9-2006

Empowerment among Pakistani nursing leaders: A grounded theory approach

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Empowerment among Pakistani Nursing leaders: A Grounded Theory Approach

By

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A thesis submitted to the Board of

Graduate Studies in partial fulfillment of the

Requirements for the degree of

Master of Science in Nursing

Karachi, Pakistan

September, 2006

AGA KHAN UNIVERSITY

Aga Khan University School of Nursing

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I want to express my immense gratitude to the '**All Mighty Allah'**, who has blessed me to accomplish one of the most outstanding achievements of my life. He is the source of my strength and the centre of my life.

DEDICATION

I want to dedicate this thesis to my beloved family: my husband, **Mr. AZIZ GULZAR,** my mother-in-law, **Mrs. GULSHAN GULZAR**, and my son, **ALISHAH**. Their moral support, love, prayers, and encouragement have made my educational journey comfortable and smooth. I would also like to dedicate this work to the **AGA KHAN UNIVERSITY to nurture my professional values and broaden my horizons**, enabling me to acquire higher education.

Acknowledgements

I found this study, “Empowerment among Pakistani Nursing leaders: A Grounded Theory Approach in Karachi, Pakistan”, a demanding and motivating task involving the contribution of several people I aspire to acknowledge.

I am pleased to express my heartiest gratitude to the Chancellor of the Aga Khan University, His Highness Prince Karim Aga Khan, for executing his vision of higher education by opening the first MScN program in our country, Pakistan.

I want to convey my sincere thanks to my thesis supervisor, Dr Rozina Karmaliani, for providing constant guidance, support and facilitation, which formed the foundation for the completion of my thesis.

I want to express my special gratitude to my committee members, Dr Yasmin Amarsi, Ms Kausar S. Khan, and Ms Rubina Barolia, for their expert opinions and precious feedback in refining my study at all steps. I thank my English language faculty, Ms Tayyaba Tamim, and my editor, Ms Fatima Shahabuddin, for constant guidance in English and language editorial support. I want to thank the secretaries, Mr Amir Ali Noorani for their timely assistance in drawing diagrams on the computer.

I want to convey my special gratitude to all my study participants for providing me with enriched data on my study area.

I sincerely thank my husband, Aziz Gulzar and my beloved son Ali, whose input, time, and thoughts helped me reach my destiny. Moreover, I warm gratitude to my brother and sisters; their presence and prayers kept me moving during a challenging period of my thesis.

Finally, I am greatly indebted to all my friends and colleagues, especially Shaneela Khowaja, Muneerah Amin, and Shamshad Begum, for moral support throughout the study.

Abstract

Empowerment among Pakistani nursing leaders

Nursing is a growing profession worldwide; however, its image still suffers from historical social disapproval, particularly in third-world countries. It has also been observed that nurses working in various capacities suffer from oppression, which not only damages their personality but reduces their performance quality. To overcome this limitation, inculcating empowerment is essential.

The increasing complexity of the healthcare system, with the introduction of sophisticated healthcare technology and increased patient acuity levels, has had a significant impact on nursing practice requirements, and this has created heavy demands and expectations from nursing leaders who are already working in a challenging environment. Thus, attaining empowerment is significantly important for nursing leaders. It plays an essential role in helping to lead the followers to bring positive change and influence society as a whole. Although considerable research has been done internationally, less attention has been paid to the empowerment of nursing leaders in Pakistan. It would, thus, be of interest to learn how Pakistani nursing leaders go through the empowerment process. Based on that, a theory will be developed that would enable nursing leaders to come up with a guiding tool that will help nurture current and future nursing leaders.

The study's objectives are to discover the key concepts and their relationship with empowerment from the Pakistani nursing leaders' perspective, identify the empowerment processes, and generate a grounded theory of empowerment. The study utilized the qualitative design using the grounded theory approach. National nursing leaders from the public and private health sectors were selected. Twelve participants (n=12) were interviewed using a structured interview guide. Data analysis was done through constant comparisons of the data and literature reviews. Open coding, axial coding and selective coding were done

using the qualitative analysis procedure of grounded theory. Finally, a theoretical model was developed as an outcome of the study.

Based on the study findings, conceptual and operational frameworks were proposed. From the conceptual framework, six significant categories highlighted the core category of ‘empowerment’. They were the status of a nurse, the nursing profession, power relationships, leadership and management and value belief systems. The operational framework focused on challenges adopted strategies and outcomes of empowerment. The outcome was the generation of a theoretical model of empowerment, which was described as a process. The core category represents the central theme, and the relationship among all the categories and subcategories has been illustrated through a diagrammatic representation.

Recommendations have been given based on the study findings. The significant recommendations are strengthening the nursing education system, providing national and international exposure to nurses, the commencement of master's and PhD programs in nursing at the government and private s levels, including courses like ethics, gender, politics and empowerment in nursing education, especially in the masters’ program, strengthening the nursing regulatory bodies like the Pakistan nursing council (PNC) and the Pakistan nursing federation (PNF) by inducting strong nursing leadership; induction of more male nurses in the profession to have a gender mix in nursing in Pakistan.

Empowerment The empowerment process is one of the significant components of enhancing the image of the nursing profession in Pakistan. It can shape the profession constructively and pragmatically. Building the competencies of nurses by providing higher education and an understanding of the political system is crucial to nurse empowerment in the Pakistani context.

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CHAPTER ONE

Introduction

Nursing is a growing profession worldwide; however, its image still suffers from historical social disapproval, particularly in third-world countries (Hemani 2003). Nurses working in various capacities suffer from lack of confidence, low self-esteem, passive aggressiveness, hostility, and fear of freedom. They are comfortable with the status quo, which damages their personality and reduces their performance quality (Roberts, 2004). To overcome this limitation, inculcating empowerment is extremely important, as Sheer (1996) stresses that empowerment permits nurses to cross over obstacles and commence creative care.

Empowerment has been defined by Mandefrot (2003), as a process by which people gain mastery over their affairs and through which the underprivileged become aware of their oppression and visualize what is concealed from them. Rowlands (1997) accentuates that empowerment is necessary for marginalized people to change their lives. Roberts (1983) strongly emphasizes that the only way to get rid of oppression is by rejecting the negative images of one's own culture and replacing them with pride and a sense of confidence to function autonomously. Feire cited in Roberts (1983) that empowerment and control by nursing only come when nursing itself is valued and supported. However, Torres insisted that the freedom to develop their destiny can only come from the nurses' initiative.

The increasing complexity of the healthcare system, with the introduction of sophisticated healthcare technology and increasing patient acuity levels, has significantly impacted nursing practice requirements, creating heavy demands and expectations from nursing leaders already working in a challenging profession. Moreover, my personal experience of working in various capacities in this profession allows me to assume that empowered nursing leaders can successfully empower other professional colleagues and,

eventually, patients and their families. This is one of the significant primary goals of the nursing profession.

It is strongly emphasized that nurses should empower their clients, but they cannot do so if they feel powerless. It is further stressed that nurses must become empowered before they can enable others (Hagbaghery, Salsali, & Ahmadi, 2004). Evidence based studies also reveal that empowerment enhances job satisfaction and organizational commitment (Schaurhofer, 2005). It also enhances nurses' retention and productivity and thus facilitates meeting the organizational goals (Jung & Sosik**,** 2002). Therefore, it is essential to explore the empowerment process among nursing leaders in Pakistan so that other nurses can learn the process and promote positive change in the nursing practice and profession.

According to Sheer (1996), the notion of empowerment is evolutionary and instrumental, at times requiring bold and demanding steps. Empowerment is difficult to achieve initially but easy to accomplish later with conscious efforts. Moreover, if empowerment is nurtured, it can become a part of the culture. According to Stanhope and Lancaster (2004), nursing leadership refers to nurses' influence on improving client health, whether clients are individuals, families, groups or entire communities. Thus, empowerment is significantly important for nursing leaders. It plays an important role in helping to lead the followers to bring positive change and influence society as a whole. Therefore, there is an urgent need to develop a theory from this study to help nursing leaders develop a tool to guide current and future nursing leaders in empowering themselves and bringing a desirable change in nursing practices.

Many authors, and others in the health care profession, have depicted the shortage of well-prepared professionals who could lead nursing into the future. WHO also recognized this need for empowered leadership and launched an initiative in January 1985 named 'Health for all, Leadership Development'. The core principle behind this initiative was to

establish and mobilize a critical mass of people in each country who are in positions to motivate others and direct their national health development processes towards the goal of health for all (Iliyas & Khan, 2003).

According to Leddy and Hood (2003), leadership gives nursing its vision and ability to transform a client's health. This transformation occurs through the leader translating vision into reality with clients. These transformations through leadership are the heart beat, the unifying and dominant features that characterize the nursing professional. The question, however, is that if there is a lack of empowered leaders in nursing at this stage, how can today's nurses prepare to assume leadership for the next decade? Therefore, there is an extreme need of prepared nurses not just to respond to change but to shape it.

Hardly any work has been done concerning the empowerment of nursing leaders from the perspective of Pakistan; therefore, there is a strong need to study this. The rationale for developing a nursing theory of empowerment from the Pakistani perspective is based on the impression that existing models and frameworks of empowerment are not fulfilling the holistic needs of Pakistani nursing leaders. Moreover, there is hardly any Pakistani empowerment model in existing literature, and very little has been written on developing the theoretical framework of nursing empowerment, even in the region. In its true sense, the phenomenon of empowerment plays a pivotal role, regardless of the level of hierarchy that the nurses function at, and, therefore, it can bring a paradigm shift in the nurses' image, which will engender sustainable institutional nursing services.

Background of Nursing in Pakistan

The nursing situation in Pakistan is quite dismal. One key issue is that nurses in Pakistan have a low social image and status, and nursing leaders face many challenges in uplifting the image of the nurses in the country. Despite being considered a noble profession globally, it does not attract many females as a career, generally and specifically in Pakistan.

Looking at the trend in Pakistan, mostly girls from the lower strata of society join this profession. The selection criterion is not very challenging in most nursing schools and is quite affordable. According to Amarsi (1998), nursing in Pakistan continues to face critical problems in preparing and retaining competent nurses. Nursing leaders still lack higher education, and nursing still has insufficient influence on policy to improve patient care and working conditions for nurses.

Another issue is migration. The migration of nurses from developing to developed countries has created a severe shortage of nurses in Third World countries. Similarly, in Pakistan, this has become a major area of concern for healthcare. Trends and Policy Implications, a multi-country investigation, shows that a series of 'push and pull' factors, such as poor pay, excessive workloads and violence, and an active international recruitment policy, are the leading causes of the global migration of nurses (Ilyas, 2006).

Yet, another challenge, as asserted by Yusufzai (2006), is that the majority of doctors, patients and their relatives regard nurses as sex symbols. Due to this, among many other female professions, nursing ranks much lower in status than medicine. Hence, nurses are amongst the most oppressed group of people, and consequently, they are not in a position to raise their voices against injustices. According to Siddiqui (2003), nurses are required to do all kinds of work in the workplace. Hospitals have supporting staff, such as clerks, money collectors, and ward masters, who help nurses do their work properly but correctly. Still, because of their high absenteeism, nurses are forced to carry out all the non-nursing jobs, which, in turn, directly affects their productivity.

Furthermore, nurses are so powerless that they are not encouraged, somewhat discouraged, to get involved in decision-making related to nursing care. Therefore, physicians are taking over the nurses' powers. "They run the show, and nurses have been reduced to mere onlookers and bystanders (Yusufzai 2006)." Iliyas and Ansari (2000) highlighted the

shortage of empowered nursing leaders in the health system in Pakistan. The most striking point is that most of the time, in many health organisations and sectors in developing countries, physicians exposed to relevant training are appointed in place of nursing leaders. It is a well-known fact that nursing leaders, particularly in Pakistan, are never acknowledged and raised to a reasonable level.

Let us look at one of the government hospitals in Karachi that highlights this point. Approximately 219 nurses working in that hospital have a vast, considerable workload on their shoulders. However, despite working for long periods and several years of struggle, some have been promoted to higher grades, while others are still struggling to get higher grades. Moreover, they are paid only meagre remunerations and hardly any benefits.

However, what is happening in most private hospitals is not much different. By and large, nurses working in private set-ups don't get any service benefit other than their salary, no matter how long they work. The nurses and the para-medical staff are at the mercy of the employer. In this case, this long, sad story of nursing will likely continue until the government upgrades its institutions, especially the nursing schools. Without this, no tangible change can occur.

One of the factors of this social disapproval could be embedded in the low standard of education and training imparted to them. Yusufzai (2006) also states that an outdated curriculum and poor-quality teaching have lessened the importance of nurses in Pakistan. The major problem that has jeopardised their careers is the acute shortage of teachers. The situation's seriousness can be sensed by scanning the teaching situation and the time spent teaching the content to the students. In most nursing schools, students state that they have hardly been taught anything, even a couple of months before the exam (Ilyas, 2006). With inadequate knowledge and poor professional training, these future nurses are not only vulnerable to abuse but can also endanger a patient's life (ibid). French, Watters, & Matthews

(1994) study indicates that nurses' low living, training, and working conditions have contributed to a lack of respect for nurses and their occupation's low social status. This has resulted in an insufficient number of nurses to meet the health needs of Pakistanis.

Given all these issues, nurses in Pakistan are struggling against set norms, and many are making conscious efforts to improve their professional status. Therefore, the development of a theory on empowerment from the perspective of Pakistan has led to the hope that significant improvement in the nursing profession will be achieved. The Pakistan Nursing Association would also like to see improvements in the nurses' work conditions by strengthening the nursing education system and empowering the nurses (Siddiqui 2003) so that nursing institutions not only prepare sound, knowledgeable nurses but also develop empowered nursing leaders who could take this profession to its absolute heights.

Aga Khan University School of Nursing: A Hope to Enlightenment

The establishment of the Aga Khan University School of Nursing proved to be a stepping stone towards uplifting the nursing profession in Pakistan. His Highness the Aga Khan, the Chancellor of the Aga Khan University, envisioned and, thereby, established this university with the primary objectives of raising the standards of nursing within the country, as well as getting it recognised and encouraging a positive attitude towards this much-neglected profession (Hemani 1996). This university's establishment strengthens the educational system, particularly nursing education in the country, and sets a role model for other academic institutions. Ilyas (2000) also declared that the Aga Khan School of Nursing (AKU-SON) has been transformed into a centre of excellence for nursing education in the country today, having a faculty of 64 members for its various programmes. Its role in uplifting nursing education and status in Pakistan is critical. It has empowered nurses through quality education and proved that nurses are as influential as doctors. It has inspired other public and private sector nursing institutions to upgrade their education and working

conditions.

The journey of success does not end here as visionary leaders of the AKUSON have introduced bachelor's and master's degree programmes in nursing and initiated nursing programmes, with collaborations, in East Africa, Afghanistan and Syria. The AKU-SON's experienced faculty provides a conducive atmosphere for learning and develops programmes to support the Underprivileged. The AKUSON also seeks assistance from international organisations to attract women from all over the country to nursing. After acquiring the respective degrees in nursing from AKUSON, these nurses can provide holistic and culturally sensitive care to the patients. In addition to this, nurses are not only prepared to provide preventive and promotive care but are also able to work effectively in leadership positions in various healthcare settings. Despite all these efforts, the issue of migration remains a challenge for quality nurses at AKU.

Since this study is about discovering the key concepts and processes of empowerment concerning the nursing perspective, it is essential to overview the background information regarding the country where the study will be conducted. A brief description of the status of women and the nursing profession in the country will also provide the context for the study.

Demography of Pakistan

Pakistan is situated on the Arabian Sea, linking India and Iran in the south, and it is bordered by China and Afghanistan in the north. The country has four provinces: Sindh, Punjab, Baluchistan, and the North West Frontier. The UNICEF (2002) report depicted that the total population of Pakistan was 157,315 million, and the population was increasing at a phenomenal speed, with a high fertility rate of 5.6%. The male and female proportion is 52% and 48% respectively. Being a Muslim country, the majority of the population is Muslim. However, there are Hindus and Christians in the minority. The adult literacy rate is 43%. The adult literacy rate for females is 28 per cent compared to 57 per cent for males. The national

language is Urdu (UNICEF, 2002). Nevertheless, it is a well-known fact that English is considered a second or sometimes third language and is being adopted in various educational and professional institutions

Governing Bodies of Nursing in Pakistan

The context of nursing in Pakistan and the empowerment of Pakistani nursing leaders will remain unclear without discussing the roles of the nursing governing bodies, in which the Pakistan Nurses Federation (PNF) and the Pakistan Nursing Council (PNC) play an essential role.

In 1972, Pakistan felt the need for its nursing federation. As Zindani (1996) stated, the objective of the PNF is to become a genuinely professional association that can respond to its members' needs, initiate changes to protect and improve the role of nurses, keep members abreast of technological advances, and lobby for changes in nursing in Pakistan. Ali (2006), in her PhD dissertation, mentioned the three levels of PNF management. It is comprised of company headquarters, the provincial level, and the branch levels. The headquarters is a national executive board representing the four provincial associations and governing bodies. The provincial associations comprise nurses, midwives, and lady health visitors. Each provincial association is responsible for working for the benefit of its members through negotiations with the government. At the branch level, the executive committees are divided into operational groups (Hemani, 2003).

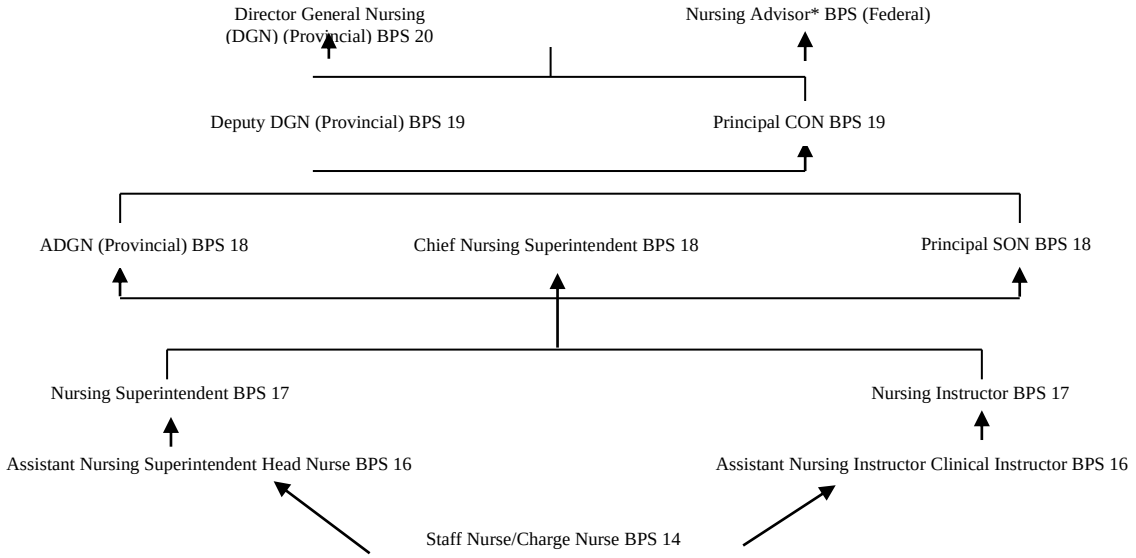
PNC is another significant nursing body whose main objective is ensuring that the country's health needs are integrated into the curriculum. The act of the Pakistan Nursing Council was passed in 1973. According to the act, four examination boards were established in each province to cope with the workload. Based on that, each province is responsible for conducting examinations and awarding diplomas. The three primary responsibilities of the PNC include developing the admission process criteria, setting the curriculum, registering the

nurses, and approving the institutions. All nursing institutions in the province must register with the PNC, which formulates the rules and regulations (code of practice) that nurses must follow in the country. There are four examination boards, and exams are held simultaneously in all the provinces to maintain consistency.

Organogram or career structure plays an important role in any organisation. Therefore, it is also imperative to know the existing career structure of nursing professionals in the government sector. The organogram provides a comprehensive picture of the positions in which nursing leaders are functioning. Moreover, it also includes information about the hierarchal ladder of nursing at the federal and provincial levels.

The following is the career structure of nursing professionals based on the report by Sultana (2003).

Figure one: Career Structure for Nursing Professional



There is a lack of research related to the nursing profession in Pakistan. This study will attempt to contribute to the knowledge of the nursing discipline by creating a conceptual framework of empowerment from a Pakistani perspective, from which a grounded theory will be derived. It will also provide baseline information for further research on the same issue in the country.

Purpose

The present study aims to discover the key concepts and processes of empowerment from a Pakistani perspective to create a profound understanding of Pakistani nursing leaders' empowerment processes. The study would also formulate a grounded theory based on the empowerment processes of nursing leaders in the Pakistani context. Although considerable research has been done internationally, less attention has been paid to the empowerment of nursing leaders in Pakistan. It would, thus, be of interest to learn how Pakistani nursing leaders go through the empowerment process. Based on that, a theory will be developed that would enable nursing leaders to come up with a guiding tool that will help them nurture nursing leaders in the future. In the long run, it would also help develop appropriate strategies to guide the professional growth of nursing in Pakistan.

Objectives of the Study

- To discover the fundamental concepts of empowerment and their relationship with each other, as perceived by the nursing leaders in Pakistan.
- To identify the empowerment processes among nursing leaders within the Pakistani context.

- To generate a grounded theory of empowerment from the perspective of Pakistani nursing leaders.

Research Question

In a grounded theory, accurate research questions cannot be spelt out before the study; however, as the researcher requires a guiding focus (Stern, 1985), this research study will be guided by the following research questions:

1. What are the fundamental concepts of empowerment from the perspective of Pakistani nursing leaders?
2. What are the empowerment processes of nursing leaders from Pakistan's perspective?
3. How do the empowerment processes influence the nursing leaders' professional lives?

Significance

This would be a highly significant study in the Pakistani context, as hardly any published research studies regarding the empowerment of Pakistani nursing leaders can be found in Pakistan It can be found in Pakistan. Thus, the findings would help formulate strategies to empower and nurture current and future nursing leaders. In addition, it would help develop appropriate strategies and bring about some changes through innovations within the organisational structure to guide professional growth in nursing. This study could be a major step in improving quality care and, eventually, the image of nursing concerning fulfilling professional requirements. The long-term vision and the indirect benefit of the study are that if nursing leaders are empowered, they will enable nurses to work under their leadership; as a result, these nurses would be able to empower their clients in society. Furthermore, this study would provide valuable insight into key concepts and empowerment

processes among nursing leaders, which would, in turn, provide insight into women's empowerment in our society because nursing is predominately a female profession.

The plan of this research report is as follows: Chapter two reviews the literature about nurses' empowerment, the status of women in Pakistan, and the history of nursing. Chapter three describes the research design and methodology, which includes ethical considerations, sampling criteria and the data analysis process of the study. Chapter four highlights the study research findings and the grounded theory framework. Discussion of findings in the light of literature will then be elaborated in chapter five. Finally, chapter six discusses some limitations and proposes recommendations based on the study.

CHAPTER TWO

Literature Review

The three areas that provide the theoretical background to the current study are empowerment, leadership, and the nursing profession. These are discussed along with general trends and empowerment issues specific to nursing in Pakistan. To keep the listed perspectives, here is a brief outline of the theoretical context within which the literature review is set.

This chapter is divided into six sections. The first section discusses the concept of empowerment and power; the second highlights the models of empowerment; the third sheds light on the concept of leadership, particularly in nursing; the emphasis of the fourth is on the health care system and empowerment; the fifth provides a brief historical overview of nursing about empowerment; and the last section presents some more literature and discusses how the current study fills the gap.

Understanding the Notion of Empowerment

The concept of empowerment has been widely adopted in nursing research and the development of nursing care, education, and management. This concept is fundamentally positive, referring to solutions rather than problems, and is dynamic. The idea of empowerment is also frequently used in nursing and health services regarding the quality of care since the mission of nursing is to provide safe and quality nursing care, thereby enabling patients or communities to achieve a maximum level of wellness (Hajbaghery & Salsali, 2005).

The Oxford Dictionary (2005) defines the verb 'to empower' as 'to give power to'. The word was first used in the 17th century and has meanings like 'authorize, delegate, or enable. ' Mandefort (2003) tried to uncover the sense of empowerment and connect it with information sharing, upward problem-solving, task autonomy, attitudinal shaping, and self-management or, simply, feeling involved.

Concept of Power to Empowerment

The association of empowerment with power is significant. As empowerment contains the word "power", some authors believe that success in empowerment depends on understanding the concept of power (Hagbaghery, Salsali, & Ahmadi, 2004). Power can be acquired dynamically over some time. Globally, it is said that nurses are the largest professional group within the health service organization that provides good quality care, but whether and how nurses can provide such care has been identified as professional power. A broader view of power would focus not only on the enactment of decisions but also on the segregation of specific issues from decision-making agendas so that they are suppressed from being decisionable (Giddens as cited in Kabeer, 1997). Power is not a static or straight term; it is a dynamic, flexible and complex concept with many dimensions. A woman may be powerless before her husband or in-laws but may be influential in relation to her children. Many times, people use power as a means to control others. However, on the other hand, power has positive connotations; ‘power with’ and ‘power to’ are associated with sharing and transforming power, which is healthy and important for the sustainability of positive change.

Rowlands (1997) introduces different forms of power, including ‘power over’, meaning controlling power; ‘power to’ is associated with generative or productive power, which creates new possibilities and action without domination. There is also a view that power is not something one person gives to another, which brings a sense of

"condescension" to the "giver" of power. Also, "an increase in one's power does not necessarily diminish that of another" (p. 12). "Power with" relates to the sense of collectiveness rather than city individuality, primarily when a group handles problems collectively, and "power from within" refers to the spiritual strength and uniqueness that resides in each of us and makes us truly human. The basis of power is self-respect and acceptance, which, in turn, can be extended to others as equals (ibid).

Women and Empowerment

Nursing is predominantly a female-oriented profession, and globally, mostly in developing countries, women are considered powerless and oppressed. Most of the time, it is observed that they are reluctant to exercise their power. Looking at the current scenario, Kabeer (1994) expressed that women tend to avoid exercising their power because they recognize that the game's rules are loaded against them, and the cost of confrontation is likely to be high. So, they learn helplessness, too and avoid facing the terrible implications of their disempowerment. For both the subordinate and the dominant groups, power relations appear so secure and well-established that both are unaware of their oppressive implications or are not competent enough to foresee new ways of 'being and doing'. The *culture of silence* indeed prevails, but it is also a fact that women's movements have started to challenge women's subordination. One should recognize both phenomena to avoid a partial impression of silent acceptance of subordination (Boje & Rosile 2001).

Hedin (1986) advocated that the reality of oppression and its effects on individuals must be brought to light so that its causes can be transformed. Maguire (1985) brought up the point that there are solutions to combat oppression, but they are not challenged because they are complex; they threaten how things are presently present. Power presently operates to prevent women from living full, self-directed lives. Fighting for an alternative society is rational, not a deviation. Learning how power operates against women is not just a

damaging, harmful, passive exercise. It is an exercise that liberates women from the constraints of an old framework and empowers them to create one better suited to their needs (ibid).

Empowerment as a Process

In the literature, empowerment has generally been considered in the context of organizations' functioning and personnel management methods. In the psychological theory, it is seen as a process of personal growth and development and community mobilization. However, empowerment has also been defined as a process through which people gain mastery over their affairs. Through this, the underprivileged become aware of their oppression and visualise what is concealed(Mandefrot, 2003).
It is also illustrated as a very slow process involving self-discovery and the development of a collective identity (Rowlands 1997).

Empowerment is also a condition whereby employees can take in their work areas without prior approval. For example, a nurse immediately discontinues medication if toxicity symptoms are observed in the patient. Rowlands (1997), on the other hand, defines empowerment as the capacity of women to increase their own self-reliance and internal strength. This is the right to determine choices in life and influence the direction of change by gaining control over material and non-material resources.

According to Roberts (1998), the process recognises individuals' rights to identify their needs. Still, it also focuses on their strengths and potential rather than their incompetence, apathy, and ignorance. If professionals are to understand and engage in an empowerment approach in their work, they need opportunities to explore the processes of empowerment in their professional development.

Rowland supported the idea that empowerment strategies for women must build on 'the power within' as a necessity to improve their ability to control resources, determine agendas, and make decisions (as cited in Kabeer 1997). However, Giddens argued that power should not be analyzed solely based on individual decision-making, failing to capture those dimensions outside observable decision-making processes (as cited in Kabeer 1997). As in the case of Pakistan, many external factors, such as the poor social image of nursing, low standard of education and training imparted to nurses, and very low pay scales, are hurdles to nurses' empowerment in Pakistan.

As said earlier, power often has negative connotations. It is referred to as control, primarily of others. Control is disempowering. Excessive power, meaning the concentration of power in one or few persons, as opposed to it being shared, often becomes unhealthy and negative and, thus, unfavourable to the individual's growth and the growth of others. Conversely, empowerment represents the increased potential for living independently while striving for self-growth.

Foucault uses a different model of power. "Power must be understood, in the first instance, as the multiplicity of force relations imminent in the sphere in which they operate and which constitute their organization: as the process which, through ceaseless struggle and confrontations, transforms, strengthens, or even reverses them; as the support which these force relations find in one another, thus forming a chain or a system, or, on the contrary, the disjunctions and contradictions which isolate them from one another; and lastly, as the strategies in which they take effect, whose general design or institutional crystallization is embodied in the state apparatus, in the formulation of the law, in the various social hegemonies." According to him, power is not a predetermined or set entity that can be located, nor a substance of which people can possess more or less; power is

relational and exists only in its exercise. It is constituted in a network of social relationships among people who are, to at least a minimal extent, free to act. He pursues power as a mode of ‘action upon action’. It differs from other definitions and perspectives because it focuses on the system and organization rather than the individual. Foucault says power is generally exercised through a “net-like organization, "and individuals “circulate between its threads.” He says we can’t understand power relations if we begin with the macro level of analysis of class oppression or gender oppression. To truly understand it, we start with the locals and see the patterns of practices and discourses, their interrelations, and how they have become inert and seemingly fixed (Blewett, 2005).

Rubino (2003) acknowledges some environmental factors that allow for empowerment. The work environment that provides an atmosphere of trust and respect for people to communicate ideas further freely encourages empowerment. The freedom to know oneself, pursue ethical, responsible choices, and work to make accountable goals and guidelines for change in an ever-transforming world is what empowerment is about. The outcome of empowerment is the enhanced quality of life for the concerned stakeholders. The empowerment process is a way to nurture individual growth and human potential that can be imparted and passed on to societal development. This empowerment process is believed to be supplemented by greater awareness of options, greater use of talents, and increased creativity and interdependence with those around us. It is further elaborated that in the empowerment process, individuals acquire resources and information, process them, and augment their knowledge. There is a dynamic attribute in which they may also help others identify and utilize their resources to their optimal capacity. Individuals not only have the ability to channel their process of self-empowerment but also can become influential in nurturing others toward their empowerment (ibid). Through the study of the

empowerment of Pakistani nursing leaders, the researcher hopes to improve the status of nursing in Pakistan so that the expectations of the nursing profession can be fulfilled.

Woolcombe (1996) asserts that empowerment is the process whereby an individual transforms into a confident, self-assured person who can contribute effectively and responsibly to patients, communities, and society. When the process is followed carefully, an excellent team of motivated young people is created, which propels energy, vision and new life into adult-directed activities. It builds their self-esteem and improves their academic performance. The qualities, values, and accomplishments are central to the individual and environmental factors are key factors here.. Job satisfaction and organizational commitment are crucial to nursing empowerment (Kuokkanen, Leino-Kilpi & Katajisto, 2003).

Professional empowerment is a dynamic process through personal, professional, cultural, and organizational interaction. On the one hand, competent nurses, those with a wide range of professional knowledge and skills, authority and self-confidence, are critical for empowerment. On the other hand, the profession's power and the public's image of nursing can affect nurses' self-confidence in exercising their full capabilities (Hagbaghery, Salsali, & Ahmadi, 2005). So, the existing image of nursing also affects the empowerment of nurses. On the other hand, as discussed earlier, empowered nurses may bring positive changes in society, so it works both ways. Therefore, the researcher believes that through empowerment, nurses can improve the image of their profession in society and make a great difference not only at the national level but internationally as well.

Jardin (2001) claims that nurses must learn to work collectively and not threaten the power of other nurses, which is unnecessary and damaging to the nursing profession. When this philosophy is operationalized at the institutional level and support for nurses is

augmented in the workplace, morale is raised, and nursing's influencing power is enhanced. This power can then trickle down to the community and national levels.

Society has long held specific images of nursing that suffocate growth, such as images of mothers, servants, and religious figures. All these descriptions affect public opinion and the nurses' beliefs about themselves as they struggle to demonstrate yet another image, that of patient advocate. Hence, the lack of ment and proper fulfilment of the advocate role leads to feelings of powerlessness among nurses, eventually frightening them and making them unable to voice their issues. In developing countries, including Pakistan, the nursing profession is still unsure of the implications of this shift, i.e., becoming patient advocates, both in respect of image and responsibility, and the nurses are afraid of leaving the traditional nursing model, that as an oppressed group (Jardin, 2001).

Models of Empowerment

Thomas and Yelthouse developed a cognitive empowerment model (as cited in Kuokkanen, Leino-Kilpi & Katajisto, 2002). This was adopted as the conceptual framework for the questionnaire used in their study, which was quantitative, titled "Do nurses feel empowered? Nurses assessment of their qualities and performance concerning nurse empowerment". His model described three categories of human existence relevant to empowerment: belief systems, assessment and enactment processes. Their study, however, categorises the qualities of an empowered nurse in this thesis, including moral principles, personal integrity, expertise, orientedness and sociability. Moral principles reflect human values in nursing, i.e. human dignity and respect for the individual. Personal integrity manifests as equilibrium and mastery over one's own life. It is expressed through using resources and conscious care for one's well-being. Expertise is associated with the esteem shown for the nurse's work and manifests as

professional competence and a wide range of knowledge. Future-orientedness involves innovation and creativity. A socially skilled nurse is active, flexible, and able to create a positive ambience in the workplace.

In 1996, Sheer wrote an article titled “Reaching Collaboration through Empowerment: A Developmental Process”, citing a developmental empowerment model. This model was originally developed by Kieffer in 1984. In this article, Sheer emphasised that this model can help nurses attain the personal characteristics to collaborate autonomously. Kieffer refers to four distinct and progressive eras or stages, which progress from powerlessness to participatory competence and comprise the era of entry, advancement, incorporation, and commitment (as cited in Sheer 1996). In the era of entry, individual nurses perceive themselves as somewhat powerless within the system. This stage encourages an individual in a manner that gives birth to participatory competence. The second era is the era of advancement in which the nurse relies on an outside mentor who acts as a role model.

There is a cultivation and clarification of pertinent issues. This process eventually leads to the maturation of empowerment. The third stage of empowerment is the era of incorporation, which talks about constructing survival skills, learning organising skills, and developing leadership skills. That’s where they see themselves as problem solvers. The fourth and last era is the era of commitment. It is the process of reconstructing and reorienting personal beliefs about social relationships. This developmental model of empowerment talks about the collaboration or functioning of nurses in interdisciplinary groups. It stresses that to move into a collaborative model adequately, nurses must be competent and believe in their competence. They must overcome apprehension, nervousness, hesitation and self-doubt and divulge a sense of value about their work. They need to develop a vision of practice. Reaching the vision is a developmental

process. This empowerment model can help nurses attain personal characteristics and collaborate equally (Sheer, 1996).

A qualitative study was conducted by Hagbaghery, Salsali and Ahmadi (2005), which aimed to design a model for empowering nurses in Iran. A grounded theory approach was used to analyse the participants' experiences, perceptions and strategies affecting empowerment. Forty-four participants were interviewed, and 12 sessions of observation were carried out. Three main categories emerged from the data collected these are "personal empowerment", "collective empowerment", and "the culture and structure of the organisation" Hagbaghery, Salsali and Ahmadi (2005) add that.

> From the participants' perspective, empowerment is a dynamic process resulting from mutual interaction between personal and collective traits of nurses as well as the organisation's culture and structure. Impediments, such as power dynamics within the health care system, hinder nurses from demonstrating that they possess the essential ingredients of empowerment to achieve shared goals. (p. 1479)

Bent (2003) conducted a study on 'the people know what they want', an empowerment process of sustainable, ecological community health, using an ethnographic study design. The researcher interviewed 33 participants, who were selected purposively. The significance of this work lies in inductively building knowledge and theory about these relations and community empowerment for community-focused nursing. From the ethnographical analysis, five cultural domains, four cultural themes, and one integrative theme about community experiences of health, environment, and culture and health policy emerged. According to the researcher, empowerment is not static or based on interventions inflicted upon people to solve their problems. Still, empowerment is an invitation to think differently about solving problems that endanger health and the profession in many ways.

Many professionals do not believe in empowerment and question its practical implications in nursing. Some of us perceive it just as the jargon of the modern world and pretend that it is easier said than done because women, particularly nurses, are in the minority oppressed group, but Bent (2003) concluded that ‘never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever had.

Empowerment and Leadership

Empowerment is especially important, and this represents a change in the delivery of care and will require a significant transition in the nurse manager's leadership style to help subordinates accept the work adjustment and their new levels of productivity (Nurses Empowerment, 2005). According to Rubino (2003), empowerment is the key to true leadership, and its process is essential to nurture individual growth and human potential that can be communicated and transferred to societal development.

However, regarding leadership, it must be remembered that ‘leaders in powerless groups have also been noted to have negative attributes: controlling, coercive, and rigid. These characteristics stem not only from dependency and low self-esteem but also from hatred of their ‘own kind’ and a desire to be like the oppressor (Roberts 1993). Roberts (1983) argues that the leadership style within nursing has evolved because nurses, like other groups throughout history, are an oppressed group controlled by societal forces that have determined their leadership behaviour. An understanding of the dynamics underlying the leadership of an oppressed group is essential if the strategy to develop more effective leaders in nursing is to be successful. In other words, leadership should be created from the root level to get an accurate insight into the existing status of nurses and the nursing profession. This would motivate and assist them in exposing the reality of the dominant and

subordinate relationships in the healthcare system. In nursing leaders, a sense of empowerment is essential, as it is only through dialogue that the profession's integrity can be maintained.

It has been argued that transformational leaders increase group effectiveness by empowering followers to perform their jobs independently, emphasising cooperation in performing collective tasks and realigning followers' values to create a more cohesive group. A study examined transformational leadership and its association with the followers' perceptions of empowerment. Results indicated that transformational leadership was positively related to empowerment, group cohesiveness, and group effectiveness. It was positively associated with collective efficacy, which, in turn, was positively associated with group members' perceived group effectiveness (Jung & Sosik, 2002). Therefore, leaders' empowerment is acknowledged and considered essential to achieve successful outcomes. Jones et al. (2000) support the idea that empowerment can result in greater energy, well-being, and effectiveness in the realisation of health professionals. Therefore, the researcher assumes that the empowerment process will facilitate personal growth for nursing leaders and nurses, and, hopefully, these leaders will be prepared to shape the future of nursing rather than respond to change.

Concept of Empowerment and Health Care System

Several authors have built a strong connection between empowerment and healthcare reformation. This being the case, there will be profound repercussions for healthcare reforms based on how nursing will be perceived. The healthcare paradigm is shifting towards health promotion and disease prevention to be more economical and accessible. These changes portray a shift from traditional medicine to primary health care and a system where nurses are equal partners and empowered in care delivery. However,

although nurses are perceived as providing all the care, the need for collaboration to achieve high-quality care regardless of tertiary, ambulatory, and primary health care is not being seen. This could be because, in the past, nurses were limited in their ability to participate fully in primary care because of the status of nurses, the image of the nursing profession, and the outdated management and traditional leadership style (Sheer, 1996).

All healthcare delivery systems witness dramatic changes in human resources and organisational ladders. For all these changes to be managed effectively, without changing the provision of quality healthcare, leaders and managers must understand how these changes and stresses due to globalisation affect the workers' attitudes. Moreover, although the issues of leadership style and work-related empowerment have become buzzwords, they represent essential ideas (Douglas, 1995).

However, one should not ignore criticism of empowerment. According to Nira Yuval Davis (as cited in Rowland, 1997), empowerment for one group of people might easily represent another group’s disempowerment. There may be a severe conflict of interest to be overcome. Hence, empowerment cannot be assumed to be non-probability. Any notion of empowerment should, therefore, be approached critically.

On the contrary, Batliwala, in the same article, pointed out that empowerment is feared to be against men and argued that the point is often missed out about women’s empowerment, that if it is a real success, this process will also liberate men, as they will be relieved of gender stereotyping, just like women. Nurses’ empowerment will not impede the stakeholders’ power. Instead, it would, in the long run, be beneficial for all. It is something like giving more, earning more and vice versa. Therefore, it is wise to point out here that one has to be empowered to empower others and bring positive and significant change to society.

Background of Nursing Concerning Empowerment

Since this study is focused on the empowerment process among nursing leaders, the background of the nursing profession will assist in giving a clearer picture of the current scenario. Nursing, as a profession, has long been stigmatised in literature and cinema, and nurses were often condemned for being sexually decadent. For example, Oommen's study (as cited in Abraham, 2004) shows that only 27 per cent of nurses would advise their daughters to join the profession while 70 per cent would not, a piece of evidence which strongly indicates that many of them do not perceive their profession as prestigious and one to be considered as an 'occupation' (Oommen, 1978 as cited in Abraham, 2004). The scenario is not different in most developing countries. Nevertheless, the profession has increasingly become viewed as respectable, profitable, and rewarding, attracting more people, particularly girls. This paradigm change has occurred due to the requirements of higher education levels of nurses, as this is one of the significant factors for competing in the world in response to the change in healthcare delivery (Abraham, 2004).

The medical profession has always been viewed as more dignified than nursing. Sheer (1996) highlighted that the medical paradigm is hierarchal, with the physician being the ship's captain. Due to this discrimination, nurses have worked hard throughout the year to shed the disgusting and disrespectful image. This discrimination becomes more evident when nurses going abroad, mainly in developed countries, have to prove their competence in pharmacology to medical boards and legislators. However, physicians are not required to do so after their initial licensure. In addition, nursing, traditionally, has drawn students from the middle and lower socioeconomic classes. However, as more nurses receive higher education in nursing, the social status gap will become less of an obstacle to becoming empowered and recognised (ibid).

Nursing records in Iran before 1915 show that household women or servants carried out nursing care. Hospitalised patients were also cared for by untrained personnel. Because of this history, lack of primary education, low cultural status, and some religious limitations for women, nursing as a profession/career has neither gained high standards nor recognition (Hagbaghery, Salsali, & Ahmadi, 2005).

This scenario possibly hinders nurses from getting empowered; therefore, efforts should be made to remove the obstacles preventing the nursing profession from progressing respectably. The nursing profession will only grow when nurses get empowered. This is one of the best ways nurses can get success and recognition. Therefore, in our current circumstances, continued empowerment needs to be accelerated, and this can only be done through an open, proactive, visionary approach to the future of nursing (Styles, 1994).

Concept of Empowerment in the Pakistani Context

The findings of this study will provide valuable insight into key concepts and processes of empowerment among nursing leaders. This, in turn, will give insight into women's empowerment in our society because nursing is predominantly a women's profession. Therefore, it is essential to first view the status of women in Pakistan.

The status of women in Pakistan is disheartening. A feudal and tribal value system with solid patriarchal trends highly dominates the cultural, social and economic system of Pakistan. Due to the patriarchal nature of society, there is gender inequality and restricted women's progression and empowerment. The share of women in professional and related jobs is relatively low and is mainly confined to the traditional teaching and medical professions (Pakistan Report, 2004).

In the context of Pakistan, generally, the role of men is supposed to be that of all bread earners; thus, he is considered the head of the family. Meanwhile, females are mostly

viewed as supporting the family, such as caring for household chores and looking after children and other family members. As far as working women are concerned, they must carry dual workies, contributing to professional tasks and domestic chores. Because of this double liability, Pakistani working women are struggling to balance their professional obligations. Hence, in all respects, social, historical, cultural, and economic, the status and rights of women are being silently damaged at every level and in all sectors and are hindering them from participating in the decision-making process autonomously, ending up in powerlessness.

However, the perception of men's and women's roles is gradually changing. Education, the wide availability of information through the radio, television, satellite dishes, etc., all give a broader perspective to society and have proved that women can play several essential roles besides being wives and mothers. Today, Pakistani women are taking an active role in managing NGOs. They are engaged in various jobs to raise their families' economic status. These jobs range from nuclear technology, food care, education, media, healthcare, diplomatic service, and social services to research and management. A more recent phenomenon has been women’s entry into the uniformed services. Women now make- up an increasingly significant proportion of the police force. The Airport Security Force also has a large complement of women. Women are also receiving training as airguards. The first woman Major General was appointed to the Army Medical Corps in 2001. Women are also being recruited in the regular armed forces. For instance, they serve as air traffic controllers and pilots in supporting roles in the air force (Gender Stereotyping: Situation in Pakistan, 2006).

Concerning nursing in the Pakistani context, the Pakistan Nursing Council (PNC) is working under the leadership of the director of general health, a medical doctor. Recently,

in one of the nursing colleges, a doctor was deliberately posted as principal, which nurses protested annually. Furthermore, in the province of NWFP, there is no position for director general nursing (DGN); instead, a DG position is required where a nursing leader is necessary to work as a DGN overseeing and representing the whole province. This also depicts how far the nursing profession is empowered.

Nurses' fear of their power and the power of others, combined with the politics between physicians and institutions, prevails everywhere, and, therefore, also in Pakistan, which discourages nurses from challenging the status quo. Physicians, administrators, and nurses often are not considered to be on the same authoritative level. There is a relationship disruption when nurses attempt to increase their power and influence. However, Nurses can be empowered through education, leadership, and collective action. When these nursing leaders empower other nurses, those nurses, in turn, empower their patients. The study hopes to achieve this in the long run once the strategies are developed through this study.

Since the 1950s, Pakistan has struggled to raise its nursing status to the optimal level. Lots of efforts have been made in the area of education and services. However, much more effort is required to raise the status of the nursing profession. Quite a few unsolved issues require specific attention for the development and advancement of the nursing profession in Pakistan. The low status and poor image of nursing and the traditional role of women in the recruitment and retention of nurses. Other inherited inadequacies from nursing education, which pose an obstacle to the empowerment of nurses, are unsound theoretical knowledge and lack of expertise about curriculum development and clinical teaching among nursing teachers, which indirectly sabotage the nurses' image significantly (Hemani, 2003).

Concerning the empowerment of nursing leaders, the researcher can foresee that ‘power to’ and ‘power within’ is essential for diverting nurses from the status quo. As discussed earlier in chapter one, nurses in most developing countries, including Pakistan, are considered an oppressed group and are happy with the status quo because they have learnt powerlessness and do not want to change the existing situation because of their lack of confidence, low self-esteem, passive attitude, and reluctance to change. Through approaches likely to emerge from the study, nurses will not only be able to earn recognition as prestigious professionals by society. Still, they will also be able to prove themselves as successful, empowered leaders. This would, eventually, raise the nursing profession in terms of recognition and respect, which quite a few professionals dream of.

Hardly any work has been done concerning the empowerment of nursing leaders from the perspective of Pakistan; therefore, it is vital to study this notion. The empowerment models highlighted in the literature review are assumed not to fulfil Pakistani nursing leaders' comprehensive requirements because they are not tested in Pakistan. Furthermore, there is hardly any Pakistani model of empowerment in the existing literature, and even in the region, very little has been written on developing the theoretical framework of empowerment of nursing.

Empowerment is a complex process involving many issues that need to be understood in detail from the participants’ perspective to find possible strategies to ease the process. Leaders, particularly in nursing, face numerous challenges and stressful experiences. In Pakistan, where the nursing profession is developing, unveiling such issues in depth would assist in preparing, training and retaining well-qualified nursing leaders. A substantive theory developed from this study would provide a theoretical framework,

guiding the nurse educators and staff development nurses to develop and implement programs that facilitate and support the empowerment process among nursing leaders.

The brief literature review signifies that empowerment is essential to ensure high-quality care, thereby enhancing the image of the nursing profession, particularly in the developing world. This largely depends upon understanding critical processes, concepts and related factors involved in the empowerment process from the perspective of the Pakistani nursing leaders, who are the focus of this study.

CHAPTER THREE

Research Design and Methodology

The chapter narrates the four steps of methodology. The first presents the research design, followed by sampling plans; the second explains the data collection method; the third justifies the ethical considerations; and the fourth describes the data analysis procedures, followed by the steps of this study's rigour.

The study is based on the transformative paradigm, which focuses on life's positive and creative aspects as a force for building a more positive thought process rather than identifying life's harmful and destructive features.

Much research is going on today, and much can be observed, suggesting that our future depends upon what we imagine. According to Mertens (2005), the transformative paradigm is an appreciative inquiry, a system of thought based on social sciences research that affirms trends and movements by demonstrating the power of generative images to create a world of hope and possibility. Moreover, it provides a broad perspective to explore philosophical assumptions and guide methodological choices for evaluating critical theory, feminist, participatory, inclusive, human rights-based, democratic, or empowerment. Through this paradigm, the dialogues often begin with three or four general dimensions, such as number one, looking at one’s entire experience with the organisation or society; number two, remembering a time when one felt most alive, most fulfilled, or most excited about one’s involvement in the organisation; number three, the conditions or factors which made it exciting; number four, description of how one felt about it and so on (Watkins & Cooperrider, 2001). Thus, the transformative paradigm acts as a tool which helps to examine the view of the world with its accompanying philosophical assumptions that directly engage

with the complexity of the researchers' encounter in culturally diverse communities, mainly when their work is focused on a social justice agenda (Mertens, 2005). Based on the transformative paradigm and guided by a qualitative approach, the current study will explore the empowerment processes among Pakistani nursing leaders, through which cultural complexity power issues are explicitly addressed, and discrimination and oppression are recognised (Mertens, 2005).

Research Design

The qualitative approach is utilised, which is a systematic inquiry concerned with understanding human beings and the nature of their transactions with themselves and their surroundings (Polite, Beck & Hungler, 2001). According to Strauss and Corbin (1998), qualitative methods can obtain complex details about phenomena challenging to extract or learn through more conventional research methods, such as feelings, thought processes, and emotions. A qualitative approach involves understanding a social or human problem and building a complex holistic picture framed with words that report detailed views of individuals. Creswell (1994) states, "Qualitative researchers are concerned primarily with process rather than outcomes and products. They are interested in meaning- how people make sense of their lives, experiences, and their structures of the world" (p. 145).

Qualitative research is concerned with developing explanations of social phenomena. It aims to help us understand our world and why things are how they are. It is concerned with the social aspects of our world. It seeks to answer questions about Why people behave the way they do, how opinions and attitudes are formed, how people are affected by the events that go on around them, how and why cultures have developed in the way they have, and the differences between social groups (Maykut & Morehouse, 1994; Hancock, 2002). Yet, it is concerned with finding the answers to questions that begin with: Why? How? And in what

way? It is also concerned with individuals' opinions, experiences, and feelings, which produce subjective data. Moreover, it describes social phenomena as occurring naturally, and no attempt is made to manipulate the situation (Maykut & Morehouse, 1994; Hancock, 2002).

As discussed earlier, the grounded theory methodology was utilised because empowerment is a process of enhancing the possibility that people will increase control over their lives (Mandefort 2003). It is a process rather than a static condition; therefore, a grounded theory methodology was selected to study the empowerment of nursing leaders.

The study conducted by Hagbaghery, Salsali and Ahmadi (2005) to develop an empowerment framework in the nursing field used the grounded theory methodology because the nurses' practice takes place in a multidisciplinary team. The grounded theory focuses on identifying, describing, and explaining interactional processes between and among individuals or groups within a given social context (Strauss and Corbin, as cited in Hagbaghery, Salsali & Ahmadi, 2005).

The grounded theory methodology offers a rigorous, orderly guide to theory development, which, at each stage, is closely integrated with a method of social research. Generating theory and doing social research are two parts of the same process (Wilson, 1985). The method rules out testing hypotheses derived from data grounded in context. As a result, fresh views of social processes develop from the participants' perspective. Grounded theory is an important research method for the study of the nursing phenomena (Streubert & Carpenter, 2003). The process explores the richness and diversity of human experience, which contributes to the development of middle-range theories in nursing (Strauss & Corbin 1998).

In the grounded theory methodology, the researcher looks for the processes involved in the phenomenon of interest; therefore, inductive methods are used to derive hypotheses,

which are then verified with data and the participants. As the researcher develops a theory, they constantly confer with the available literature related to the emerging hypotheses of the study in progress (Stern, 1985). The researcher starts with an area of interest, collects the data, and allows relevant ideas to develop without preconceived theories and hypotheses to be tested for confirmation (Holloway &Wheeler, 2002).

On the other hand, the symbol interactionism theory is a unique perspective that explores basic social processes. In the symbol interactionism theory, it is believed that people behave and interact based on how they interpret or give meaning to specific symbols in their lives. They emphasise that “it is also through the meaning and value these symbols have for us that we try to interpret our world. In this way, we try to read minds and act accordingly. Learning the meaning and value of interactional symbols is everyone’s lifetime study and no easy task” (Streubert and Carpenter 2003, p. 99).

Glaser and Strauss (as cited in Holloway & Wheeler, 2002) pointed out that rigid preconceived assumptions prevent research development, imposing a framework that might block the awareness of significant concepts emerging from the data. One of the fundamental features of the grounded theory approach is that data collection and data analysis coincide (Polite, Beck & Hungler, 2001). The grounded theory has similarities with other qualitative methods in data sources. However, it does not stop at merely reporting them or describing participants' experiences. However, the researcher would go beyond that and interpret the data. The researcher searches for relationships between concepts, tries to uncover patterns, and develops links between categories to formulate a theory that ultimately offers insight, enhances understanding, and provides a meaningful guide to action. They further affirm that grounded theory is true to real life and should be understandable to the participants and professionals linked to the study area (Strauss & Corbin 1998). Therefore, under the qualitative research approach, a grounded theory methodology was used to develop a

substantive theory to describe the underlying vital concepts and processes involved in empowerment, as perceived by nursing leaders, and to uncover its effects on the nurses' professional lives.

Literature Review in Grounded Theory

In the grounded theory methodology, it is recommended that the researcher go back to the literature even after the categories are formed (Strauss & Corbin, 1998). Streubert and Carpenter (1994) also affirm that a selective literature review is suggested in grounded theory, which generally follows or coincides with data analysis. In contrast, Leininger (1985) discourages pre-study literature search and considers it disadvantageous for several reasons. First, it may lead to pre-judgment, premature ideas and search inquiry closure. Second, the direction may be wrong, and the available data may be inaccurate. Although a comprehensive literature review was not required before data collection, a selective literature search related to the focus of the study was done to familiarise me with the phenomena under study. Then, the analysis of data was continued and done simultaneously.

Study Sample

It is said that empowerment is a Western concept. It does not seem justified because, in the present era, it is being discussed at various levels in Pakistan as well, and people have started developing awareness about the concept, hence the need for such study in Pakistan. As the researcher aimed to understand empowerment processes among nursing leaders in Pakistan, national nursing leaders from the public and private sectors were selected. It is acknowledged that the empowerment process is at all levels, but given the time limitations, the study's scope was focused on nursing leaders only. However, for future studies, all categories of nurses could be included in the design. Initially, purposive and theoretical sampling were used as the codes and categories emerged. A purposive sample is often used in qualitative studies where the researcher seeks to develop a theoretical understanding of some

phenomena under study (Burns & Groove, 2001). This study initially selected a purposive sample of ten participants for the interview. Strauss and Corbin (1998) emphasise that theoretical sampling is essential when exploring new or unfamiliar areas because it enables the researcher to choose those avenues of sampling that can bring about the greatest theoretical return. Therefore, the researcher initially selected those individuals who could contribute to the evolving theory. The two participants were included during concept development for theoretical saturation. Creswell (1994) recommends that the participants' inclusion be continued until theoretical saturation is achieved. Regarding theoretical sampling, Holloway and Wheeler (2002) and Strauss and Corbin (1998) suggest that "sampling in grounded theory should continue throughout the study and is not planned before the study starts" and is cumulative. Each event is sampled, built from, and added to the previous data collection and analysis.

In this study, the participants were Pakistani nursing leaders who could contribute vastly to developing an empowerment theory from a Pakistani perspective. The second and third meetings with individuals were conducted over the telephone to clarify codes and saturation of emerging themes. As suggested in the literature, the researcher generated as many categories as possible during the initial sampling to gather data in a wide range of pertinent areas. Once the analyst had some categories, sampling aimed to develop, densify and saturate those categories.

Sampling Criteria

Nursing leaders from private and public sectors who agreed to be interviewed were interviewed till the saturation level of data was achieved. The inclusion criteria for

participants were based on their leadership positions. Nursing leaders from public and private health institutions, such as deans, directors, directors of general nursing, principals of schools and colleges of nursing, and chief nursing superintendents of hospitals, were selected. Furthermore, leaders of the Pakistan Nursing Council (PNC), the Pakistan Nursing Federation (PNF), and the Registrar of Nursing were also included.

Sampling Framework

According to the operational definition of Pakistani nursing leaders, a sampling framework was developed based on the institutional list of nursing leaders provided by the directors' office of Aga Khan University, School of Nursing, and the office of Nursing Directorate, Sindh. Those Nursing leaders who were assumed to be empowered were purposefully inserted from the federal and provincial levels. This framework guided the researcher in collecting data in a more organised manner and in moving towards theoretical sampling as saturation of data was achieved.

Setting

The nursing leaders were chosen from public and private sector health institutions from all over Pakistan, such as the office of the Pakistan Nursing Council Islamabad, Nursing Federation, Directorate Nursing in Sindh, Punjab, and NWFP, Office of the Registrar, School of Nursing, Sibbi, Balochistan, College of Nursing JPMC, and the Aga Khan University.

All 12 study participants were posted in leadership positions and involved in service and education management at various hospitals and nursing educational institutions. The mean age of the participants was 52.5 years. Two nursing leaders had PhD degrees in nursing and had 21 and 35 years of experience in education and practice. The other three nursing leaders had their masters in health administration and management. Among these three participants, one was expected to complete her PhD in nursing. These nursing leaders had

more than 23 years of experience in nursing. The other two participants hold BScN degrees and are assistant directors in general and registrar nursing. The rest of the four participants possessed RN (registered nurse) degrees with more than 18 years of working experience, and two had diplomas in teaching administration, with one of the participants having 41 years in the nursing field; all participants were total-time employees at their respective institutions. The demographic descriptions of participants with their codes are summarised in table one.

Table One: The Profile of the Participants

CODE	DEGREE	YEARS OF EXPERIENCE	FIELD OF EXPERIENCE	DURATION OF INTERVIEW	PLACE OF INTERVIEW
001	BScN; Masters in Health Administration	25	Management Of Nursing Services	60 Minutes	Participants' Office
002	PhD	21	Service Management	50 Minutes	Participants' Office
003	BScN	11	Education; Management; Policy Making	60 Minutes	Participants' Office
004	BSc	18	Administration	60 Minutes	Participants' Office
005	BScN	10	Education Management	60 Minutes	Participants' Office
006	RN; DTA	41	Management	60 Minutes	Participants' Office

007	RN	18	Nursing Advisor Service management Teaching	45 Minutes	Participants' Office
008	PhD	35	Education Management	60 Minutes	Participants' Office
009	MA	23	Service Management	45 Minutes	Participants' Office
010	Masters in Health Administration	20	School Management	55 Minutes	Participants' Office
011	post-graduate nursing (DTA)	20	education administration	45 minutes	telephone from the researcher's home
012	Postgraduate (DTA) and diploma in teaching	33	Education and Administration	60 minutes	Participants' Office

Data Collection

To elucidate the associated notions from different viewpoints, data in grounded theory research is collected through interviews, observations, reflections, and literature review (Creswell, 1998). Glaser and Strauss (1967) recognise that a researcher does not approach the

study with an empty mind. Most inquiries are based on prior interests and problems the researcher has experienced and reflected on, even when there is no hypothesis. In this connection, the researcher encountered several situations during her professional life which stimulated her to reflect upon this important notion. She always had this assumption that empowered nurses could bring about a significant difference, regardless of the setting, capacity and position in which they worked. So, exploring the processes of empowerment had taken root in the researcher's thoughts even when she was quite a novice in nursing.

Data is considered the most critical asset; as Strauss, cited by Leininger (1985), said, "Everything is data". In this study, data was gathered through in-depth interviews. Interviews are imperative in the grounded theory (Creswell, 1998). Based on the literature, the ' views were obtained through semi-structured formal interviews to understand empowerment issues from the perspective of Pakistan nursing leaders. An interview guide was developed to extract key concepts and processes of empowerment. This interview guide also enabled participants to reflect on their professional lives and share unique experiences that assisted their empowerment. Munhall and Boyd (1993) assert that interviews assist the researcher in understanding a problem through the eyes of the participant and facilitate the search for the meaning of the concepts given by the study participants, which is essential in the grounded theory design.

The semi-structured interview guide was pilot-tested on two participants before conducting the actual interviews to ensure participants' clarity and understanding of language and concepts. After getting the result of pilot testing, the interview guide was modified based on the feedback provided. Moreover, this also assisted the researcher in developing insight into the interview process and practising interview skills before entering the field. However, one pilot-tested participant was included as a study participant, and no major significant modification was required in the interview guide. The second pilot-tested participant was not

included in the study because she was not a Pakistani by nationality. Interviews were conducted in English or bilingually, i.e. listening to both English and Urdu, as English is not the primary language. Therefore, bilingual interviews were conducted as needed because participants were willing to share their views and experiences more comfortably in their preferred language.

The duration of each interview was about 45-60 minutes. The interviews were conducted in a pleasant atmosphere with minimal distractions. A conducive environment was promoted to allow the interviews to be conducted in a comfortable milieu, with water, tea, and suitable room temperature. Each interview was audiotaped after obtaining permission from the participant. Notes on participants' settings, descriptions, nonverbal behaviours, interruptions, and other significant occurrences were noted throughout the interview to ensure rigour and improve fittingness or transferability. At the beginning of each interview, informed written consent was obtained from each participant (Appendix A). Participants were also requested to fill out the demographic profile (Appendix B).

Glaser and Strauss (1967) highlight that the participants' viewpoint directs the course of further inquiry and broadens the focus of the interview. The interview started with an opening question regarding their understanding and experience as a nurse leader undergoing the empowerment process. This was followed by various probes and further questions guided by the flow and direction of the interview. Questions were modified (Appendix C) and added to the interview as new categories or themes emerged from the data. Data collection, data analysis and literature review were done simultaneously as per the requirements of the grounded theory method. Data was collected until saturation was reached.

Most importantly, the development of a theory is the ultimate goal of grounded theory, where the researcher assumes that the theory is concealed in the data provided by participants for the researcher to discover. Thus, theory derived from the data is more likely

to resemble reality than theory derived by putting a series of concepts based on experiences and speculation (Strauss & Corbin, 1998; Resources papers in action research: grounded theory: thumbnail sketch, 2002). This is why memoing is a crucial element in the grounded theory methodology. It continues in parallel with data collection, note taking and coding. Morrow (1998) writes about analytical and self-reflective memos that enrich the analytical process for thoughts to be explicit and to expand the data. Analytical memos consist of questions, thoughts, and speculation about the data and emerging theory, and self-reflective memos depict personal reactions to participants' narratives. In addition, a memo is a note to the researcher or herself about some hypothesis the researcher possesses about a category, particularly relationships between categories. Constant comparison is at the heart of the process. At first, the researcher compared one interview with another interview or the previous data and then with the literature, as the researcher compared the literature in the same way that she compared data to the emerging theory.

Bracketing is essential in the grounded theory design. Munhall and Carolyn (1993) stress that as grounded theory research requires interpersonal interaction, the researcher is inevitably a part of the daily observations. Therefore, the researcher must know personal conceptions, values and beliefs. Self-awareness is necessary to understand the participants' worldview. For bracketing purposes, a daily journal was maintained in which the personal feelings of the researcher and reflections were written to sustain the level of self-awareness and to avoid the contamination of data by putting personal conceptions, values and beliefs. Berger and Kelner (as cited in Munhall & Boyd, 1993) state,

> Suppose such bracketing (of values) is not done. In that case, the scientific enterprises collapse, and what the [researcher] then believes to perceive is nothing but a mirror image of his hopes and fears, wishes, resentments or other psychic needs; what will then not be perceived is anything that can reasonably be called social reality. (p.187)

Theoretical Sensitivity

Theoretical sensitivity is one of the critical components in data collection. The researcher can differentiate between significant and less important data and understand their meaning. It guides the researcher in examining the data from a broader perspective rather than a narrow one (Holloway & Wheeler, 2002). Maintaining theoretical sensitivity was a big challenge for me as a novice researcher in grounded theory methodology. However, this was achieved through being immersed in interviews and during data analysis. The article Resources papers in action research: grounded theory: Thumbnail Sketch (2002) mentions that while collecting and interpreting data about a particular category, the researcher reaches a point of diminishing returns in time. Eventually, interviews add nothing to what is known already about the category, its properties, and its relationship to the core category. When this occurs, the researcher ceases coding for that category. This was a big challenge for the researcher from a qualitative perspective. However, expert opinion/consultation, literature review, and piloting the study helped overcome this to some extent. Moreover, the participants' interview transcriptions and translation by the researcher enabled her to immerse herself in the data and gain more insight into theoretical sensitivity.

Study Time

The study was conducted from May 2005 to September 2006. (Please refer to Appendix E for the study timeline).

Data Analysis

Data were transcribed and analysed manually. Data analysis was conducted as a continuous process integrated with data collection and coding (Streubert & Carpenter, 1994). Interviews were audiotaped, transcribed, and coded line by line. Field notes from the observation during the interview were included in the coded data. Coded data were clustered

into related categories and then compared with one another and with new data to discover the relationships among the data to continually refine or discard emerging hypotheses, as described by Strauss and Corbin (1998). Specific questions helped focus the process of constant comparative analysis, such as perception of empowerment, successful events in their professional life, conditions of empowerment, and strategies.

The constant comparative data analysis method, as described by Strauss and Corbin (1998), was used. It consisted of three steps: open, axial, and selective coding. The researcher analysed the texts, including transcripts, field notes, and personal journals, in open coding and formed the categories. In axial coding, the researcher identified a single category as a vital phenomenon and investigated the interrelationship between categories. Finally, the last step of selective coding built up the prepositions (relationships) that connected the categories. In axial and selective coding, the researcher used inductive and deductive methods and continued to interview till no new categories emerged. The data was then categorised and compared with other data to form theoretical constructs or hypotheses (Glaser & Corbin, 1967; Strauss & Corbin, 1998). Literature was then searched to confirm the emerging theory and fill the theoretical concepts' gaps. Therefore, the research questions were reformulated through constant comparative analysis to reflect the empowerment process emerging from the data, like how nursing leaders create the conditions necessary for empowerment in their ongoing professional lives.

The researcher in this study initially coded the transcript using open coding in level I to obtain complete theoretical coverage. Additionally, open coding allowed the analyst to compare the codes with the data, which allowed the categories to emerge. Level II and III steps were used to explore the central category and its relationships. As discussed earlier, this process uses inductive and deductive methods of inquiry, in which core categories that interrelate with other categories emerge from abstract data (Glaser & Strauss, 1967; Strauss

& Corbin, 1990). The abstract data was categorised further and compared with other data to formulate a theoretical construct or hypothesis. The interrelationships between these hypotheses were sought to identify the core variable, the central concept of a broader scope, and contextual meaning. As justified by Stern (1980), this means applying a variety of analytical schemes to provide abstraction to the idea. This means the researcher moves from description to the theoretical explanation.

The participants were subsequently contacted via phone as the themes emerged. The purpose of the second contact was to clarify, validate or obtain further information about emerging themes. The participants agreed with the codes and categories and provided input for categorising a few codes within specific frameworks. The framework was developed with the help of diagrams and directions. These illustrations were also shared with the participants. Their feedback was also incorporated to ensure the credibility of the resultant framework.

According to Glaser & Strauss (1967), a quality-grounded theory has codes that naturally fit the data into its places; the researcher does not need to force them into a code where there is only a marginal fit. That is why participants were involved in the final formulation of the framework. This study held the final meeting with the participants to share the final concepts, their relationships, the resultant diagrams of the antecedents, and the core categories ensuring "fit" (Glaser & Strauss, 1967, p. 238). The participants agreed on most categories, codes, and emergent themes; however, some suggested a few changes in the directional relationships, which were recommended by some participants and incorporated into the final theory development.

Strategies for Ensuring Rigor

To ensure the quality of the research study, rigour was followed. Rigor maintenance has different methods in the qualitative approach as compared to the quantitative. It tests the usability of the theory. A theory should be understandable to the participants and its users in

practice (Strauss & Corbin, 1990). Trustworthiness is the term used by qualitative researchers to demonstrate rigour, which is the top priority of research. Trustworthiness is the degree to which a study's findings genuinely represent the experience of the study participants (Lincoln & Guba 1985). It refers to the adherence to the detail and precise accuracy of the data. According to Polit, Beck, and Hungler (2001), rigour has to be maintained through credibility, dependability, confirmability and transferability.

Credibility

Credibility includes activities that increase the probability that credible findings will be produced (Lincoln & Guba, 1985). It means a researcher takes careful steps to improve and evaluate data credibility, which refers to confidence in data truth. One way that credibility can be established is through prolonged engagement with the subject matter, and another way is to confirm from the study participants whether they recognise that the study's findings represent their own experience (Streubert & Carpenter, 2003). The researcher's own professional experience in multiple capacities, such as Register nurse, school health nurse students' counsellor, health researcher and nursing instructor, was also an enabling factor as it led to her familiarisation with the concept of empowerment in detail and assisted her to develop an interest towards the subject matter under study. Moreover, Morse (1991) states that interviewing the study participants several times and at several places enhances the study's credibility. The study participants were met multiple times: during interviews, after forming the codes and categories, and finally, when the grounded theory was conceived.

Dependability

Dependability refers to reliability, and it illustrates how dependable the study results are. An audit trail is the usual way of providing dependability in a study (Lincoln & Guba 1985). An audit trail refers to the plan provided by the researcher that is traceable by others, such as peers and the researcher's supervisor. For this purpose, all the research study

material, which comprised data transcripts, coding, and core categories, was documented and discussed with the thesis supervisor and committee members. In addition, reflective journals and memos were maintained throughout the study.

Conformability

Conformability can be ensured when two or more independent people agree about the data's relevance or meaning. It is also defined as a technique researchers use to provide objectivity within the study. Strauss and Corbin (1998) mention that codes must explain and reflect the participant's views. The participant's words enhance the audibility and provide written evidence of conformability to other readers. This objectivity assures that the findings are grounded in the data. Creswell mentions that "in strict terms, the findings are the theory itself, i.e., a set of concepts and propositions which link them" (p. 178). The data and the thought process written at the conceptual level have been presented in diagrams and narrative form (Lincoln & Guba, 1985). In addition, the transcripts were checked at three stages: first, the researcher checked congruency with the tapes, then she verified the accuracy, and finally, participants agreed that their views were not distorted in the transcription. The open, axial and selective coding process ensured that the analytical method was integrated within a systematic framework of the grounded theory. The thesis supervisor and the thesis committee members simultaneously reviewed the entire thesis material.

Transferability

Transferability refers to the extent to which the findings from the data can be transferred to other settings or groups; in other words, study findings have meaning for others in similar situations. According to Lincoln and Guba (1985), transferability is depicted as 'fittingness'. It is the capacity to transfer the conclusions to other settings. To be specific about transferability, thick descriptions and verbatim quotations were presented so that a person using the research could speculate the appropriateness of transferring the study

findings to other groups (Streubert & Carpenter, 2003). Purposive sampling with theoretical saturation was done so that the collected data is sensitive to the contextual condition to formulate a grounded theory on empowerment.

The procedure ensured the researcher integrated scientific principles to achieve the study's rigour.

Ethical Considerations

Permission to conduct the study was sought from the Ethical Review Committee of Aga Khan University by submitting the study proposal so that the survey would be evaluated concerning the protection of human rights (Refer to Appendix D for the ERC approval letter). Informed written consent was obtained at the time of individual initial interviews. Initially, the participants were contacted through phone calls to get their verbal consent. A brief overview of the study was also shared, including the purpose, method, and study guide to determine the participants' willingness to participate. Moreover, it also helped the researcher to build rapport with the study participants. The interview was conducted in the participants' preferred formal setting. Privacy was ensured by having a closed environment. Since the researcher acknowledged that clarification and confirmation would be required as the themes and categories emerged from the interviews, participants also sought permission to negotiate and clarify their ideas and themes. Each interview was audiotaped, and each tape was assigned a code to ensure confidentiality.

The study procedure was included by completing a demographic profile before the participants' interview. The participants' identities were not disclosed during any study phase or dissemination. All the study data was kept under lock and key, and all related documents on the computer were password-coded. Selected content of individual interviews has been shared by maintaining anonymity and confidentiality. The participants were informed about

the sharing of study findings. It was ensured that any changes occurring during the study were conveyed to the ERC committee.

Participants were ensured that their participation in this study was voluntary; they reserved the right not to share any specific information during the interview. The participants were assured that their participation would not influence their employment or affiliation with the professional nursing bodies. The in-depth, long interview process was expected to cause some minor fatigue; this was compensated by providing light refreshments and a short break during the interview on a need basis.

The study was expected to benefit the participants indirectly as the time and experience they shared with the researcher would help formulate further strategies to empower nurses in the future and nurture current and future nursing leaders.

CHAPTER FOUR

Findings

The chapter focuses on the analytical presentation of the categories and their relationships to develop a theoretical model of empowerment of nursing leaders from a Pakistani perspective. The chapter is divided into two parts: the first will present the conceptual framework's findings, and the second will focus on the operational framework. This research study aimed to explain the empowerment processes from a Pakistani perspective and to develop a theoretical model of empowerment of nursing leaders using the grounded theory methodology. The presentation of the data in this chapter is followed by the directions suggested by Strauss and Corbin (1998).

A comprehensive analytical overview will be initially narrated, revealing the data's critical concepts through coding. A core category of “empowerment” was identified from the study findings. The themes, categories, and -were described using examples from the transcribed interviews. Transcribed examples also accentuate that the theoretical relationships are grounded in the data. The theoretical model formulated through the study findings illustrates the core category of ‘empowerment’ and its relationship to various concepts of empowerment from the Pakistani perspective.

Explication of the Story from Data

the data revealed that empowerment is a long, demanding, complex, and dynamic process. There appears to be a constant struggle between constructive and non-constructive derives. The non-constructive factors are those that negatively impact a nurse’s empowerment. In contrast, constructive drives are the ones that have a positive impact on an individual on the road to empowerment. Though the researcher was exploring the personal empowerment of the participants, they almost always shared their professional

empowerment, creating an impression that professional and individual empowerment are strongly interrelated.

On the one hand, the value belief system and concepts related to leadership and management served as constructive derives. The existence of sound professional knowledge, skills, authority and self-confidence was crucial for empowering nursing leaders in Pakistan. On the other hand, the mediocre nursing education system, the public image of nursing in Pakistan, the Power relationships, the dominance of the medical profession over the nursing profession, and the status of a nurse-negatively for demonstrating their full capabilities and power.

The study revealed that nurses' knowledge, actions, and behaviour influence personal and professional power.: The credibility of the nurses, particularly nursing leaders, was enhanced through acquiring professional knowledge, which enabled them to build their personalities to carry out their responsibilities effectively and exhibit interpersonal relationships, resulting in a sense of empowerment.

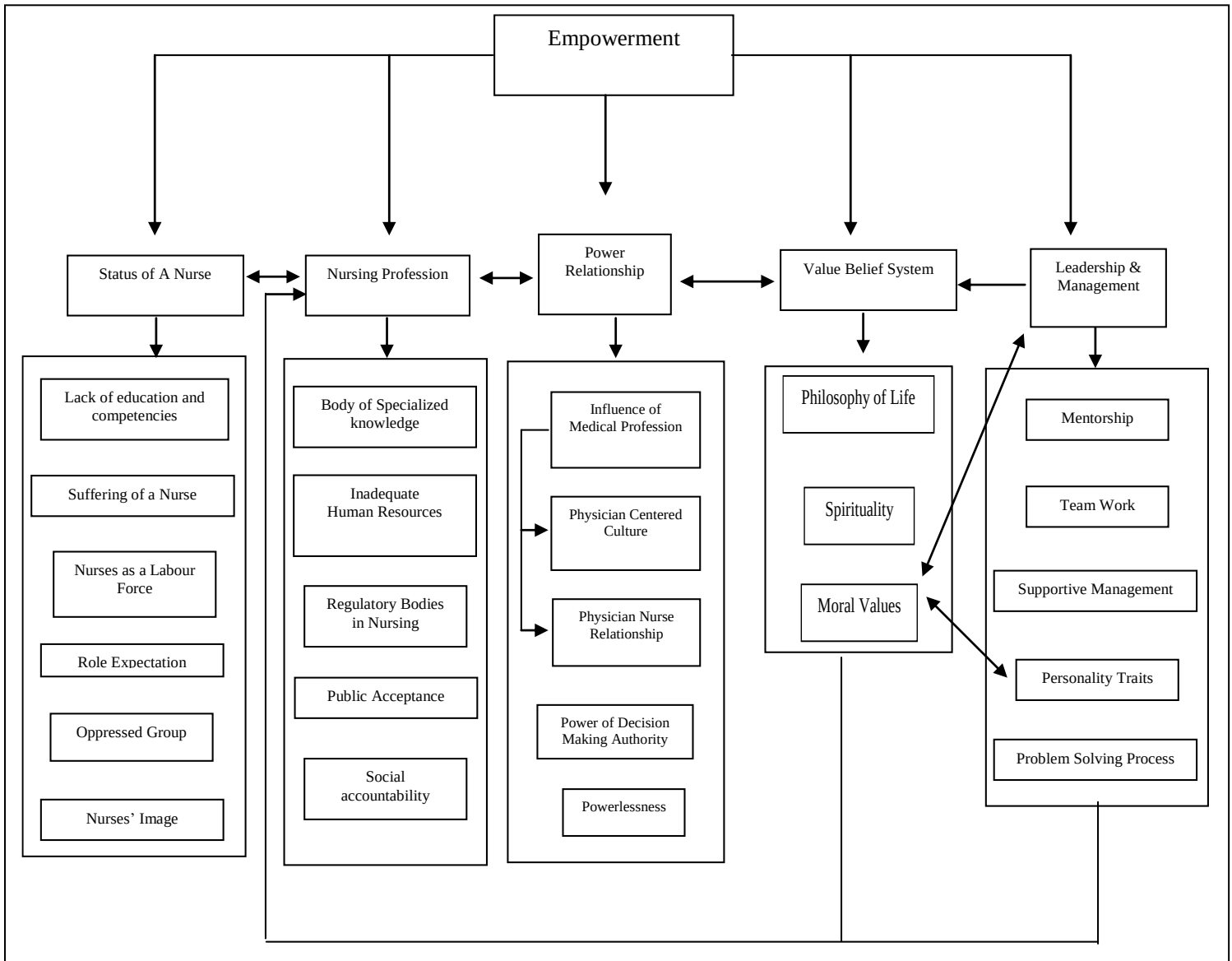
It also emerged that poor nurses'/nursing image, being stigmatised as subordinate and handmaids to physicians and dominancy of the medical profession, had been negatively affecting nurses' and nursing leaders' self-confidence, further aggravating the image of nurses. Subsequently, this hindered nursing's professional growth, and they maintained the status quo. Other task-oriented natures of nurses and their lack of application and involvement in research have hampered the empowerment of nurses as professionals and NS professionals.

The data also powerfully portrays the significant concern shown by the nursing leaders about the need to strengthen the nursing education system, which plays a vital role in empowerment/disempowerment. The incompetent and insufficient number of nursing teaching faculty, lack of clinical teaching follow-up, and utilisation of nursing students as a

labour force in hospitals were also depicted as having a negative effect on the nursing profession.

After a critical review of the data, it was affirmed that nurses; lack of higher education and competencies, as well as the dominance of the medical profession, are vital factors having a negative effect not only on nursing leaders and nurses' empowerment but also affecting the nursing profession as a whole. Thus, an empowerment model was developed that emphasised restructuring the nursing system. Two frameworks emerged from the data: the conceptual framework of empowerment and the operational framework. The subsequent paragraphs will discuss the emerging themes, categories and sub-categories. All the categories and the subcategories reflect the core category of moving towards 'empowerment'. The primary identified categories and subcategories are shown in Figure 1.

Figure Two: conceptual framework: The model of nursing leader's empowerment in Pakistan



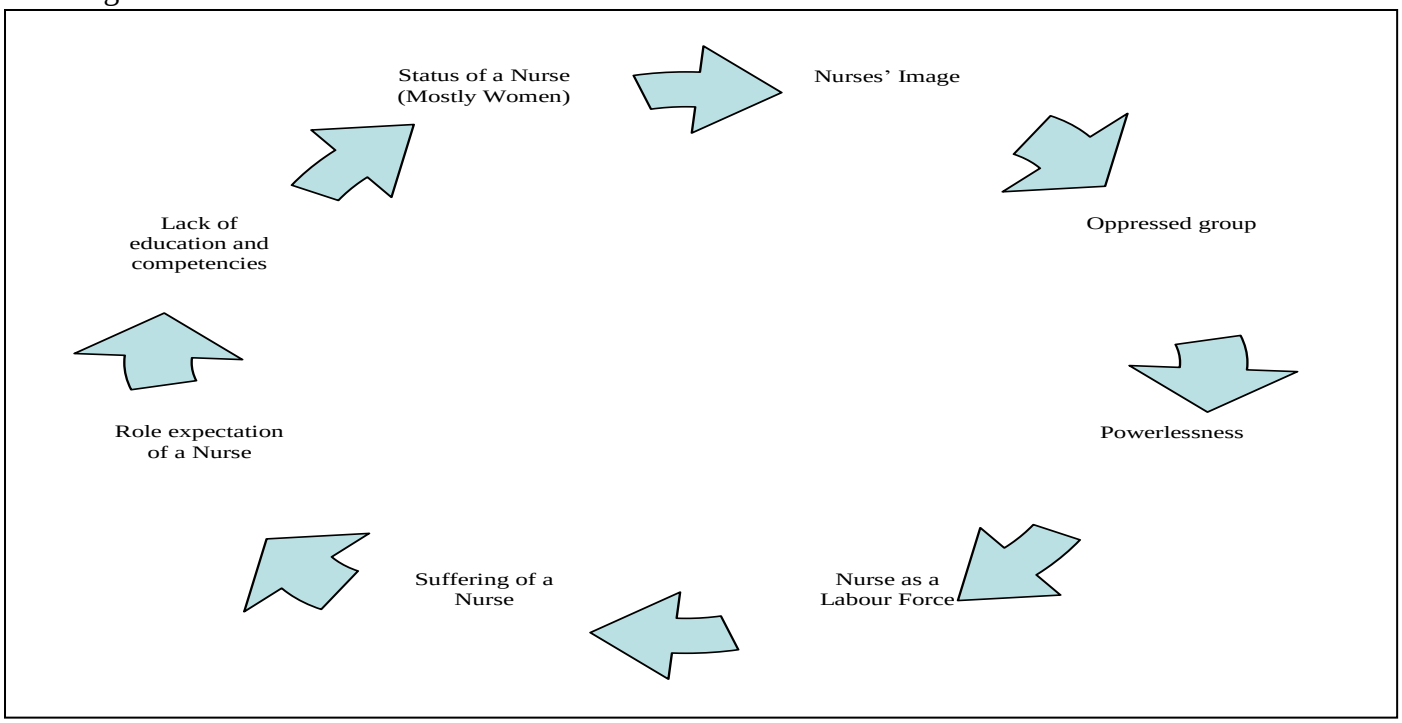
Conceptual Framework

The conceptual framework theoretically describes the empowerment of nurses in Pakistan. The relationships between the concepts are shown with the help of arrows to show the interrelationship amongst them. The factors that promoted and impeded nurses' empowerment in Pakistan included the status of a nurse, the nursing profession, power relationships, leadership and management, and the value belief system. Furthermore, Nurses' image in society, characteristics of nurses as an oppressed group, the heavy influence of the medical profession, and nurses' limited ability to exercise their power in the organisation were critical in nurses' empowerment. The nursing leaders in Pakistan are struggling very hard to overcome this. These are outlined below:

Category # 1: Status of a Nurse

The first category, 'Status of a Nurse,' relates to empowerment from the Pakistani perspective. Six sub-categories emerged from the Pakistani perspective of the status of a nurse. All these have been explicitly defined using various quotes from participants. They are depicted in Figure 3. They are a lack of education and competencies, the suffering of nurses, nurses as a labour force, role expectations of nurses, nurses' image, and oppressed groups.

Figure Three: Status of Nurse



Category # 1.1 Lack of education and competencies:

Data revealed that nurses' lack of qualifications and competencies caused them to suffer from a lack of confidence, which resulted in them not wanting to put themselves in hardship. Consequently, they didn't take any interest in preparing themselves professionally. Therefore, it is indeed necessary that nurses acquire the competencies and skills needed for empowerment.

One of the participants expressed her concern about the nurses' competencies. She said that nurses with qualifications and competence can demonstrate that they can handle empowerment. According to s, confidence and competence go together.

> "But really, to be able to given empowerment means that you have to work competently, and I am not sure if competence is there" (Code 008, line 49, 70)

Another participant highlighted that nurses lack updated knowledge and cannot contribute efficiently to the nursing profession.

> Several new research types are conducted daily in the medical profession. Each issue has a research study, but our nurses still rely on the knowledge acquired during the Diploma. Whatever content they teach is based only on that. That's why it is imperative to upgrade nurses so that quality care can be provided. If quality care existed, this profession would be understood as a profession (Code 009, lines 20-24).

Other participants also verbalised the lack of competencies and skills among nurses in Pakistan, which are essential for getting empowered. One nursing leader expressed her views and said:

> They do not prepare themselves for the meeting. They do not know; they don't speak. So, the nurses will have to give up this attitude because if they know and have information about the subject and prepare themselves, they will be empowered. They must create confidence to participate equally, like physicians and other multidisciplinary members. (Code 002, line 48-53)

Participants further highlighted essential skills that were deficient among nurses but were crucial for empowerment. Participants asserted that if nurses don't know the budget,

don't have the knowledge of hospital design and knowledge about the patient's care, and don't have knowledge of hospital issues, and if they are not interested in solving and involving themselves in issues, then definitely she cannot be empowered; she cannot ask for empowerment b she has to raise a voice in a given situation to empower herself. So there is a strong relationship between knowledge and empowerment, as one of the participants said:

> …Mostly, nurses come late. Most of the time, nursing leaders do not submit things on time. And then people lose the confidence in them….. The fourth is the writing skills of nursing people. This requires a lot of attention … and whenever they (nurses) have to do a presentation or write a paragraph on something, or they have to document anything, say anything, or write anything, they face many problems. So, I think nurses must develop qualities among themselves before asking for empowerment (Code 002, line 54-66)

Participants also focused on the dire need for nurses to build essential competencies to be liaisons between the patient and physician. Participants revealed that nurses take care of 24 hours for the patients. In 24 hours, doctors may remain for three or 4 hours. But the nurse remains for 24 hours. That's why nurses need to be updated to provide holistic patient care.

> The nurse is the bridge between patients and doctors. If the bridge is weak, how does communication occur? (Code 009, lines 64-65).

Participants also realized that because of low competencies, policymakers don't involve nurses in policy-making; therefore, the policy can be anything. These policies don't need to be pro-nursing, which is another reason the nurses' image didn't rise as such.

> … that neither their education is vital nor they know any reading, writing or speaking, and they don't even know what a policy is and how to make it. That is why the policy doesn't involve or let us participate in the policy. (Code 001, line 160-161)

Participants also highlighted the importance of professional development. Nurses' professional attitude positively impacts them and gives them an equal place as physician-physicians. Participant said:

"They should talk and behave like professionals. They are half part of the health care system. Care & cure are equal".(Code 009, lines 49-50).

Category 1.2: Suffering of nurses.

The participants said they are also deprived of many facilities within the organisation. This includes educational facilities, hostel facilities, dining room, nurses' cafeteria, ' (car) parking, and so on, which again shows how little empowered the Pakistani nurses are. Due to the image and status of nursing, nursing leaders do not do this planning related to nurses; non-nursing leaders do it. The participants further said that the nurses do the supervisory job, but others make policies; the nurses face difficulties, but others do the planning. So, how can it be feasible for nurses to perform the job well? Like in their institution, there is so much construction going on; new units are opened, but nurses are still deprived of basic facilities, as one of the participants said:

> …in the nursing hostel, we have a capacity of 112 people, but in that (hostel) with a capacity of 112, over 300 nurses reside there. Despite insisting again and again, it has not been expanded yet. … In the entire hospital, I don't remember you finding a separate portion for nurses, their dining room, nurses' cafeteria, nurses' or nurses' (car) parking (Code 00 9, lines 55-61).

A participant found that even to avail themselves of higher education, they had many constraints. Getting educational opportunities is a big problem. They don't have that kind of opportunity. They have to come to the job straight. They either have to go or don't come; they don't have a third option, as it was said:

> You have been sitting (in a position) for so many years there, and you don't get enough salary. As we say, you do a part-time job, which takes education. If the government sends, then it's good; if not, then you sit here for 20 or 30 years. You forget what you have studied and are asked whether you are eligible for leadership. This would remain a question mark (Code 001, lines 154-156).

One of the participants shared the importance of continuing education for nurses but stated that they could not do it without the provision of space. Participant said:

> We wanted to begin the bedside nursing education program but could not. We urge that a small office be allocated at least for this purpose where we can upgrade our nurses, but despite asking them or requesting them in writing, we could not get it (Code 009, lines 20-21)

Participants also shared their experience of disempowerment when things were not in their sand because of their hands; they could not contribute to the profession. According to a participant, she wanted to benefit the nursing profession but couldn't, although she had remained in that position for five years. Though she could work a lot even then, she believed a lot needed to be done for which nursing leaders were too much behind. This was depicted by one of the nursing leaders:

> …due to insufficient sanction seats, nurses who deserve promotion and are good at their work are left behind. Because we didn't have enough sanctioned seats, we tried for that and the nursing directorate; we have developed a service structure three times….but things got stuck at a higher level (Code 005, lines 26-28)

Category 1.3: ' Nurses as the labour force.

It also emerged that nurses are used as a labour force due to a lack of required qualifications and competencies, further damaging the nurse's image in society. One of the participants said:

> We have used nurses as a labour force, and we want to use them as such. Even government policy does not have a provision for them to be treated as professionals, and in every institution, nurses are being used as a labour force (Code 009, line 31, 32)

Category # 1.4: Role expectations of a nurse.

The data also revealed dual responsibility on nurses' shoulders and household and professional responsibilities. As the inflation rate is relatively high, and everyone wants a quality life, according to the participants, this is only possible by doing double jobs simultaneously, affecting their personal and professional lives. This behaviour developed

because salaries did not increase proportionally to the time requirement, and women also had to share the economic burden.

> Now, the trend has changed. A husband wants a working woman as his wife. If both husband and wife are involved in jobs, who will take care of the children? A maid is required for them. Computers have become a must for children, and now and then, they want the latest things. School fees have gone up, and lifestyles have changed. The cost of living is sky-high, and as a result, everyone has to work. 60% of the practical nurses are doing double jobs (Code 006, line 153-156)

Participants also shared how stressful it had been to learn that they were transferred away from their family, and then they were pretty concerned about who would look after their family, as she said.

> When I was called upon at the directorate office, I was scared and thought I would be transferred from Hyderabad. I got married here, and my husband was working here, so I brought my domicile with that impression (of transfer) in mind. I told them my domicile is in Kohat, but my husband is here, and you gave me a transfer. (Code 005, line 75-78)

Category 1.5: Oppressed group.

As per the views of the participants, poor nurses' image is one of the factors that negatively affects the nurses' professional lives and, thus, affects society's views. As a result, the nurses exhibit characteristics of an oppressed group in Pakistan. The participants verbalised the characteristics of oppressed behaviour in nurses, which included maintaining the status quo, being at ease, confined to their shell, mentally they are Frightened, cowered to speak and perform, taking a stand, they don't want to work hard, are fearful, can't take risks, blame others, and never place themselves in difficulties.

One of them said:

> Almost all nurses at the senior level are so cowered that they can't take a stand. The way they are dictated, they say 'yes' to it. … They don't want to work hard. As per their lifestyle, they want to keep

> everything at ease. Consequently, when one does not work, how can empowerment be achieved? (Code 006, lines 23, 26).

Another participant also shared the same concern and said:

> Everybody wants to be at ease, and no one wants to work hard. …I am trying to start and want them to take the AKU test. But no one is ready for it. When I ask them, they say, "Ma'am, we can't do it". The reason is that they will go to the JPMC and do it from there quickly, and they will get their degree. No one likes to work hard (Code 001, line 223-231)

Category 1.6: Nurses' image.

Most of the participants mentioned that the poor image of nursing in Pakistan hampered them from empowerment. It was revealed from the data that the importance of nursing was missing, and that was why other health professionals and NGOs did not realise that nurses were as influential as doctors in providing holistic care to patients. One of the participants said:

> "In the ward, the decision maker is the doctor. Patient also gets the impression that if something needs to be done, nurses also approach the doctor" (Code 001, line 181)

Another participant stated that nurses still fail to convey their importance to society. Like during the earthquake, the participants felt everyone was asking for doctors' needs; even other companies, NGOs and the government only demanded doctors. As the fifteen days passed, they realised that the patients who had their feet operated on, the patients who had surgeries done, or patients who got leg amputations had developed gangrene. The reason behind this is that due to the poor image of nurses, people do not give due importance to nurses, and doctors perceive that patients are cured only because of their efforts. Participants felt that if the government and our NGOs had the whole concept of the team at the right time, they would have taken the entire team, and they wouldn't have just taken doctors. So you see, nurses have still failed here; they cannot tell the world how important they are for the health care team.

> Nurses cannot even portray their needs; for that reason, we cannot tell how important we are to this profession. Participants further referred to the earthquake disaster incident and said…. Patients didn't get the proper medicine. This happened because the right persons were not there for the appropriate care (Code 001, 71-80).

The data also revealed that the poor image of nurses hindered their participation in policy development because policymakers perceived that nurses were not capable enough to be involved in such an important activity. Hence, they did not affect them. This created image is because nurses do not have a sound educational background or reading and writing skills. The result is that developed policies do not favour the nurses or 'pro-nursing'. The participants perceived this as a vicious cycle which needed breaking to improve the image. This is evident from the response of one of the participants.

> Our policymakers don't understand that a nurse is developed (professionally) at that level and can discuss. They are not ready to give the power because of the image, which is the created image ….If we can improve our image there, then I think many things can improve. Like we say, it's like a cycle. If we were to say that our image gets better when nurses acquire power, and if power is given to nurses, they would be able to improve the institution. Her quality of care will be enhanced. If the quality of care is better, then the image of the population gets better. If the image amongst people gets better, then our (public) acceptance will occur (Code 001, lines 157-168).

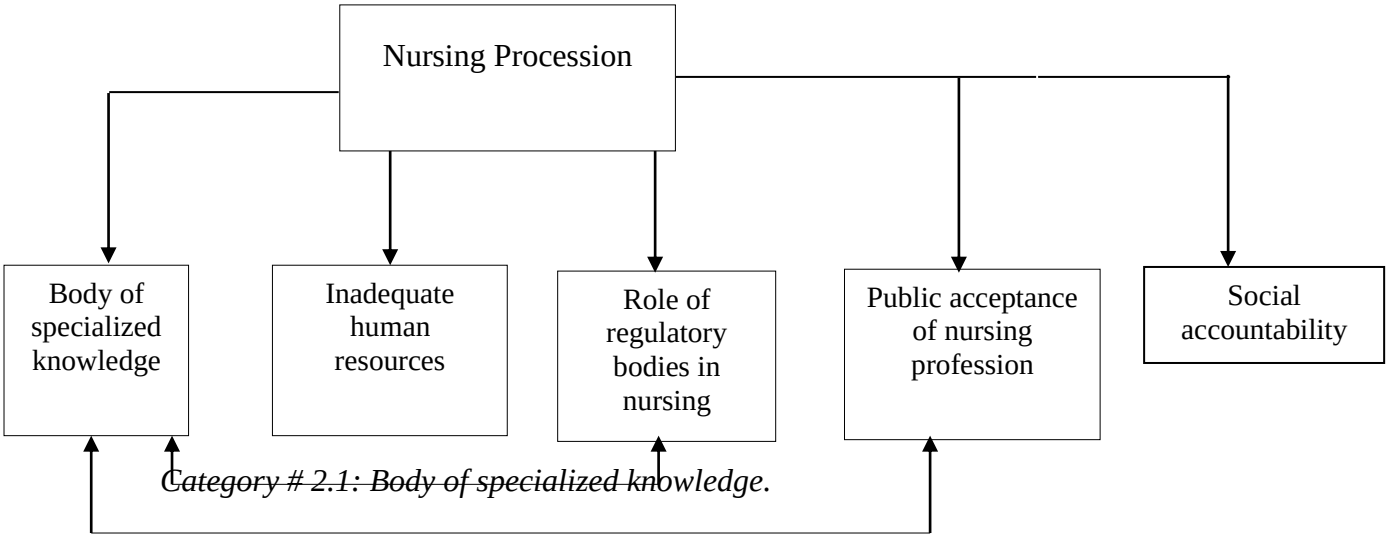
Overall, all the data gives the impression of nurses in Pakistan that due to lack of higher education, they are unable to acquire the necessary competencies and thus suffer from numerous inadequacies, eventually stigmatised as an oppressed group, which further damages poor nurses' image. Subsequently, when working in the practice setting, these nurses don't have their say and are only involved in performance-oriented hospital tasks. Therefore, most nurses suffer as they do not get enough salaries and promotions despite having 20 to 30 years of experience—dual responsibilities as a professional and a housewife also affect nurses significantly.

Category # 2: Nursing Profession

The second category extracted from the data is ‘Nursing profession’ in the Pakistani context. This also has a significant impact on the nurses’ empowerment. Participants aspired to see the nursing profession as being given the same importance as other professions. According to the participants, if nurses get empowered, the nursing profession in Pakistan will eventually improve. On the other hand, if nurses are not empowered, this profession will not move towards quality. So, until and unless nurses are empowered, nursing in Pakistan will not be recognised as a profession but as an occupation. Subsequently, the nursing image will not improve, and the profession cannot stand independently. Sometimes, people use political and unprofessional ways to achieve empowerment, but to achieve empowerment; nurses have to work competently. Thus, it was highlighted that the nursing education system must be strengthened to produce well-qualified and competent nurses.

Figure four shows the sub-categories that emerged in this category: body of specialised knowledge, human resources, role of professional bodies, social accountability, and public acceptance.

Figure four: Nursing Profession



Category # 2.1: Body of specialized knowledge.

The Nursing leaders expressed great concern about the nursing education system and stated that it should be improved. They highlighted that the education system was substandard. They felt the nurses’ competencies were not built up to the level because of the

weak education system. They suggested a need to work on the admission criteria, which was not sound. One of the participants mentioned:

> A drastic change is needed in our education system, not only at the planning level but at the implementation level as well. Till then, this profession will not be called a profession. Instead, it will remain an occupation. I assessed that if our education is substandard, why are we getting 100% results? That means our board has set a shallow level of standards. If we raise the standard, a person will strive to meet the standard. (Code 009, line 66-71)

Another participant echoed the concern about the diminishing admission criteria. They highlighted the detrimental effect of this trend on the quality of education, stating:

> In the past, our academic standards were robust, with an average mean of 85%. Those who didn't meet this standard were not selected for the program. However, the current trend allows even those with a 60% average to enrol in the DT program. This compromise in our criteria is the reason we are not producing high-quality faculty. It's clear that our standards need to be more stringent. (Code 012, lines 220-225)

One of the participants also stated that due to the comprised education system, the cheating trend among nursing students is very high, which means that education has failed to build a sense of integrity. The Participant said:

"Whatever education system we now have, our output has weakened to a certain extent; the cheating trend has increased" (Code 006, lines 181-183).

The participant also shed light on the richness of the nursing curriculum; however, she felt that delivering the curriculum to the nursing students through competent educators was missing, although this was an essential aspect of education. Participants felt our weaker area was our education; the nursing curriculum was enriched and comprehensive. Higher-ups always ask nursing leaders to train the nurses because quality care is unavailable. But we are unable to see what the root cause is till today. The root cause is that nurses have not been prepared as they should. Therefore, it's not wise to demand quality care, as one of the nursing leaders mentioned:

> … Nursing curriculum meets the international standards. It has all the things that should be in a professional curriculum. Okay, we agree. But, based on that, are we preparing our nurses according to the curriculum? No, we are not; when we can not prepare our nurses accordingly, how can we discuss quality care (Code 001, lines 98-91)?

The participants also talked about the commercialisation of nursing education. Agencies have taken advantage of the shortage of nurses and, thus, made it a source of their income. This trend leads to mediocre nursing education in Pakistan. Participants urged to strengthen the nursing education system. Globally, there is a shortage of nurses, and opportunists are trying to make this opportunity available. They know this shortage of nurses will remain for a few decades. And in the meantime, they can start schools and achieve their targets. In this connection, a participant shared:

> …. everybody is after opening a nursing school. They are not bothered (about quality), they are not professionals, and they are not concerned about what they need to teach or what the outcome will be for these graduates. They just want to grape the opportunity… production of nurses has become a commercial activity (Code 003, line 30-37).

One of the participants shared her experience and uncovered the traditional model of education, as she verbalised:

> "Although I was working at the staff nurse level, I was also working as a night supervisor, plus I had to deliver lectures in the morning" (Code 003, lines 79-87)

Category 2.2: Inadequate Human Resources.

Participants also emphasised that the shortage of well-trained teaching faculty is the major problem of not producing competent nurses as one of the participants said:

> We have an acute shortage of faculty in the market. Whether it's the government or the private sector, we don't have any faculty for training….. Whatever skilled person and teachers we had, they are all gone abroad. Now we have number two staff (less skilled and having less knowledge) to live with. When this is the situation, how can we produce the quality we strive for? (Code 006, line 163-167)

Data also revealed the importance of human resources, as they play a pivotal role in the empowerment of nursing leaders and the profession in Pakistan, one of the nursing leaders said:

"All the manpower contributes largely to being empowered. If the manpower is in adequate number, then empowerment can easily be achieved". (Code 011, line 68-69)

One more participant tried to develop an insight about incompetent nurses in the following words:

> Nobody can point a finger at her if a nurse is competent and knows her job. Naturally, our attitude will not be professional if we don't know our job. We keep trying to hide ourselves; we cannot speak, perform, skip off duty early, go early, and come late; these things are mixed. And put in a jar then this jar would reflect what you have made (Code 003, line 50-54)

Category 2.3: Regulatory bodies of nursing.

The participants also shared the Pakistan Nursing Council's role in improving Pakistan's nursing education system. PNC has the authority to give written instructions on how to improve things. Otherwise, the institution will be derecognised. Due to that, institutions can work on their deficiency, according to one of the participants:

> The Pakistan Nursing Council gives us all the educational guidelines, and if we have any problem, we quote their rules and regulations and gain our power…. Even the PNC inspect institutions closely and explores our bad points because this is our power; PNC tells us to correct our deficiencies …this written format is our very big tool (Code 001, lines 114-121).

The participants also verbalised the role and importance of regularity bodies in nursing in Pakistan, which is significant to empowerment. It was highlighted that PNCs have rules, regulations, and executive bodies. But then they expressed that to some extent, PNC is independent, but still a lot of improvement is needed in terms of proper functioning and exercising its power, as one of the participants said:

> To a certain extent, the Pakistan Nursing Council has become autonomous. So, it can make rules, regulations, and policies and is governed by its executive committee and members. So empowerment

> has occurred at that level. …They can inspect any institutions and to a great extent approve or not approve institutional strategies and programs,"…. and I think still more needs to be done to work proficiently (Code 008, line 25-26)

One of the participants reported about the Pakistan Nursing Federation and said: Our federation is very weak. There is no membership". (Code 006, line 19-

The participants emphasised the importance of the Pakistan Nursing Federation, a powerful professional body of the nursing profession in Pakistan (PNF). It was depicted that PNF had great significance in the profession if it was strong enough. It was also reported that these regulatory bodies are underutilised. However, those who utilised it got the positive result, as one of the nursing leaders said:

> The Pakistan Nursing Federation is a very big power of nursing. You may have heard that a few days ago, the principal of the College of Nursing was changed, and a doctor was designated there. We held meetings, and after two meetings, we didn't even bother to meet the seniors. We took two press releases and stood before them. We gave statements before the press. And all the people came out, and it did not take even two minutes to turn (this decision) back. You can see that things like this are such a big power, and if we utilise them, we can solve many problems (Code 001, lines 123-130).

Category 2.4: Public acceptance of the nursing profession.

The participants also shared their thoughts about the public image of nursing, the status of women, and socio-cultural values in Pakistan. Participants mentioned that in Pakistani society if someone looks at the status of medicine and one looks at the post hired within medicine, it is always status, according to one participant:

> If we look at nursing worldwide, nurses are comparatively less empowered because they are women ….it has nothing to do with knowledge itself or the degree itself, but it has to do with the socio-cultural values and the status of women. (Code 010, line 39-43)

Participants also related acceptance of the nursing profession positively with the improvement of the status of women in Pakistan; it has been closely observed that when nurses go into any department, be it the directorate or the secretariat, female nurses can now

approach easily and convey their point, and they receive proper treatment from all; the officials treated both the male and female nurses equally. She said:

> Nurses are greatly respected in our province. …. The respect and honour given to women in our region are due to our cultural values. All the Balochis respect women highly in our daily routine, whether in a shop, bus stop or a queue. The image of nursing in our province has improved a lot with time. Earlier, the family elders restricted their daughters from going out and working because of cultural restrictions (Purdah). But now they all are educated and realise the importance of nursing and have started encouraging their family members to join this profession (Code 011, line 75- 86)

Participants shared that if nurses would acquire higher education and build competencies, then people certainly recognise them, as one of the nursing leaders said:

> …your style of talking, sitting and walking will convey what sort of leader you are. When she talks, it portrays how knowledgeable she is. Is she the master of her field or not. .. When the public develops this sort of feeling that nurses are capable and can lead independently, the government will recognise them. (Code 006, lines 43-45)

Category 2.5: Social accountability

Some nursing leaders found that accountability is the key to the nursing profession. Participants verbalised that many times, work depends on other people. If it is not achieved, they are left with accountability, but the work may not be done in the way they want it to be done because there were so many people involved, as it was reported:

> I think that the challenge of empowerment is to make sure that the work you delegate to others is done to the right people with the right competencies, and many times, I found that although you seem to have managed enough rigour, it is not that way. Somebody qualifies, and somebody has the position. You empower other people, and at the end of the day, you are accountable because it's your work and the university has assigned you to do it, but you empower other people to do it where that gets done or not get done; it's a huge, huge challenge. (Code 008, line 80-83)

Nursing leaders focused on the importance of being cautious while dealing with the public for empowerment among nurses in Pakistan, she said:

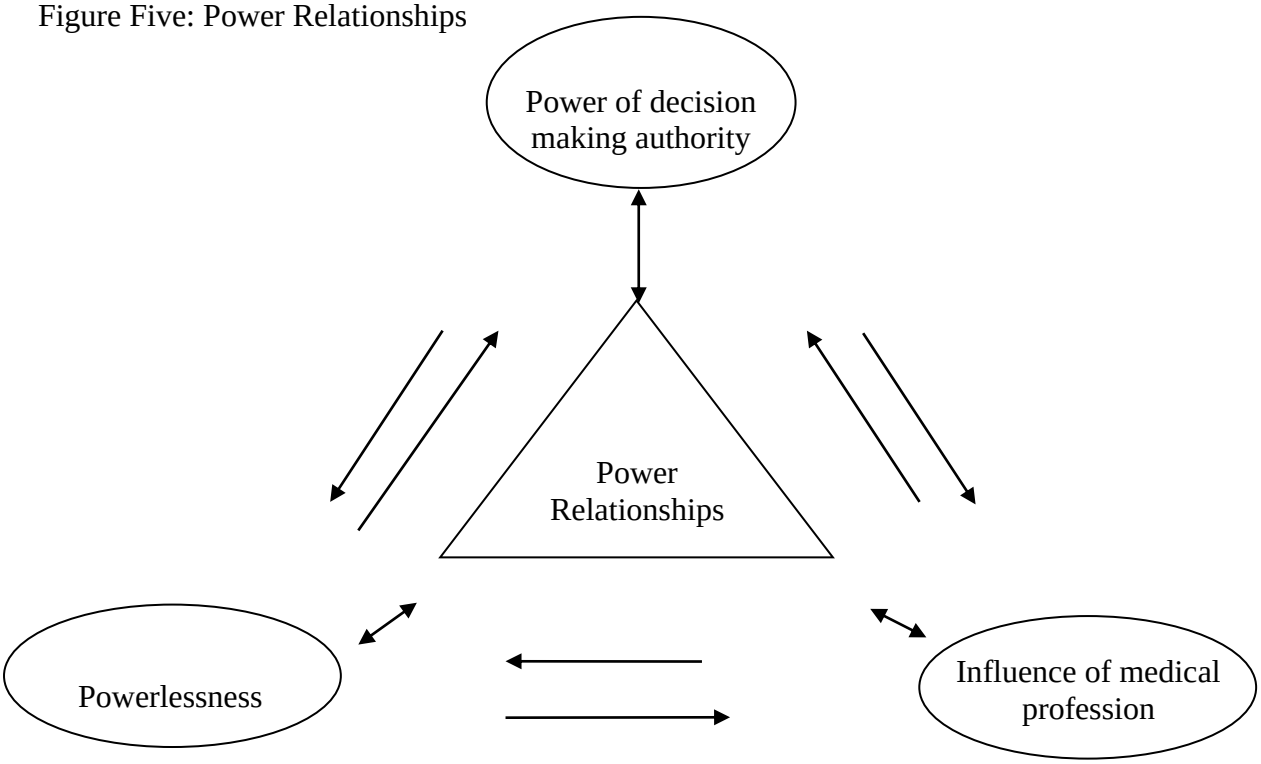
"Nurses or any professionals working for the public, as front-line soldiers, naturally have to be conscious. And once you become professionals, you become a responsible person; you are not an ordinary person" (Code 003, lines 55-58)

All the factors mentioned above can play a significant role in empowering the nursing profession in Pakistan. Currently, they are considered impeding factors in major parts of Pakistan. Because of that, they deteriorate the structure of our nursing education system, which eventually negatively impacts nurses' empowerment in Pakistan.

Category # 3: Power Relationship

The third category that was spelt out by the participants was 'power relationship'. This was considered a part and parcel of the term 'empowerment. This has a great significance in nursing, particularly for nursing leaders. Most participants linked the concept of 'power' with decision-making authority and carrying out certain major responsibilities autonomously. Data strongly suggested that nursing leaders in Pakistan did not perceive themselves as fully empowered; almost all the nursing leaders shared that they had limited power. Quite a few participants said that having a position in the nursing profession did not mean having power; it might serve only to a certain extent. On the other hand, some nursing leaders believed that power depended upon the position and institution that they worked with. Power relationships are extremely important among nursing professionals, and the data also reveals a very strong association with the other concepts of the model. Subsequent categories are seen as sub-categories, including the power of decision making, the influence of the medical profession and powerlessness. These are shown in Figure 5.

Figure Five: Power Relationships



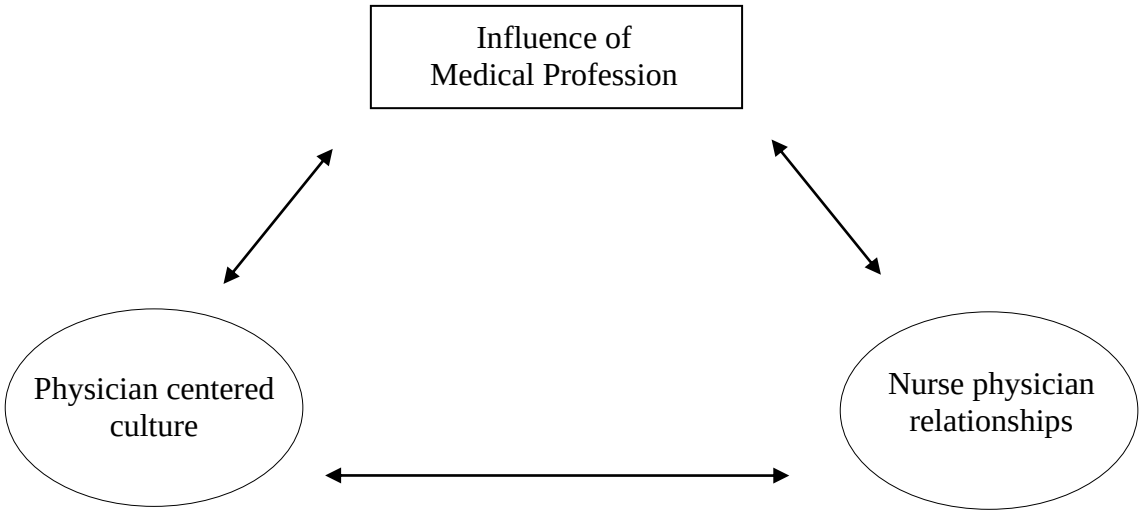
Category # 3.1: Influence of the medical profession.

The first sub-category that emerged from the data was the "influence of the medical profession" over the nursing profession in Pakistan, which was one of the impeding factors in nurses' empowerment. Most of the participants mentioned physician dominancy and perceived them as oppressors. They stated that in health organisations, the medical personnel mostly exercise power (Medical Director or Medical Superintendent, MS). This was also evident from the data that, according to the structural hierarchy, the Minister of Health and the Director General of Health in Pakistan were always males and mostly doctors. They always gave preference to doctors only. They never understood nursing issues and have always addressed medical issues rather than nursing issues. Sometimes, doctors are even hired as nursing leaders. Therefore, the decision-making power remains with doctors, and nurses have to consult, for every and any decision, their medical counterparts, even if they are non-nursing persons. The physicians also treat the nurses as their subordinates, and even today, nursing care is provided on doctors' orders. So, physicians are more powerful and

greatly influence the nursing profession in Pakistan. Data also highlighted that institutional leaders like the director general and president give more importance to physicians than nursing leaders.

Therefore, the two sub-categories that emerged were physician-centred culture and nurse-physician relationship in the nursing context in Pakistan, depicted in Figure Six.

Figure six: Influence of Medical Profession



Category # 3.1.1: Physician centered culture.

The participants highlighted that nurses are not treated equally within the health organisation; medical leaders are treated better than nursing directors. This made the organisation's culture more physician-oriented. Mostly, physicians are selected as heads of the organisation, and all the major decision-making powers, such as budget-related power, are given to them only. The nursing leaders have to struggle a lot and approach them for approval. One of the participants said:

> If you look at a hospital, they are always under a medical superintendent. Their budgets are with the Medical superintendent, the decision-making regarding their work is too, you know, whether they can travel or whether they want to go out anywhere, all these budgets are with the Medical superintendent of the hospital…. and they have to ask for any and every decision from their medical counterpart or from the superior administrator, both of whom are non-health professionals (Code 008, line 31, 45-47).

Because the Charge was the MS. (Medical Superintendent), they faced many problems and felt she was not empowered. One more participant said:

> The medical superintendent (M.S) exercises all power, and nurses have not had a separate budget from the MS until now. This is evident if the MS belongs to the medical department. He would prefer the medical department only and address their issues more strongly rather than nursing issues. (Code 009; lines 27-29, 63)

The participants also focused on the disbalance of power within the organisation and said:

> When I sit with the physician group, I feel that I am not empowered enough. My words are not valued by the president or the director general because the physician has more power. Even the department chair has more power than me (Code 002, lines 18-20).

Participants also verbalised that the nurses were still dependent on the doctors, which is disempowering for the nursing profession. One nursing leader believed:

> Matching empowerment with others, especially in the medical profession, was a very difficult job.... A physician should be only a physician, not a dictator of the ward, about caring for the patients. It has a huge effect. Even now, we have some areas where nurses provide nursing care on doctors' orders (Code 006, line 6, 103-104).

One more participant shared her concern about the domination of physicians, even in minor cases of staff nurses, regardless of whether they want that stuff to be changed. Still, they don't have the authority to make decisions. Participants said that they didn't get the answer; if they asked them why, they just used to reply in a way that they were saying so, as one of the participants said:

> You get the order from the senior doctors or directors that a person needs to be dismissed from the staff. Then you don't have the choice. In such a case, will you fight with them for this decision? If I say that we won't do it, it's impossible because the directorate has the higher authority, and we cannot bypass them; we have to obey her orders (Code 001, lines 10-11).

Later, the participant expressed that nurses' needs are often neglected and its been overlooked for the sake of higher management interest, as it was shared:

> The director is sitting over there making decisions; she cannot see the nurses' special needs. She didn't assess them properly. If things are according to her interest, then she will take some actions; if not, then she won't (Code 001, line 192-193)

Another nursing leader discussed that despite having a nursing act, nurses do not have full autonomy to bring some change within the organisation; it was depicted:

> … the Ministry of Health and the Director General Health were mostly male doctors. Yes, there is a nursing act that gives them autonomy, but there was no self-regulation, and if the nursing professional wanted to do something, she could do it without prior approval. This is not there (Code 008, line 60)

Data revealed that the nursing leaders are not even authorised to make minor decisions, So there is such a wide spectrum of empowerment to disempowerment that the nursing leader verbalised that she doesn't know where to draw a line between the two of them; one of them said:

> However, something that hurts us while we work is that I always see that the physician medical director is treated better in the institution than the nursing director. The nursing director is female. I am the only female director in the director group, and despite working very hard, her pay scale and many benefits are lower. In many situations, they (doctors) are more empowered. Institutional leaders like the director general and president give them more importance in many areas than nursing (Code 002, lines 11-14).

Participants also emphasised that a nursing directorate was necessary to empower the nurses and the nursing profession in Pakistan. Participants shared that having a nursing head would make it easier to decide when to promote a nurse to a higher level, three or five years. How are they supposed to be promoted? The directorate can then create a list of all eligible nurses, collect their data and record it to make decisions regarding their promotion, which will ultimately make their task easier, as the participant pointed out:

> In our province, getting nurse promotions is not easy, and a lot of struggle is needed. Only then is there a probability of creating a post. If we have a directorate, then the directorate can make necessary decisions ….Hence, if we have a proper hierarchy and the higher authorities have been selected from our nursing division, then they will be able to help us be empowered (Code 011, lines 40-47).

The distribution of power, in particular, in the organisational structure, causes a lot of difficulties for nursing leaders. However, participants felt that if the head is selected from nursing, it is more feasible for nurses to approach them. One of the nursing leaders said:

> ….EDO's (executive district officer) has to do things over there. I feel that the Director or Director of Nursing is better at dealing with Nursing schools because, being female, I know all the problems of females. The nurses came to me directly; they felt at ease instead of going to a male over there talking to the EDOs. And they (EDOs) don't have time; they are in meetings sometimes and are not in their offices. So they walk out and find it difficult to approach them. On the other hand, approaching me is easier for nursing instructors and nursing students (Code 004, line 12-21)

The excerpts mentioned above reveal a strong influence of the medical profession, making our organisation purely physician-centred, negatively impacting nurses' empowerment. The nursing profession would have been in a different shape if nursing leaders had been an equal part of the health system as doctors.

Category # 3.1.2: Nurse physician relationship.

The tussle between the physicians and the nurse also became apparent from the data. This shows the existence of unhealthy relationships among them. Due to this, physicians always view nurses as comparatively inferior to themselves. This has a negative impact on nurses' empowerment. A participant shared an incident:

> A few days ago our staff had some problem with the doctors. The doctor asked him to leave the ward immediately, saying you were not working properly, and I didn't want you to be here. Our staff said that I would not leave this ward because I was not working under you; I was under the ward in charge and, after that, under the supervisor. If they tell me to leave the ward, only I will leave; otherwise, not. He (doctor) said I am ordering you; the staff said I don't obey your order. They both argued and began to fight (Code 001, lines 19-24).

Another participant articulated her views in this manner,

> "Doctors feel that nurses are under their thumb" (Code 004, line 31)

Participant verbalised that despite being at the wrong site, physicians are never penalised;

but if the nursing staff made even some minor mistake, it's been overstressed several times. This also shows the overriding dominance of medical professionals. A participant elaborated:

> In some joint staffing meetings, I can recall simple examples of nursing being quoted by the chair or medical director, and I don't have the power to clarify the situation. At that time, I felt a lack of empowerment and respect. I often feel that there are physicians who make many errors in patient care areas. Their incidents are not raised. They said that these were known complications, but if the medical director has seen an NA (nursing assistant) eating a biscuit in patient care areas from the patient property, he gives this example in every meeting (Code 002, line 29-33)

Thus, nurses are suppressed because of the strong influence of the medical profession. That is one of the major reasons nurses are hindered from becoming empowered.

Category # 3.2: Power of decision making authority.

Mostly, the participants verbalised that they didn't have decision-making authority. Rather, they had suggestive authority.

> Yes, to some extent, they are not fully empowered … the medical and the nursing superintendent positions are not equivalent within the structure. Nursing-related decisions and policies are made by nurses only, and doctors-related decisions based on overall cure should be made by the M.S. So, at the cure site, the medical superintendent should be there, and at the care site, the nursing superintendent should be there. This does not exist anywhere in the structure. Rarely do I feel empowered; I only have suggestive authority. (Code 009, line 2-5)

Another participant articulated that if the position has been designated with all the authority and power, then the person is empowered. And suppose it's not with the power; one is just designated to some particular position without any power and authority, without any decision. In that case, he or she is not considered empowered. Participants shared the following words:

"If the position which has been designated to you with all authority…empowerment is as you can say is with authority you are empowered, and without it you are powerless" (Code 001, line 3).

Some nursing leaders declared they were not equipped with full power. One said, "I have some percentage of power….full power is with the DG. Until, and unless we don't have power, we cannot achieve anything" (Code 005, line 37).

One of the participants related the power with decision-making within the organisational structure, especially if it had to do with day-to-day operational issues, so the participant felt that she had that. However, coming back to some policy decisions that require change, she cannot make an independent decision. She has to consult higher management for some decisions regarding a policy change. But To her, that is okay because it does not make her feel disempowered; it's just the process of the university, and she is quite comfortable with it. As she feels that she is accountable for everything, she does and says:

> I feel that I have the power to make decisions in many of the matters related to the school…. but with it, I have a great responsibility to understand what I am doing and that I am accountable if anything goes wrong. (Code 008, line 1-9)

One of the participants shared that nursing leaders did not have power. Hence, they didn't have the authoritative power to make decisions independently. Rather, their power was limited. They are authorised to provide leaves, but they are mostly restricted to giving suggestions only; participants expressed that nurses should make independent intake decisions for the nursing profession; one of the participants defined empowerment in these words:

> Empowerment, to me, means giving power for decision-making and taking action; i.e. it is not just empowerment but translating into responsibility and accountability. So you get the responsibility to do something you are accountable for and have the authority to maintain it. So, I see empowerment as three things: responsibility, accountability and authority.
>
> (Code 008, line 1-3)

Some nursing leaders believed there was a strong power relationship with the institution they worked with and shared its role in perceiving power. They felt empowered being affiliated with the institution they work with compared to many nurses working in government and semi-government hospitals. As other nursing leaders, they have a reporting relationship with the physician, and they cannot even make simple decisions about their nurses about changing the system because they are dependent on the physician. However, she felt that she could make independent decisions because of the conducive environment of an organisation, as one of the participants said:

> I feel that the chancellor of the university has given value to nursing in this institution. I can bring any changes I can make to the nursing services here. So, comparatively, I have got more power and being affiliated with the (participant's institution), I get a lot of respect from people (Code 002, line 38-45)

Participants also related power with job description, and they felt that it's like if a position is given or assigned as in a government job, they are promoted or assigned according to the government rules, nursing and it is not only about the job description because they perceived as government servants and have civil servants rights, rules and regulations. People of a particular grade have this power, and a person of this grade has a particular power. We also have books for rules and regulations, which guide them properly regarding a person's authority and powers. How they are supposed to utilise them, one of the nursing leaders shared:

> You have the job description, and because of that description, all the powers and authorities also come with it automatically, as it is written to you that you must do this. This, and to do this, means you have the authority and power to do that particular job... (Code 001, lines 4-6).

One more participant shared her experience while working with a government organisation, where they felt they should have the authority to discipline the program, which is currently not there. A participant said:

> Because we work with government institutions, we are being asked to help, and we help. But at the end of the day, we do not have any decision-making authority. We have all the responsibility and accountability, but no authority (Code 008, lines 12-16)

One of the nursing leaders proudly shared how power comes through independent decision-making in the organisation, as if she is involved in every aspect impacting her division. Participant verbalised that as a director of nursing services, many things on her, any new program at IED (institute of Educational Development), any new poverty program, housekeeping, wherever opening up a new building which requires staffing, she is actively involved and able to make decisions, as participant said:

> To me, the empowerment of a leader is like she has enough power to decide every level. For example, at the staffing level, budget level, and institutional level…. so I am in control of everything, and my decisions are respected. And I have the power to control wherever possible. Then I feel I have a say, I have a voice, wherever I sit, and I feel empowered enough (Code 002, lines 1-6)

These excerpts convey that authority is one of the crucial components of empowered nursing. Until nursing leaders in Pakistan have full authority, this profession will not be able to reach the heights it has in developed countries. Moreover, the role of nursing regulatory bodies in Pakistan significantly strengthens the nursing profession. These bodies must also be strengthened.

The participants also showed concern about the misuse of power by some nursing leaders and the fact that they often confined it within themselves, which endangered the entire nursing profession's empowerment. They believed that if one gives power to others, they will get more in return. Participants also shared that empowering as many people as possible is necessary if one wants the result. One could enjoy it if one localised or centralised the power, but it would not give the needed results. If someone wants to succeed and make the profession successful, then it is mandatory to empower others, one of the participants said:

> If we don't empower people, in other words, only certain people will have power, and it means you are not developing other people. You will retain all you have, so whenever you have a disbalance in power, the profession cannot grow … That is something: the more you distribute, the more you will have, and you earn power (Code 010, lines 50-58)

The participants also talked about the context in which one defines power. They stated that it depended upon individual definitions of how one utilised power, whether negatively or positively. One of the participants expressed:

> It (power) could be negative, too, if you are given power. People often misuse power, depending on how you define it. Does power mean I am superior, and everybody else is below me, and I can order them around? Is that power? (Code 008, lines 26-27).

Another nursing leader shared a similar sort of expression:

> "If you are the director, you hold the highest authority, and one should distribute this power, but most leaders do not share the power". (Code 012, line 30)

Category 3.3: Powerlessness.

Powerlessness was another concept which emerged from the data. The concept of 'powerlessness is the antonym of having 'power'. Most Participants felt powerless when they failed in some areas of action. Despite struggling hard, they cannot achieve the target, leading to powerlessness. As expressed by the nursing leaders, the feelings of powerlessness were being frustrated, helpless, ill feeling, bad, and hurt. A participant expressed that she has to go to the EDO and then needs to request them, whatever their difficulties are, to solve them. So there she feels helpless, as the participant mentioned:

> There were 45 nursing schools in Punjab. They were under the control of the Director General Nursing, but the moment the district government were established, all the schools were given to the EDOS. Then, my position becomes very awkward. When my instructors or students are in trouble, I can't do anything for them. Directly, I can't tell them what to do this or do, or I can't help the students over there. I can't transfer to the Nursing Instructor; I am helpless. (Code 004, line 11-17)

Having a doctor designated in the position of a nurse leader also caused a feeling of extreme powerlessness. A participant shared:

> "We experienced great ill feeling when, at the eleventh hour, a doctor was designated on the position of a nurse". (Code 006, line 64)

Another participant stated:

> We could have set some kind of conditions. Still, we have not done that, and therefore, we suffer from disempowerment, and we cannot carry out our responsibility and meet our mandate and goals. (Code 008, line 21)

The above-quoted responses show several occasions when nursing leaders in Pakistan, despite working very hard, experienced powerlessness during the empowerment process. These factors made their journey towards empowerment more challenging.

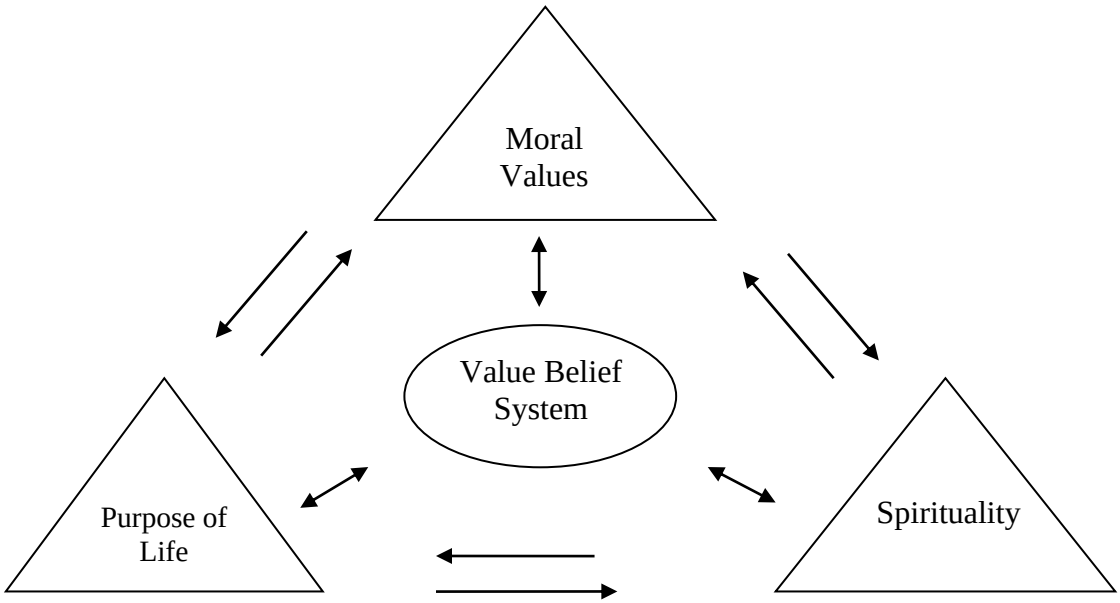
The nursing leaders verbalised some constructive derives, which assisted them in coping with the challenges successfully and made them confident enough to move further up on the road to empowerment. These include 'value-believe system' and 'leadership and management'. These categories are mentioned below.

Category # 4: Value Believe System

In this category, the participants verbalised that their value belief system provided them, as nursing leaders, a direction to successfully move professionally. Under this category, most participants relate it with faith in God. This is one of the unique data from the study findings. This is very much embedded in the

socio-cultural context of Pakistan. This system also instilled in them a sense of motivation, considered the most important deriving force in the empowerment process. Philosophy of life, spirituality and moral values are the subcategories identified under the value belief system. This is shown in Figure seven.

Figure Seven: Value Belief System



Category 4.1: Purpose of life.

It was revealed from the data that the nursing leaders' 'purpose of life' continued towards their commitment to the nursing profession. This also proved to be a stepping stone for serving the nursing profession with sincerity and integrity. According to a nursing leader's view:

> In our belief, we are born once only, and everything will be finished, so whatever responsibilities almighty God or my profession has given us, we should do them honestly. Whatever work has to be done by me or my team, we should do that, and that is the great satisfaction we get out of it (Code 004, lines 79- 80).

The data showed that their belief system made the nursing leaders courageous enough to even face life-threatening situations with boldness. One of the nursing leaders said:

> It happened in the past, and a discussion was held at my table with four Kalashnikovs. But I was firm enough and said that if she (the student) has passed, then she has; if she has failed, then she has failed. You are showing me this Kalashnikovs, but life and death are in the hands of God. You can't do anything to me. Pick this Kalashnikov and get out of here. So, for empowerment, you should have firm faith that everything will be done; you have to be daring. You have to set your life accordingly (Code 006, lines 257-264).

One of the nursing leaders connected the concept of ‘empowerment’ with her inner instinct and said:

. You cannot do it until and unless you desire it internally (within your heart). Nobody can impose it on you as your duty. Until and unless you are convinced in your heart and agree to do it, and then take it as a challenge and do it, nobody, not even ALLAH (God), can come down and say that you do it. You will do it but as your duty. On the other hand, if you will do it because it comes from the depth of your heart, that is something you will do for your soul. You cannot measure those things. But you need a feeling for that wherever you are working. Like a mother is doing something for her kids, in return, she does not want a reward for that. But that thing always comes from the depth of her heart; that’s why she does it. We need that sort of spirit, working being professional and empowering females, especially nurses (Code 003, line 186-197)

The data showed that the purpose of life greatly influenced an individual’s philosophy of life, giving them a sense of inspiration that enabled nursing leaders to perform their jobs ethically.

Category 4.2: Spirituality.

Faith in God is one component of spirituality. Data from the participants also demonstrated that faith provided them with positive energy to perform their jobs enthusiastically. The concept of ‘spirituality’ instilled in them confidence that they would be able to achieve their targets and hope that positive changes would occur. Hence, this served as a positive stimulant for most nursing leaders.

A participant shared that she didn’t perceive she had the required capabilities. However, God blessed her with this job to contribute towards the betterment of the nursing profession, as one of the participants said:

I must do it with the help of Al-might Allah. This job and administration are given to me because of Almighty Allah. And the prayers of my patients, seniors, in-laws, and parents. I think Allah chose me for this appointment. That’s why I am here. I don’t have the capabilities to be appointed to this position. Then why did I get this appointment (position)? I think for the betterment of my profession.

> That's why I have started working on improving the infrastructure of the school of nursing at the Federal level, increasing nursing positions at the federal level and establishing nursing directorates at the federal level. (Code 007, line 30-33)

One of the nursing leaders also conveyed that faith has instilled a sense of courage, and practising regularly in professional life helped them cope with difficult situations. Moreover, participants believed that firm faith is one of the necessities of empowerment, as one of the nursing leaders said:

> When I leave home for work, I always recite the table (prayers); on the way, until I reach the office, I only think of Allah, who gives me the strength and empowerment I need. (Code 012, 27-29).

Category 4.3: Moral values.

The nursing leaders also talked about the moral values of life, which had an equally important role in professional life. It was highlighted that empowered leaders should be impartial, transparent, and fair, as these are the major moral values. One of the participants said:

> But once empowered, you have to be seen as fair, not taking sides, and transparent that just because you are my friend, I will make you my leader; this should not be so. You should be transparent, impartial, fair, self-actualized and hard-working, so you have to be in a role modelling effect for others. Moreover, you should have humility. You should be selfless, be an honest, and caring person. If you have the power to do something, you become a leader for others. Those are some ingredients that you should have (Code 008, lines 142-144)

Data also revealed that nursing leaders had to be selfless to empower others. Participants emphasised that once they become empowered, it becomes their moral duty to do something wherever they work for a profession, the organisation, or colleagues, which is a big responsibility for them being leaders. According to one of the participants:

> You have to bear this burden and work for it. At this stage, you must stop thinking about self-development and self-promotion, as you have already achieved the maximum (Code 003, lines 149-153).

Another nursing leader articulated:

> By giving time to others and listening to them, you often show a willingness to empower others; one should not think about what will happen to you. You have to be somewhat selfless because it's difficult to empower others (code 010, lines 63-65)

One of the nursing leaders emphasised the importance of moral values for nurses and their connection with the nursing image; she said:

> "I think if somebody is up to the mark …. if you are rightly doing things according to your custom, socio-economic status, and behaving appropriately, your image will automatically rise.". (Code 003, line 48-49)

The participants shared that patience and tolerance were crucial for empowered nursing leaders. One of them said:

"And in any situation, never lose your temper, regardless of how angry you are. You have to be sure that you are cool and calm. Otherwise, you will lose it" (Code 006, lines 58-59)

Another participant expressed similar views:

> "I worked on myself a lot like I used to be a very aggressive lady. However, I had to work on being soft in the meetings and giving messages in different tones rather than in a direct tone. These are things which I have done also". (Code 003, lines 111-113)

Participants mentioned that strong morals affect nurses' empowerment. She said:

"I never paid a bribe. I built my rapport and kept my character (moral) strong. If a woman is morally weak, you will lose your voice. This is the main psychology". (Code 006, line 301-303)

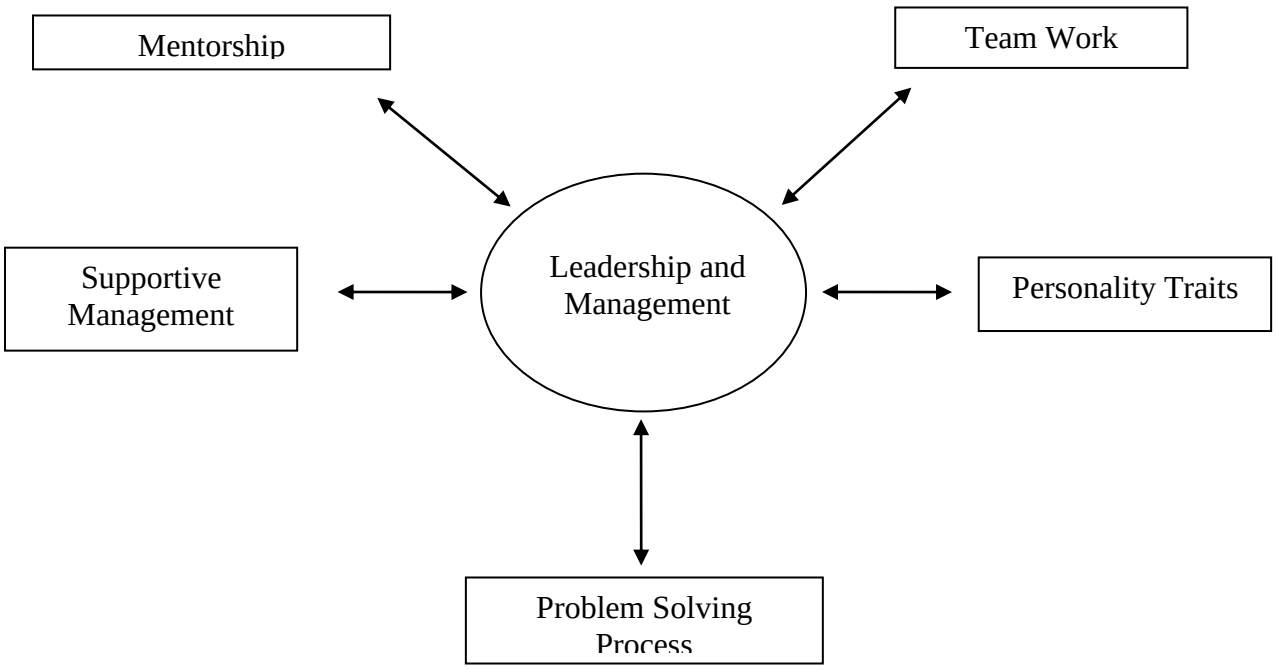
The concept of a 'value belief system' plays a critical role in attaining empowerment among nurses. This system enables people to spend their lives around moral and ethical principles, which gives them inner strength, makes them courageous, and makes them morally and ethically sound leaders.

Category 5: Leadership and Management

The concept of leadership and management is quite broad. Data revealed that this concept acted as a constructive derive, which helped nursing leaders become empowered.

The subcategories that emerged from this concept are mentorship, supportive management, teamwork, personality traits, and the problem-solving process. This is shown in Figure eight.

Figure eight: Leadership and Management



Category 5.1: Mentorship.

The participants verbalised that the role of mentorship helped them greatly and facilitated their empowerment. The participants got mentorship in their workplace, eventually enabling nursing leaders to mentor other nurses. This concept is crucial for empowerment among nurses in Pakistan. One of the participants explained the principles of mentorship and said:

> Give people a chance and space to make mistakes, definitely with some parameters. Give them some room. Be there, support them, encourage and guide them …. trust them, and you have to give them some room for improvement. We have to respect people, accept their strengths, and simultaneously remember that there is no person on earth with no weaknesses. And no person in the world is perfect. So you have to accept people as a whole package.
>
> (Code 010, line 75-77)

Support of a mentor can work wonder; this was another important piece of data that came out from participants' discussions. The nursing leader shared that one of the things she

likes about empowerment is to look at it in a true sense and allow people to make decisions. Then, if they make a mistake, stand by them and mentor them and support them and teach them and tell them where they have gone wrong so next time they will not make the same mistake, as one of the participants said:

> Delegate work to people, give them responsibility and accountability, and give them mentorship and support; in this way, you give them work to succeed and not work to fail. This is very important in empowerment. Then, it is seen as a positive tool for empowerment (Code 008, lines 124-126, 129)

Another nursing leader expressed the importance of getting advice from seniors, and during the discussion, she appreciated the advice that she had received from one of her nursing leaders; she said:

> Whenever a person wants to do something, he/she needs to share his/her idea about it first. For that, I talk via telephone to someone at the college of nursing or sometimes to the controller or whoever is experienced as the chief nursing superintendent…. Sometimes I call her at home to seek her advice. . …I have learnt many skills from her (Code 005, lines 41-44, 47-48)

Another nursing leader said:

> I have to ensure that they feel empowered and accountable when we mentor and work with them. It's not as easy as it sounds because empowerment brings with it huge accountability (Code 008, line 89)

According to the participants, mentorship plays a significant role in empowering nurses in Pakistan. Therefore, a formal mentorship program in nursing institutions can be an important step in the development of empowered nursing leaders in Pakistan.

Category 5.2: Team Work.

Data revealed the significance of teamwork in the workplace and its strong association with nurses' empowerment in Pakistan, as a participant said:

> Empowerment cannot be achieved without a team, without the support of your professionals, and the support of your subordinates and seniors. Empowerment always comes vertically and horizontally; if you work in a team with their consensus, you will achieve the targets; otherwise, if you go single-handed or single-minded, you have something in your mind, and you keep on struggling for that, and you cannot do it (Code 003. line 59-62)

The participants gave credit to teamwork for all the success that they had achieved in their professional lives; one of them said:

> We all work as a team. We can conclude that if you can work along with people, then it is very rare that those who are subordinates disagree with you. (Code 011, line 68-72)

One nursing leader stressed the nurses' unity; she urged:

> Nurses should work together, regardless of whether they are private nurses, public nurses or federal nurses. We should work united; our attitude, behaviour, and conduct should portray that we want to serve and set an example for others. (Code 007, line 38-39)

Participants indirectly proudly expressed that whatever success they have achieved is because of the support of nurses. One of the nursing leaders articulated:

> For example, we have constructed this building (directorate nursing). My boss did not allow me to construct this building, so I gave them money. I didn't. After that, I had a very tough time. But thanks to Allah, my nurses greatly supported me….and achieved our goal (code 006, line 10-18)

Participants felt that teamwork has a great role in achieving goals. Teamwork has a great effect. She empowers the assistant, deputy, superintendent, or ministry staff to meet the targets. But one person can not do all the work. She verbalised that nursing leaders have to distribute the work and empower others. Another participant said:

> A single person can't do anything. We have to decentralise the power, and the team has to work for this. ….. and I think organisations can not cope with the work if it is done by one person; we have to work as a team. (Code 004, line 81-85)

One more nursing leader verbalised that due to teamwork, they don't face too many problems, as she said:

> I have my administration team, my NS, and my ANS, and whenever we have any such problem, we all sit together and make one decision, and then we inform our seniors that we have explored these things. We have concluded such possible results, which are like this: These things help us (Code 001, lines 106-110)

In light of the participants' views, it was evident that unity and teamwork are crucial for empowering nurses in Pakistan. Therefore, nurses should focus on how to strengthen teamwork and thereby empower the profession in Pakistan.

Category 5.3: Supportive management.

The role of supportive management is another important concept apparent from the data. The nursing leader said:

> When I came to this position, though I possessed the required knowledge and experience, I didn't have the experience in file work, and here I would certainly like to mention the name of the brigadier (participant's mentor). He helped me greatly in this matter, always supported me, and taught me how to study the rules. (he told me that) Whatever notes the assistant writes on the file, you must critically review them. You have to study the positive and negative aspects, and then you are supposed to summarise them. He helped me solve several problems. He also told me that if I had difficulty writing in English, I could write it down in Urdu as well, or I could write in English. (He said) we will make sense of it. So you don't feel any hesitation. You first have to make the notes or summary clearer. He remained in this position for 2-3 years, and during his presence, I learnt a lot and gained a lot of experience, and I feel that I became outstanding (Code 005, lines 55-65)

Another nursing leader narrated that with management support, she was able to make her place in the organisation, according to:

> Different hurdles do come, and people try to take your authority back. For example, let me give you an example of my present job. When I joined, the whole authority was with the current staff. And they were not willing to give me any authority. They wanted me to sit there but didn't want to give me authority like saying yes and no to anything. At that time, my vice president advised me to just observe them. (She said) Keep doing your job, which is necessary for you, but don't ask for authority to say that today I will do this. Don't do it; they will automatically give it to you. Well, I started observing it and found some weaknesses out of that. Then I discussed it with them, and they said okay, madam, we have done enough; now this is your responsibility. And eventually, they started bringing things back to me, on which, from the very beginning, I eagerly wanted to work (Code 003, lines 88-98)

The nursing leaders recognised that the support and confidence of the higher management could become a source of empowerment for them, as one of the participants said:

> I remember I was at Shifa International Hospital, and we had a lot of responsibilities. While assigning reporting relationships, the hospital administrator asked rather than assign the respiratory therapist to report to me because it was part of the nursing services. So, the head nurse and the manager reported to me similarly; the respiratory therapist was supposed to report to me. He refused and said that I would not report to a woman. But more than that, I think he was more qualified than me. I was BScN, so I had an undergraduate degree, and that fellow was double masters. And the administrator said she is the leader; she knows her job. Yes, may be a little less qualified in your area. But I am very confident she can do what is expected. And I am very confident that she can do it. So, either take the job or you can leave the institution. And he left. Somebody hired from another country came, so when your leader shows confidence in you, that is one part of empowerment. They are not only giving you a free hand to do this, but they also support you (Code 010, line 6-21)

Category 5.4: Personality traits.

Personality traits very apparently came out of the data. Certain traits proved to be crucial for empowerment among nurses in Pakistan. Nurses found that teaching these traits or characteristics enabled nursing leaders to work effectively within the organisation. The major personality traits identified from the data were critical thinking, assertiveness, proactivity, flexibility, courage, optimism, and motivation. It was said by one of the participants that self-motivation is key to empowerment; data depicted:

"So you get empowerment from outside, but I think you can empower yourself from within by saying to yourself that I think I can do this and I will, and I am comfortable doing that" (Code 008, line 77)

Participants stressed the critical thinking component and verbalised that if a leader cannot do eye reading and observe facial expressions, then she or he won't be able to get things done. She further said that if one wants empowerment in getting the work done, one has to be a critical thinker. She felt that knowledge is not confined to books only. Books may

depict the method or process of doing things, but this method may not apply to everybody. So, a leader needs to decide which job one is supposed to do at a particular time, as was said by one of the participants:

> "If you can't read the faces, if you don't know critical thinking, according to the situation, you can never get a hold on things. For this, you must be a very strong thinker". (Code 006, line 55-56)

The participants also emphasised the importance of being active and alert, which is necessary for empowered leaders; one of them said:

> They need to be fit to do the job. They need to keep themselves active. Smartness, proper diet, and proper sleep are also contributing factors in a leadership role that they should adopt. (Code 002, line144-149)

Other participants stressed the value of leadership; she articulated:

> "But reflecting again, I would say, the value of leaders who are empowering other people, they need to be ready to empower others". (Code 010, line 60)

While other nursing leaders said:

> "I guess Allah blessed me with courage, and I have a quality that I have courage, determination and patience, and I am never afraid of anything". (Code 005, line 73-74)

Optimism is another unique trait highlighted by the participants; they always learn from failure and reflect on how they could have done it better, where she has gone wrong, what should not have happened, or what did not happen that should have happened. One of the participants reported in the following words:

> If I look at things this way, "Why did that person tell me that?" I get lost, then I get angry. But if I were to look at "why did this happen and how could I have done it differently", that allows me to progress. …So these are some of the things that I do. (Code 008, lines 95-107)

Category 5.5: Problem-solving process.

One of the important concepts reported by the participants is the problem-solving process. As one of the nursing leaders said:

> We wanted to do some work in several situations, but we couldn't. But then we were given some time, we did the analysis, and after that, we changed our style. Once we changed the style then, we changed

> the strategies. Then we proposed some operational plan about how to handle a particular matter (Code 006, lines 48-51)

Excerpts from the data show that the participants stressed the importance of leadership and management, which is one of the necessary factors for releasing from oppression and equipping them with qualities that are indeed significant for empowered leaders. Nurses could use these as constructive means to attain empowerment in Pakistan.

The following table summarises the conceptual framework of empowerment.

Table Two: Empowerment Model Various Categories and Sub-Categories

Categories	Status of a Nurse	Value believe system
	Sub-Categories	
	Lack of qualifications, skills and competencies	Purpose of life
	Nurses as an oppressed group	Spirituality
	Suffering of nurse	Moral principles
	Nurses as a labour force	
	Role expectations of a nurse	
	Nurses' Image in Pakistan	
Categories	Nursing Profession	Leadership and Management
	Sub-Categories	
	Body of specialized knowledge	Mentorship
	incompetent and inadequate human resource	Teamwork
	Regulatory bodies in nursing	Supportive management
	Public acceptance of the nursing profession	Personality traits
		Problem-solving process
Categories	Power Relationships	

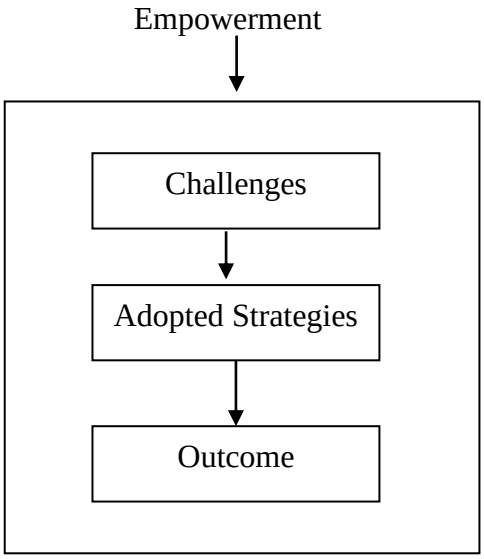
	Sub-Categories Influence of the medical profession Physician centred culture Nurse physician relationship Power of decision-making Powerlessness	

Operational Framework

During the journey of empowerment, nursing leaders confronted many challenges. Although most of them have already been discussed under the conceptual framework, they have been approached more pragmatically. Through constant struggle, nursing leaders are coping with these challenges. Furthermore, they have adopted certain strategies, which have helped them to move on the road to empowerment. Subsequently, they have come up with some positive outcomes, which have been rewarding for them.

The operational framework is shown in Figure nine. These are outlined below:

Figure Nine: Operational Framework



Category 1: Challenges

Nursing leaders in Pakistan face numerous difficulties during the empowerment process. These include limited sanctioned seats in the nursing profession, political influence, a mediocre education system, negative colleagues' attitudes, teaching to male nurses, incompetent nursing leadership, a lack of nurses’ competencies, and a physician-centred culture. The challenges are shown in Figure 10.

Figure Ten: Challenges

Category 1.1: Limited Sanctioned seats for nurses.

Another big challenge that the nursing leaders and nurses face is limited, sanctioned seats for nurses. That is the reason why promotions are not done on a timely basis. The nursing leader stated that she forwarded a proposal for a nursing directorate in which she has demanded at least two deputy directors of nursing and two assistant directors of nursing, as the participant shared:

> In the province of NWFP, there is no director general nursing (DGN) position. Rather, they have a DG position where a nursing leader must work as a DGN, overseeing and representing the whole province. We have developed a service structure and put up to the government…. So, one deputy director of nursing could handle the service side, one assistant director and one deputy director of nursing could manage the education side. Therefore, if our two wings work, they can easily perform this job. Now, I am alone and facing difficulties. (Code 005, 17-20)

One participant also shared a sad story about her challenge and said:

> I wish that we had power or that our nursing representation could have a seat at the government level, or we could have our nursing directorate that could do the follow-up for the cases and have its environment. So, certain activities are stuck in the middle, because of which I don't feel empowered, and I wish I could do more for the benefit of my profession. (Code 005, line 25-32)

One more nursing leader uncovered the factor that hinders nurses' promotion.

> In many situations, like some when we make a selection, there is so much pressure, and nurses or CNS don't realise whether the person is eligible for the post, but we are so pressurised that we should do that job. Sometimes, there are very hard-working, competent nurses who deserve to be promoted to a high level or provided with incentives, but their suggestion is not heard. However, this is very necessary for the smooth running of the profession. (Code 009, line 6-8)

Category 1.2: Incompetent nursing leadership.

The participants stated that the nursing profession in Pakistan had a shortage of competent Nursing leaders, which was a big challenge. One nursing leader said:

> I wouldn't say that nursing leaders at this point have the empowerment they should have for progress, professional development, and improvements on the national level. On the other hand, I don't know whether we have well-qualified nursing leaders who are professionally able to deal with empowerment if they get it. I don't know if you have nurses to lobby for empowerment. That is the third thing because nobody comes and gives you the power to regulate yourself in your hands. You have to fight for it, lobby for it, and negotiate for it. And all these things the leaders have to do, and I don't know if we have done enough of that. (Code 008, line 42-47)

Category 1.3: Scarce resources.

Scarce resources were another big challenge that most of the participants reported. Participants expressed that they got empowered by starting the program, but at the end of the day, they needed resources to do that, which was another big constraint. Data revealed:

> Sometimes, a lack of resources prevents you from doing what you want. For example, we have great human resource constraints, and we don't have the competent teachers that we need. So, if you are starting a program and you don't have enough teachers, the program may or may not be successful. (Code 008, line 91-93)

One more participant articulated this in the following words:

> We have started our Programme but don't have qualified teachers. Our nursing school commenced 18 years ago, but until now, it does not have its building and hostel. Our College of Nursing started 18 years ago without any instructors. Not a single nursing instructor was appointed in the College of Nursing. (Code 009, line 16-19)

Budget problem was reported as another major issue, as one of the nursing leaders said:

> "Like I was developing institutions. While building institutions, budget remains a big problem. We have developed those institutions but didn't have the budget. Now, the question arises of how we run these institutions. (Code 006, line 60-63)

Another nursing leader shared the lack of resources in the ward and said the hospital systems are now changed. As the costs have gone high, nurses didn't have enough equipment. This resulted in the fact that nurse rapport and skills being affected, as one of the participants said:

> So, she cannot give proper care in this situation; for example, if she wants to sponge but the equipment is unavailable. So it happened that, little by little, the nurse gave up working. We have water problems in our ward. The infection rate has risen even more because there is no water in the wards. When you attend to a patient, you must wash your hands. But there being no water, you are infected; thus, you pass it on to the patients. (Code 006, line 136-150)

Category 1.4: Negative attitude of colleagues.

The negative attitude of colleagues is a very big challenge that most nursing leaders in Pakistan face, affecting their performance at work. One of the participants said:

> "I am facing a lot of difficulties, and these had faced in the past, as well. Nobody has digested (accepted) me happily till now". (Code 009, line 62)

Another nursing leader elaborated on the lack of nurses' support from the platform of the Pakistan Nursing Federation and reported:

> Initially, despite having several nurses, they were not ready to support us. Our position was very weak. In our setting, when one wants to do something good (productive) professionally, our nurses do not support that person. (Code 006, line 19-22)

Whereas another one said:

> The deputy secretary is in grade 18, but he thinks he is above me because he is sitting at the secretariat. He behaves like he is in grade 21 or 22, although in grade 17 or 18. (Code 004, line 36-37)

One of the nursing leaders talked about the non-accepting attitude of colleagues, i.e., a nurse behaving like a boss, which affected their personal and professional life; she narrated That people are practising for a long time, and it's not easy for them to accept a nursing leader mentally as boss. Because they were independent and wholly in charge of the (participant's institution), and they also were doing what they wanted to do. In the beginning, I also had a fear that this lady sitting in this position would take all the power, as one of the participants elaborated:

> They started writing anonymous letters against me, talking against me in public and saying that look, she has two young children, she will not be able to cope with the job, it requires a lot of travelling. They started talking to my family members. At that time, I had a two or three months old daughter. They insisted that I go to Gilgit and Chitral, where I would have to stay for 8 or 9 days, especially in December. They tried to give me a hard time, so I quit that job (Code 003, lines 104-115)

Category 1.5: Political pressure.

The Nursing leaders also verbalised that they had to involve themselves politically most of the time, facing several problems. One of the participants said:

> I often had to go to court. If any student failed, then people used to come to me. They asked (insisted) that I give a pass grade to that girl. I said, 'No', I cannot give her a passing grade. Consequently, the (doctors) came to my office and tried to kill me. I ran away to home. I launched FIR. We wrote to the president as well. It was the era of Nawaz Sharif. Then, orders came from Nawaz Sharif for inquiry. This case was debated in the court. They launched a case against me in court. I went to court. Then, the case proceeded to the high court. (Code 006, line 240-247)

Another nursing leader, who also faced a similar sort of political pressure, said:

> There are several challenges that I face; people give us threat calls. Sometimes, these political people are a part of higher management. Once we get frightened because of threat calls, then we cannot stand on our own. There was a boy (male candidate) from JPMC; I was told to give him admission. I told them how I could enrol him. Because he has failed twice in the Islamic mission (nursing school), he is now a year II student and does not meet the admission criteria. He cannot attempt for a third time. Therefore, we cannot give admission to your candidate. Whatever you want to do, go ahead! They said, mam, we will do this or that. (Threat). (Code 012, line 100-108)

Category 1.6: Educational issues.

The participants also found that upgrading and developing oneself professionally was a huge problem; one of the participants reported that working and struggling to become empowered is a challenge. The path to empowerment has many hindrances in one form or another. For example, insistence by seniors that junior isn't allowed to go for further studies. The nursing leader reported that it was a challenge when she planned to complete her postgraduate studies. When she completed the four-year nursing course, she got to know that in the fourth year, they were supposed to go further for graduation; she said:

> At that time, the JPMC was the only medical college I applied to, and I worked hard to get into the institution. Unfortunately, my seniors insisted on sending senior nurses for further studies rather than junior nurses like me. (Code 011, lines 80-89)

Category 1.7: Organizational structure.

Dealing with higher management in the organisation is sometimes very challenging because the organisation's culture is not conducive enough to allow one to question one's higher-ups. They do not take it positively as it is a discussion whenever they talk with our seniors; it is in our culture that they never like it, as a participant said:

> … Challenges come that whenever you want to influence someone else's decision, obviously you face resistance. It's not a matter of today, I think. When I entered my job, from that time, whenever someone senior to you or your colleagues, whenever you try to tell them that it's not right, it's (considered) a big problem; they think someone is opposing them. Or if you say there is another option,

> they think we are against them, or we are their enemies, or we are fighting against them. (Code 001, line 142-150)

Some nursing leaders found that the organisation's hierarchy is a huge challenge; participants repeatedly emphasised that she has to go to the government, then she has to plan, and again, the plan is given to the government. Whatever she wants to do, she has to get permission from the government. This was the only problem; she felt that if direct power was given to her or her Deputy Director, they could have got the work done smoothly and quicker, as she reported:

> There were a lot of challenges; in this post, I came as a DGN because the principal and CNS had so many problems, and I just had to deal with the schools. The Chief Nursing Superintendent deals only with nursing orders because the Charge is the MS. (Medical Superintendent). Here, I face a lot of problems because I am not empowered. … But when we have to go to the government, and then again the procedure is very long, I feel there is a delay and nurses get frustrated over there (Code 004, line 61-65).

Category 1.8: Nurses' incompetence.

Data also revealed that a lack of nurses' competencies hindered them from achieving the goal, which was perceived as a big challenge.

> In policy-making, we must improve our writing skills to express ourselves and tell people about our problems. When our students come to us for some issue, I ask them to give it to me in writing. They don't even have the skills to write it down on paper, and I have this problem. Consequently, all the issues remain in the pipeline. They cannot be solved (Code 001, lines 109-113)

Category 1.9: Teaching to male nurses.

Though some of the participants found that the introduction of male nursing had proved to be beneficial, however, it was found that teaching them was quite difficult. The participant reported that male nurses, even during their training period, do not demonstrate an enthusiastic attitude towards the training, and it is difficult for the trainers to control them. It has been observed that whenever these trainees are assigned particular duties, they show

irresponsible attitudes and fail to perform their duties properly, as one of the nursing leaders said:

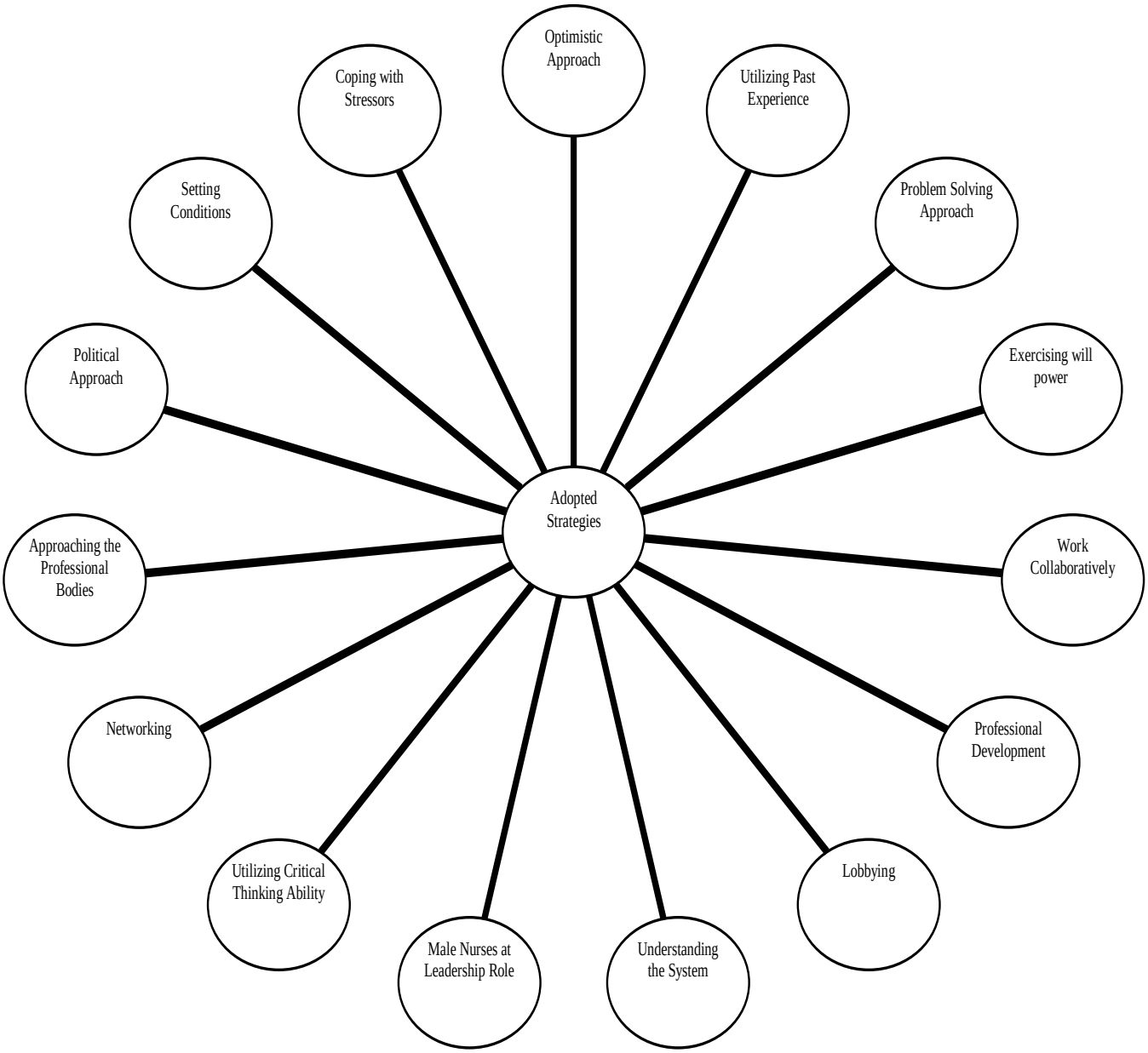
> We initially had several male nurses with us in our institution, but for some reason, these male nurses went on strike against the institution. A considerable number of female nurses also supported them. The strike continued for nearly two to three months, and after that, the employment of male nurses was abolished. We are now reconsidering recruiting male nurses in our institution again. However, I would say that it is much easier to control female nurses than males.
>
> (Code 011, lines 90-104)

The excerpts mentioned above reveal that nursing leaders in Pakistan face numerous challenges, and struggling to cope with these difficulties often results in non-productive outcomes.

Category 2: Adopted Strategies

There were some strategies that nursing leaders in Pakistan adopted to cope with the challenges and attain and retain empowerment. It included working collaboratively, lobbying, having male nurses in leadership roles, self-determination, problem-solving approach, political approach, coping with stresses, setting conditions, understanding the system, critical thinking, networking, approaching professional bodies in nursing, and through professional development. The adopted strategies are shown in Figure 11.

Figure Eleven: Adopted Strategies



Category 2.1: Optimistic approach.

The nursing leaders emphasised an optimistic approach to overcoming the challenges and empowerment of nursing in Pakistan. One of the participants said:

> Some people are very stubborn; sometimes, they know they are wrong but don't want to accept it. I have had one or two experiences like that; I tried my best, but it didn't work despite trying repeatedly.

> But again, I don't see it as a failure because it relates to one person. We have not failed with the organisation. We have failed with one single person (Code 003, lines 138-142)

Another participant said:

> "I accept the challenges and try to solve them. Thanks to almighty God, I can face them". (Code 004, line 72)

One of the nursing leaders expressed:

> To become empowered, I had to cross a lot of barriers, but whatever I did was based on my honest efforts, along with a lot of my fellow nurses, instead of planning conspiracies against the people who withheld the higher posts (Code 011, line 60)

Category 2.2: Utilizing experience.

Nursing leaders also said that using past experiences helped them achieve the goal.

> I would say that for me, controlling everything in the province, managing the examinations, and managing para-medics while controlling various other processes was a difficult task. But managing all this was made easy by some strategies, for example, paperwork and the arrangement of my documents; my experience of being a teacher and a student came in handy on many occasions, and finally, dividing each task into smaller steps so that ultimately you get the required results which are accurate as well as satisfying. (Code 011, lines 90-94)

Category 2.3: Problem-solving approach.

Many of the participants used the problem-solving approach to cope with challenges, as one of them reported:

> I think one of my strengths is that I can talk to myself, and therefore, I am able to tell myself, okay, you made a mistake, and it went wrong, and I have to be careful and not repeat it next time. So that is another way that I deal with it. What I usually tell my husband is don't cry over spilt milk. That is the sort of philosophy I have. Don't cry over what has happened because it has happened you can't change it. And how can you not let it happen again, or how can you improve what has happened? I think this is very important. And that, I think, makes me look for new ways of doing things and new strategies to look at. Looking at opportunities (Code 008, line 107-110).

Another nursing leader articulated it in the following words:

> I do a lot of work, like identifying gaps, taking steps, discuss with groups, and once the groups have agreed to it, they give me space to perform it, and they allow me to resolve the issues accordingly, which is right for the organisation (Code 003, line 3-5).

One more nursing leader said:

> We identify a problem, then we utilise a positive approach to that problem.
>
> If you explore the matter, you understand it, and it's easy to decide. Through this, you identify proper people and the risk of picking up the wrong people is minimised (Code 001, lines 197-199)

Category 2.4: Exercising willpower.

The nursing leaders found that exercising their willpower boosted them, and they were able to manage the hurdles in the process of empowerment. Data revealed that self-determination is crucial to empowerment for Pakistani nursing leaders. A participant said that once she got a promotion, she used her self-determination to fulfil the expectations of her job, as one of the participants said:

> But even though I had the courage, I promised myself that I would do (my work) this job. I would learn it. I might bear the pain and learn it. And that's how work automatically begins. That's how I cope (Code 005, lines 73-82)

Another nursing leader reported:

> The position also demands something from you, and you must do it. And if you get the chance, do it sincerely; do it with your full strength and will. And even if you are not in that position, keep doing that for your profession. (Code 003, lines 154-158)

Category 2.5: Work collaboratively.

Working collaboratively was another strategy that the participants identified. The participant verbalised that she always kept in touch with her colleagues. She stated that about matters related to the benefits of the nursing profession for developing service structures or for work which is asked by the government, she certainly approached them. Even when she asked about nominations for the workshop, she talked to her nursing colleagues about their

views and asked for names of suitable candidates as she felt she had valid views and suggestions; she reported:

> I have not only stayed in touch with my seniors but also involved my juniors. Like my controller, she is junior to me, but I also take their suggestions or sit in meetings with them to discuss matters. I consider that (Code 005, lines 88-96).

Another participant articulated in the following words:

> "We have set rules, refreshing my knowledge, meeting with all nursing officers of each department and discuss our problems". (Code 007, line 37)

Nursing leaders also emphasised collaboration with government to achieve the desired goal; it is said:

> The things (issues) that are under my power, I talk to the government, and the government agrees with me and tries to help the directorate of nursing. I think this is the empowerment of nursing …I try to write repeatedly to the government. I justify them, and I fight a lot for my nurses. I somehow managed to keep up and satisfy the nurses (Code 004, line 71)

Category 2.6: Professional development.

Developing professionally and upgrading one's self is important in coping with challenges, one of the participants reported:

> I upgraded myself—to a diploma, a post-basic Diploma, a BScN, and then a master's. I upgraded myself so that I may know about what I am supposed to do further. Otherwise, I would face many difficulties, which I have also faced (code 009, lines 33-34).

One of the participants used higher education as a significant strategy for empowerment. She said:

> I think all my struggles, the file work and my higher education were sufficient strategies for empowerment. 011, 78

Nursing leaders also emphasised that as leaders, they should provide training to those under them; one of them elaborated:

> Empowerment does not mean that you have everything within you. In my opinion, you have the authority, but side by side, you are giving your responsibility and sharing it with your colleagues,

> which means you are giving them training as well to prepare second-line leadership for the future (Code 003, line 123-125)

One more participant discussed the importance of professional development and believed:

> I prepare myself very well, which is knowing things. Suppose I go to a pediatric cardiac surgery meeting. I have the knowledge, and knowledge is power, and if you have the power, you cannot be disempowered by others. In that way, I know that all the decisions will be made eventually. Furthermore, I would say that continuous involvement of the nurses in research and continuous engagement of the nurses in new knowledge is also very important (Code 002, lines 24-26)

A participant also emphasised the significance of research work and internship. According to the participants, it is very important, as most of the physicians come from abroad and exposure to different layouts of hospitals and patients' experiences in the hospitals. So it's very important for nurses also, in every capacity they are working besides the formal education, they should have internship working hospital, as she stressed:

> I do a lot of reading and research and keep myself continuously trained in everything. The interesting thing is that I engage myself in upgrading my knowledge. For example, internship for my master's, I go every alternate year to the Johns Hopkins Hospital….. I think I would have been left far behind if I hadn't acquired an internship in 1999 and then again in 2003. (Code 002, line 91-97)

Category 2.7: Lobbying.

The participants also focused on lobbying to get the required output; one of them said:

> So, I feel that we cannot achieve it single-handedly. We must share what we want and convince our peers, partners or professionals to work together. And start working as a team. In my view and feelings and the few things that I have done in my life, I feel I have achieved 70% of those through teamwork, like convincing my group and then going to the higher authority; so when my higher boss will talk to another one of my team members she will have the same opinion, and she keeps on checking with other members. Everybody would say the same thing we are saying, So we achieve at the end of the day, and it's a quick way of doing things (Code 003, lines 65-70).

Another participant explained that we have to strengthen our nursing leaders by all means, along with education; nursing leaders should know how to lobby, as one of the participants said:

> Our nursing leaders need to refer to them in any way; some people like the nursing profession. And think of it as a blessing, but they are powerful; you should convince them or lobby and take them with you. If you can't do anything by yourself, at least you can involve them so that you get some support from them (Code 001, 172-177)

Category 2.8: Understanding the system.

Getting into the organisation and attaining empowerment requires a sound understanding of the environment, hierarchy and norms of the existing health system, which is reported by nursing leaders, it is said:

"Start understanding the system, and once you know the strengths, then you discuss with them."
(Code 003, line 102)

Another expressed a similar idea and shared:

"First, you understand your system, and then fit yourself in that hierarchy".
(Code 006, line 306)

Category 2.9: Male nurses in leadership roles.

Introducing male nursing and having male leaders in the nursing profession in Pakistan is a unique aspect of nursing. The participants also used this as a successful strategy; one of them pointed out:

> We have introduced male nursing. We send our male nurses to places where our females cannot go. Where our female nurses were afraid, there we forwarded our male nurses. Males worked side by side with them (nurses), where female nurses were reluctant to speak, and the males spoke. As a result, Sindh's position is different today. (Code 006, line 80-83)

Category 2.10: Utilizing critical thinking ability.

The participants also stressed the importance of utilising the critical thinking ability of nursing leaders in Pakistan. She focused on that one must wait for the right time to hit the

right thing. Whenever one wants to get things approved by higher officials, one must assess their mood variations first. One should not forward the file if their mood is not good enough. Otherwise, one will not get fair remarks on it, so one should acquire strong judgment, as it was explained by one of the participants:

> While entering the office, we would know his mood; we should do an eye reading. If you haven't done eye reading and observed facial expressions, then you won't be able to get things done. And if you want empowerment in getting your work done, then you have to be a critical thinker (Code 006, line 291-293)

Category 2.11: Networking.

Building linkages was one of the successful strategies which the nursing leaders found very effective; one of them said:

> There should be linkages between the government and the private sector. After my retirement, this linkage has been reduced. This would have a negative impact in the long run. It is a two-way process. ….We have given membership to private institutions and developed consistent rules for them so that the private and government. Nurses can share (participate) equally. Unless we do this, professional bodies can not become stronger (Code 006, line 329-335)

Category 2.12: Approaching the Regulatory Bodies.

The regularity bodies in nursing are considered very important in the nursing profession, and approaching them is found to be of great help. One of the nursing leaders said:

> Keeping professional organisations and regulatory bodies with us will mean a lot of power for us. For example, we have our Pakistan Nursing Federation and Pakistan Nursing Council. The Pakistan Nursing Council gives us all the educational guidelines, and if we have any problem in this regard, then we quote their rules. Due to that, we got all the things that we required. Another is the Pakistan Nursing Federation, which, you know, is a very big power of nursing. (Code 0011line, 13-122)

Category 2.13: Political approach.

The nursing leaders in Pakistan have to take a political approach to overcome the challenges, data revealed:

> When I was in Geneva to attend an ICN meeting, a doctor was appointed to the position of principal of the College of Nursing. I was informed. I said to my nurses first, you protest and then go on strike for two days. Consequently, within four hours, his appointment was cancelled. Rules, strategy, and unity will all work together. (Code 006, line 337-340)

One of the nursing leaders explained that she had responded politically when she was confronted with political pressure; she stated:

> I have my sources to deal with political pressure. I have told concerned political people that your people are pressurising me. Not only one, but a couple of people did that. When I discussed this with them, they guided me and told me to ask them who they were. And just tell them that I was the sister-in-law of somebody. The next time these people visited again, their attitude changed completely. They said, mam! Why didn't you tell us before? I told them, see, you people frustrated me to such an extent that I told you who I am despite being unwilling to disclose who I was. I knew that people were involved with a political party. And at the moment he is in charge of this party. So, sometimes, we need to adopt such strategies to resolve the issue. (Code 012, 109-119)

Category 2.14: Setting conditions.

The nursing leaders also focused on setting conditions for resolving organisational issues. A participant narrated an incident about quarrelling between a nurse and a physician, and one of the participants elaborated:

> If you want to compromise, we can sit down and see how we can resolve this problem, and the person at fault will apologise. We will try to prevent this from happening again and inform all the people that if our staff is dismissed, then what is the right way to do it, and it will not happen? (Code 001, line 38-40)

The participants also verbalised that setting conditions before and after implementing them is important in achieving targets. Participants said that if they were to do this again, what we could have done was they could have set conditions for success. They should have talked to the government before embarking on the program, as one of them reported:

> Telling them we can only do this program if we get the authority, responsibility, and accountability. Then we would be able to enforce some kind of discipline in our program that people must attend, and

> if they don't, then what will happen/if you are absent for so many days, then you don't get the certificate or you know, you can not continue to work or things like that. (Code 008, line 17-20)

Category 2.15: Coping with stressors.

The participants highlighted many stressful situations and used numerous coping strategies to cope with them. Participants also believe that faith is a blessing, which assisted them in coping with the challenges peacefully. The participant shared:

> Having empowerment and decision-making skills is hard work. Not easy. You have to make sure that you cover all the ground, so it's very hard work, and sometimes, the more you are successful, the more work you put in, and you become a victim of your success. Therefore, there are more challenges and more stressors, and to cope with stressors, many times, I try faith, peace, and prayers.
> (Code 008, line 99-101)

Another nursing leader verbalised:

> "I do cry and share with my colleagues". (Code 002, line 36)

Playing games have been identified by one of the participants as effective coping, as it was said:

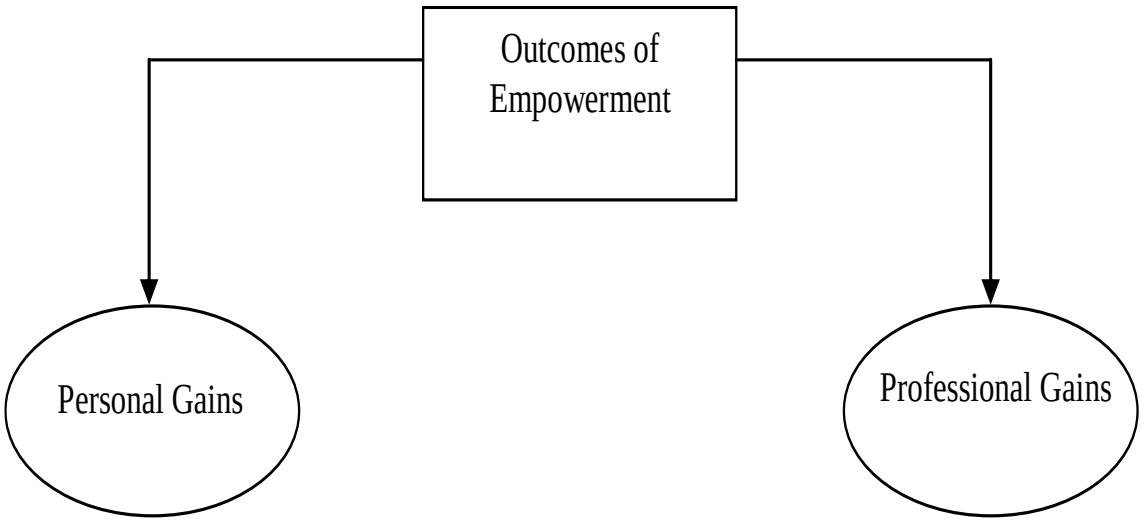
> "Sometimes I play a game of cards just to get myself off., but what helps me to cope with stress is to look at the issue rather than the person". (Code 008, line 102)

Data revealed that empowerment strategies are significant for nurses and nursing leaders in Pakistan. Nursing leaders in Pakistan have adopted these strategies, which have proven that no matter how challenging the situations they confront, they can be resolved effectively through these strategies.

Category 3: Outcome of empowerment

Data also revealed that certain outcomes were achieved after implementing the strategies during the empowerment process. The outcomes have been bifurcated into personal and professional gains. The empowerment outcome is shown in Figure twelve.

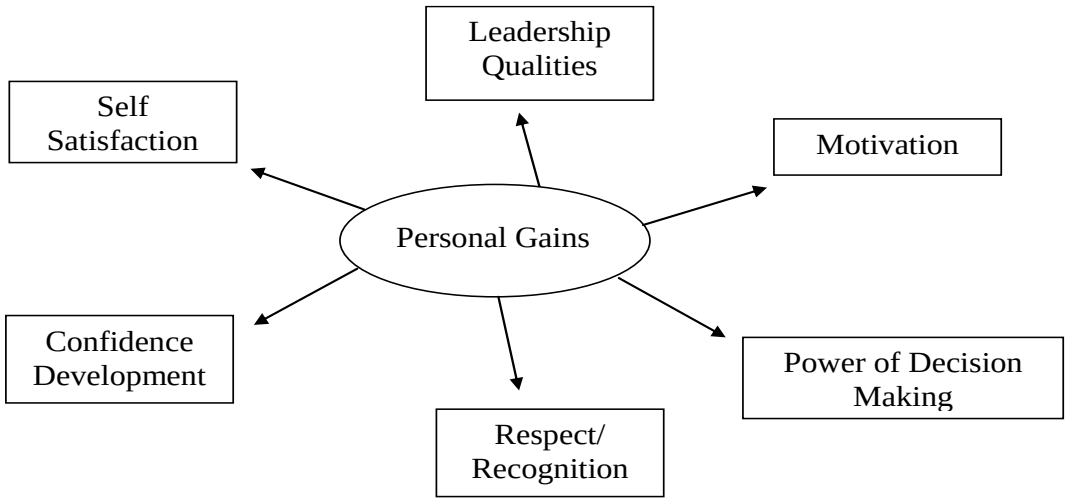
Figure Twelve: Outcome of Empowerment



Category 3.1: personal gains.

The nursing leaders highlighted a few personal gains that were due to empowerment. These comprised gaining self-satisfaction, gaining the power of decision making, and gaining self-esteem and self-confidence. The personal gains of empowerment are shown in Figure 13.

Figure Thirteen: Personal Gains of Empowerment



Category 3.1.1: Leadership qualities.

The nursing leaders of Pakistan focused on the leadership qualities that they gained through the empowerment process, as one of the nursing leaders said:

"I think it gives me a lookout for new ways of doing things and new strategies to look for. Looking at opportunities or maybe harnessing more new talent and potential."

(Code 008, line 110)

The participants also reported developing some influential capabilities necessary for empowerment. One of the participants stated:

> There are a lot of benefits to getting empowered. You have a proper status. When you have a position and are authorised to perform different duties, it is easier for you to approach people and make them work for you. That means I can easily influence and convince people because I am empowered. Overall, the benefit is that I can use my powers to work for the benefit of others. (Code 011, line 85-83)

Category 3.1.2: Self-satisfaction.

Most of the nursing leaders reported self-satisfaction as a major outcome of empowerment; one of them reported:

> "I have gained a lot of personal besides getting professional gain. And the second thing is that I do not cry; I do not have a lot of burnout". (Code 002, line 157)

Another participant expressed in these words:

> "The government gave me a lot. I am satisfied with my job and the facilities they gave me". (Code 007, line 29)

The participants also expressed that a feeling of happiness is also an outcome of empowerment; one of them said:

"I enjoyed my work, as an in-charge nurse and last but not the least as Director General Nursing…. and I am satisfied that I have done my job" (Code 004, line 59-60).

One more nursing leader reported:

> … The benefits of empowerment are before you; you feel encouraged and happy whenever you do something and achieve the result. Our nurses got a promotion, but I feel delighted for them. I perceive it as an achievement of mine. Many people have encouraged me and commented on the number of promotions that I did, so I feel happy about it. (Code, 005, lines 84-87)

One nursing leader expressed satisfaction in the following words:

> I have always performed my duty with dignity, respect, and authority. Everywhere, whether I performed my duty in the ward, as an instructor, or as a matron, my colleagues gave me respect, and they listened to me, so I had no problems. They empowered me, and I owe it to them that they accepted my wordings. I owe it to them, the way I worked. And they gave my example to others, so they were with me in any situation. (Code 007, line 5-7)

Category 3.1.3: Confidence development.

Developing self-confidence was highlighted as a personal gain by one of the nursing leaders, who said that nurses got nervous. At the same time, they were asked to be the keynote speaker and to do the presentation, but due to empowerment, she felt confident, as it was said:

> I gained a lot of confidence; for example, I am not afraid of speaking in public. I can speak everywhere. So I feel that is also my gain that not only at the institutional level, but I am getting a lot of importance at AKDN institution where I work, I work for many committees. So I feel this is my gain (Code 002, line 120-123)

One of the participants related it with family's benefits, as it was depicted:

> … what you get empowers the woman even, and I feel that the family gets empowered because females instil that confidence in their children in a family, so I feel that this empowerment goes a long way for nurses (Code 008, line 118)

Category 3.1.4: Respect/Recognition.

A rise in nurses' image was one of the important outcomes reported by the participants, as one of them revealed:

> "People start recognising you; sometimes people praise you, which is good" (code 003, line 147).

It was articulated the benefits in these words,

> I have seen now in many hospitals like Liaquat and Dr Ziauddin hospitals that if nursing leaders are intelligent enough and do their job properly, they are getting respect and they are getting empowered (code 002, line 137)

Category 3.1.5: Power of decision making authority.

The participant also viewed decision-making power as an outcome of empowerment; it was revealed:

> "Exactly the benefits of empowerment are that if you are empowered, then you can take the right decision at the right time … they agree to your decision making (Code 001, line 183-184)

Category 3.1.6: Motivation.

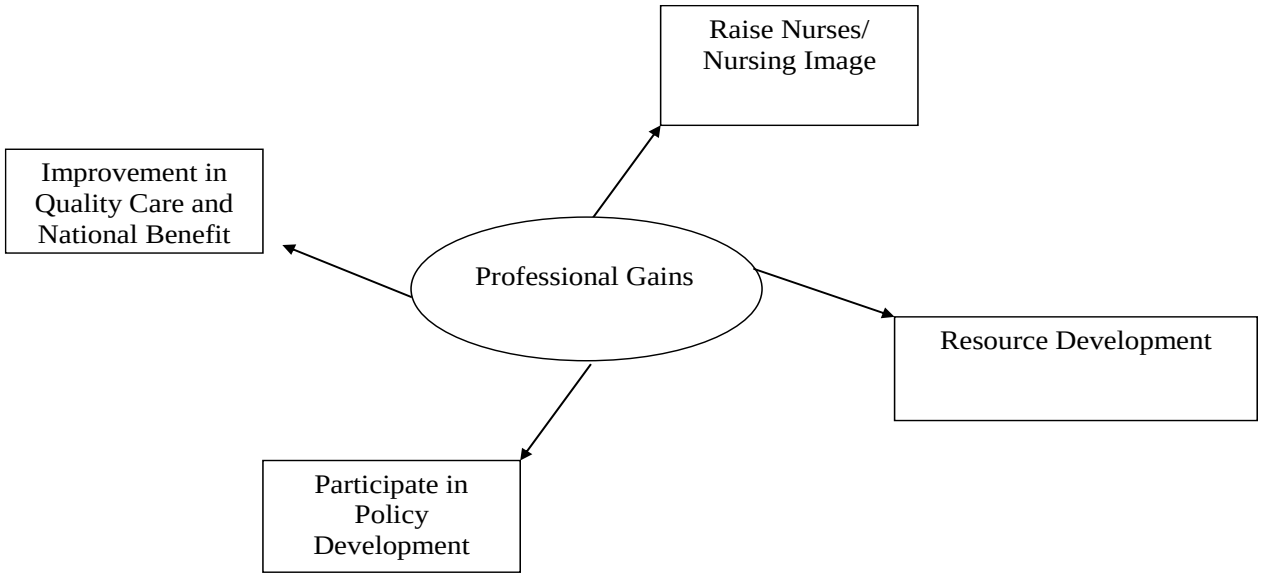
The motivational force was also identified as a positive outcome of empowerment by one of the participants who said:

> There are many benefits of empowerment … You feel motivated because you are competent and feel confident. When there is an internal locus of motivation, you feel motivated internally. And because you are empowered, you achieve, and because you achieve, people feel, and therefore people appreciate what you do, and you get more motivated; so in that way, empowerment helps in achieving motivation achievement and the locus of control; consequently, your confidence and competence and your self-esteem will get better. (Code 008, lines 111-113)

The outcomes mentioned above are considered personal benefits of empowerment. The following are the professional gains the nursing leaders identified as positive outcomes.

Category 3.2: Professional gain. Figure thirteen shows the professional gains of empowerment. These include a rise in nursing image, quality care and national benefit improvement, and policy and resource development participation.

Figure fourteen: Professional Gains of Empowerment



Category 3.2.1: Raise nurses/nursing image.

Raising the nursing image was one of the outcomes of empowerment, which is crucial for the nursing profession in Pakistan; one participant elaborated:

> All the government medical and paramedical professionals who used to hate us before now don't hate us. The public is aware that nurses are united and empowered. They can think, they can say, and they can implement. Due to this, the image of nursing has also been impacted (Code 006, lines 36-38).

The participants also related nursing empowerment to women empowerment, and one of them said:

"I don't know if it is relevant, but nursing empowerment equals to women empowerment, equal half of this society's empowerment" (Code 008, line 118)

One of the nursing leaders associated the nursing image with the culture of the organisation and stated:

> I think we have also seen that empowerment brings recognition because, for example, we can take the example of our university. I think we as nurses are recognised at the (participant's institution) because our senior management and our chancellor have given us empowerment so other people who are looking at us, doctors, and the support staff. After all, they see respect and equal empowerment as recognition, another benefit of empowerment. (Code 008, line 120-121)

Category 3.2.2: Improvement in quality care and national benefit.

The participants also verbalised that through empowerment, quality care can be enhanced; data revealed:

> If professionals upgrade themselves, then nursing will be considered a profession. People will get their rights. They will work productively. And get satisfaction once nurses are satisfied, they can work with dedication in patient care. If patients receive quality care, they will recover quickly; you will benefit nationally once they recover in a shorter period. If a patient is admitted to the hospital for a longer duration, i.e. for 20 days, it is counted as the patient's loss. If he recovers within ten days, his family is saved from suffering. If a patient's stay is reduced, the government expense will be saved for ten days. So, that's how benefits at the national level can be achieved. (Code 009, line 42-47)

Category 3.2.3: Participate in policy development.

Nurses' involvement in policymaking is significant to nursing empowerment; the participants shared that nurses can be part of policy development if they are empowered. Participants expressed that unless nurses get empowered and get involved and participate in the Health Care Delivery System, in making institutions, in making policies, until it is done, nurses will not be recognised as one participant said:

> I think empowerment is much needed for the nursing profession in Pakistan to gain autonomy and progress to be recognised as a professional, make an impact on the Health Care System, and be involved in policy-making, policy implementation, and policy formulation. (Code 008, lines 150-151)

Category 3.2.4: Resource Development.

Resources are considered the backbone of any organisation, and through empowered leaders, they also impact positively; one of the participants said:

> I proved myself. We give them a good education and build our resources internally. For this, I try to give my teachers a lot, for example, stationery or books, whatever is in our limited budget, we do for them. (Code 001, line 151-152)

Numerous empowerment outcomes, elaborated by the participants, could strengthen the nursing profession in Pakistan. Altogether, the operational framework, which comprises challenges, adopted strategies, and empowerment outcomes, can facilitate the development of some practical plans of action that could help nursing leaders empower the profession in Pakistan.

The summary of the operational framework is given below:

Table Three: Operational framework

Category	Challenges	Adopted strategies	Outcome: personal gain	Outcome: professional gain
Subcategories	Limited sanction seats for nurses Incompetent nursing leadership Accountability and delegation Scarce resources Negative attitude of colleagues Political pressure Educational issues Organisational structure Nurses' competency Physician centred culture Teaching the male nurses	Optimistic approach Utilising experience Problem-solving approach Exercising will power Work collaboratively Professional development Lobbying Understanding the system Male nurses in leadership roles Utilising critical thinking ability Networking Approach the professional bodies Political approach Setting conditions Coping stressors	Leadership qualities Self-satisfaction Confidence development Respect/Recognition Power of decision-making Motivation	Raise nurses/nursing image. Improvement in quality care Participate in policy development Resource development

The two frameworks emerging from the data, conceptual and operational, provide insight into two dimensions of the issue of nursing leader empowerment. The conceptual framework is theoretical, whereas the operational framework is pragmatic. The next chapter discusses the findings.

CHAPTER FIVE

Discussion of the Study Findings

This chapter discusses the major findings and themes emerging from the study and other research studies done on empowerment. According to Strauss and Corbin (1998), while utilising the grounded theory methodology, it is necessary to constantly review and consult the literature during the data analysis to support emerging themes and find new areas. This method provided a profound understanding of the concepts illustrated under the established theoretical framework and a contextual meaning and purpose to the area under study, i.e., empowerment.

The study findings reflected that the empowerment process was long, demanding, complex and dynamic, requiring constant struggle. On the journey of empowerment, the nursing leaders in Pakistan were confronted with numerous non-constructive drives, which negatively affected their personal and professional lives. Despite the strong influence of non-constructive drives, the nursing leaders kept moving on the road to empowerment in the presence of constructive drives. These constructive drives enabled them to fight enthusiastically against non-constructive drives. Going through all the trials and turbulences, the nursing leaders in Pakistan adopted certain useful strategies that helped them develop several positive outcomes and, eventually, aided in achieving the desired goal. Thus, all the categories revolved around the core category of ‘empowerment’.

Gibson (1991), while doing the concept analysis of empowerment, says that the notion of empowerment is appealing because of its psychological, political and ethical connotations. Recently, empowerment has been linked with discussions on strategies for prevention and community interventions. Lewis and Urmston (2000) mention that empowerment is prevalent in social work literature, nursing studies, health promotion and nursing and general education. In the light of the literature, it is revealed that the notion of

empowerment is indeed important for nurses in Pakistan to study to bring about a positive change in the nursing profession. Rodwell (1995) elaborates that this will contribute to developing a nursing knowledge base, which Mason, Backer, and Georges (1991) view as the key to nursing's power and credibility as a profession and within society. Thus, the current study of empowerment among nursing leaders in Pakistan would serve as a stepping stone in empowering nursing leaders in Pakistan.

Most studies on empowerment have shown that it remains difficult to define. Its absence more clearly explains it: powerlessness, helplessness, hopelessness, alienation (isolation, hostility), victimisation, subordination, oppression, loss of control over one's life, and dependency (Lewis & Urmston, 2000). Overall, the study's findings demonstrate that nurses in Pakistan have most of these characteristics, and empowerment is crucial for them.

The existing studies on empowerment have also demonstrated that empowerment is a process and an outcome (Gibson, 1990; Jones & Meleis, 1993; Fulton, 1997). Although current studies aim to discover the process of empowerment, however, during the discussion, the participants also highlighted some significant outcomes of empowerment, which have already been mentioned in the findings chapter.

The findings of the study proposed two frameworks, conceptual and operational. Under the conceptual framework, the status of a nurse was one of the categories that reflected various factors that affected nurses in Pakistan. These factors are nurses' image, nurses as an oppressed group, lack of education and competencies, suffering of nurses, role expectations of a nurse, and nurses as a labour force. Therefore, these must be addressed to eliminate oppression and attain empowerment. Several nursing studies have found that nurses are oppressed (Mason, Backer & George, 1991; Erickson, Hamilton, Jones & Ditomassi, 2003). Freire (as cited in Hedin, 1986) defines oppression as the prescription of one person or group's behaviour by another that imposes its own choices on others. As nursing leaders

identified that nurses in Pakistan were oppressed, it portrays that nurses are aware of their oppression. The researcher believes this awareness is significant for bringing about any meaningful change in nursing. According to Klein (as cited in Mason, Backer and George, 1990), Group consciousness is a critical pre-condition to politics. As nurses collectively identify their personal and private concerns and translate these as social issues in the political and public arenas, they will begin their empowerment. Klein's assertion is consistent with Frier's thinking about mobilising oppressed people. Therefore, in Pakistan, there is a dire need to create awareness about their oppressive behaviours.

The nurses' image in Pakistan is one of the factors that impede nurses' empowerment in Pakistan, and hence, nurses find it difficult to challenge the status quo. Meleis and Boyle (as cited in French, Waters & Mathews, 1994) discuss in their study that in contrast to Western societies, nursing has not been an acceptable profession in most countries, particularly in Muslim societies. The lack of respect for the nurses and the status of nursing as a profession hamper nurses' progress. Pakistan is also illustrative of this situation.

These factors collectively restrict nurses from voicing their issues, making it difficult for them to make their place in the healthcare delivery system. So, collective efforts are needed for nurses to escape from oppression. Freire (as cited in Roberts, 1983) suggested two essential phases for liberation. Number one unveils the world of oppression, and number two expels the myths created and developed by the old order. Freedom, therefore, involves rejecting the negative images of one's culture and replacing them with pride and a sense of ability. The oppressor is not able or willing to grant autonomy; rather, it must be acquired.

The findings of the data very clearly highlighted that nurses in Pakistan possess some characteristics of an oppressed group. It could be an exceptionally healthy debate whether lack of competence leads to oppression or because of the oppressed nature of nurses, they lack competencies and higher education. One might support the idea that because of the

nurses' oppressed behaviour, they are deficient in the required competencies and skills necessary for empowered nurses, as they are reluctant to acquire higher education. This is well supported by Hedin (1986). She explains while explaining the myths of oppressors that, as oppressors, want to keep the nurses' status quo; thereby, they propagate that nurses cannot be educated. Another associated myth is that nurses know nursing care and physicians know health care; therefore, physicians are the only ones capable of making all the decisions in this domain. These myths reflect that physicians are keepers of knowledge about health care. Accepting these myths contributes to developing feelings of inferiority amongst nurses and strengthens the unbalanced hierarchical structure. This assumption is well supported by Ellis and Hartley (2001) as well. Therefore, it is important to challenge the distorted images and to differentiate the professional self of nursing. With a clear professional self-concept, the nurse can challenge the myths and assumptions from the previous generation (Hood & Leddy, 2003), and the researcher has a passionate belief in that.

Another finding was the role expectations of nurses in the nursing profession. Data reveal that nurses are not paid adequately and cannot cope with the high demands of a competitive world. Furthermore, the high inflation rate forces them to work other jobs to share the economic burden. This phenomenon requires further examination. However, Kuokkanen and Katajisto (2003) narrate that nurses felt their work was not generally rated highly. That is the reason why most of the nurses go for another job. However, the researcher believes socioeconomic factors greatly impact nurses' empowerment/disempowerment in Pakistan. It is a well-known fact that there is a socio-economic status gap between nursing and medicine. Nursing, traditionally, has drawn students from the middle and lower socio-economic classes. Medicine has drawn students from the upper middle and upper socioeconomic classes. As more nurses receive master's and doctoral degrees, the social status gap will become less of a barrier (Fagin, as cited in Sheer 1996). Heyes (2005) argued

against increasing the remuneration of nurses. He said that given the longstanding shortage of nurses in many jurisdictions, why should nursing wages not be raised to attract more people? He tells a story in which the status of nursing as a 'vocation' is raised, which implies an increase in wages, but the result is a reduction in the average quality of applicants attracted. The underlying message accords with the notion that increasing wages might attract the 'wrong sort' of people into the profession and highlights the inefficiency of wages in the mechanism, in particular professions, which makes wages sticky upwards. The analysis has implications for job design in professions such as nursing and teaching. However, the researcher said combining education and high remuneration would contribute to nurses' empowerment. Abraham (2004) supports that the profession has increasingly become viewed as a respectable, profitable, and rewarding job, attracting more people, particularly girls, to the profession. And, therefore, lead to professional empowerment as a whole.

This paradigm change has occurred as higher education levels are required of nurses today, as this is one of the major factors for competing in the world in response to the change in health care delivery (Abraham 2004). Despite these positive effects, nursing education, particularly in management, has been criticised because education alone cannot achieve desired organisational outcomes. There is truth in that premise. Acceptance of nurses as managers will need salary and other rank indicators corresponding with educational preparation. However, long-term success in achieving managerial goals will depend on physician support of nurse managers, for without capable physician/ nurse teams to implement systematic change, management education alone will not be enough (Narsavage, Education in nursing management).

In light of the existing literature, nurses' awareness of their oppressive behaviour needs to be spread among nurses in Pakistan. One of the ways of educating nurses about it is through conducting research studies on related subjects. However, acquiring higher

education in nursing would remain a top priority in eliminating nurses' oppression. Rodwell (1996) emphasised that for empowerment to exist, nurses need an educational process that supports and encourages the development of attributes essential for empowerment. Hawks (1992) further elaborates that education goes beyond simply sharing information to helping others; one must learn to use the information and create new information (Hawks, 1992). Clay (1992) also supports the idea and says that education is a fundamental prerequisite for empowering nurses and that educating nurses is the key to empowering the people we serve.

Another category identified under the power relationships category was 'influence of medical profession'. This category is mentioned as a subcategory in the study conducted by Fulton in 1997. This concept was found to be strongly linked with other concepts, as it negatively affected the nursing profession in Pakistan for a long time. This category describes the dominance of physicians over nurses as professionals. This makes the organisation culture extremely physician-centred, where nurses are less or sometimes less valued than physicians in Pakistan. The organisation's culture has become such that people in higher management do not appreciate nursing leaders as equal to physician leaders despite the designation of equivalent leadership positions. Due to the physician-dominant culture, it was identified that the nurse-physician relationship remained an issue and was always found unhealthy; because of that, nurses, particularly nursing leaders, faced numerous afflictions at personal and professional levels. According to Hawks (1992), empowerment in the matrix is viewed as an interactive process with two or more people. This is surely the case with the nursing profession in Pakistan because, in the health organisational structure, physicians and nurses carry out patient care; however, their collaboration in providing quality care remains a question.

Heavy influence on the medical profession was also identified in Fulton's 1997 study. In her study, she describes the nurses' views on empowerment. Four categories emerged from

the data to provide the framework for the themes: ‘empowerment’, ‘having personal power’, ‘relationship within multidisciplinary team’, and ‘feeling right about oneself’. Within the category of ‘relationship within multidisciplinary team’. The subcategories identified were ‘medical power’ and ‘autonomy about medical staff’. Her study also revealed that the nurses believed they gave input, but most said the doctors had the last word. The doctors’ prescribing power limited their autonomy. The doctors overpowered everybody. The nurses had to deal with the doctors’ interference and felt they had little authority. This dominance of physicians is well supported by Sheer (1996), who focuses on the fact that empowered nurses can better collaborate with other stakeholders, which is pertinent for nursing. She also says that nurse-physician relationships are characterised by physician dominance. Prescott and Bowen, cited in the same article, stated that physicians frequently challenge the authority of nurses with respect to making certain decisions based on the belief that nurses lack the necessary knowledge base. However, Fulton (1997) argues that these nurses accepted this medical domination. They described it but did not attempt to question why it was happening. It seems to be given the fact that they neither fought against it nor saw it as wrong. This fits with the nurse's image as an oppressed group.

Kuokkanen and Katajisto (2003) state that uncommunicativeness and lack of cooperation, such as conflict between various professional groups, are severe obstacles to interaction, mutual reflection, and empowerment. Their study findings showed a low-hierarchy organisational structure in which governance with opportunities, trust, and open communication—all elements contributing to the empowerment process—were identified as insufficient in the healthcare system, which impeded nurses’ empowerment.

Lack of respect for colleagues has had damaging effects on the development of the nursing profession. Hajbaghery and Salsali (2005) conducted a qualitative study to design a model for empowering nurses in Iran. They also identified the influence of physicians, which

was discussed under the subcategory of ‘organisational culture and structure’. They believe that public and organisational culture has led to the development of a physician-favoured structure in the health care system, which was well articulated by most participants. This is evident in the following quotes: "The health system is in the hands of the physicians," "All of the top managers of the health system and also in hospitals are the physicians," and "Nurses are only considered as tools for carrying out the doctor’s orders." The design of the nursing system is greatly affected by this physician-centred structure. According to Ledgister and Scarborough (2003), social issues such as the relationships between nurses and other health professionals must change. The nurse-doctor game, first identified in the early 1970s by Stevenson and Young and discussed in an interview with Jennifer White RN, a retired hospital executive, teacher and author, in 2001, is still prevalent. It refers to the interaction between two professions where, because of social and professional barriers, a nurse must defer to the physician even though she may have a solution to the patient’s need that is obvious to her because, to assist people in coping, a nurse needs a complexity of knowledge and skills.

The third category that has been identified is the ‘nursing profession’. Data related to the nursing profession were categorised under the following subcategories: body of specialised knowledge, human resources, professional bodies in nursing, and public acceptance of the nursing profession. Data reveals that a drastic change is needed in the nursing education system in Pakistan. According to Ellis and Hartley (2001), the primary criticism of nursing is that it has no ‘body of specialised knowledge’ that uniquely belongs to nursing. Critics state that nursing is borrowed from various disciplines like biology, medicine and social science. Nursing leaders and theorists disagree with this assumption. Rather, they view it as the uniqueness of the profession. Nursing researchers are constantly developing an organised body of knowledge unique to nursing. AKU is going to play a significant role in

this connection, as a master's in nursing started a few years back from this platform. Thesis writing is one of the course requirements for a master's degree. As more students are involved in thesis writing, more evidence-based research will be published in the context of Pakistan, thus augmenting the exclusive body of knowledge in the nursing discipline. This would ultimately affect the strengthening of the nursing profession in Pakistan.

The findings from the data revealed that nursing is deprived of professionalism in Pakistan. Low admission criteria, shortage of well-trained faculty and their attitude towards teaching are disheartening in this country. Moreover, professional bodies such as the PNC and PNF, whose roles remain crucial, are currently not functioning up to the mark. These deficiencies were also highlighted by Sultana (2003) in "Assessment Report on Nursing Issues in Pakistan". Major gaps in the PNC include a lack of monitoring and evaluation of nursing practice, research and educational activities and a lack of visionary leadership. Zindani (1996) highlighted that the most effective way to influence federal policy decisions in health care is through a strong nursing organisation. Ellis and Hartley (2001) also support the idea and say that regulatory bodies in nursing all have the power to stimulate change in the system. If these bodies are strong, then nursing organisations can work on addressing their deficiencies.

Public acceptance of the nursing profession is another element critical to empowering the nursing profession in Pakistan. It has already been highlighted that people do not perceive nursing as a prestigious profession in Pakistan. The researcher believes that the root cause of all these factors is the nursing education system of Pakistan. All efforts must be directed towards strengthening and restructuring the nursing education system to promote nursing. After a constant struggle for more than 50 years, developed nations have now succeeded in developing their own body of knowledge in nursing, and that has occurred because they came out from the apprenticeship model of education to the higher education model, thus,

recognised as a profession rather than an occupation. However, Pakistan is young in entering a higher education model for nursing. As discussed, a Master of Science in nursing has recently commenced in Pakistan. Yet, nursing is a profession and still needs to advance to be called a profession or an independent discipline.

The profession can improve its status if the PNC and PNF start playing an active role in improving the quality of nursing education. Suppose the education system is strong enough to prepare competent nursing leaders or effective educators in Pakistan. In that case, this profession will be able to meet all the challenges and will certainly be able to progress. In other words, it is a cycle; if the nursing education system is good and there are sound admission criteria, the result will be competent and skilful nurses. Whether they work in any capacity, these nurses can serve better in the healthcare delivery system. Eventually, this will lead to a better nursing image and public acceptance of nurses in Pakistan. This would ultimately enhance job satisfaction (Kuokkanen, Leino-Kilpi, Katajisto, 2003) and, consequently, increase nurses' retention.

Narsavage (n.d) discusses that the educational process is only one primary factor that results in quality nurse managers. Quality nurse managers develop not only from gaining knowledge but also by becoming empowered. Empowerment is … an enabling process …arising from a mutual sharing of resources and opportunities, enhancing decision-making to achieve change. Those nurses who have been educated in management and have become empowered have been described as having increased self-esteem, being able to set realistic goals, controlling the change process, and communicating a sense of "hope" for the future. Management-educated nurses impact their staff and patient care (education in nursing management).

As far as the public acceptance of the nursing profession is concerned, which has been identified as a subcategory of the 'nursing profession', it greatly influences nurses'

empowerment. Clay (1992) claims that, throughout the world, 95% of nurses are female. Yet the cause of women's liberation and the empowerment of nurses have not been synonymous. It is, thereby, essential to introduce male nurses to the nursing profession. We need more men in nursing, not because a simple injection of "maleness" would increase the profession's status but because it is believed that patients and the broader community are better served by having a broader mix of genders within the nursing team. In the long run, this better balance could have positive spin-offs in changing stereotyped perceptions of nursing as 'women' work.

According to an old perception, men have relatively less impact on nursing, and women have been more successful than men in impacting nursing, but times may change yet (Clay 1992). One could argue that in some healthcare facilities, male nurses are not allowed to care for female patients. However, in medicine, this is not considered a problem. Male physicians have not been excluded from any branch of medicine (Ellis & Hartley 2001). Then why should this be the case in Pakistan's nursing system? From the researcher's point of view, male nurses would be able to provide care to male patients, as currently, female nurses are providing all the nursing care to male patients, which, again, is culturally not perceived as acceptable. Some may also consider inequality among men and women as an underlying cause of the existing concern.

Chamiec-C and Sherr (2005) shed light on it and unveil the assumption mentioned above; they say that it is not that women and men are not equal but that they are just different from each other. The differences exist to sustain the evolutionary process. We can grow only when we understand these differences in the qualities and skills of men and women. This understanding is also beneficial for men as they integrate themselves. Men and women have different skills. This will provoke a unique way of thinking and thus open up doors for the future and bring revolution to the lives of nursing professionals.

‘Power relationship’ was another category that was identified from the data. Three subcategories have been identified under this category. It includes ‘power of decision making’, ‘influence of medical profession’, and ‘powerlessness’. Rodwell (1996) found an apparent dichotomy between empowerment and power. Kuokkanen and Katajisto (2003) also supported the idea and asserted that the concept of power cannot be omitted when discussing empowerment. Thus, empowerment provides people with opportunities and resources that must be understood to change the world. Shared decision-making and translating responsibilities are empowerment tools (Hawks 1992).

Powerlessness was another finding that came out of data on Pakistani nursing leaders. Campbell (1994) states that “we have been told that power corrupts and absolute power corrupts absolutely … in most organisations… it is feeling powerless that corrupts most of all” (p. 46). Robert & Hedin (as cited in Fulton, 1996) mention that some of the senior nurses appear to have a fear of power. It seems that internalised oppression has made nurses doubt that there is an alternative to the status quo. However, the researcher feels that the concept of power strongly relates to the other category of ‘influence of medical profession’. Most of the data also reveals the same. Mason, Backer, and George (1991) shed light on this and say it has noted that men and women often relate differently to power, with the dominant model demonstrating power-grabbing and exercising it over others, while the feminist model is one of power sharing. Power grabbing is associated with holding power close to oneself, whereas power sharing is linked with others. It is asserted that a power-sharing model may be more beneficial to the development of women and nursing than power-grabbing, as the former promotes equality.

A great concern arises in the researcher’s mind, which directs her thoughts again towards nurses’ professional growth and knowledge acquisition by nurses in Pakistan, as power and knowledge are closely interlinked. Kuokkanen and Katajisto (2003) support this

notion and assert that when there is power, there is also knowledge, leading to power. Here, personal empowerment is crucial to nurses. In their study, Lashbinger, Finegan, Sbamian, and Wilk (2001) tested Kanter's structural empowerment model, which specified the relationship according to structural and psychological empowerment, job strain, and work satisfaction. Kanter argues that people react rationally according to the situation in which they find themselves. When the situation is structured such that employees feel empowered, they respond accordingly and rise to the challenges present in their organisation. Thus, the organisation will likely benefit from improved employee attitudes and increased organisational effectiveness. Kanter believes that the structure within the organisation is particularly important for the growth of empowerment, which includes having opportunities to learn and grow; further, association with superiors, peers and subordinates within the organisation further influences empowerment. Going through Kanter's model, the researcher can reflect upon the organisational structure of Pakistan, which does not appear very empowering.

On the other hand, Gilbert (1995) shares another dimension of powerlessness from the client's perspective. According to him, nurses working in a multidisciplinary team often have to interact with people who have long-term health needs, many of whom are considered disabled. The consequences of disability identified by Michael Oliver in 1990 are frustration or denial of social and human rights and rejection of the disabled person's view, with the imposition of medical definitions of needs, poverty, dependency and powerlessness. Given Gilbert's views, researchers can relate it to nurses' powerlessness. If nurses are dealing with patients' negative feelings while providing care, it is very possible that this powerless feeling may transfer to nurses, which affects them.

A category of value belief system emerges from the data, which comprises three subcategories, i.e., 'Philosophy of life', 'spirituality', and moral values, and these have their

uniqueness in the concept of empowerment. Quite a few participants related their empowerment process to their life's philosophy based on faith in God. Pierce (as cited in Hawks, 1992) states that the mind is not a spectator; thought produces belief, and belief leads to action. According to him, belief and action are connected because life is the interplay between belief, doubt, inquiry and action. However, James argued Pierce's notion; he thought that action and belief were interdependent; the thought was connected with the aims, hopes, and desires of one who thought. From the researcher's point of view, the philosophy of life directs leaders in a positive direction, liberating positive energy all around, thus agreeing with Pierce's viewpoint.

The concept of 'Spirituality' is another significant data source; most participants associated it positively with their personal lives at work. However, relatively little attention has been paid to the broader topic of spirituality in the workplace. Chamiec & Sherr (2005) examine how social workers integrate their spirituality with the non-practice-related aspects of their jobs, their relationships with colleagues, their workplace behaviour and attitudes, and their commitment to the mission and goals of their organisations. There is an unquestioned assumption that competent organisational leaders should not let their spirituality or values interfere with their actions or decisions in the workplace. In direct opposition to this assumption, it is said that for many organisational leaders, work has become where they spend most of their waking hours, develop many of their strongest relationships, and experience the most significant amount of personal and professional growth. As a result, the argument maintains, requiring organisational leaders to leave their most deeply cherished beliefs and values at the company door prevents them from achieving optimal levels of satisfaction, meaning, fulfilment, and a sense of wholeness or integrity in their work – and, by extension, in their lives. In addition, many have claimed that there are many valuable benefits associated with organisational leaders integrating their spirituality into their work,

including increased productivity, motivation, and creativity, increased overall performance, the likelihood of developing more ethical organisations, increased job satisfaction and organisational/job commitment (ibid). Therefore, more research needs to be done in relation to spirituality and nurses' empowerment in the Pakistani context.

Under the operational framework, the concept of politics has been identified from the data. Participants found political pressure a challenge and used it as a strategy to cope with challenges. It is high time to reflect upon how much nurses are aware of politics, particularly about the nursing profession in Pakistan. Does our nursing education system cater to this need of today's world? Mason, Backer and George (1991) have tried to uncover this notion and explore the feminist empowerment model. It has been shown that this model is consistent with promoting nurses' values and appropriate for altering the traditional, paternalistic healthcare system, which negates these values. As a model of political action, empowerment involves the development of three dimensions: raising the consciousness of the socio-political realities of a nurses' world, strong and positive self-esteem, and political skills needed to negotiate and change the health care system. It is further discussed that nurses' political effectiveness has been hampered not only by profession perpetuating, with or without intent, this societal matrix of inequality but also holding an outdated perception of political behaviour by some nurses as 'unfeminine' and unprofessional (Ashley and Allen as cited in Mason, Backer & George 1991).

The root cause of this is the prejudice that society has regarding women and politics, and thus, perceives that women are not capable of effective politics. However, Jardin (2001) expresses that politics can be considered "the exercise of influence." Nurses can increase their political power and have a greater effect on all levels of politics, from institutional to federal, by using three elements of influence, i.e. Communication, collectivity, and collegiality. Many nurses see collectivity as negative behaviour, but it becomes collegiality

when other groups are included in addition to nursing, increasing respect and understanding across professions and, thus, increasing nursing political power. Ellis and Hartley (2001) say that nurses have always been involved in politics. Florence Nightingale used her contacts with powerful people in government to obtain the human and material resources she needed for wounded soldiers. Hannah Ropes took a similar sort of action in her era. Data from the current study reveals that modern times are no different. Therefore, it can be said that professionals who understand power and politics are the ones most likely to obtain the resources needed to accomplish the desired goals.

Zindani (1996) suggested that nurses in Pakistan still need to learn political skills to influence decision-makers at the national level. She further stresses that Pakistani nurses must be educated about the importance of politics in nursing care, the political power nurses already have, how to use it and how to use it responsibly to bring about change. Moreover, they should be able to use formal channels. These channels are often bureaucratic and complex, but nurses should master the skill despite difficulties. The PNC and PNF can help bolster their drive towards change.

Chamiec-C and Sherr (2005) supported the notion uniquely, which revolves around women. They said that today, female managers score over men in qualities like teamwork, decision-making ability, collaboration, patience, commitment, devotion, etc., which are inherent in women. It is further elaborated in the same article that women are superior to men in spirituality. They have subtler senses, are more sensitive, compassionate, and loving, and get easily enlightened. Then the question arises: why haven’t they flourished? The social, cultural, and religious conditions make them feel suppressed and afraid of estimating themselves and having confidence. Women need to learn about themselves to break away from these conditions. They must know about their body, mind, relationship, parenting, and spiritual self.

Finally, it can be concluded that nursing leaders persistently kept moving towards the road of empowerment despite the non-constructive derives associated with nurses' empowerment. These factors negatively influence their personal and professional lives. Nonetheless, by appraising the positive factors, nursing leaders handle challenges successfully and attain positive empowerment outcomes. Therefore, empowerment can be achieved through constant struggle, knowledge of politics, quality education, and enrollment of more male nurses.

CHAPTER SIX

Limitations, Recommendations and Conclusion of the Study

Limitations

Some of the limitations which the researcher could foresee are described below:

- The researcher's limited experience conducting in-depth interviews may have hindered the complete exploration of the participants' experiences and understanding; this was dealt with by conducting pilot interviews before the actual interviews to gain confidence and competence in interview skills.
- There is a possibility that during the interview, participants may have provided socially acceptable answers. This was minimised by building rapport, explaining the study's purpose, and conducting interviews in a conducive environment.
- As grounded theory is not an area of the researcher's expertise, that, there is a possibility that few of the concepts and categories may be have been overlooked during the data analysis process. To overcome this, constant consultation with the thesis committee supervisor and members was sought throughout the data analysis process.

- Due to a lack of expertise in the grounded ground theory methodology, proper utilisation of memos was another limitation that the researcher faced. However, the understanding acquired through memos in this study will enhance the process of keeping memos in future research.
- Some of the interviews were conducted in Urdu. One limitation the researcher faced was translating from Urdu to English. Due to that, some of the data's essence or meaning could be lost. To overcome this, the participants were requested to check the transcriptions of their words from Urdu to English.
- Due to the scope of the graduate program and limited time (five months for the thesis), the study has focused on nursing leaders only and chosen to take a purposive sample. Thus, the grounded theory of empowerment will be derived from them. The study could be conducted on a larger scale, including all levels of nurses from private and government health institutions.
- As nursing is predominately a female profession, all the nursing leaders interviewed were female. However, future studies could also include male nursing leaders of mixed genders in the study.

Recommendations of the Study

During the interviews, the participants were also suggested a few recommendations, which were categorised separately during data analysis. The recommendations below include those from the study participants, the researcher, and the literature review.

Study Participants' Recommendations

- Nurses should have representation at all levels of government, like in the assembly and the Ministry of Health, so that nurses are involved in policy making. This would have a very positive impact on nurses and, overall, the nursing profession in Pakistan. Through

this, nurses would get their rights and receive timely promotions. This, eventually, would lead to job satisfaction and enthusiasm among nurses.

- There should be a liaison between the government's and private institutions' nurses to build a strong networking system. Nurses could collectively strive for their common rights and goals and achieve desirable outcomes.
- In the nursing education system, nursing leaders should be involved in planning and implementation. Education is considered a prerequisite for the profession's empowerment. This would help strengthen and restructure the nursing education system in Pakistan according to national priorities. It would also serve to prepare nursing leadership, which is a desperate need today.
- Nurses should also be sent for higher education abroad so that they get international exposure and are, thus, able to broaden their horizons. This will assist in building individual competencies, and, as a result, the nursing profession will grow overall. For this, scholarships could be provided to the nurses so that financial matters become less of a barrier to acquiring higher education.
- Exchange programs for the nursing faculty and the relevant expertise should be launched to expand the human resource base. This way, both government and private organisations can benefit.
- A sound nursing education system is necessary to strengthen the profession. Clinical plays a pivotal role in transforming learning. Therefore, a proper mechanism for clinical supervision should exist. Some simulations should be provided to students to enhance their learning, thus empowering them from the beginning of their student life.
- To harmonise their professional and personal lives, nurses at all levels should be encouraged to pay attention to their overall health, including physical, social, psychological, and spiritual health. This would assist them in developing a positive self-

concept, and hence, they would be perceived as empowered. For that, a physical fitness facility for nurses should be provided on campus.

- Nurses at all levels should be provided with opportunities for national and international internship programs, as this inculcates a sense of independence and confidence, enabling them to work in any professional capacity. Moreover, nurses should also be sent to conferences at the national and international levels for professional development, a key element of empowerment.
- Nurses should be encouraged to attend internship programs for professional development on an ongoing basis. This would keep them abreast of current practices in nursing, improving the quality of care for clients.
- Education is the key to empowerment. Therefore, master's and PhD programs in nursing should be started at the government and private levels. Though this would benefit all nurses in general, it would particularly help those nurses who cannot go abroad due to financial and family constraints.
- Since politics is critical for having an influence and, thus, for nurses' empowerment, a course on 'politics' should be included in nursing education, especially in the masters' program, for the nurses' development. This would enable them to adopt strategies while working with other disciplines and protect themselves legally. The feminine model of nurses' empowerment, which was adopted by Georges, Backer, and Mason (1990), can be adopted.
- As empowerment is crucial for the nursing profession in Pakistan, an empowerment course can be developed for nurses at the graduate level to select it as an elective at the time of higher studies.

Researcher's Recommendations

- Sessions could be arranged for nurses in Pakistan to raise awareness about their oppressive behaviour and devise strategies to overcome it.
- To liaise between the government and private organisations, nurses should meet regularly on a platform to develop a strong networking system among nurses in Pakistan. This would also promote a sense of unity among all nurses in Pakistan. In addition, the platform would provide the nurses with a sense of identity and belongingness.
- Nurses should be given leadership exposure through opportunities to get involved in leadership positions within and outside the organisation to harness potential talents within them. Moreover, this would inculcate leadership qualities in them, allowing them to perform effectively and work collaboratively within the healthcare system in Pakistan.
- Nursing institutions in Pakistan can adopt and apply the empowerment model of nursing used in Iran by Hagbaghery, Salsali, and Ahmadi (2005). This model would provide direction for the institutions to work toward uplifting nurses and the nursing profession in Pakistan.
- To enhance collaboration among various disciplines in the organisation, the collaborative model of empowerment developed by Kieffer (1984) (cited by Sheer, 1996) can be adopted by nursing organisations to facilitate nurses' attainment of the personal characteristics needed for collaboration on an egalitarian level.
- Nursing regulatory bodies like the PNC and PNF should strengthen the profession by inducting strong nursing leadership. These professional bodies would then be able to act efficiently to promote nursing education and service structure.
- There is a need to develop a mentoring program within the organisation to empower nursing professionals. Mentorship would give nurses guidelines on functioning effectively according to organisational norms and values. Furthermore, this would facilitate nurses' gaining the dual benefits of being mentors and mentees, as both will be

nurtured simultaneously through this facilitation. The mentee would be able to attain moral values from the mentor as a role model, and the mentor would be able to see herself developing others and yet obtaining a sense of accomplishment.

- Professional development remains significant for nurses' empowerment. Hence, continuing education programs should be mandatory for nurses at all levels to keep abreast of current knowledge and acquire essential personal attributes to empower themselves and others. Through this, nurses could contribute to the welfare of patients, families, communities, and the profession at the maximum level.
- Schools and colleges of nursing should encourage and induct more male nurses into the profession. This would not only liberate the nursing profession from being a women-oriented profession but would also empower the profession by having a gender mix, which would, in turn, enhance the image of nursing in Pakistan.
- Further qualitative and quantitative research studies should be conducted on nurses' empowerment, such as 'empowerment and spirituality' or 'role of value belief system in empowerment' in nursing. Pakistan lacks evidence-based research. Therefore, this area requires special and immediate attention. Evidence-based research would, eventually, enhance the body of knowledge within nursing, strengthening the nursing profession as a whole.

Implication for Nursing

This study has identified many concepts related to empowerment in nursing from a Pakistani perspective; most are already known and discussed in the nursing literature. However, the entire concept would remain unique in the Pakistani context. Predominantly, it has been identified that the nursing education system is not functioning at the expected level; as a result, it is not producing competent and empowered nursing leaders. Therefore, the theoretical empowerment model would provide a base for restructuring nursing education in Pakistan.

Moreover, after testing the model, a tool can be developed to empower nurses in Pakistan. This tool can be utilised in practice as well as in the education setting.

Hopefully, this research will add to the body of knowledge in the nursing field, thereby addressing the criticism by some of the authors that nursing has borrowed knowledge and does not have its own unique knowledge. The conceptual categories discovered in this study will help nursing leaders reflect on their empowerment process. Research has discovered that basic concepts of empowerment with different dimensions may help modify the nursing curriculum by adding courses on professional development and leadership management. Thus, it facilitates nursing educators in teaching nurses by focusing on all the dimensions of empowerment. Furthermore, nursing leaders can foster an empowering atmosphere in practice settings by applying the concepts discovered from the frameworks of empowerment from Pakistan's perspective.

Conclusion

The study result reveals that empowerment is a significant component in enhancing the image of the nursing profession in Pakistan. Empowerment can shape the nursing profession constructively and pragmatically. However, various factors negatively impacted the nurses' personal and professional lives during empowerment. However, the empowerment process instilled some positive values that facilitated and boosted them to move steadily with a sense of accomplishment. Empowerment has numerous positive outcomes, eventually benefiting the nurses and the nursing profession. Therefore, building the competencies of the nurses by providing higher education and an understanding of the political system is important for nurses to attain empowerment in a Pakistani context.

This study reveals that the empowerment of nursing leaders in Pakistan is multidimensional. Nursing leaders have adopted a variety of strategies to empower themselves.

However, they struggle with numerous challenges, including physician-centered organisational structures, a lack of advanced educational competencies among nurses, and political pressures. Therefore, strengthening the nursing educational system, creating shared governance structures and processes, enhancing nurses’ understanding of the political system, and actively participating in policy dialogue and implementation are important for nurses' attainment of empowerment in Pakistan.

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APPENDIX A

Consent form

Research Topic: Empowerment among Pakistani Nursing leaders: A Grounded theory Approach

Principle Investigator: Saleema A. Gulzar
Aga Khan University School of Nursing, Karachi
Contact #: 021-4865495

Study Purpose:

I, Saleema A. Gulzar, a Master's Student at the Aga Khan University School of Nursing, Karachi, am conducting research on Empowerment among Pakistani Nursing leaders. For this purpose, please give me 45-60 minutes of your time to share your experiences.

Approval from the ethical review committee of Aga Khan University is sought. The study processes involve no known risks, harm or threat to your position at the organisation, family, institution, or nursing profession. The in-depth interview may cause some minor fatigue and will be compensated by providing light refreshments and short breaks during the interview on a need basis. The study will not benefit you directly, but the time and experience you shared with me would help formulate further strategies to empower nurses in the future and nurture current and future nursing leaders, which in turn will benefit the nursing profession.

The data will be collected through in-depth interviews with nursing leaders in Pakistan. The study procedure will include completing a demographic profile and key informant interview. The researcher will tape each interview and take written notes.

Participation in this study is purely voluntary; you reserve the right not to share any specific information during the interview. This will not influence your employment or affiliation with the professional nursing bodies.

The place of the interview will be in your own preferred formal setting. Privacy will be ensured by maintaining a closed environment. Your identity will not be disclosed during any study phase and dissemination. Moreover, you will be assigned a code that the researcher will only know. All the study data will be kept under lock and key, and all related documents on the computer will be password-coded. The selected content of individual interviews will be shared by maintaining anonymity and confidentiality.

You, as study participants, are welcome to ask any questions regarding the study. For further information or questions, I, Saleema A. Gulzar, can be contacted at (021-4865495).

Study Findings to be shared:
Are you interested in knowing about the study results? Yes No

Signature:

I have read and understood the above information, and my signature below suggests that I agree to participate in this study.
You will receive a copy of this form.

Participating Interviewee's Signature: _____
Date: _____

Researcher's Signature: _____
Date: _____

APPENDIX B
Demographic profile

Code: _____

Personal:

Name of Participant: _____

Address: _____

Contact information (preferred):

E mail address:_____ Tel No. : _____ office: _____ mobile: _____

Gender: ☐*Male* ☐*Female*

Age: _____

Marital Status: ☐ *Married* ☐ *Unmarried* ☐ *single*

Academic Qualification: (Please begin with the highest academic qualification first)

s.no	Qualification	Name of institution	Year of completion

Working experience: (Please begin from the most current position)

s.no	Position/designation	Name of institution /department	Years of experience	Major job responsibilities

APPENDIX C

Semi-structured Interview Guide

Introduction

I am a student in the Master's program at the Aga Khan University School of Nursing, Karachi. I am researching to discover the key components of empowerment and its processes from Pakistani nursing leaders' perspectives. The study's outcome will be formulating the empowerment theory from a Pakistani perspective, guiding nursing leaders to nurture themselves in practice settings. This interview aims to seek your views on empowerment from Pakistan's perspective.

Leading questions:

1) What do you understand by empowerment?
2) Illustrate any situation when you feel yourself empowered.
3) Illustrate any situation when you feel yourself disempowered.
4) How important is the notion of empowerment in the nursing profession in Pakistan?

Probing questions:

5) What are the conditions for you being empowered in your experience?
6) What are the processes that empowered you at your workplace?
7) What challenges have you faced in the empowerment process?
8) How did you manage those challenges?
9) What are the benefits of becoming empowered in your experience?
10) What are the strategies of empowerment you used in your experience?
11) How does organisational structure affect empowerment in your institution?
12) Any questions or comments you would like to add?

Probing statement:

Can you explain_____?
What do you mean when you say_____?
Could you elaborate _____?
In your opinion _____?

APPENDIX D

آغا خان یونیورسٹی
THE AGA KHAN UNIVERSITY

May 2, 2006

Ms. Saleema Gulzar
School of Nursing
Aga Khan University
Karachi

Dear Ms. Gulzar,

Re: 554-SON/ERC-06. PI–Saleema Gulzar: Empowerment among Pakistani Nursing leaders: A grounded theory approach.

Thank you for your application for ethical clearance received on April 5, 2006 regarding the above mentioned study.

Your study was reviewed and discussed in our last meeting held on April 21, 2006 at Aga Khan University. Members commented that this is an informative study. There were no major ethical issues. The study was given an approval for a period of one year.

Any changes in the protocol or extension in the period of study should be notified to the Committee for prior approval. All informed consents should be retained for future reference.

Thank you.

Yours sincerely,

Dr. S. Q. Nizami
Chairman
Ethical Review Committee

Stadium Road, P. O. Box 3500, Karachi 74800, Pakistan.
Cable: Akaproject, Telex: 29667 AKHMC PK, Fax: (92) 21 493-4294, 493-2095, Telephone: 493-0051, www.aku.edu

APPENDIX E
Timeline

	April	May	June	July	August	September	October	December
Proposal writing	***							
ERB Approval	***	***						
Pilot study	***	***						
Data Collection (Interviews)		***	***					
Data Analysis		***	***	****				
Thesis writing and editing				***	***			
Thesis defence					***	***		
Thesis revision based on feedback, printing							****	***

APPENDIX F

AKUSON Thesis Committee Agreement Form

Name: Saleema A. Gulzar

Date: July 27th, 2006

Proposed Topic: Empowerment among Pakistani Nursing leaders: A grounded theory Approach

The following has agreed to be members of my committee:

Chair / Supervisor: Dr. Rozina Karmaliani

Signature: R Karmaliani

1) Member: Dr. Yasmin Amarsi

Signature: Y Amarsi

2) Member: Ms. Kausar s. Khan

Signature: Kausar S Khan

3) Member: Ms. Rubina Barolia

Signature: Rubina

Masters level students must have a minimum of 2 members on this committee. Please include their name and signature on this form.

Cc: Director, MScN programme
Chair, Thesis committee
Members, Thesis committee
Board of Graduate Studies
Student File

APPENDIX G

LIST OF ACRONYMS

DGN	Director General Nursing
ADGN	Assistant Director General Nursing
CNS	Chief Nursing Superintendent
AKU	Aga Khan University
DTA	Diploma of Teaching and Administration
PNC	Pakistan Nursing Council
PNF	Pakistan Nursing Federation
EDO	Executive District officer
NA	Nursing Assistant
NS	Nursing Superintendent
ANS	Assistant Nursing Superintendent
IED	Institute of Educational Development
MS	Medical Superintendent
DDO	Deputy Dispenser Office