end." Peter (2002, p. 2) modified Liashenko's definition to specify *moral agency*, which Peter (2002, p.2) defined as "a mix of motivation and physical action directed toward some moral end". Using feminist ethics to define the meaning of moral, Peter (2000b, p.110) suggested that "the development and maintenance of relationships; care; justice; and freedom from exploitation and oppression" are the core values of a feminist ethic in nursing.

[6] Governmentality, according to Foucault (1990b), describes the meeting point between the power technologies exercised by others and those exercised by the self. Dean (1999) defined government as the "conduct of conduct" (p. 10), emphasizing that "the term *governmentality* seeks to distinguish the particular mentalities, arts and regimes of government and administration that have emerged since 'early modern' Europe, while the term *government* is used as a more general term for any calculated direction of human conduct" (p.2).

[7] Author's free translation from the original Portuguese.

(2000) argued, some elements can interfere in the fulfilment of these activities, such as the way in which health professionals understand their own work, particularly nurses and physicians, and both the qualitative and quantitative precariousness of human and material resources available in the work setting, especially in less affluent countries like Brazil.

These critical perspectives about nurses' perceived powerlessness inform the discussion that follows. We will explore some relations between ethics and politics to search for potential explanations of the current power anorexia orientation that is pervasive in nursing.

POWER ANOREXIA AND ETHICAL CONCERNS

The Canadian and Brazilian nursing codes of ethics serve as our point of departure to analyze the relationship between ethics and power relations. The stated values within the Canadian Nurses Association Code of Ethics for Registered Nurses (1997) continually reinforce the nurse's responsibility to advocate for the interests, health and care conditions, policies, and environments that protect clients from unethical care. Beyond direct client care, it is the nurse's responsibility to "advocate for work environments in which nurses are treated with respect" (p. 22) Similarly, in Brazil, the Code of Ethics for Professional Nurses (Codigo de Ética dos Profissionais de Enfermagem, CONSELHO FEDERAL DE ENFERMAGEM, 1993) asserts in its preamble that the code is client-centred. Moreover, it assumes that nursing professionals are allied with clients, fighting for safe, quality care that is accessible to the entire population.

These moral responsibilities reflect a historical evolution that has seen nursing's role change from that of a dependent servant to physicians and health institutions to the current one of patient advocate[8]. Yarling, Mcelmurry (1986) described how nurses from American nursing schools during the nineteenth century were taught to believe that "absolute and unquestioning obedience must be the foundation of the nurse's work" (p. 66). By the end of World War II, however, the changes that had taken place in nursing were reflected in the American Nurses Association's (ANA) Code for Nurses, which indicated nursing's increasing professional autonomy and the shift in accountability from the physician to the patient. Although professional codes may have little impact on practice, each new version registers a professional evolution. For example, the most recent ANA code, which was adopted in 2001, not only promotes patient advocacy, it also highlights the duties nurses owe to themselves, such as their responsibility to preserve their own integrity and safety.

Yarling, Mcelmurry (1986) argued that while student nurses learn this new ideology when they join the profession, they also quickly learn that these commitments must be contained: "Nurses who openly challenge established authority structures of powerful physicians in a hospital bureaucracy most often put their jobs, their economic welfare, and their professional careers on the line, even if they are acting on behalf of the patient and have strong justification for doing so" (p. 70). Therefore, Yarling & Mcelmurry asserted that nurses "are often not free to be moral" (p. 63) and "have no moral status" (p. 66). Nevertheless, they also contended that nurses "are in some limited sense free, they are also in some limited sense culpable, for the risk attached to an action does not completely cancel the obligation to perform the action. If it did, nurses would have no moral problems, but unfortunately they do" (p. 70). We maintain that for nurses to be free, to be moral, they must develop a strong sense of professional autonomy and be able to act on their responsibilities to the patient.

In acting on their responsibilities, nurses can face problems related to the organizational conditions in which they must provide care to patients. A number of Brazilian authors, for example, (MIRANDA 1993, LUNARDI 1994, 1999, PEREIRA; NAKATANI; SOUZA 1994, SIQUEIRA, 1998, 2001, SOARES, 2000) emphasized the impact of a lack of human or material resources or of poor working conditions on the moral agency of nurses. In contrast, research published in English language journals tended to be focused on institutional and professional hierarchies that limit the capacity of nurses to act, not on the lack of human and material resources. This is not to say, however, that English-speaking authors are unaware of limited resources. Instead, these issues tended to be cast as resource allocation/priority setting concerns as opposed to issues of moral agency. In addition, resources are likely not as scarce in the health care systems they described, for example, American or Canadian.

In short, the constraints to moral agency that Brazilian nurses experienced were frequently relative to the serious insufficiency of human and material resources, although they could also be of an interpersonal nature, reflecting conflicts and power differences among health professionals, health administration, and patients. But when the necessary material conditions to provide nursing care are nonexistent, it may be more difficult for nurses to identify and problematize circumstances of a political nature where their responsibility to advocate for patients is thwarted.

When nurses accept working in precarious conditions where they cannot do what they have learned to believe and value, they are denying themselves the opportunity to bring respect to themselves and their profession and possibly also failing to bring respect to their patients. What impact does this situation have on nurse-patient relationships? Do patients know that their care is not adequate? Do they know they are being disrespected? Are the nurses aware of the relation between their self-denial and the denial of patients' rights? Finally, who benefits from such a current arrangement of power relations? Worthley (1997) described how professionals deny that they wield power or at least underestimate the power they exercise. In doing so, professionals, such as nurses, can avoid responsibility and can as Rubin (1996) described,

[8] "Advocacy is one of the fundamental values of professional nursing" (HAMRIC, 2000, p. 103), having been discussed in the literature since 1980 (beginning with GADOW, 1980). As a moral concept, it requires an active movement to support patients in their rights and possible choices. It has been described by all recent codes as a core responsibility (HAMRIC, 2000).

"delegate up" (p. 183), a process whereby nurses can avoid ethical decision making by invoking physicians' authority as the basis for their decision making. As Germano, Brito, Teodosio (1998, p.376) explained, "it is not enough to understand reality and to have the tools of know-how to assure that our project for nursing and health will occur. To make it happen, it is necessary to want, to have the political will, the intentionality, and the perception of duty."

By demanding better working organizational conditions, nurses indirectly advocate for patients. Nurses can also more directly advocate for patients by explicitly demanding that nurses' values, as well as their professional and ethical responsibilities, be upheld. However, nurses must be convinced that their actions are fundamental to patient care, and they must develop a sense of professional identity and pride. Advocacy could be easier if nurses had more of the sense of confidence that stems from professional self-worth.

Unfortunately, when nurses do not intentionally exercise power towards a given professional/ethical agenda, they, to some extent, participate in their own oppression and are morally culpable for accepting the status quo. Nurses need to consider what responsibilities are realistically theirs. It is a Nurses commonly talk among themselves aboutin nursing to talk inequalities, but rarely take their concerns outside of nursing. The challenge resides in taking action and speaking out. enacting such a theoretCan nurses use their knowledge to change social relations and values when they benefit in distinct degrees from the current arrangement of power relations?[9] As Jameton (1993) suggested, nurses can choose different possibilities beyond resigning, screaming, saying a prayer, or doing nothing, depending on the situation. They can "talk with the physician in an attempt to reach a compromise on handling these situations; submit an incident report; discuss the problem with the medical head of the unit; discuss the problem with the head nurse or a higher level nursing supervisor; discuss the problem with the medical head of the unit; ... pose the issue to the hospital's committee; call the newspapers; join an activist public or professional organization" (JAMETON, 1993, p. 544-545).

Likely, nurses can use many other possibilities to attempt to make the changes they believe they must. In any case, nurses should understand how and why they exercise power in some situations to be able to transfer such knowledge to other circumstances. Nurses should feel comfortable with their own appetite for power, implement their power strategies, and after feel satisfied or "full" because they did what they believed was necessary. Still, nurses must also reflect upon their own want or need to exercise power: Motives of personal vanity and professional agenda may inevitably get intertwined on some occasions. Although the exercise of power involves multiple situations of oppression and dominance, a reflexive process that guides the search for ethical standards in care can involve scrutinizing the different agendas being addressed in each situation. This reflexive process could be informed by the values inherent in a feminist ethics approach.

FEMINIST BIOETHICS: UNDERSTANDING AND OVERCOMING NURSES' POWER ANOREXIA

Feminist bioethics is a perspective that offers a means to both understand and overcome nurses' power anorexia. Feminist bioethics, unlike mainstream approaches to bioethics, focuses directly upon power and strives to overcome unjustified power differences. Sherwin contended that, "questions about dominance and oppression are essential dimensions of feminist ethical analysis" (SHERWIN, 1996, p. 52). Feminist bioethics unearths issues of dominance and privilege in the "interpretation and responses to illness and other health-related matters as well as in our interpretations of the ideal of autonomy" (SHERWIN, 2000, p. 76). As such, feminist bioethics resists reproducing the inequities that can go unexamined in other mainstream approaches.

Understanding women's experiences of being members of an oppressed group is the starting point to a feminist approach, along with the commitment to overcome this oppression (LIASCHENKO, 1993, p.72). A feminist bioethics approach politicizes ethical concerns by attempting to understand lived problems and conflicts and their expression within power relations. Therefore, "only when we understand the ways in which oppression can infect the background or baseline conditions under which choices are to be made will we be able to modify those conditions and work toward the possibility of greater autonomy by promoting non-oppressive alternatives" (SHERWIN, 2000, p. 80). To understand how oppression affects the baseline conditions of nurses' ethical practice, it is necessary to be aware of how oppression is internalized. Sherwin (2000, p.79) described how internalized feelings of being incapable and or not important compromise self-esteem and "how such diminished expectations readily become translated into diminished capacities.". Similarly, Bartky (1990) observed the psychological impact of oppression. She stated that, "psychological oppression is such that the oppressor and oppressed alike come to doubt that the oppressed have the capacity to do the sorts of things that only persons can do, to be what persons, in the fullest sense of the term, can be" (BARTKY, 1990, p. 29). In addition, the social stereotype of the passive and vulnerable woman may lead some women, such as female nurses, to feel self-conscious or unladylike when they make known to others the power they are capable of exercising. An appreciation of the internalization of oppression and stereotyping helps us understand why nurses have power anorexia in certain situations, but not in others.

Although acknowledging oppression and its psychological and social impacts on nurses is important, more action is required. Beyond consciousness-raising, collective efforts to make change are necessary, much in the way that Yarling, Mcelmurry (1986) advocated that nurses develop a special ethic focused upon social reform.

[9] In the Brazilian case, usually nurses not only suffer suffer from the lack of a lack of available resources available to them with which to provide care;, these same conditions also make them indispensable to the everyday functioning of their work places. and tTheir competence is acknowledged, for instance, by their problem solving capacity (LUNARDI FILHO, 1995).

Specifically, they suggested that hospitals be reformed so that nurses acquire sufficient power within them to create a balance of power between physicians, administrators, and themselves. They also maintained that, as members of a caring profession, nurses at all ranks have been too concerned with the personal and have not been adequately politicized. Feminist healthcare ethics offers a reform ethic that would address the need to make structural/systemic changes to policies, institutions, and hierarchical relations among nurses, physicians, managers and others. It also can act as a much needed politicizing agent.

FINAL REMARKS

Perhaps highlighting the ethical implications of power anorexia is an effective way of urging nurses to be more responsible for a greater understanding of the ways in which they are already powerful and exercise power. But, it could also be a sub-product of the mentality of anorexia that reasons that nurses can only accept dealing with power if they see that it benefits others rather than themselves. In other words, nurses may make the change to deliberately exercising power only if they can continue to perceive themselves as self-sacrificing.

As we have seen in this paper, feminist thinkers remind us of the psychological impact of oppression, that stereotypical views about women are socially constructed, and that, therefore, they can be changed. We believe that nurses using this framework should go beyond exploring the implications of how the notion of caring is central to the ways in which we exercise power. Perhaps de-constructing caring by focusing upon how nurses exercise power could help us to re-conceptualize nursing and promote new agendas for health and health care. These days anorexia is treatable.

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