Wiley
Nursing Forum
Volume 2025, Article ID 9343933, 12 pages
https://doi.org/10.1155/nuf/9343933

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Research Article

Nursing Autonomy and Evidence-Based Practice in Acute Care: Navigating Power and Promoting Collaboration

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Received 19 December 2024; Accepted 17 May 2025

Academic Editor: Cheryl Green

Aim: This study explores how power dynamics between nurses and physicians in acute care settings influence nursing autonomy and the implementation of evidence-based practice (EBP). It also identifies organisational strategies that can enhance interprofessional collaboration (IPE), leadership and shared decision-making.
Design: A qualitative case study approach was used, underpinned by social constructivism to explore nurses' lived experiences within the context of acute care hierarchies.
Methods: Data were collected from two large NHS acute care hospitals in the Midlands, through 33 semistructured interviews, 12 nonparticipant observations and document reviews. The sample included 37 staff nurses, ward managers, nurse managers and physicians. Braun and Clarke's thematic analysis framework guided data analysis, supported by reflexive field notes and triangulation of data sources.
Findings: Nurses reported restricted autonomy due to entrenched medical dominance and were frequently excluded from key decision-making processes. These hierarchical imbalances contributed to moral distress, burnout and disengagement from EBP. However, the study also uncovered everyday acts of resistance, including subtle negotiation and knowledge-based advocacy. Leadership training, IPE, shared governance and structural reforms were cited as effective strategies for enhancing collaboration and restoring nursing voice. Participants who experienced nurse-led initiatives and inclusive decision-making reported improved confidence and patient care outcomes.
Conclusion: Hierarchical power dynamics significantly constrain nursing autonomy and hinder EBP implementation in acute care. Nurses respond with resilience and agency, often advocating for evidence use in informal ways. Organisational reforms that promote shared governance, empower nurse leaders and foster respectful collaboration are essential for shifting entrenched dynamics and improving care quality.

Summary

- Impact
  - This study highlights the need for NHS organisations to address power imbalances by investing in leadership development, inclusive governance and interprofessional teamwork to support sustained EBP and improve outcomes.
- Reporting method
  - The study followed COREQ guidelines.
- Patient/public involvement
  - Patients were not directly involved; however, the focus on nurse-led care has implications for improving patient safety.

1. Introduction

Safe and high-quality care in acute settings requires more than clinical competence; it demands that healthcare professionals, especially nurses, are able to exercise sound

judgement and act with professional autonomy [1, 2]. However, in many hospital environments, nursing autonomy remains significantly restricted due to enduring hierarchical structures that place physicians at the apex of clinical decision-making [1, 3]. These power dynamics are particularly pronounced in acute care, where urgency, tradition and institutional norms converge to reinforce physician control over decisions, often excluding nurses despite their close proximity to patients [3].

The influence of organisational hierarchy on nursing practice is not a new concern. Freidson's theory of medical dominance continues to offer a relevant lens through which to understand the persistence of unequal professional relationships in contemporary healthcare [4]. Although nurses are increasingly expected to champion evidence-based practice (EBP), they are frequently constrained by systems that privilege medical authority over collaborative decision-making [5]. This limits not only their professional agency but also the quality of patient care, especially when evidence-based recommendations are overlooked or dismissed due to structural power imbalances [6].

In such environments, nurses often face difficulties in integrating EBP into routine practice. While common barriers include time constraints, lack of access to evidence and limited training, these often reflect deeper issues related to power and professional silencing [7]. The marginalisation of nursing input in clinical decisions has consequences not only for nurses' job satisfaction and retention but also for patient safety and care outcomes [8]. Nurses report moral distress when they are unable to act in accordance with evidence and patient needs, especially when physician-led decisions contradict their clinical judgement [7, 9].

Efforts to improve EBP implementation in nursing have increasingly focussed on leadership development and structural reform. Leadership training, shared governance models and interprofessional education (IPE) are identified as key strategies for empowering nurses and fostering more inclusive decision-making [8, 10]. These approaches may aim to address not only individual confidence but also the broader cultural and systemic barriers that maintain hierarchical dominance in healthcare teams.

Despite these developments, there remains limited understanding of how nurses navigate power dynamics in their day-to-day clinical practice. Recent studies suggest that nurses engage in subtle forms of resistance and negotiation to influence care while avoiding open conflict with physicians [10]. However, these actions are often emotionally taxing and rarely acknowledged within formal systems of power. Exploring these lived experiences can provide deeper insights into the hidden work nurses perform to uphold evidence-based care in the face of structural constraints.

This study, therefore, investigates how nurses in acute hospital settings experience and respond to power imbalances, and how these dynamics affect their ability to implement EBP. Focussing on real-world accounts of autonomy, resistance and collaboration, the study aims to inform organisational strategies that promote equitable professional relationships and enhance the role of nurses in delivering evidence-based care. A preprint of this manuscript has been previously published [11].

1.1. Aims. The aim of this study is to examine how power dynamics between nurses and physicians influence nursing autonomy and the implementation of EBP in acute care settings. The study seeks to understand the structural, cultural and interpersonal barriers that shape these dynamics and identify opportunities for advancing collaborative, evidence-informed nursing practice. The specific objectives are as follows:

1. Explore organisational and cultural barriers that limit nurses' autonomy and constrain their ability to implement EBP in acute care settings.
2. Explore the everyday strategies nurses employ to navigate, resist or adapt to hierarchical power structures when contributing to clinical decision-making.
3. Examine the conditions, including leadership development, interprofessional collaboration and shared governance, that facilitate greater nursing autonomy and more inclusive, evidence-based team practices.

2. Methods

2.1. Research Design. This study used an interpretive qualitative case study design, guided by the principles of social constructivism. This approach was well suited to examining how nurses working in acute care settings understand and respond to power relations in their professional practice. The case study method enabled a close examination of these dynamics within their real-world organisational contexts, where roles, relationships and hierarchies are deeply embedded and interrelated [12, 13].

The interpretive paradigm shaped all phases of the research, from framing the questions to analysing the findings. It emphasised the subjective meanings that nurses assign to their experiences of autonomy, collaboration and resistance within hospital teams. Rather than seeking generalisable findings, this approach focussed on how knowledge is socially constructed through practice, language and institutional culture [14]. The researcher's dual role as a nurse academic required critical reflexivity to mitigate potential bias and ensure analytical rigour [15].

To generate a layered understanding of professional dynamics, the study combined interviews, observations and organisational documents. This multimethod strategy allowed for triangulation of findings and supported contextual interpretation [16]. The research and reporting process followed the guidelines of the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist [17].

2.2. Participants and Setting. The study was conducted in two large NHS acute care hospitals in the Midlands region of England, selected due to their hierarchical structures and institutional emphasis on EBP. These sites included

emergency, medical and surgical units, enabling exploration of power dynamics across diverse clinical contexts. Their structural complexity and standardisation of practice procedures reflected broader trends in NHS acute care, thereby enhancing the study's relevance.

A total of 37 participants were recruited using purposive sampling, including staff nurses (SNs), ward managers (WMs), nurse managers (NMs) and physicians. Inclusion criteria were a minimum of 5 years of clinical experience, fluency in English and willingness to discuss EBP implementation and interprofessional collaboration. Convenience sampling was also applied to accommodate varying shift patterns. This sampling strategy captured a range of perspectives while prioritising individuals with substantial experience of the organisational environment.

2.3. Sample Size and Eligibility. Participants included 12 SNs, 14 WMs, 2 NMs and 2 physicians. All met the eligibility criteria. Staffing levels varied across departments, though no formal vacancies were advertised during the study. Participants had between 6 and 35 years of clinical experience, ensuring a wide range of insights into nursing roles and EBP engagement. Educational qualifications were not recorded as part of the demographic data due to the potential identifiability of individuals holding doctoral qualifications in a relatively small sample. Demographic information is presented in Table 1.

Table 1: Participants' characteristics.

Participant ID	Role	Gender	Age	Interviewed/ observed
P1	Physician	M	52	Interviewed
P2	NM	F	57	Interviewed, observed
P3	WM	F	58	Interviewed, observed
P4	WM	F	52	Interviewed, observed
P5	WM	F	46	Interviewed
P6	WM	M	44	Interviewed
P7	WM	F	57	Interviewed, observed
P8	WM	F	57	Interviewed
P9	WM	M	38	Interviewed, observed
P10	WM	F	36	Interviewed, observed
P11	SN	F	26	Interviewed, observed
P12	SN	M	29	Interviewed, observed
P13	SN	M	26	Interviewed, observed
P14	SN	M	27	Interviewed, observed
P15	SN	F	25	Interviewed, observed
P16	Physician	M	47	Interviewed
P17	NM	F	62	Interviewed, observed
P18	WM	F	52	Interviewed
P19	WM	F	40	Interviewed, observed
P20	WM	F	44	Interviewed, observed
P21	WM	M	51	Interviewed, observed
P22	WM	F	47	Interviewed
P23	WM	M	43	Interviewed
P24	SN	F	25	Interviewed, observed
P25	SN	M	28	Interviewed, observed
P26	SN	M	24	Interviewed, observed
P27	SN	M	28	Interviewed, observed
P28	SN	F	29	Interviewed, observed
P29	SN	M	28	Interviewed
P30	SN	F	31	Interviewed, observed

2.4. Data Collection. Data collection took place over a 7-month period, from April to November 2022. This timeframe followed an informal preparatory phase involving site access permissions, early rapport building and communication with clinical leaders. While no formal prefieldwork phase was conducted, ethical access procedures were completed in advance, and researcher presence was gradually introduced to support participant trust and minimise disruption to clinical routines [18].

A triangulated data collection strategy was adopted, incorporating three primary methods: semistructured interviews, nonparticipant observations and document review. This integrated approach allowed for multiple perspectives on the research questions and enhanced the depth and credibility of findings [14, 16]. Observational and interview data were complemented by reflective notes and institutional documents, facilitating analytical triangulation and enabling comparisons between stated policies and practice.

Throughout the data collection period, COVID-19 protocols were adhered to, including the use of personal protective equipment and avoidance of unnecessary contact, in accordance with NHS Trust and national guidance.

2.4.1. Semistructured Interviews. A total of 33 semi-structured interviews were conducted, each held once per participant. Interviews were scheduled after a preliminary period of observation to ensure field insights could inform and refine the questioning process. Interviews were conducted in private, on-site rooms chosen to respect participants' confidentiality and reduce workplace fatigue. Each session lasted between 45 and 90 min. Most were audio-recorded with participant consent; for the two participants who declined recording, detailed notes were taken instead [19].

The interview guide was iteratively refined and informed by field observations, allowing exploration of observed behaviours, communication patterns and reported decision-making processes. The revised guide included descriptive, structural and contrast questions to elicit detailed narratives about power, professional autonomy and EBP. The revised questions are shown in Table 2.

2.4.2. Nonparticipant Observation. Twelve nonparticipant observation sessions were conducted, each lasting approximately 3-4 h. Observations took place during day, evening and night shifts across various clinical settings, including medical, surgical and emergency wards. Contexts observed included ward rounds, shift handovers, multidisciplinary team meetings and informal clinical discussions. These sessions enabled the researcher to explore real-time nurse–physician interactions and team dynamics related to clinical decision-making and EBP use.

The researcher adopted an overt observer role, wearing neutral clinical attire and clearly identifying their presence to staff. In line with ethical principles, staff were reminded of

Table 2: Interview guide.

Question type	Questions
Descriptive	• Can you describe a recent shift where you felt your professional judgement was valued or overlooked? • What kinds of evidence or information do you rely on most when making patient care decisions? • Tell me about how you typically engage in care planning or decision-making discussions.
Structural	• How does your team usually share updates about clinical guidelines or new protocols? • What formal and informal routines support interprofessional collaboration here? • Who typically leads decision-making during multidisciplinary rounds or emergencies?
Contrast	• How do decision-making processes differ during busy shifts compared with quieter periods? • Can you compare what happens in formal handovers versus informal corridor conversations? • How does following guidelines differ from relying on personal or collective experience?

their right to opt out of observation at any point. Each observation session was structured according to Spradley's Developmental Research Sequence [20]. Early sessions focussed on environmental orientation and general behaviours, followed by more targeted observation of power negotiation, leadership influence and participation in decision-making processes.

Field notes captured interaction patterns, verbal and nonverbal cues, inclusion or exclusion in discussions and the presence of organisational routines. These were supplemented by reflexive memos, which allowed the researcher to document positionality, emerging interpretations and emotional responses to the observed events [15].

2.4.3. Document Review. Document analysis was conducted in parallel with observations and interviews, focussing on materials produced by the participating hospitals. Documents included clinical guidelines, shift communication templates, staff bulletins, governance records and internal policies related to EBP and professional roles.

These materials were used to contextualise observed behaviours and participant accounts, particularly around how evidence-based protocols were communicated, adopted or resisted. Comparison between formal policies and lived practice enabled the identification of discrepancies, reinforcing the interpretive focus of the study.

This multimethod approach triangulating interviews, observations and documents facilitated a robust and contextually grounded understanding of how nurses navigate power relations and implement evidence within acute care environments [21].

2.5. Data Analysis. Data were analysed using Braun and Clarke's six-phase thematic analysis framework, chosen for its flexibility and theoretical compatibility with the interpretive case study design and social constructivist paradigm underpinning this study [3]. This approach enabled a nuanced exploration of meaning within and across narratives, observations and documents and allowed the integration of experiential and contextual insights into a coherent thematic structure.

The analysis followed the following six iterative stages: (1) data familiarisation, (2) initial coding, (3) theme development, (4) theme review, (5) theme definition and (6) narrative construction.

First, the lead researcher immersed themselves in the data by reading and rereading all interview transcripts, observational field notes and relevant documents while concurrently reviewing reflective memos. This step facilitated a holistic understanding of the dataset and allowed for the identification of recurring patterns and tensions [3].

Second, initial codes were generated inductively using NVivo software. Coding was performed line-by-line, with attention to discursive indicators of power, professional autonomy, knowledge negotiation and decision-making. Examples of recurrent codes included "excluded from decision-making," "moral distress," "leadership role," "informal resistance," and "peer recognition." These codes reflected both semantic and latent meanings in the data [21].

Third, codes were organised into potential themes based on their conceptual similarities and relevance to the research questions. The triangulated dataset allowed themes to be substantiated across interviews, observations and documents, enhancing analytical robustness. For instance, nurses' verbal accounts of exclusion from care planning were mirrored in observation field notes that documented team meetings where nursing input was bypassed.

Fourth, themes were reviewed and refined collaboratively by the research team to ensure internal consistency and external heterogeneity. During this process, some themes were consolidated while others were divided into subthemes to better represent the data structure. Observational data were particularly valuable in clarifying how interactions unfolded in situ, validating or complicating claims made in interviews.

Fifth, each theme was clearly defined and named to reflect its core conceptual contribution. For example, the theme "Resistance and Professional Empowerment" encompassed acts of subtle negotiation, advocacy and strategic communication, while "Emotional and Psychological Impact" captured experiences of burnout and moral distress linked to power asymmetries.

Finally, a coherent analytical narrative was constructed, integrating themes with illustrative quotes and contextual interpretations. Themes were reported with reference to specific empirical examples, ensuring transparency and grounding in the data.

2.6. Ethical Considerations. This study followed the ethical principles of the Declaration of Helsinki of 1964 and received approval from the University Research Ethics Committee. Each hospital's management also granted permission for participant recruitment. Broader ethical approval was not required, as the study did not involve minors, clinical trials or pose any risks to participants, per UK regulations. Participants received electronic and written invitations detailing the study's purpose, confidentiality, data handling and their right to withdraw without consequences. Informed consent was obtained in line with GDPR. The researcher shared their professional background and explained the study's aims to build trust [20], ensuring anonymity in reporting. All data will be securely stored and destroyed after publication, and participants were treated with respect throughout.

2.7. Rigour and Reflexivity. Rigour in this study was supported through methodological coherence and ongoing critical reflection. Rather than relying on checklists alone, trustworthiness was established through purposeful alignment between the philosophical orientation, design and analytical strategy. The interpretive case study design was suited to the research aim and allowed for contextual depth, while the use of triangulated data sources, namely, interviews, observations and documents, enhanced interpretive validity by facilitating cross-comparison of perspectives and practices [12, 13].

The analytic process was iterative and reflexively grounded. Coding decisions were not simply data driven but were guided by engagement with theoretical constructs around professional power, voice and autonomy. Attention was paid to negative cases and disconfirming evidence, which helped ensure a more nuanced interpretation of participant accounts [18].

Reflexivity was embedded not only in diary entries but also in real-time field interactions. The researcher's dual identity as a nurse academic and external observer was explicitly managed through conscious efforts to maintain a learner stance, regularly questioning assumptions and documenting positional influences on interpretation [15]. This dual role offered insight into insider knowledge while also demanding vigilance against overidentification with the participants.

Crucially, credibility was supported by prolonged engagement in the field and participant familiarity, which fostered openness in interviews and richer observation opportunities. Dependability was enhanced by maintaining detailed records of analytic decisions, including codebooks and thematic maps, which can be audited independently.

Finally, confirmability was addressed through team-based dialogue during theme development and through regular consultation with senior colleagues outside the research setting, who challenged interpretive decisions and helped guard against interpretive bias.

3. Results

Following data analysis, five key themes were developed through an iterative process of thematic analysis, each illustrating a distinct aspect of how nurses experience and respond to power dynamics in acute care settings. These themes were generated through the integration of interviews, nonparticipant observations and documentary data and are presented in Table 3, which summarises the main themes, subthemes and illustrative quotes.

3.1. Autonomy and Professional Power. This theme explores the restricted autonomy nurses experience within hierarchical healthcare systems, highlighting the pervasive influence of physician dominance on clinical decision-making and nursing practice. Participants repeatedly described feeling professionally constrained, with their expertise undermined by dominant medical hierarchies that prioritised physician authority over collaborative input.

3.1.1. Limited Decision-Making Authority. Nurses consistently reported feeling unable to make meaningful contributions to care decisions despite their frontline knowledge of patient needs. There was a common perception that their voices held little weight in formal discussions. The "doctor knows best" culture remained deeply embedded, limiting opportunities for nurse-led interventions.

> "One staff nurse described this frustration plainly: "I don't have the power to decide what needs to be changed or not; the doctors do" (P11, SN).

Another SN reflected on the daily implications of this culture.

> "Even when I know something isn't working for the patient, I have to wait until the doctor agrees. We're trained professionals, but we're not treated like it" (P24, SN).

This sense of professional disempowerment was mirrored in real-time practice.

> "The nurse paused before carrying out a new prescription and later shared privately, "I wanted to suggest something

Table 3: Key themes and subthemes with illustrative quotes.

Theme	Subtheme	Illustrative quote
Autonomy and professional power	Limited decision-making authority	*"I do not have the power to decide what needs to be changed or not; the doctors do"*
	Subordination in care decisions	*"We just follow the orders, even when we know better. It feels like we are just here to assist, not to decide"*
Nurse-physician power imbalance	Exclusion from key discussions	*"We are rarely consulted, even when we are the ones with the most information"*
	Power imbalance in clinical settings	*"The doctors decide, and we obey. That is just how it is always been"*
Resistance and professional empowerment	Advocacy through knowledge	*"I may not have the final say, but I will speak up when I know something is not right"*
	Subtle negotiations	*"Sometimes it is not about arguing. . .it is about finding a way to get them to consider another option"*
Emotional and psychological impact	Burnout and emotional fatigue	*"We put in so much effort, but it feels like it does not make any difference"*
	Moral distress	*"I knew the decision was wrong, but I did not have the power to stop it"*
Addressing power dynamics in teams	Promoting collaborative practice	*"We learnt to appreciate each other's roles. . .it improved our teamwork significantly"*
	Enhancing communication & transparency	*"Weekly interprofessional meetings help ensure everyone is on the same page"*
	Empowering nursing leadership	*"Leadership training has given me the confidence to advocate more effectively"*
	Policy and structural change	*"Policy changes recognising all contributions created a more inclusive environment"*
	Fostering respect and understanding	*"Cultural competence training has reduced some of the tension between professions"*

different, but I knew it wasn't my place to question the doctor's orders" (Observation Note, S1).

This lack of decision-making autonomy contributes to a broader theme of subordination and silencing within acute care environments, setting the foundation for the professional disempowerment explored in the next subtheme.

3.1.2. Subordination in Care Decisions. Nurses described how their role was often reduced to task execution rather than strategic input. This feeling of being peripheral to core decisions led to professional demoralisation and a weakened sense of identity.

"We just follow the orders, even when we know better. It feels like we are just here to assist, not to decide" (P14, SN).

This sentiment was evident during clinical rounds.

"During the meeting, the nurse attempted to offer a suggestion but was dismissed without acknowledgement. The discussion quickly moved on" (Observation Note, S2).

This sense of subordination reinforces the limitations on autonomy outlined earlier and directly intersects with the power imbalance between physicians and nurses explored in Theme 4.2.

3.2. Nurse–Physician Power Imbalance. Power asymmetry between nurses and physicians is a dominant theme, manifesting through exclusion from clinical discussions and the devaluation of nursing input. Despite being closest to patient care, nurses were often denied access to the very conversations that shaped care plans.

3.2.1. Exclusion From Key Discussion. Participants expressed deep frustration at their consistent exclusion from discussions that directly impacted their patients. This exclusion had both practical and psychological consequences.

"We're rarely consulted, even when we're the ones with the most information about the patient's daily care. It's like our input doesn't matter" (P21, WM).

This pattern was confirmed during data collection: "The doctor gathered the team for a care plan meeting but failed to include the nursing staff who had been monitoring the patient overnight" (Observation Note, S2).

Document analysis at Site A indicated that while multidisciplinary input was encouraged on paper, actual participation of nurses in care planning discussions was inconsistently enacted (Document Analysis, Site A Clinical Guidelines).

Hospital policy documents reviewed at Site A referenced the importance of multidisciplinary collaboration, yet examples from practice indicated inconsistent implementation. This disconnect reinforces a systemic exclusion of nursing input, as described in the following subtheme.

3.2.2. Power Imbalance in Clinical Settings. The structural dominance of medical professionals was deeply entrenched, shaping daily interactions in ways that silenced or overrode nursing judgement.

"The way it is done here is that the doctors decide, and we obey. That's just how it's always been" (P8, WM).

Another nurse echoed this imbalance as follows:

"Sometimes I feel like my input is just a formality. Even when we say something, the plan is already made" (P26, SN).

A nurse on a surgical ward described a case where she followed a care directive she disagreed with: "I did not agree with the plan, but what can I do? The doctors have the final say" (Observation Note, S1).

These dynamics echo the marginalisation discussed in Theme 4.1 and highlight the professional tensions that lead nurses to seek informal avenues of influence, as seen in Theme 4.3.

3.3. Resistance and Professional Empowerment. This theme highlights the quiet, strategic resistance undertaken by nurses seeking to assert their professional knowledge within rigid hierarchies. These efforts reflected courage and commitment to patient care, even in disempowering environments.

3.3.1. Advocacy Through Knowledge. Despite limited formal authority, nurses relied on their clinical knowledge to advocate for safer, more effective care. They often chose their battles carefully, asserting their views when patient safety was at stake.

"I may not have the final say, but I will speak up when I know something is not right. Sometimes they listen, and that's what matters" (P10, WM).

This was observed in action:

"The nurse persuaded the physician to adjust the dosage after calmly presenting her observations. The doctor agreed, though reluctantly" (Observation Note, S2).

Hospital guidelines reviewed at Site B encouraged evidence-based teamwork but provided minimal support for informal advocacy by nurses, illustrating a gap between rhetoric and reality (Document Review, Site B Clinical Policy Manual).

A review of Site A's medication protocol guidance supports the importance of joint decision-making though

real-time implementation, as shown here, depends heavily on interpersonal negotiation.

3.3.2. Subtle Negotiations. Many nurses employed subtle communication techniques to influence care decisions without confronting authority figures. This form of quiet negotiation reflected a sophisticated understanding of workplace dynamics.

> "Sometimes it's not about arguing. . .it's about finding a way to get them to consider another option without making it a fight" (P13, SN).

In one ward round, this strategy was evident.

> "The nurse framed her suggestion as a query. The physician adopted the change without realising the origin. The nurse gave a small nod. . .she knew it worked" (Observation Note, S2).

This form of resistance through diplomacy connects closely with the emotional toll described in Theme 4.4, as it often required nurses to suppress frustration while still advocating for safe patient care.

3.4. Emotional and Psychological Impact of Power Imbalance. The cumulative effects of powerlessness manifested in emotional distress and moral tension. Nurses reported experiencing burnout and ethical dissonance, particularly when compelled to carry out decisions that conflicted with their judgement.

3.4.1. Burnout and Emotional Fatigue. The toll of repeated exclusion and professional minimisation often resulted in emotional exhaustion. Nurses described a sense of futility and fatigue that extended beyond physical tiredness.

> "It's exhausting. We put in so much effort, but it feels like it doesn't make any difference. At the end of the day, we're just following orders" (P19, WM).

This emotional weariness was visibly observed.

> "She looked drained, and when her suggestion was dismissed, she whispered, "I don't know how much longer I can do this" (Observation Note, S1).

Such experiences compound the power imbalances discussed in Themes 4.1 and 4.2 and are further intensified by moral conflict, as discussed next.

3.4.2. Moral Distress. Many participants shared painful reflections on moments when they knew the right course of action but lacked the authority to pursue it. These experiences left lasting emotional scars.

> "I knew the decision was wrong, but I didn't have the power to stop it. It's heartbreaking, and it stays with you long after your shift ends" (P30, SN).

A nurse was seen visibly shaken following a patient deterioration:

> "She said quietly, "I knew this would happen, but I had to follow orders. It's hard to sleep at night knowing you could have done something different" (Observation Note, S2).

These insights provide the emotional backdrop that makes the strategies described in Theme 4.5 essential for long-term professional sustainability and patient safety.

3.5. Addressing Power Dynamics in Interprofessional Healthcare Teams. This theme explores proposed and enacted solutions to improve interprofessional relationships and redistribute decision-making power within healthcare teams.

3.5.1. Promoting Collaborative Practice. Joint training initiatives, such as IPE, were described as effective in fostering mutual understanding and dismantling traditional silos between nursing and medicine.

> "Through interprofessional workshops, we learned to appreciate each other's roles and contributions, which improved our teamwork significantly" (P2, NM).

The impact of this approach was observed as follows:

> "Everyone was given the chance to speak. The nurse's insights were actively engaged with by the consultant" (Observation Note, S2).

Such efforts provide a tangible counterpoint to the exclusion detailed in Theme 4.2 and help rebuild respect.

3.5.2. Enhancing Communication and Transparency. Regular interprofessional meetings were cited as foundational for creating open, inclusive environments that allowed nurses to contribute meaningfully.

> "Weekly interprofessional meetings have helped us address issues collaboratively and ensure everyone is on the same page" (P1, Physician).

In one such meeting, transparency made a difference: "A nurse voiced a concern, and the lead physician acknowledged her input, thanking her for raising it. It was a turning point" (Observation Note, S2).

These examples reflect early signs of shifting power balances and validate the leadership development strategies in the next subtheme.

3.5.3. Empowering Nursing Leadership. Leadership training was identified as transformative for nurses who had previously lacked the confidence or institutional backing to challenge poor practice or exclusion.

> "Leadership training has given me the confidence to advocate for my patients and my team more effectively" (P3, WM).

This shift in power was evident: "The nurse led the morning briefing and ensured all staff, including junior doctors, were heard. It was clear she had command of the room" (Observation Note, S2).

These findings link directly to the advocacy and negotiation tactics explored in Theme 4.3.

3.5.4. Policy and Structural Changes. Participants highlighted the importance of institutional reforms, including shared governance models that enable more equitable decision-making.

> "Policy changes that recognise the contributions of all team members have helped create a more inclusive environment" (P6, NM).

This change was observed during a governance meeting.

> "All roles were represented equally. Decisions were discussed rather than declared. The atmosphere felt collaborative, not top-down" (Observation Note, S1).

These examples illustrate structural approaches to levelling the playing field in decision-making.

3.5.5. Fostering Mutual Respect and Understanding. Cultural competence and training in respectful communication were cited as important interventions to reduce tension and improve collaboration across roles.

> "Cultural competence training has helped us understand and respect each other's backgrounds. It's made our team more cohesive" (P22, WM).

This was apparent during a cross-cultural team meeting as follows:

> "Team members from different backgrounds shared ideas openly, with visible support from colleagues across disciplines" (Observation Note, S2).

This theme reinforces the emotional and relational aspects of team collaboration already highlighted in Theme 4.4.

3.5.6. Recognition and Valuing Contributions. Formal and informal recognition emerged as powerful mechanisms for boosting morale and affirming the professional value of nursing staff.

> "Recognition programs that highlight achievements of all team members have boosted morale and improved collaboration" (P16, Physician).

During a recognition event,

> "A nurse was publicly thanked for improving care protocols. The entire team applauded. It clearly meant a lot" (Observation Note, S1).

This subtheme provides a hopeful conclusion to the challenges explored in Themes 4.1–4.4, suggesting that sustained investment in recognition and structural equity can rebalance power dynamics.

Figure 1 presents a conceptual model derived from the thematic analysis of interview, observation and document data. The model illustrates the complex interplay between power dynamics and the implementation of EBP among nurses in acute care settings. At the core is the constrained autonomy experienced by nurses, shaped by hierarchical structures and physician dominance. This is exacerbated by exclusion from decision-making and the emotional toll of moral distress and burnout. Despite these barriers, nurses engage in acts of resistance and knowledge advocacy, often negotiating power informally. The outer layer highlights organisational strategies, such as leadership development, interprofessional collaboration and structural reform that can enable more inclusive and equitable professional practice. The model underscores how system level changes are essential to restoring nursing voice, enhancing patient care and embedding EBP into routine clinical decisions.

4. Discussion

The findings of this study offer critical insights into the entrenched power dynamics between nurses and physicians in acute care settings and their impact on nursing autonomy, implementation of EBP and patient care. These findings align with existing literature demonstrating that hierarchical structures limit nurses' decision-making authority, which affects their ability to integrate EBP into practice effectively [6, 22, 23].

Nurses in this study expressed dissatisfaction with being excluded from critical care discussions despite their intimate knowledge of patient needs. This exclusion compromises patient safety and reduces job satisfaction, echoing findings from McHugh and Stimpfel [24]. The structural marginalisation of nursing input contributes to role conflict and moral distress [10, 23]. Nurses are often perceived as peripheral to decision-making, which reinforces medical dominance and creates barriers to knowledge mobilisation [25].

Power imbalances also negatively affect patient outcomes when nurses' contributions are marginalised. The need for collaborative care models where nursing expertise is valued is clear [1, 25]. Despite these constraints, nurses in this study demonstrated subtle resistance and asserted their professional expertise through everyday negotiation and

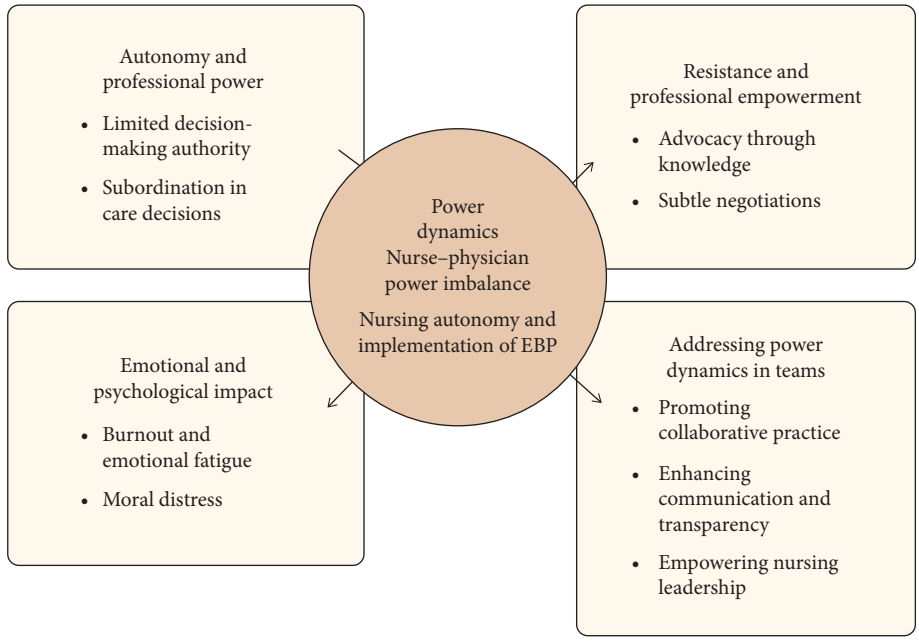

Figure 1: A conceptual model illustrating the influence of power dynamics on nursing autonomy and EBP in acute care settings.

advocacy strategies [26, 27]. However, these efforts come at a cost, with participants reporting emotional fatigue and burnout, consistent with findings from O'Connell et al. [28] and Schaffer et al. [29].

This study highlights the potential of interprofessional collaboration to mitigate negative effects of power imbalances. Participants noted that joint training programmes such as IPE were effective in fostering mutual respect and improving teamwork. Reeves et al. [30] support this, showing that IPE reduces professional silos and encourages shared decision-making. Interprofessional meetings and shared governance models were also identified as strategies for improving communication and empowering nurses in decision-making processes. Shared governance has been shown to improve job satisfaction and patient outcomes by equitably distributing decision-making power across teams [31].

Organisational reforms to support nurse leadership and empowerment were further emphasised. Leadership training increased nurses' confidence to advocate for their teams and patients, aligning with findings from Schaffer et al. [29] and Ominyi and Alabi [25]. Nurse-led initiatives in infection control and medication review highlight how enhanced autonomy contributes to improved care delivery and knowledge utilisation [11, 25].

The value of professional recognition was also underscored. Participants felt affirmed when acknowledged for their clinical input, suggesting that even small organisational changes can reinforce professional identity and morale. This supports evidence from Ominyi et al. [32] that recognition and leadership visibility improve EBP engagement.

Finally, while structural and cultural constraints were evident, this study reaffirms that nurses are not passive actors. They actively navigate institutional barriers and engage in microresistance to uphold patient-care standards. Such agency is essential in shifting team dynamics, and future work must explore how to sustain this agency over time.

4.1. Strengths and Limitations. This study's strength lies in its triangulated approach, integrating interviews, observations and document analysis to strengthen interpretive validity and ensure contextual depth.

However, the study also has limitations. It relies on self-reported data, which may be influenced by social desirability or underreporting of conflict. Besides, the absence of direct patient perspectives limits the analysis to professional viewpoints. Though the design offered depth, its cross-sectional nature prevents assessment of how interventions such as leadership training may influence outcomes longitudinally. Despite these limitations, the use of critical reflexivity and triangulation enhanced analytical trustworthiness.

4.2. Implications for Practice. Healthcare organisations must address power imbalances that undermine nursing autonomy and obstruct EBP implementation. Promoting interprofessional collaboration through IPE and adopting shared governance models will improve nurses' participation in decision-making and foster inclusive team dynamics. Leadership development programmes should be institutionalised to support nurse advocacy and elevate the visibility of nursing expertise.

Recognition and feedback mechanisms should be formalised to validate nursing input and reinforce morale. Shared governance, nurse-led quality initiatives and regular forums for inclusive communication are recommended. Addressing cultural competence through training will also enhance team cohesion and reduce interprofessional tension.

4.3. Implications for Research. Future research should investigate the psychological effects of power imbalance over time, particularly regarding moral distress, burnout and intent to leave the profession. Longitudinal studies are needed to evaluate the sustained impact of leadership development, nurse-led initiatives and policy reforms on nursing autonomy and EBP uptake.

Further exploration of informal resistance strategies and their effects on team dynamics would offer valuable insights. Studies focussing on patient perspectives could complement professional narratives and help contextualise how power dynamics influence care quality. Finally, evaluating organisational interventions designed to flatten hierarchies and support shared governance in real-world NHS contexts is a critical research priority.

5. Conclusion

This study highlights the persistent influence of hierarchical power dynamics on nursing autonomy and EBP implementation in acute care settings. Despite systemic constraints, nurses continue to advocate for evidence-based care through microresistance and informal negotiation, underscoring their resilience and agency within rigid hierarchies.

Strengthening nursing leadership, adopting shared governance and fostering interprofessional collaboration can mitigate these power differentials. Organisational reforms that recognise and elevate nursing input are essential for improving patient outcomes and embedding EBP in daily practice. The findings underscore the need for NHS institutions to invest in inclusive, sustainable models of professional collaboration that value all contributions equally.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

Disclosure

A preprint of this manuscript has been previously published [11].

Conflicts of Interest

The authors declare no conflicts of interest.

Funding

No funding was obtained for this study.

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