

Emancipation in decision-making in women's health care

Ruth A. Wittmann-Price MSN RN

Assistant Professor, Department of Nursing and Health, DeSales University, Center Valley, Pennsylvania, USA

Submitted for publication 29 May 2003

Accepted for publication 15 January 2004

Correspondence:

Ruth Wittmann-Price,
Department of Nursing and Health,
DeSales University,
2755 Station Avenue,
Center Valley,
PA 18034-9568,
USA.
E-mail: rw0@desales.edu

WITTMANN-PRICE R.A. (2004) *Journal of Advanced Nursing* 47(4), 437–445

Emancipation in decision-making in women's health care

Background. Emancipation as a nursing concept is derived from a long-standing history of social oppression and is easily addressed by both critical social theory and feminist theory. It is the apparent concept to describe a phenomenon witnessed in nursing when caring for women in the decision-making process about health care issues. Emancipation has been recognized by expert clinical observation.

Aim. The aim of this paper is to define the concept of emancipation for possible future application to nursing practice for the promotion of humanistic nursing care in women's health, specifically applied to the decision-making process.

Method. A literature search was carried out using the CINAHL database and the keywords nursing and emancipation, and covering the period 1985–2003. The Rodgers and Knafl (2000) method of concept analysis was then used to derive a conceptual meaning of emancipation that benefits patient care as well as professional nursing development. Emancipation is broken down into antecedents, attributes and consequences. Related concepts are also explored, compared and discussed to synthesize relevant characteristics.

Findings. This concept analysis identifies emancipation in decision-making as a nursing phenomenon by discussing the antecedent of oppression and exploring the identified attributes: (a) empowerment, (b) personal knowledge, (c) social norms, (d) reflection and (e) flexible environment. The consequence of emancipation is free choice. It is a futuristic concept with strong historical ties in need of exploration and development within the context of women's health care in relation to decision-making.

Conclusions. The concept model illustrates emancipated decision-making, with its five attributes in relation to oppression as a non-linear phenomenon. Areas for further study include the exploration of the contribution of each critical attribute and its relationship to emancipated decision-making, and the decision-making process in relation to patient satisfaction and how long the person continues to adhere to the decision. Also the professional nursing role in promotion of emancipated decision-making is virtually unexplored, but is an important concept in the paradigm of shared decision-making about health care alternatives.

Keywords: emancipation, nursing, critical social theory, feminist theory, oppression, decision-making

Introduction

The purpose of conceptually analysing emancipation as a nursing concept is to define it more precisely, and thereby clarify it, theoretically and operationally, as a process that promotes humanistic patient care and professional growth in the clinical realm of decision-making for women about health care issues. Nursing experts recognize a need for better understanding of emancipation by referring to the presence of oppression as a negative phenomenon within the profession, as shown by Scarry's (1999) statement, 'Oppressed nurses deliver oppressed care, thereby compromising the physical, emotional and social well-being of the client' (p. 424), which summarizes Kendall's 1992 discourse on promoting emancipatory nursing actions. The specific intent of this concept analysis is to define emancipation for future application to nursing practice in order to promote free choice in decision-making for women about health care issues and to promote professional growth in nursing by increasing awareness of oppressive systems.

Search method

The past two decades have produced a steady flow of nursing publications containing the concept *emancipation*. A search of the CINAHL database during 2003 revealed articles containing the keywords '*emancipation and nursing*' at a rate of one to two per year for the time period between 1985 and 1992 increasing to an average of 12–17 journal articles for each of the last 6 years. The total number of articles found was 132 for the keywords: *emancipation* and *nursing*. This suggests a constant presence and growing awareness in the nursing profession of emancipation as an underlying persistent phenomenon.

Search findings

The 132 articles retrieved were reviewed for the use of emancipation and it was revealed that the term has been used in a variety of ways. The majority of authors discussed emancipation related to the theoretical paradigm shift in nursing education from a system or behavioural model to a phenomenological model of caring and reflection sometimes called humanism (Bevis & Watson 1989, Duchscher 2000). A lesser number of papers dealt with emancipating patients by means of patient education. Few dealt with emancipation as part of the nursing research process. More than 35% of the papers ($n = 51$) had variety of usages for the term *emancipation*. No previous concept analysis was found and there

were few references to an emancipated decision-making process.

Decision-making for women is a significant nursing concern as women make the majority of health care decisions for themselves and family members. A recent cross-sectional Canadian survey found that women make 71% of the health care decisions, when compared with 55% for men (O'Connor *et al.* 2002). Current decision-making science focuses on decisional aids, decisional conflict resolution and emotional control. Personal values are addressed in decisional theories (O'Connor 1995, Sawka *et al.* 1998), but societal norms may also affect value systems oppressively.

Decision-making about health care issues has historically reflected the social norms of paternalistically derived systems of medicine and academia, in which providers decided on the health care alternative (Holmes 2002). Currently, decision-making has moved into a different paradigm to include a shared decision-making process between patient and provider (Bunn *et al.* 1997). Building decision science from a nursing perspective is an important field of inquiry in today's health care environment because of the increasing alternatives presented to patients and providers. This is reflected in the comment of Pierce and Hicks (2001) that 'Given the ubiquitous nature of human decision making and the nature of the current health care environment, it is imperative to further develop this knowledge and integrate it into clinical care' (p. 267). Developing decisional science without discussion of oppression and an emancipation process in the humanistic care of women is to deny obvious barriers to shared decision-making. The presence of oppression and struggles of emancipation are not only obvious throughout history but are still a part of the health care system today (Bevis & Watson 1989, Kendall 1992, Scarry 1999).

Nursing education

The literature search yielded a substantial body of knowledge about emancipation developed in the field of nursing education built on the 1970 work of Paulo Freire in *The pedagogy of the oppressed*. Emancipatory education has been proposed as an educational methodology that looks beyond the Tylerian (Tyler 1969) educative process which uses behaviourism and linear knowledge acquisition. Freire (1970) challenged educators to consider social norms as a primary factor in the educational process. The traditional educational system has also been charged with applying negative power to women, which has 'marginalized and silencing them' (Gore 1993, p. 120). Shor (1992) classified schools as systems of socialization that reflected the values of the wider society.

The concept of emancipation is most fully developed in the education discipline and from this development basic constructs can be identified and applied to nursing. Emancipatory educational methodologies used in the classroom should assist teachers to 'encourage student questioning, avoid a unilateral transfer of knowledge, help students develop their intellectual and emotional powers to examine their learning in school, their everyday experience, and the conditions in society' (Shor 1992, p. 12). An emancipatory curriculum has been proposed as one way to establish fundamental human rights, because it is based in an environment that is flexible and encourages uninhibited critical thinking (Shor 1992).

Emancipatory education has been encouraged in nursing education but may be difficult to implement within the existing patriarchal system. Another educational consideration is that emancipatory methodologies of learning may be difficult for reticent students (Leonard & Johnson 1998). Owen-Mills (1995) described the challenge more globally and proposed that 'the challenge for nurse educators, however, extends beyond the confines of an institution and into the homes, hospitals and communities where nursing is practised. For a caring curriculum to be truly emancipating, its effects must become internalized as a way of being' (p. 1193). Nursing educators must rise to this challenge because it is the 'emancipatory starting point' (Kuokkanen & Leino-Kilpi 2000, p. 237) but the concept still needs expansion and exploration in the realms of nursing practice and research.

Nursing research and practice

Emancipation as a concept has been explored a little in the context of nursing research and practice (Clare 1993, Owen-Mills 1995, Harden 1996, Leonard & Johnson 1998, Scarry 1999). Several studies have explored the emancipatory role of the nurses in direct patient care, suggesting that it leads to improved decision-making skills for patients or an increase in autonomy, a related concept. This limited exploration of emancipation in clinical practice may reflect the idea that patients are an oppressed group when confronted with health care options (Lehmann 1982, Burks 1999, Jairath & Kowal 1999, O'Brien *et al.* 1999, Henshaw 2001, Leino-Kilpi & Luoto 2001).

Consequently, in humanistic nursing paradigms, those caring for women must enact emancipation by accepting the multifaceted issues surrounding women's health, culminating in their freedom to choose. Aoki (2002) described this humanistic paradigm as 'receiving equal treatment is a human right' (p. 18). In addition, Aoki questioned intuitively

the social position of current nursing practice by posing the question, 'Are the rights of patients and nurses usually compromised in some way?' (p. 17). This concept analysis will explore women's decision-making about health care issues as a possible compromised area of nursing care.

The study

Aim

The aim of this study was to define the concept of emancipation for possible future application to nursing practice. My intent was twofold: to promote humanistic nursing care, as realized by ensuring free choice, and stimulate discussion of the nurse's role in promoting emancipated decision-making in women's health care.

Method

The Rodgers and Knafl (2000) method of concept analysis was used to encompass the evolutionary aspect of this concept. Oppressive health care practices relating to women have always been present and continue to evolve. The historical aspect of oppression in women's health care will not be elaborated on here because of space limitations. Emancipation will be defined within the realm of professional nursing practice as an evolving concept with antecedents, attributes, consequences and related concepts. To complete the analysis, application to actual practice in which women are central in the decision-making process is simulated through an exemplar case and implications for further development will be discussed (Rodgers & Knafl 2000).

Concept analysis

Emancipation: the concept of interest

Emancipate is defined by the Merriam-Webster Online (2002) as a verb meaning (1) to free from restraint, control or power of another, (2) to release from paternal care and responsibility, and (3) to free from any controlling influence. Emancipation is the act or process of emancipating. Synonyms for emancipate are free, discharge, liberate, loose, loosen manumit, release, unbind, unchain and unshackle (Merriam-Webster Online 2002).

In contrast, oppression or lack of freedom, is the direct antonym and necessary antecedent of emancipation and has negative interpretations and outcomes. Oppression can be overt or insidious, and serves the purpose of dehumanization by producing a 'culture of silence' and a 'fear of freedom' that

is exploited for labour in exchange for perceived security (Freire 1970, p. 36).

Logically, an oppressive force must precede emancipation. If no oppression existed, there would be no need for emancipation. The outcome of emancipation is to equalize power between dominant and deprived groups, enabling free choice and promoting true humanistic paradigms in society and health care.

Although I will explore emancipation theoretically in the context of clinical decision-making in nursing, I recognize that other nursing realms, including nursing research and education, need further investigation in order for nurses to facilitate the emancipation of patients. Freire (1970) eloquently illustrates the magnitude of this phenomena and the great task for nursing by stating, 'This then, is the great humanistic and historical task of the oppressed: to liberate themselves and their oppressors as well' (p. 44).

Theoretical basis

Critical social theory

The majority of the papers reviewed concerning the concept of emancipation were based on critical social theory. This began in Germany during the 1920s as the Frankfurt Theory, was built on the philosophies of Marx and Hegel and denounced oppression to promote positive change (Paley 1998). Oppression is maintained by social institutions in order to control people, their resources and finances (Kuokkanen & Leino-Kilpi 2000). The purpose of critical social theory is to expose oppressions that may place constraints on individual or social freedom. Furthermore, emancipation must free not only individuals but also oppressive social structures, and replace them with a humanistic philosophy based on the fundamental value of freedom (Holmes 2002). That fundamental value of freedom begins with the right to choose freely.

Habermas (1969), a German philosopher, applied critical social theory to dialogue and defined it as a reflective practice of communication which stimulates cognitive awareness of oppressive practices (Duchscher 2000). Praxis through reflection is considered a main component of emancipation (Fleming 1992, Duchscher 2000, Kuokkanen & Leino-Kilpi 2000).

Critical social theory further recognized human behaviour to be inseparable from environmental influences, and that historically society has imposed disadvantage on some groups. It assumes that there are underprivileged groups, and that injustices must be addressed on both individual and social levels. Some authors contend that the entire social structure can only be changed by political action (Romyn

2000), and thus collective autonomy is one of the primary values of critical social theory. Others view critical social theory as influencing personal as well as group choice recognizing that many of life's options are influenced by social attitudes (Owen-Mills 1995). Therefore, social attitude or norms may also control many options in women's health care.

Feminist theory

Closely related to critical social theory is feminist theory. Pohl and Boyd (1993) outlined three basic schools of thought within feminism. Liberal feminism arose during the same time period as liberal political theory, and it considered that equal opportunities for women should be based on the same standards as for men, and individualism was valued. Radical feminist theory was born out of the 1960s as part of the women's liberation movement and claimed that oppression of women is a part of all systems, both micro and macro. A third view was socialist feminist theory which has incorporated the biology, society and physical environment as factors that construct oppression. It holds that feminist theory has applicability to individuals as well as groups.

Epistemological views about women's place in the world may differ in various feminist theoretical approaches, but all concentrate on the oppression of women, regardless of its origin, and advocate methods for change, whether individually or collectively. Regardless of its origin, power or domination over women causes oppression and denies equality or 'voice' (Arslanian-Engoren 2001). The main concepts of feminist theory substantiate the premise of oppression as a constant phenomenon that penetrates decision-making in women's health care.

Nursing feminist theorists propose equal rights, equal treatment and caring as basic values. Another concept linked with equality and emancipation is 'authentic voice'. The 'growth of voice' is a metaphor for empowerment, a related concept in the nursing literature, and the term 'silence' has come to symbolize oppression. Feminist theory claims that for women to have a 'voice' requires safe space (Johns 1999). In this concept analysis, safe space is interpreted as a flexible environment for decision-making.

Professional growth

A complicating factor to the concept of emancipation in decision-making in clinical practice are nurses themselves, the majority of whom are themselves women and are thus part of an oppressed group. Authors have identified characteristics that nurses demonstrate that are similar to those of oppressed groups, such as alliance with the oppressor, horizontal

violence, fear of freedom, emotional dependence, lack of self-esteem and disdain for other women (Romyn 2000). Nurses are said to assimilate the value system of an oppressed group, and this has been reflected in the nurse–patient relationship (Kuokkanen & Leino-Kilpi 2000). Harden (1996) explained this phenomenon as a result of exploitation of nurses since the institutionalization of patients in hospital, because administrators and physicians ‘need nurses’. It was this need for nursing care, as well as the fact that the majority of nurses were women, that produced oppression as a means of control.

Antecedents

In order for emancipation to be realized when making health care decisions, individuals or groups must recognize that oppression exists and that it is negative (Freire 1970). Freire (1970) called oppression ‘dehumanization’ and explained that ‘it is a concrete historical fact, not a given destiny but the result of unjust order’ (p. 44). Oppression or unequal power decreases a person’s self-esteem and autonomy, and thereby restrict choices.

Recognizing oppression is a type of awareness that actions are not harmonious with individual or group needs. It is an affective experience which produces the feeling that ‘something is not right’ or ‘this choice is not right for me’. Awareness of this feeling is necessary to understand oppressive forces (Astor *et al.* 1998). Recognized oppression is the direct antecedent of emancipation.

Critical attributes

In the clinical setting of women’s health care, specific attributes must be present for emancipation in decision-making to occur. I have identified these attributes from the related literature and the contributing theories, and they are: reflection, personal knowledge, empowerment, awareness of social norms and a flexible environment.

Reflection

Freire (1970) described reflection as a consciousness or a learned method of perceiving society and its oppressive influence. It has also been called a form of critical thinking or cognitive awareness (Romyn 2000). Reflection is developing a perception of questioning practices that are based solely on tradition or authority. Reflectiveness was further explained by Penney and Warelow (1999) as a behaviour: ‘reflection in action – stepping out of one self – freeze framing the moment to understand it better’ (p. 263). It has been considered a valid way of knowledge acquisition from

practical experience and a valid source of analysis (Penney & Warelow 1999). Johns (1999) explained that ‘the true way to desirable practice or action is stop and think about what we are doing, to truly reflect’ (p. 241). Habermas’ (1969), in writing about hermeneutic praxis, viewed developing critical consciousness by reflection as a necessary tool for understanding groups, and not only individuals (Holmes 2002). Freire (1970) also considered reflection a method that be used could change society for the better (Penney & Warelow 1999). Reflection is needed to think critically about the information gained from personal and professional knowledge in order to synthesize the latter into a decision.

Some methods that promote reflection are dialogue, journaling and concept mapping. Dialogue has been discussed as one of the most used modalities. The term for dialogue was coined by Habermas as ‘communicative action’ (Habermas 1969). Dialogue has been described in education as an interactive method that is powerful enough to change societies as well as individuals (Mill *et al.* 2001). Harden (1996) cautioned that reflection alone may not be enough to be considered emancipating; it must take the form of further action or it will fall prey to ‘wishful thinking’ (Harden 1996, p. 36). Action may be taken after true reflection, but reflection may lead a person or group to defer intentional action. For the purposes of this concept analysis, reflection is defined as a cognitive or interactive process in which a woman consciously engages when considering alternatives in health care.

Personal knowledge

Personal knowledge is a type of knowledge that also has components of self-awareness. It has been described as the ability to understand one’s self. Personal knowledge influences everything one does because it is being aware of one’s own feelings (Berragan 1998). Polanyi (1958) described personal knowledge as objective because it makes a person aware of how knowledge affects any one situation. For the purposes of this concept analysis, personal knowledge is defined as awareness by a woman that she has thought about alternatives presented in health care in relation to herself.

Empowerment

The concept of empowerment has been described extensively in the nursing literature. It can be interpreted as professional knowledge imparted to patients within nurse–patient relationships (Kuokkanen & Leino-Kilpi 2000). Empowerment is a positive process that promotes autonomy and independence and implies that, through knowledge, some type of power is shared or transmitted to patients. It has been described as ‘the process that provides the resources, tools, and environment to

develop, build, and increase ability and effectiveness of others to set and reach goals for individual and social needs' (Hokanson-Hawks 1992, p. 610). Empowerment is a component of the emancipation process but it alone may not ensure freedom of choice. Kuokkanen and Leino-Kilpi (2000) state that 'where there is power, there is also knowledge and power begets knowledge' (p. 237). Knowledge as power can be used to liberate or oppress, depending on its delivery and intent (Fleming 1992). For the purposes of this concept analysis, empowerment will be interpreted as the information and resources that health professionals provide to women about health care alternatives.

Awareness of social norms

Emancipation allows innately free people to use resources acquired through reflection based on personal and professional knowledge or empowerment to make appropriate health care decisions for themselves, regardless of the popularity of those choices in the current political and social climate. It is awareness that social norms set standards and establish paradigms that are sometimes difficult to change (Cody 2000), and refers to awareness that social norms have sanctioned one of the possible alternatives as more acceptable than others. Emancipation involves recognizing that knowledge development always occurs in a social context and exerts influence over information transfer, thereby influencing individual perceptions (Berragan 1998). For the purposes of this concept analysis, awareness of social norms will be defined as awareness of how society places more value on one or more of the alternatives being considered.

Flexible environment

A non-judgmental environment that supports freedom of choice is imperative because if the chosen alternative attracts sanctions of any sort, then this just elicits another type of oppression. Kalischuck and Thorpe (2002) state that 'flexibility frees students to apply knowledge' (p. 161). Flexibility should also free patients to make choices. A flexible environment can also be described as one that is responsive to change leading to personal benefits for individuals and therefore society. It increases choice and thereby enhances self-esteem and understanding (August-Brady 2000). For the purposes of this concept analysis, a flexible environment will be defined as an environment that allows women unopposed enactment of a chosen alternative.

Consequences

Choice is emancipating when a person is not only free to choose what is right for them but when that decision can

be enacted without consequence. If the choice carries negative consequences, it is still bound by oppression. Emancipation involves equalizing external and internal demands, which means patients themselves choosing what is best for them, even if this is not the popular alternative sanctioned by society's norms (Kalischuck & Thorpe 2002). The consequence of an emancipated decision is free choice with or without an associated intentional action. Emancipated decision-making must be cognitively liberating and involve awareness by the women that this is the best alternative for them personally; therefore producing the ultimate goal of emancipated decision-making, 'free choice'.

Derived definition

Emancipation describes a process of reaching a more positive state of being, a state of relative freedom in choice by first acknowledging an affective experience of oppression. The experience is cognitively reflected upon, with or without dialogue. The choice is arrived at by using personal knowledge in combination with empowerment from professional knowledge. The decision is made in a flexible environment and precipitates the desired outcome of free choice. The emancipation process in decision-making in women's health care is illustrated in Figure 1.

Related concepts

Autonomy

Autonomy, like emancipation, has been described as an outcome of empowerment because it also has the ability to produce independent thinking and action. Empowerment may lead to autonomy when there is sharing of responsibility and authority (Wade 1999, Duchscher 2000). Every autonomous decision does not necessarily reflect emancipation because the decision-maker may not recognize oppressive forces, use reflection or consider personal knowledge in a flexible environment. An emancipated decision is one that takes into account both individual and social implications (Cody 2000).

Intentional action

An intentional action occurs when an individual or group chooses to act on a plan (Burks 1999). Intentional action may be the outcome of an emancipated decision-making process and may represent free choice, but can also be a less thought-out process. It involves establishing a personal plan that is reasonable, but may not have been reflected upon and therefore does not contain all elements of an emancipated decision.

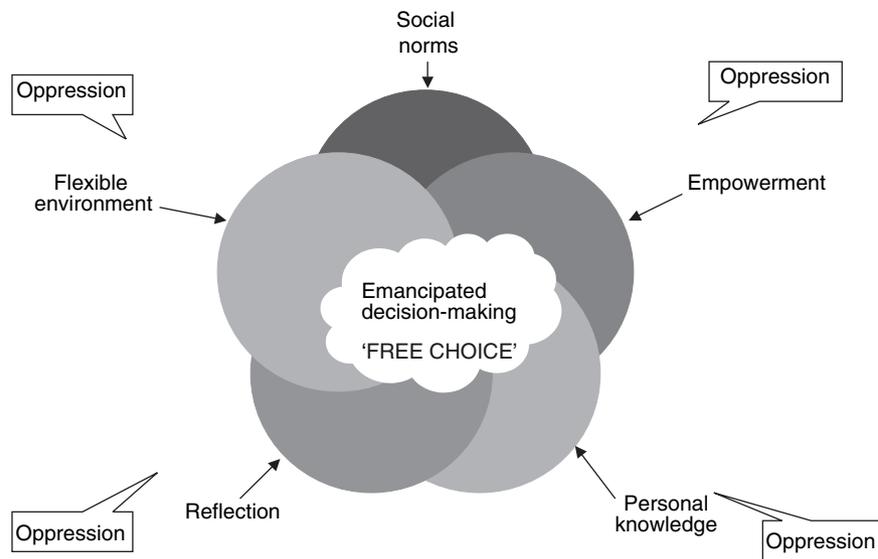


Figure 1 Emancipated decision-making in women's health care.

Active participation

Active participation by patients is, at times, used synonymously with decision-making and intentional action (Burks 1999, Kennedy & Rogers 2001, Lund *et al.* 2001). Burks (1999) described self-management through active participation as a process similar to emancipation because health care professionals relinquish control and allow patients to act on their own behalf. Burks (1999) applied this assumption in a successful nursing practice model for patient rehabilitation. The self-management process described by Kennedy and Rogers (2001) included patient experiences as well as evidenced-based practice to facilitate active participation. Their model supports self-management, active participation and decision-making as a foundation for emancipatory care. Active participation is emancipation when the decision-making process produces 'free choice' after oppression is recognized.

Exemplar

A woman had delivered a viable infant at 1500 h, and called the professional nurse at 02.00 hours 'for something for discomfort'. She was sitting in bed, watching her newborn. Her partner was asleep on the guest coach provided in the private room. She described her feelings of being uncomfortable and tired. She also stated that it was difficult to sleep with the baby in the room, as she woke up for 'every little noise'.

She had just finished breastfeeding the baby, who was asleep in the bassinet. The nurse detected the woman's dissatisfaction with the current rooming-in arrangement and so encouraged her to 'think of anything else that would make her more comfortable and promote her rest tonight'.

The nurse left the room to fetch the analgesic and to review the woman's birthing plan. This stated that the woman and her partner did not want to be separated during the experience. The nurse returned to the woman with the analgesic and asked if there was anything else she could do. The patient hesitantly answered, 'No'. The nurse verbalized to the new mother her observation of how tired she appeared and that the newborn appeared content.

The woman inquired if 'all mums roomed-in' as the hospital brochure said. The nurse explained that there were alternative care modes on the perinatal unit and that the baby could be taken to the central nursery between feeds. The nurse reassured the woman that the nursing staff would wake her to breastfeed should the baby cry. The woman verbalized her exhaustion and how she had felt that she was not doing an adequate job of mothering. After discussing the ill-effects of sleep deprivation, the nurse encouraged the woman to think about her options. The woman decided to have the baby taken to the central nursery so that she could obtain at least three hours of uninterrupted sleep.

Discussion of exemplar

One of the current nursing issues in women's health nursing is rooming in (Zwelling 2000, Ecenroad 2001). Although family-centred, rooming-in care was a revolutionary concept in the 1950s and 60s (Clayton 2000), it may currently be applied to the point of oppression if social pressure rather than choice is causing the woman to conform. Practices adopted in health care that limit choice, based explicitly on one type of research method, may and

What is already known about this topic

- Emancipation as a concept and methodology has best been explored in the educational realm of nursing.
- Oppression of women has a long-standing history that is pervasive and penetrates patient care and professional growth.
- Decisional science is becoming increasingly important in today's health care environment, which calls for shared patient-provider decision-making.

What this paper adds

- Emancipation is a concept well suited to describing a phenomenon involving decision-making in women's health care.
- The process of making an emancipated decision must contain critical attributes in order to arrive at free choice.
- Ensuring free choice in the nursing care of women is fundamental in humanistic care.

oppress women in health care (Allen 1985). Nurses should advocate re-evaluation of practices that may be over-applied to the point of oppression.

Implications for nursing

Through a feminist philosophy based on a critical social theory, nurses can use the concept of emancipation to influence the health care of women in relation to decision-making. Patients need not only be empowered through education, but also emancipated by unconditional acceptance of choice. This discussion also recognizes that nurses themselves need emancipation from the constraints imposed on them by the systems in which they practise. The first step in creating an emancipated health care environment for women by women is awareness and recognizing that oppression exists. Oppression today may be more pervasive and less obvious than it has been in the past, making it difficult to recognize and bring to a cognitive level of interpretation (Holmes 2002).

Health care practices must be examined for their effect on patients' ability to arrive at free choices. Oppressive health care practices often take the deceptive form of innovative nursing and medical therapeutic interventions. The political and social environment that supports oppression is grounded in traditions that have been established to promote patient compliance (Fahrenfort 1987).

Conclusion

Emancipation in decision-making related to women's health care has been defined as a nursing concept with the goal of promoting humanistic care by prompting free choice. Emancipated decision-making is a nursing concept that is also applicable for further developing the role of nurses as promoters of emancipated decision-making in women's health care, thereby promoting professional growth. Emancipated decision-making has oppression as its clear antecedent, and has critical attributes which lead to the humanistic consequence of free choice, namely empowerment, personal knowledge, social norms, reflection and a flexible environment.

The current status of women's health care encourages shared decision-making in health care practices. Decisional science needs to consider the impact of social norms as depicted in critical social theory and the oppression of women as pointed out in feminist theories as factors in women's decision-making. Oppression is a historical and universal phenomenon that is still evolving and still has a tremendous effect on women when making personal choices. Nurses themselves need to deal with oppression through emancipation within the professional realm in order to make a social impact. Recognition of this concept in the health care of women and possibly all patients is long overdue.

Author contributions

RAWP contributed to study conception and design, data collection, drafting of manuscript, critical revisions of manuscript for important intellectual content, administrative, technical or material support, and supervision.

References

- Allen D.G. (1985) Nursing research and social control: alternative models of science that emphasize understanding and emancipation. *Image: The Journal of Nursing Scholarship* 8(2), 58–64.
- Aoki Y. (2002) Reflections on empowerment. *Nursing Older People* 13(10), 17–19.
- Arslanian-Engoren C. (2001) Feminist poststructuralism: a methodological paradigm for examining clinical decision-making. *Journal of Advanced Nursing* 37, 512–517.
- Astor R. Jefferson H. & Humphrys K. (1998) Incorporating the service accomplishments into pre registration curriculum to enhance reflective practice. *Nurse Education Today* 18, 567–575.
- August-Brady M. (2000) Flexibility: a concept analysis. *Nursing Forum* 35(1), 5–14.
- Berragan L. (1998) Nursing practice draws upon several different ways of knowing. *Journal of Clinical Nursing* 7, 209–217.
- Bevis E. & Watson J. (1989) *Toward a Caring Curriculum: A New Pedagogy for Nursing*. NLN, NY.

- Bunn M.H., O'Connor A., Tansey M.S., Jones B. & Stinson L. (1997) Characteristic of clients with schizophrenia who express certainty or uncertainty about continuing treatment with depot neuroleptic medication. *Archives of Psychiatric Nursing XI*, 238–248.
- Burks K.J. (1999) A nursing practice model for chronic illness. *Rehabilitation Nursing 24*(5), 197–200.
- Clare J. (1993) A challenge to the rhetoric of emancipation: recreating a professional culture. *Journal of Advanced Nursing 18*, 1033–1038.
- Clayton M. (2000) Health and social policy: influences on family-centered care. *Pediatric Nursing 12*(8), 31–33.
- Cody W.K. (2000) Paradigm shift or paradigm drift? A meditation on commitment and transcendence. *Nursing Science Quarterly 13*, 93–102.
- Duchscher J.E. (2000) Bending a habit: critical social theory as a framework for humanistic nursing education. *Nurse Education Today 20*, 453–462.
- Ecenroad D. (2001) Childbirth: a family affair. *Advance for Nurses (Greater Philadelphia) 3*(25), 31–33.
- Fahrenfort M. (1987) Patient emancipation by health education: an impossible goal? *Patient Education and Counseling, 10*(87), 25–37.
- Fleming V.E. (1992) Client education: a futuristic outlook. *Journal of Advanced Nursing 17*, 158–163.
- Freire P. (1970) *Pedagogy of The Oppressed*. The Continuum International Publ, NY.
- Gore J.M. (1993) *The Struggle for Pedagogies: Critical and Feminist Discourses as Regimes of Truth*. Routledge, Chapman and Hall, NY.
- Habermas J. (1969) *Toward a Rational Society: Student Protest, Science, and Politics*. Heinemann, London.
- Harden J. (1996) Enlightenment, empowerment and emancipation: the case for critical pedagogy in nurse education. *Nurse Education Today 16*, 32–37.
- Henshaw L. (2001) The impact of class position on women's experience of receiving health education information whilst in hospital. *Health Education Journal 60*, 241–255.
- Hokanson-Hawks J. (1992) Empowerment in nursing education: concept analysis and application to philosophy, learning and instruction. *Journal of Advanced Nursing 17*, 609–618.
- Holmes C.A. (2002) Academics and practitioner: nurses as intellectuals. *Nursing Inquiry 9*, 73–83.
- Jairath N. & Kowal N. (1999) Patient expectations and anticipated responses to post surgical pain. *Journal of Holistic Nursing 17*, 1984–1996.
- Johns C. (1999) Reflection as empowerment? *Nursing Inquiry 6*, 241–249.
- Kalischuck R.G. & Thorpe K. (2002) Thinking creatively: from nursing education to practice. *The Journal of Continuing Education in Nursing 33*, 156–163.
- Kendall J. (1992) Fighting back: promoting emancipatory nursing actions. *Advances in Nursing Science 15*(2), 1–15.
- Kennedy A. & Rogers A. (2001) Improving self-management skills: a whole systems approach. *British Journal of Nursing 10*, 734–737.
- Kuokkanen L. & Leino-Kilpi H. (2000) Power and empowerment in nursing: three theoretical approaches. *Journal of Advanced Nursing 32*, 235–241.
- Lehmann A. (1982) Anorexia nervosa: emancipation by emaciation. *The Canadian Nurse Nov*, 8231–8233.
- Leino-Kilpi H. & Luoto E. (2001) The multiple sclerosis nurse as patient educator. *Journal of Neuroscience Nursing 33*, 83–89.
- Leonard T. & Johnson J. (1998) The reticent student: implications for nurse educators. *Journal of Nursing Education 37*, 213–215.
- Lund M.L., Tamm M. & Branholm I. (2001) Patients' perceptions of the participation in rehabilitation planning and professionals' view of their strategies to encourage it. *Occupational Therapy International 8*, 151–167.
- Merriam-Webster Online (2002) <http://www.m-w.com/cgi-bin/dictionary>, last accessed 26/10/02.
- Mill J., Allen M., Morrow R. (2001) Critical theory: critical Methodology to disciplinary foundations in nursing. *Canadian Journal of Nursing Research 33*, 109–127.
- O'Brien A.P., Woods M. & Palmer C. (1999) The emancipation of nursing practice: applying anti-psychiatry to the therapeutic community. *Australian and New Zealand Journal of Mental Health Nursing 10*(1), 3–9.
- O'Connor A. (1995) Validation of a decisional conflict scale. *Medical Decision Making 15*, 25–30.
- O'Connor A., Jacobson M. & Stacey D. (2002) An evidenced-based approach managing women's decisional conflict. *JOGNN 31*, 570–581.
- Owen-Mills V. (1995) A synthesis of caring praxis and critical social theory in emancipation curriculum. *Journal of Advanced Nursing 21*, 1191–1195.
- Paley J. (1998) Misinterpretive phenomenology: Heidegger, ontology and nursing research. *Journal of Advanced Nursing 27*, 817–824.
- Penney W. & Warelow P.J. (1999) Understanding the prattle of praxis. *Nursing Inquiry 6*, 259–268.
- Pierce P. & Hicks F. (2001) Patient decision-making behavior: an emerging paradigm for nursing science. *Nursing Research 50*, 267–273.
- Pohl J.M. & Boyd C.J. (1993) Ageism within feminism. *Image: Journal of Nursing Scholarship 25*, 199–203.
- Polanyi M. (1958) *Personal Knowledge: Towards a Post-critical Philosophy*. The University of Chicago Press, Chicago.
- Rodgers B.L. & Knafel K.A. (2000) *Concept Development in Nursing: Foundations, Techniques, and Applications*, 2nd edn. Saunders, Philadelphia.
- Romyn D.M. (2000) Emancipatory pedagogy in nursing education: a dialectic analysis. *Canadian Journal of Nursing Research 32*, 119–138.
- Sawka C., Goel V., Mahut C., Taylor G., Theil E., O'Connor A., Ackerman I., Burt J. & Gort E. (1998) Development of a patient decision aid for choice of surgical treatment for breast cancer. *Health Expectations 1*, 23–36.
- Scarry K.D. (1999) Nursing elective: balancing caregiving in oppressive systems. *Journal of Nursing Education 38*, 423–426.
- Shor I. (1992) *Empowering Education: Critical Teaching for Social Change*. University Press, Chicago.
- Tyler R.W. (1969) *Basic Principles of Curriculum and Instruction*. The University of Chicago Press, Chicago.
- Wade G. (1999) Professional nurse autonomy: concept analysis and application to nursing education. *Journal of Advanced Nursing 30*, 310–318.
- Zwelling E. (2000) Trendsetting: Celeste Ecenroad, the mother of family-centered care. *Journal of Obstetric, Gynecological and Neonatal Nursing 29*, 90–94.

This document is a scanned copy of a printed document. No warranty is given about the accuracy of the copy. Users should refer to the original published version of the material.