ABSTRACT

Seeking Connectivity: An Analysis of Relationships of Power from Staff Nurses’ Perspectives

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Nurse empowerment is a well-researched area of nursing practice yet the quality of work environments continue to be eroded, and interactions between nurses and nurse managers continue to be fragile. Power is integral to empowerment, yet the exercise of power between nurses and their managers have been under-investigated in the nurse empowerment literature. To advance our knowledge in the empowerment literature, the study explored the process of how power is exercised in nurse-manager relationships in the hospital setting.

Strauss and Corbin’s (1998) grounded theory methodology informed the study. Multiple qualitative fieldwork methods were utilized to collect data on staff nurses about how the manager’s role affected their ability to do their work. The researcher conducted semi-structured interviews and participant observations with 26 participants on three units within a tertiary hospital in Western Canada.

Seeking connectivity was the basic social process in which nurses strive to connect with their manager to create a workable partnership in the provision of quality patient care while responding to the demands in the organizational context. Conditions, actions, and consequences
formed the theory of seeking connectivity as an extension of nurse empowerment theory. The overarching finding is that the manager plays a critical role in modifying the work environment for nurses and as such, nurses seek connection with their manager to accomplish their work. Institutional policies and practices combined in various ways to influence nurses’ thinking and shaped their actions. The first pattern of the process was characterized by the absence of meaningful engagement with the manager. Power was held over nurses restricting discussions with the manager, and nurses employed a variety of resistance strategies. In the second pattern of the process when managers provided guidance, advocated for nurses, and engaged nurses as collaborators, nurses were better able to problem solve and make decisions with the manager to positively influence patient outcomes. The theory of seeking connectivity is the explanatory framework emerging from the study that reveals how power is exercised in social relations between nurses and managers. Seeking connectivity is a recursive process that continues to evolve. The results of this study advance nurse empowerment primarily from a structural perspective and secondarily from a critical social perspective, suggesting that nurses’ perceptions and abilities shape their work role and are foundational to promoting change through collective action. Study implications for research, practice and policy are addressed.
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CHAPTER ONE:
THE INTRODUCTION

The purpose of this introductory chapter is to: i) provide the background for the study; ii) provide rationale and support the need for the study; iii) delineate the problem statement; iv) identify the purpose of the study; v) delineate the significance of the study; and vi) address the assumptions of this research study.

Background to the Problem

The reorganization that took place more than a decade ago in Canadian healthcare has resulted in leaner structures designed to emulate business models of efficiency, productivity, and cost effectiveness (Aiken, Clarke, Sloane, & Sochalski, 2001a; Aiken, Clarke, Sloane, Sochalski, Buss, Clarke et al., 2001b). These changes have profoundly shaped the way healthcare is delivered and affected nurses’ work (Laschinger, Finegan, Shamian, & Wilk, 2001c). There has been a shift from hierarchical organizations in which strict control combined with rewards and punishments were the norm, to an emphasis on making work meaningful and a commitment to the work itself as a consequence of the new managerial model (Block, 1987; Powell, 2002; Spreitzer, 2008; Thomas & Velthouse, 1990).

In the 1990s, business organizations appeared to be taking significant steps toward improving profits, customer satisfaction, and the quality of employees’ work lives (Hardy & Leiba-O’Sullivan, 1998; Liden, Wayne, & Sparrowe, 2000). These “empowerment initiatives,” as they were termed, became more prevalent following major structural reorganization. With fewer middle managers remaining in business
organizations, efforts were undertaken to make workers more autonomous so that responses to customers could be more effective and efficient (Denham Lincoln, Travers, Ackers, & Wilkinson, 2002).

Organizational restructuring in healthcare institutions also occurred in response to the need to address fiscal challenges and to create more efficient patient-care delivery systems. Restructuring in some facilities resulted in hospital closures, mergers, program downsizing, and the reconfiguration of physical resources. Corresponding with organizational changes were staff layoffs carried out to reduce healthcare costs.

Not surprisingly, these organizational changes adversely affected nurses’ work lives. Nurses struggled to cope with heavy patient workloads, excessive overtime, and demands by consumers for higher standards of patient care. These events compounded the intensity of patient-care activities, stretching nurses’ ability to provide adequate care given the limited physical and human resources. Moreover, organizational policies led to the replacement of nurses with less costly healthcare workers and the creation of non-nurse manager positions for nursing units in some healthcare facilities (Blythe, Baumann, & Giovanetti, 2001).

In particular, a reconfiguration of the head-nurse role and an erosion of nursing leadership affected staff nurses’ work life. With organizational change, head nurses assumed the role of nurse manager and took on the administrative responsibilities of senior leaders who were laid off. The meaningful relationship nurses had with supervisors was lost because supervisors were less accessible or visible; the supportive role of the head nurse as a coach and mentor also was lost (Canadian Nursing Advisory Committee, 2002). The role change adversely affected the working dynamics and the relationships
between nurses and their managers.

Healthcare restructuring resulted in striking changes in nursing leadership roles creating a set of tensions and challenges. Nurses were left with the pressure and stress of inconsistent guidance and support from their manager to navigate practice changes in their work. This resulted in nurses having increased responsibility for patient care without the corresponding knowledge, autonomy, and skill to actively participate in decisions affecting their practice. Nurses advocated to their leaders for the care required for their patients, but with minimal results (Brown, 2001). Nurses became pessimistic and cynical about believing in and supporting nurse leaders who appeared to have shifted their allegiance from “quality patient care” to bottom-line “financial concerns.” Nurses felt their skills and abilities were not respected in the workplace (Laschinger, Finegan, Shamian, & Wilk, 2003). Nurses also felt they could no longer trust nursing leadership to support and advocate for the care they believed was necessary for their patients (Brown, 2001). How nurses experienced their work and its effect on staff nurses’ work life was negative and dramatic.

The structural and human resource changes that affected nurses’ work lives were implemented, for the most part, in the absence of staff nurses’ participation. Nurses’ voices were not included in most of the decisions affecting their work life. This left nurses feeling they held little or no control over their working conditions, nor the ability to, actively advocate for the needs of their patients (CNAC, 2002). The literature states that nurses were angry and they turned their anger on the nurse leaders they believed had created the changes in the workplace, and on a system that undervalued their work (Brown, 2001; CNAC, 2002). The result was broken trust and fractured relationships
between staff nurses and their leaders. Yet, these tensions challenged leaders’ ability to provide the infrastructure and direction to ensure nurses can practice professionally and deliver safe, high-quality care.

In response to these structural and human resource changes, nurses became increasingly dissatisfied with their jobs, experienced low morale, job strain, and began leaving the profession or immigrating to other countries (Aiken et al., 2001a; 2001b; Baumann et al., 2001; CNAC, 2002). This in turn could have contributed to the nursing shortage, that Canada is experiencing, that challenges nurses’ ability to provide quality care (Health Canada, 2006; O’Brien-Pallas et al., 2005). Adding to nurses’ overwhelming responsibilities and low morale was the constant threat of negative patient outcomes (O’Brien-Pallas et al., 2005). In response government, policy makers, and employers initiated several key collaborative reports to address the instability of nursing human resources and the poor quality of work environments. These reports concluded efforts need to be made to retain current nurses in the system, attract new recruits to the profession, and improve nurses’ work environments (Baumann et al., 2001; CNAC, 2002).

In a landmark study, Aiken and colleagues (2001a) examined the state of hospital nursing care during significant restructuring in 700 North American and European hospitals. The study consisted of 43,329 nurses; of those, 17,450 were Canadian. Aiken et al. found that within the Canadian context, frontline manager roles were reduced by 39.9%. With fewer managers in the system, these changes resulted in the adoption of wider managerial spans of control and increased responsibilities for supervising more staff (Doran, McCutcheon, Evans, MacMillan, McGillis Hall, Pringle, et al., 2004;
Laschinger et al., 2008; McCutcheon, Doran, Martin, McGillis Hall, & Pringle, 2009). Laschinger et al. reported first-line managers had large spans of control ranging from five to 264 which was slightly higher than findings by Doran et al. (range = 36 -151). Doran et al. found large spans of control reduced the effect of positive leadership styles on staff and patient satisfaction. Similarly, Meyer et al. (2011) found when managers had transformational leadership styles and were assigned compressed operational hours in combination with wide spans of control, nurses’ experienced lower job satisfaction. However, Laschinger et al.’s study revealed that first-line managers were positive about their role effectiveness and influence within the organization. These studies point to the relationships between leadership style and span of control on nurses’ job satisfaction, and the discrepancies that exist between how nurses and managers experience their work.

More importantly, studies have found wider spans of control, organizational demands, and time constraints have resulted in limited opportunities for interaction between the manager and nursing staff (McCutcheon et al., 2009). Specifically nurses have indicated they experience a lack of feedback, support, recognition within their unit and organizations, and a lack of input into decision-making (Laschinger, Finegan, & Shamian, 2001a). Overall, the limited interaction may decrease the ability of the manager and nurses to develop high quality and growth fostering relationships, hampering nurses’ ability to experience satisfaction in their work role and reducing their ability to contribute to activities and processes enhancing patient care. Clearly, the reconfiguration of front-line nurse managers’ roles lessened nurse managers’ ability to effectively communicate and be responsive to the concerns of bedside nurses.

Compounding the changes in the leader role and affecting nurses practice was a
nursing human resource shortage. O’Brien-Pallas et al. (2005) addressed the gap in nursing human resource planning by creating long-term strategies to ensure an adequate and sustained supply of knowledgeable nurses for the Canadian healthcare system. Findings revealed that although there has been an average annual growth rate of approximately 2.2% from 2003 (241,415) to 2007 (257,961) of registered nurses (Canadian Nurses Association, 2007) — there is an inherent problem not readily apparent: Seventy percent of nurses surveyed were over 40 years of age. Additionally, there was evidence that the stress of nurses’ work lives has led to early retirements, more part-time work, and fewer young people being attracted to or remaining in the profession (CNAC, 2002). This empirical analysis of an aging workforce has been described as a “demographic time bomb” (O’Brien-Pallas et al., 2005, p. viii) that could significantly compromise patient care requirements. The outcome of these human resource findings has heightened awareness of an untenable crisis.

The work environment literature has indicated that quality work environments promote nurses’ mental and physical health and are necessary to maximize nurse, patient, and system outcomes (Aiken et al., 2001a; 2001b; Baumann et al., 2001; CNAC, 2002; O’Brien-Pallas et al., 2005). Nursing studies have acknowledged that certain leadership qualities and behaviours contribute to the development and sustainability of a healthy work environment (Pearson, Laschinger, Porritt, Jordan, Tucker, & Long, 2007). Improving nurse empowerment is one strategy suggested to improve working conditions, recruitment, and retention in enhancing satisfying workplaces for nurses (Greco, Laschinger, & Wong, 2006; Laschinger, Finegan, Shamian, & Wilk, 2004; Laschinger, Wong, McMahon, & Kaufmann, 1999; O’Brien-Pallas et al., 2005). Lashinger and
colleagues tested Kanter’s model (1977; 1993) of organizational empowerment in which structural factors such as access to resources, information, support, and opportunity in work settings have a significant influence on employee’s ability to accomplish their work. Laschinger and colleagues also tested Conger and Kanungo’s (1988) view of leader empowering behaviours in which the leader removes conditions in the work environment that decrease employees’ self-efficacy. Consequently, Laschinger et al.’s research supports Kanter’s theory (1977;1993) and Conger and Kanungo (1988) that highlight the key role of leadership behaviour in shaping nurses’ work experiences. In related research on nurse empowerment, studies show that when effective nurse managers empower their staff nurses, they also increase staff nurses’ commitment to the organization, reduce job stress, and reduce nurse turnover (Laschinger, Finegan, & Shamian, 2001a; 2001b; Priest, 2006). Researchers have found that involvement in unit decisions, supportive management, trust in management, and job satisfaction have been positively linked to staff empowerment (Laschinger & Finegan, 2005; Laschinger & Havens, 1996: Laschinger, Finegan, Shamian, & Wilk, 2001c).

However, recent reports indicate that nurses’ dissatisfaction in the workplace continues to be highly problematic. Nurses see managers as unsupportive, lacking effective leadership, and identified inadequate resources as affecting working conditions in meeting patient care requirements (CNAC, 2002; O’Brien-Pallas et al., 2005; Priest, 2006). In conjunction with staff nurses’ tenuous relationships with their supervisors, Laschinger and colleagues (2005) found that staff nurses reported low levels of trust in management, especially in relation to their superiors’ sense of honesty and concern for their needs. Studies have indicated that building trust between nurses and their managers
is critical to patterns of nurse empowerment, and occur within relations of power which contribute to a positive work environment (Brown, 2001; Hardy & Leiba-O’Sullivan, 1998; Hokanson Hawkes, 1992; Laschinger & Finegan, 2005; Moye & Henkin, 2006). While there is considerable support for access to workplace sources of power (Kanter, 1977; 1993) and empowerment as a motivational construct (Conger & Kanungo, 1988; Spreitzer, 1995a; 1995b) in the nurse empowerment literature, a gap remains in our understanding of power that exists in the nurse-manager relationship. Laschinger et al. (1999; 2008) assert the importance of the nurse manager creating empowering work conditions to support positive practice work environments to increase nurses’ job satisfaction. The context of nurses’ work is carried out in relationships with others, and some scholars (Fletcher, 2006; Manojlovich, 2007) state that nurses need to focus on relationships to build power as another dimension that could expand the view of nurse empowerment. Specifically, a gap remains in our knowledge about nurse empowerment. More importantly, there is a gap in how power is manifested in the nurse-manager relationship to enhance nurses’ ability to accomplish their work.

**Problem Statement**

Organizational pressures such as fiscal constraints, organizational downsizing, an aging workforce (Priest, 2006) are taking their toll on nurses and effective leadership is needed to assist nurses to respond to these challenges. There is evidence in the literature that empowerment is related with nursing leadership (Laschinger, 1996; Upenieks, 2003a; Upenieks, 2003b). In light of fractured working relationships that staff nurses continue to have with their nurse managers, there is a need to examine the power that
exists within this relationship (Fletcher, 2006; Manojlovich, 2007) and the underlying processes that contribute to staff nurse empowerment and improve nurses’ work environments.

The central problem to be addressed in this study is how power in the staff nurse and nurse manager relationship fosters or constrains staff nurse empowerment. To date, research on nurse empowerment has produced valuable information on the nurse manager’s role in enhancing staff nurses’ perceptions of empowerment. It has also highlighted the magnitude of individual and organizational outcomes that are associated with staff nurse empowerment. However, research to date has not fully explicated the underlying processes by which power is shared or created within the nurse-manager relationship. To date some examples of managers sharing power resulted in the following nurse empowering behaviours: communicating goals of management (access to information), encouraging collaboration among health providers (access to support), and ensuring adequate time and resources to accomplish work (access to resources) (Laschinger, Gilbert, Smith, & Leslie, 2010). Creating power within the nurse-manager relationship refers to how power can be mobilized by nurses to accomplish patient and organizational goals and be used as a form of resistance. However, the latter form of power may take on a visible form to challenge domination in nurses’ practice, thereby creating the will to resist (Hardy & Leiba-O’Sullivan, 1998). To better understand nurse empowerment, we must first examine how nurses and their managers exercise power in order to address this gap in our knowledge.

**Purpose of the Study**
The purpose of this study is to extend empowerment theory by developing a substantive theory to explain how staff nurses and their managers exercise power in a hospital setting, and thus to better understand what fosters or constrains staff nurses’ empowerment. To address this problem, a grounded theory method (Strauss & Corbin, 1998) was conducted to theorize the process of how nurses and their managers exercise power in their relationships. It is anticipated that this inquiry will provide the foundation for “the elaboration of existing theory” (Suddaby, 2006, p. 635) and may produce a more comprehensive understanding about how nurses exercise power, thus influencing empowerment practices and improving the quality of their work lives. Empowerment cannot be fully understood and acted upon unless there is an understanding of power (Bradbury-Jones, Sambrook, & Irvine, 2008; Gilbert, 1995; Hardy & Leiba-O’Sullivan, 1998; Masteron & Owen, 2006; Rodwell, 1996; Ryles, 1999), and as such, power in the nurse-manager relationship has been under-investigated in the nurse empowerment literature, and in particular, in the hospital setting.

**Significance of Study**

Power is central to understanding nursing practice (Bradbury-Jones, Sambrook, & Irvine, 2008). The increased attention to nurses’ work environments and nurse outcomes by administrators, researchers, and policy makers has created an imperative to advance a theoretical understanding of the exercise of power in the nurse-manager relationship. Therefore, this study is significant as it may contribute to: (i) uncovering the process of how power is exercised in the nurse-manager relationship, which could lead to the development of additional manager empowering behaviours that could contribute to
improving the context for organizational change; (ii) increasing nurses’ awareness of power by making their power more visible and explicit, and advancing our knowledge of power and empowerment (Manojlovich, 2007); (iii) extending nurse manager’s awareness to learn new ways of leading and managing to enhance nurse empowerment and achieve a more engaged, innovative, and productive staff, which in turn, could aid the retention of nurses (Casey, Saunders, & O’Hara, 2010; Wilson, Squires, Widger, Cranley, & Tourangeau, 2008); and (iv) developing and testing theoretical based propositions based on the findings of this grounded theory study.

Assumptions Underlying the Study

This research was based on the following assumptions:

1. Empowerment takes on various forms in different individuals and contexts (Rappaport, 1984; Zimmerman, 1995).

2. An individual’s acquisition of a variety of skills, knowledge, and actions in developing control in different contexts influence their empowerment experiences (Foster-Fishman, Salem, Chibnall, Legler, & Yapchai, 1998; Zimmerman, 1995).

3. The context of empowerment is dynamic and constantly changing (Foster-Fishman et al., 1998; Zimmerman, 1995).

4. Empowerment is viewed as being on a continuum as individuals are at various points of being less or more empowered (Spreitzer, 1995a; Zimmerman, 1995).
Summary

This chapter has provided an introduction to the current research study. Information was presented outlining the background to the problem, culminating in the problem statement. The purpose of the study, significance of the study, and the assumptions underlying the construct of empowerment were delineated. The following chapter will review the literature on empowerment and its relevance for this grounded theory study.

In Chapter Three, I provide an overview of the grounded theory method utilized in this study. I present the strategy of data sampling, data collection, coding, and analysing (Strauss & Corbin, 1998), and the implementation of the research design. I discuss considerations for ensuring scientific quality and ethical considerations. Chapters Four and Five form the foundation for the presentation of research findings. Specifically in Chapter Four, I outline the organizational context to reveal the conditions shaping how staff nurses and managers exercise power. I also explore how interactions and communication influence the way nurses relate with their manager. In Chapter Five, I delineate a range of consequences for nurses as a result of being situated in social relations of power with their manager. In Chapter Six, I highlight how the substantive theory that emerged from the data, process of seeking connectivity, is theorized in an effort to extend our understanding of nurse empowerment. Finally, in Chapter Seven, I further interpret the research findings by describing the new knowledge gained in this research and its contributions to the discipline of nursing. I present key conclusions and outline the implications for practice, policy, and administration.
CHAPTER TWO:

REVIEW OF THE LITERATURE

Introduction

This chapter provides an overview of the literature related to this study. Preparing my research prompted me to explore a range of theoretical and empirical literature related to how power is exercised between staff nurses and their nurse managers in the hospital setting and its association with nurse empowerment.

The key terms *power* and *empowerment* were used to search electronic databases such as CINAHL, Medline, PsycINFO, Social Sciences Abstract, and ABI/INFORM Global. Searches were limited to English-language documents from 1985-2011.

The literature review is organized into three sections. First, I begin by briefly differentiating between power and empowerment, and provide definitions of power, empowerment, social relations, and social process as it pertains to the purpose of this grounded theory study. Second, I review the current state of knowledge related to empowerment and its link with nurse-manager relations which is encapsulated within the following theoretical perspectives: i) organizational (includes the psychosocial and structural perspectives); and ii) critical social. These divergent understandings have arisen because power, which is integral to empowerment, has different connotations for each theoretical perspective and shapes how individuals conceptualize and enact power. I then show how managerial practices and programs offered through the organizational perspective illustrate how nurses experience their work within an organization. I then show how power is exercised within the nurse-manager relationship from a critical perspective to uncover the nature of enabling or restrictive practices for nurse
empowerment within social institutions.

Finally, I conclude by summarizing the state of knowledge to reveal how power is exercised in nurse-manager relations as central to the discussion of nurse empowerment, the key points and gaps in the literature that set the stage for the significant contributions of this study, and the methodological perspective that lends direction for this study. This study offers and explores these theoretical perspectives in ways that challenge and balance each other, thus confirming the multidimensional aspect of empowerment.

**Power and Empowerment: What is the Difference?**

The concept of power is at the core of any empowerment analysis (Bradbury-Jones, Sambrook, & Irvine, 2008; Gilbert, 1995; Hardy & Leiba-O’Sullivan, 1998; Masteron & Owen, 2006; Rodwell, 1996; Ryles, 1999). Power is conceptualized in different ways, but it is noted primarily for its negative connotation. We typically associate power with authoritative leadership, where one person restricts another’s freedom of action. We also equate power with the individual acquisition of control in traditional hierarchical work settings.

The word “power” comes from the Middle English (1250-1300) and the old French verb “poeir” meaning “to be able” (Merriam-Webster Online Dictionary, 2009). Hokanson Hawks (1991) classifies power by two distinctions: “power over” and “power to”. “Power over” is defined as the “ability or official capacity to exercise control” (Hokanson Hawks, 1991, p. 758) and is associated with intentional forcefulness and struggle for dominance (Hokanson Hawks, 1991). Power in this instance also represents the capacity to impose one’s will against the will of others, can arise from an inferior to
superior position, and has a directive force or impact (Clegg, Courpasson, & Phillips, 2006; Raatikainen, 1994; Ward & Mullender, 1991). Power encompasses control, competitiveness, and authority (Raatikainen, 1994).

Power can be achieved through an individual having a source of power that is informational, is rewarding or coercive which constitutes their power over others (French & Raven, 1959). Power can be associated with the restriction of one person’s freedom of action so someone else can increase his or her power (Kuokakken & Leino-Kilpi, 2000). These authors’ definition of power compares to critical social theory, where power is interpreted in terms of coercion and domination and where certain groups are subordinate to another group.

Power is also defined as the “power to” which refers to the “ability or capacity to act or get things done” (Hokanson Hawks, 1991, p. 758). “Power to” is an interpersonal process involving a relationship with others that includes the capacity and the competence to achieve objectives in a mutually satisfying manner (Gibson, 1991; Hokanson Hawks, 1991). In this instance, power is viewed similarly to the concept of empowerment. Power is a multi-dimensional construct and is dependent on the specific situation and the positions of the individuals in a social relation (Clegg et al., 2006).

Empowerment is also an important concept in nursing practice. The Merriam-Webster Online Dictionary (2009) defines “empower” as giving official authority or legal power to; to enable; to promote self-actualization or to influence others. Empowerment can be understood in terms of individual or group attributes (Ryles, 1999), conceptualized from different perspectives (Bradbury-Jones et al., 2008; Kuokkanen & Leino-Kilpi, 2000), originate from the work environment (Kanter, 1977; 1993), or from one’s own
psyche (Conger & Kanungo, 1988), and may be viewed as overcoming barriers or domination (Fulton, 1997).

Empowerment is a dynamic process of helping others to choose to take control over and make decisions about their lives (Gibson, 1991; Rodwell, 1996). Empowerment as a process suggests a redistribution of power (Gibson, 1991). For instance, common themes in empowerment encompass the notion of sharing resources, cooperation, shared decision making, and collaborative processes that foster mutually beneficial interactions (Hokanson Hawks, 1991; Katz, 1984). Keiffer (1984) conceptualizes empowerment as a developmental process of helping individuals develop a critical awareness of the root causes of their problems and a readiness to act on this awareness. An individual’s mastery may occur through individual change, interpersonal change, or a change of social structures that impact the individual. In a broad sense, empowerment is a process by which people, organizations, and communities gain mastery over their lives (Rappaport, 1984). Empowerment is generally viewed as positive, focusing on solutions rather than problems, and capitalizes on individual’s strengths and abilities rather than on their deficits and needs (Bradbury-Jones et al., 2008; Gibson, 1991; Kuokkanen & Leino-Kilpi, 2000).

The focus of much of the management literature addresses the procurement and use of power in organizations (Conger & Kanungo, 1988; Kanter, 1977; 1993; Liden & Arad, 1996). Kanter (1977; 1993) views power as the ability to get things done, to mobilize resources, and to obtain whatever a person requires to achieve intended goals. Kanter’s version of power creates the capacity for individuals to have control over the conditions that make their actions possible, which is in sharp contrast to the negative
connotations associated with hierarchical domination. In this instance, power is shared and is equated with empowerment. The application of empowering principles and strategies is inconsistent in practice to a large extent because of the imprecise and varied definition of empowerment, because it takes on different forms in different people within various contexts (Foster-Fishman et al., 1998; Masteron & Owen, 2006; Ryles, 1999; Zimmerman, 1990).

I am adopting the following multi-dimensional construct of power based on the review of the literature and that correspond with the purpose of this study: **Power** refers to the ability to get things done, and can restrict the freedoms of another in doing something. **Empowerment** refers to (1) enabling an individual to act by sharing power with others to achieve a common goal; and (2) enables individuals to gain control over their lives as they become aware of aspects of the organizational system and their practice that constrain their work.

The mandate of nurse managers in hospital settings is to create a workplace environment that facilitates nurses’ ability to achieve safe, quality patient care. The central problem to be addressed in this study is how the social relations of power between staff nurses and the nurse manager foster or constrain staff nurse empowerment. In other words, how does the nurse-manager relationship influence nurses’ ability to get things done or to something they would not ordinarily do, foster or constrain staff nurse empowerment. Based on symbolic interactionist theory (Blumer, 1969), **social relations** in this study is defined as the sequence of interactions and actions between the manager and nurses that influence nurses’ ability to accomplish his/her work. Because the central problem denotes a social process between nurses and their manager, **social process** in this
study is defined as the sequence of evolving interactions and actions between nurses and their manager and how power is exercised through this process (Corbin & Strauss, 2008; Strauss & Corbin, 1998). Finally, the process in which power is exercised in nurse-manager relations and how this fosters or constrains nurse empowerment are elaborated upon in this literature review.

**Organizational Theory: The Psychological Perspective**

The psychological theoretical perspective describes empowerment from the point of view of the individual. Keiffer (1984) and Rappaport (1984) were among the first to describe empowerment as a developmental process from the community psychology literature. From this perspective, empowerment is a transforming process in which individuals reconstruct their social practices and acquire new skills that can be successfully applied to their work role (Keiffer, 1984; Rappaport, 1981; 1987). In this framework, empowerment is conceptualized as cognitive and behavioural components of a multi-dimensional construct in which individuals experience a positive self-identity.

The first scholarly writings of empowerment appeared in the management literature by Conger and Kanungo (1988). From this perspective, empowerment is viewed as enabling which creates the conditions for enhancing motivation in accomplishing tasks through a strong sense of personal self-efficacy. Conger and Kanungo argued that management practices are necessary but not sufficient conditions for empowering employees; the subordinate’s predisposition toward acting in an empowered manner needs to be considered. In an attempt to further clarify the developmental concept of empowerment, Thomas and Velthouse (1990) described empowerment as what an
employee perceives as they attempt to interpret their work situations. They advanced Conger and Kanungo’s work by defining empowerment more broadly as increased task motivation manifest in four cognitive dimensions that an individual must experience:

- **meaningfulness** (how individuals value the task in relation to their ideals),
- **competence** (skilfully performing tasks),
- **impact** (making a difference in the organization),
- **choice** (making decisions that influence his/her actions).

The core of Thomas and Velthouse’s (1990) cognitive model lies in a cycle of task assessments, which in turn energize and sustain the individual’s behaviour.

Using Thomas and Velthouse’s work (1990) as a theoretical foundation, Spreitzer (1995a) developed a four-dimensional scale in an attempt to measure the four cognitive domains that include:

- **meaning** (the fit between a given activity and one’s belief, attitudes, values, and behaviours),
- **competence** (belief in one’s capability to perform a task),
- **impact** (individual’s belief that he or she can influence organizational outcomes),
- **self-determination** (sense of control over how one carries out his or her job).

All four cognitions are required to capture the full essence of empowerment. Psychological empowerment is a process because it begins with the interaction of the work context and personality characteristics shaping empowerment conditions, which in turn motivate individual behaviour (Spreitzer, 1995a).

Finally, psychological empowerment emphasizes the personality or attitudes of an individual, and reflects an active orientation to work in which the employee feels able to
shape his or her work role and context. In the following section, I examine the individual factors, organizational factors, characteristics and qualities of psychological empowerment, individual and work outcomes of how managers facilitate nurses’ ability to shape their work role.

**Relating Psychological Empowerment to Individual Factors**

In this section, I examine how managers work with or collaborate with nurses to facilitate empowerment at the individual level from the psychosocial perspective. Nurse empowerment is influenced by personality, attitudes, and behaviours, as well as demographics.

First, an individual’s self-esteem, moral principles, personal integrity, and motivation influence feelings of empowerment (Kuokkanen & Leino-Kilpi, 2001; Spreitzer, 1995a; Suominen, Kilpi, Merja, Irvine Doran, & Puukka, 2001). Specifically, Spreitzer’s study (1995a) suggests that nurses who hold themselves in high self-esteem view themselves as valued resources and are able to take an active role in their work and assume a sense of competence influencing feelings of empowerment. In a qualitative study, empowered nurses were found to value dignity and respect for others, as well as honesty and fairness in their interactions with others (Kuokkanen & Leino-Kilpi, 2001). Personal integrity for an empowered nurse consists of assertive and courageous behaviour, ability to act under pressure, and being broad minded to bring new perspectives to situations at work (Kuokkanen & Leino-Kilpi, 2001). In Suominen et al.’s study, motivated nurses exhibited confidence in their job performance, participated in group discussions, and could bring about improvements in their work more effectively than unmotivated nurses. Together these studies point to nurses having personal
confidence and professional competence as central to empowerment. Believing that one has the capacity and ability to take effective action is an aspect of the inherent belief that personal power is central to empowerment. These findings support Spreitzer’s contention that specific personality traits, attitudes, and behaviours shape how nurses see themselves in relation to their work environment when managerial interventions create the conditions for psychological empowerment.

Second, demographics such as education, age, experience, and nursing specialty, influence feelings of empowerment. Suominen et al. (2001) found nurse’s sense of empowerment increased linearly with age, length of nursing experience, and acquirement of a baccalaureate degree (95% had nursing degrees). The critical-care nurses in this study also described themselves as highly motivated (93%), which strengthened their sense of empowerment.

Together these features (education, age, experience, nursing specialty, and high motivational level) described in Suominen et al.’s (2001) study may have uncharacteristically heightened nurses’ sense of empowerment within this specialty group. The environment in an intensive care unit attracts highly motivated individuals — it commands teamwork and cooperation with other disciplines that is not typically characteristic of nurses employed in other hospital departments, and may result in enhanced self-efficacy. In addition, intensive care nurses may be empowered because of advanced analytical and problem solving abilities arising from caring for critical and complex patients. These advanced abilities predispose intensive-care nurses to be more confident in their verbal skills with others and in successfully performing their jobs.
In contrast, Kuokkanen and Katajisto (2003) found that public-health nurses (59%) and long-term care nurses (50%) feel more empowered than critical-care nurses (46%). Using Thomas and Velthouse’s (1990) cognitive model as a foundation to their study, these authors determined that public-health nurses frequently assume more decision making and team-leading duties that support their sense of empowerment than do intensive care nurses. A critical care environment is complex and unpredictable and that could potentially adversely affect the quality and safety of patient care (Bucknall, 2003). Due to the nature of patient acuity and the complexity of the decisions, critical care nurses are more likely to participate in group decision making, thus requiring more time to optimize clinical judgment and provide appropriate treatment for patients.

Tenure within an organization has also been shown to influence empowerment (Koberg, Boss, Senjem, & Goodman, 1999). When individuals have worked in an organization for a long time, they become more familiar with their role and the practices in their work. This in turn can lead to feelings of competence in successfully achieving outcomes, and thereby the individual is more likely to experience feelings of empowerment.

Relating Psychological Empowerment to Organizational Factors

Psychological empowerment is influenced by the nature and quality of leadership and the structural context of organizational work. Some researchers have found that the nurse manager’s leadership style and behaviour relate to staff nurse perceptions of empowerment. Managers who used a transformational leadership style were approachable, encouraged group decision making and the sharing of responsibilities and problems openly were more likely to enhance an individual’s sense of competency and
self-determination, thereby contributing to empowerment (Koberg et al., 1999; Larrabee, Janney, Ostrow, Withrow, Hobbs, & Burant, 2003; Morrison, Jones, & Fuller, 1997).

Using Bass’ transformational leadership behaviours, two studies suggest that nurse leaders who are charismatic, who can inspire and encourage subordinates to view problems from another perspective, and who provide individual consideration can positively affect nurses’ competence, sense of meaning in their jobs, and impact their work (Larrabee et al., 2003; Morrison et al., 1997). These findings suggest that the manager who fosters collaboration and participative management creates a positive work environment in which nurses gain a high level of meaning in their work. This creates opportunities to have an impact on the organizational system.

Leadership behaviours that relate to empowerment are those that promote self-direction, self-problem solving, and initiative (Irvine, Leatt, Evans, & Baker, 1999). Specifically, Irvine et al. (1999) found that self-leadership behaviours correlate significantly with employees’ confidence in their ability to make improvements in their work and to make a difference to organizational effectiveness. However, nurses’ self-leadership behaviour had minimal influence on their ability to successfully perform their jobs and participate in discussions with co-workers.

Klakovich (1996) found that perceptions of a manager’s connective leadership style were modestly associated with staff nurse empowerment. Connective nurse leaders are seen as motivating staff nurses to achieve their goals as well as other’s goals by recognizing and nurturing their strengths using a variety of behavioural strategies. In this study, leaders who are inspirational, provide individual consideration, and are able to mobilize nurses towards the achievement of mutual goals create a sense of shared
responsibility. This is consistent with Laschinger et al.'s (1994) study which suggests that the manager can manipulate the work environment to allow greater access to power and opportunity structures thereby promoting nurse empowerment.

These studies suggest that certain leadership styles and behaviours among nurse managers are more favourable than others in influencing staff nurse empowerment. Staff nurses prefer a leader who takes a more active leadership role which in turn enhances the meaningfulness of nurses’ work and aides their ability to take an active role in providing patient care and shaping their work.

The structural context refers to the context and nature of the unit and organizational environment. The structural context, which operates within the domain of the leader’s practice, can influence individual perceptions of empowerment. Based on research of middle managers from an industrial organization, Spreitzer (1995a; 1995b; 1996) found that social structural characteristics of a work unit create the context that facilitates middle manager’s sense of empowerment. The factors that contribute modestly to perceptions of empowerment include:

- access to information about the work unit,
- working for a boss with a wider span of control,
- clarity regarding tasks, roles, and authority, and a
- supportive network of co-workers.

These studies suggest that a participative culture specifically one that has clear goals and clear lines of work responsibility, increased span of control, sociopolitical support from subordinates, work groups, peers and superiors, and access to information is associated with managers’ cognitions of an empowering workplace. This line of research
suggests that a high-involvement social structure helps individuals to value their contributions to the organization as a result of knowing about the organization they work for, and they experience a sense of ownership and understand how their work role and behaviour affect the organization’s success.

In contrast, nurse researchers have found that as spans of control increase in size for managers, nurses’ job satisfaction and patient satisfaction decrease (Doran et al., 2004; McCutcheon et al., 2009). The results from these studies indicate that not even a transformational leadership style is enough to overcome a wide span of control. Time constraints and managerial demands likely account for limited opportunities for interaction between nurses and managers and affect the quality of this relationship.

Trust in a leader is also acknowledged as having an important association with employee empowerment. Studies have linked employee empowerment and trust in managers in industrial organizations (Ergeneli, Ari, & Metin, 2006; Moye & Henkin, 2006). In both studies, trust was defined as consisting of two components, namely cognitive based trust and affect based trust in an organizational environment (McAllister, 1995). Cognitive trust is based on rational decision making, and affect-based trust requires a deep emotional commitment in a relationship. Both studies found that employee empowerment was significantly related to interpersonal trust. However, Ergeneli et al. found that a significant relationship existed between cognitive based trust in immediate managers and overall psychological empowerment. Therefore, trust influences empowering practices and a belief in the immediate manager’s reliability, dependability and competence which increase overall psychological empowerment. This suggests that employees who view managers as willing to help them complete their tasks
correctly and promptly, find their work more meaningful, have a greater sense of autonomy, and have an impact in their work. Affect based trust reveals that when interests and positive emotional ties between employees and managers occur, the employee’s belief in their own influence on certain organizational outcomes in their work unit increases. These studies support Koberg et al.’s (1999) findings that trust enhances communication, provides opportunities for effective problem solving and encourages individual discretion, and this trust enables individuals to feel empowered. Together these studies (Ergeneli et al., 2006; Koberg et al., 1999; Moye & Henkin, 2006) reveal that employees who feel empowered in their positions appear inclined toward a positive relationship with their managers.

In a nursing environment, an authoritarian or directive leadership style signified a manager’s lack of trust and prevented staff nurse empowerment (Kuokkanen & Leino-Kilpi, 2001; Kuokkanen & Katajisto, 2003; Irvine et al., 1999). When this occurred, nurses perceived that the manager did not trust them, nor shared information or facilitated nurse participation in unit activities. This manifested as nurses’ lack of initiative and limited nurses’ ability to have autonomy and influence their work environment, and nurses claimed their power was limited. This line of research suggests that nurses experience limitations in making meaningful contributions in their job and limits their ability to influence strategic or operational outcomes within the organization, which ultimately is counterproductive to achieving organizational goals.

Nurse managers play a key role in developing trust, since they must share critical information, delegate responsibility, and demonstrate concern for staff nurses (Whitener, Brodt, Korsgaard, & Werner, 1998). This is consistent with Conger and Kanungo’s
(1988) claim that the leader’s behaviour plays an essential role in creating conditions for heightening motivation for task accomplishment and influences employee work productivity. This may suggest that the nurse-manager relationship is dependent on a substantial level of interpersonal trust in a manager. Therefore, the nurse-manager relationship contributes to a positive working environment, and is one of the fundamental factors of managerial and organizational effectiveness.

Minimal research exists on perception of empowerment at the organizational level, which encompasses the organization’s mission, goals, and governance reflecting managerial structures, policies, and practice (Koberg et al., 1999; Kuokkanen et al., 2001; 2003; Shortell & Kaluzny, 2000). Koberg et al. (1999) found organizational rank related to psychological empowerment. They found employees feel empowered and work more interactively with individuals who have a higher status or rank in the organization. This study suggests that if staff nurses worked closely with managers in a participatory manner and were involved in decision making affecting their practice, their perceptions of empowerment would be enhanced, which would ultimately contribute to more effective individual and organizational outcomes.

Characteristics of Psychological Empowerment

There is considerable evidence in the literature that empowerment is a multidimensional concept (Keiffer, 1984; Rodwell, 1996; Spreitzer, Kizilos, & Nason, 1997). First, Irvine and colleagues (1999) found support for the behavioural, verbal, and outcome dimensions of empowerment. These authors used Thomas and Velthouse’s (1990) theoretical framework of empowerment as manifest in four cognitions reflecting an individual’s orientation to his or her work role. The three operational indicators of
these dimensions of empowerment are *behavioural* (successfully performing one’s job and confidence in learning new skills), *verbal* (participating in group discussion and being able to confidently express one’s viewpoint regarding workplace issues), and *outcome* (bringing an improvement to one’s work and making a difference to organizational effectiveness). From this perspective, psychological empowerment is a set of cognitions concerning one’s ability to achieve certain outcomes.

Results for studies by Irvine et al. (1999) and Suominen et al. (2001) revealed moderately high empowerment scores. These authors found that nurses and other healthcare professionals scored higher than unskilled workers for behavioural and verbal dimensions, but not for outcomes. In other words, nurses felt they were able to express their opinions and participate in group discussion and they felt confident in learning new skills and successfully performing their job, but they felt less capable of bringing about improvements in their work or making a difference to organizational effectiveness. Nurses therefore found their work more meaningful and felt more capable of performing tasks than unskilled workers. For example, nurses found their work meaningful when they felt confident in learning new skills and handling more challenging jobs (behavioral) and debating their point of view with coworkers (verbal). What was not discussed was why nurses felt less confident about their ability to influence outcomes of their work and the organization. This may be attributed to nurses’ professional knowledge, skill, and competence in being able to carry out activities within the patient domain, and less able to influence outcomes beyond direct patient care. Zimmerman (1995) asserts that the interactional component of empowerment includes decision making, problem solving, and leadership skills. Zimmerman (1995) further submits that these skills may be
developed in settings where participants have opportunities to become involved in decision making, or inhibited where participation is not an option. Given that managers have wider spans of control and increased managerial responsibilities (Doran et al., 2004; McCutcheon et al., 2009) reduces their visibility and decrease availability for mentoring and supporting nurses (CNAC, 2002). This necessarily limits nurses’ ability to understand the administrative and operating issues related to their work unit, and as such, constrains their ability to participate in unit outcomes and to have control over their work unit.

Second, Kuokkanen et al. (2001; 2002) found that empowerment is a process influenced by the qualities inherent in Finnish nurses. These authors used the theoretical framework proposed by Thomas and Velthouse (1990) as a template for constructing interview questions to describe what an empowered nurse is like and how he/she performs tasks. Although the majority of nurses are female, this study assumes a gender neutral approach and is not focused on producing gender differences. Qualitative data analysis emerging from interviews with nurses described an empowered nurse as possessing expertise (an ability to perform one’s job and possession of a wide range of knowledge associated with work); future orientatedness (ability to suggest new ways of proceeding in one’s job and work); and sociability (ability to contribute to a positive work culture). Examples of what an empowered nurse is like includes being honest, courageous, and autonomous while contributing to a positive workplace culture. Examples of how an empowered nurse acts include treating others with respect, acting skillfully, and finding creative solutions to problems in the workplace. An empowered nurse possesses qualities that lead to successful performance, creativity, and progress in
one’s work. In this study, nurses assessed themselves as empowered (3.5-4.5; scale 1-5; 1 = least, 5 = most) but did not feel that they act in an empowered manner (3.0-4.0; scale 1-5; 1 = least, 5 = most). “Acting empowered” scored low in the area of sociability where the work context limits nurses’ active participation in discussing and resolving problems.

In a more recent study, Suominen et al.’s (2011) findings revealed the importance of the manager facilitating staff experience’s of empowerment during organizational restructuring. Using the work empowerment questionnaire (Irvine et al., 1999) and the work-related empowerment promoting and impeding questionnaire (Kuokkanen et al. 2001; 2002), findings revealed that a sense of confidence and support during ongoing organizational changes, being heard, and having access to information were associated with staff empowerment. A key finding in this study identified that it is essential for managers to facilitate staff participation in the decision-making process.

Finally, based on several key studies (Kuokkanen & Kilpi, 2001; Kuokkanen et al., 2002; Irvine et al., 1999; Suominen et al., 2011; Suominen et al., 2001), the ability to act constitutes the characteristics of an empowered nurse, which include the following:

- Treats others with respect, acts equitably, and honestly.
- Acts effectively under pressure and is courageous.
- Conscious care of well-being.
- Possesses a range of knowledge and skill to successfully perform one’s work.
- Being heard and interacting with others.
- Has autonomy and freedom in decision making.
- Has support during organizational change.
- Finds creative ways of performing one’s work.
• Has an effect on unit or organizational outcomes.

Findings reveal that psychological empowerment is a process enabling nurses to assert control over and make decisions in their work. These studies reveal that nurses understand what empowerment means but have less ability to make improvements in their work or influence work outcomes.

Relating Psychological Empowerment to Work Outcomes

The literature examining the consequences of psychological empowerment focuses on individual and organizational outcomes in the healthcare setting and industry.

Psychological empowerment offers the potential to positively influence individual outcomes. Psychological empowerment increases job satisfaction, heightens perceived work productivity, decreases job strain, and reduces the probability of the employee leaving the organization (Koberg et al., 1999; Larrabee et al., 2003; Morrison et al., 1997; Spreitzer et al., 1997). Managers and nurses who have access to meaningful work, confidence in their ability to perform their work roles, a sense of control over their work, and an ability to influence organizational outcomes are more likely to accomplish goals, contribute to work productivity, minimize job strain, and increase likelihood of organizational commitment.

More recently, Boudrias et al. (2006; 2009) extended research on psychological empowerment by investigating how managerial practices influence not only employee motivation but also employee behaviour. These authors posit that empowerment is fostered not only to change cognitions, but to foster behaviour that have an impact on organizational outcomes. In response to a lack of available instrumentation, Boudrias and Savoie (2006) developed a conceptual framework and instrument to assess behavioural
empowerment (BE). Boudrias and Savoie (2006) defined BE as “relatively self-determined behaviors aimed at securing work effectiveness or at improving work efficiency within the organization” (p. 626 - 627). The difference between psychological empowerment and BE lies in the fact that the former captures employee cognitions, whereas the latter captures active and proactive behaviours of employees.

The questionnaire developed by Bourdias et al. (2006; 2009) measured five types of behaviour: (1) **efficacy in performing job tasks** (perseverance in achieving the best standards of quality in my work); (2) **improvement efforts in job tasks** (making change to improve efficiency in performing my tasks); (3) **effective collaboration** (keeping coworkers apprised on my work in group projects); (4) **effort for improvement in the work group** (introducing new ways of doing activities); and (5) **involvement at the organizational level** (making suggestions to improve the organization’s functioning).

Boudrias et al. (2009) found managerial empowerment practices that foster a proactive motivational orientation in employees as well as BE are important to work outcomes. More specifically, it might be necessary for supervisors to sustain a high level of psychological empowerment to ensure their employee experience positive psychological states, and feel personal ownership in their work role, thereby enabling employee’s to manifest observable empowerment behaviours. This finding supports Spreitzer’s theoretical model (1995a; 1995b) suggesting that managerial practices can influence employee behaviour through instilling proactive motivation in individuals.

Research conducted in the Netherlands confirmed that empowerment motivates employees to engage in more innovative behaviour in the workplace (Knol & van Linge, 2009). The findings suggest that the motivating effect of psychological empowerment on
innovative work behaviour is attributed to the impact nurses have in their work environment. These authors contend that impact is externally directed and related to the work environment. Therefore, impact is a belief in the possibility that one can influence work processes, such as innovation. These researchers assert “….nurses should reflect on their own empowerment and make the choice to strengthen it” (p. 369). Nurses can then be proactive and take the necessary measures to facilitate change and participate in innovation and improve their practice environment.

Numerous studies have established links between structural empowerment and psychological empowerment and demonstrated that both are associated with individual attitudes and behaviour in the organizational setting. Kanter (1977; 1993) identified six structural organizational conditions conducive to workplace empowerment: access to information, support, resources, learning opportunities, formal power, and informal power (elaborated upon more fully in the subsequent section on The Structural Perspective). Laschinger and colleagues expanded Kanter’s model to include Spreitzer’s (1995) concepts of psychological empowerment and job satisfaction for staff nurses. Psychological empowerment represents a response to working in structurally empowering work environments, and consists of competence, a sense of accomplishing work in meaningful ways, feelings of control over one’s work, and the ability to have an impact in the organization. Thus psychological empowerment is the mechanism through which structural empowerment affects employees work attitudes and behavior (Faulkner & Laschinger, 2008; Laschinger et al., 2001b; 2001c; 2004; Manojlovich, 2007). A study by Laschinger et al. (2009) advanced understanding of how leadership affects both unit and individual-level outcomes; for example, nurses’ organizational commitment. This study
found that unit level leader-member exchange (LMX) quality and unit-level structural empowerment positively influenced nurses’ feelings of psychological empowerment and organizational commitment. More specifically, the contextual effect of positive supervisor relationships and their influence on empowering working conditions influenced nurses’ organizational commitment. The results revealed that the quality of the relationship between the nurse and their manager is critical to creating empowering work environments that promote commitment of nurses by increasing nurses’ perceptions of psychological empowerment.

A systematic review by Wagner et al. (2010) revealed a significant relationship between structural empowerment and psychological empowerment for registered nurses. Research at the individual manager level revealed a significant relationship between structural empowerment and psychological empowerment for managers (Laschinger, Purdy, & Almost, 2007). The results suggest that when managers perceive that they have a positive relationship with their supervisor, they are more likely to feel their work environments empower them to accomplish their work in meaningful ways and experience feelings of psychological empowerment. When this occurs, they are more likely to experience job satisfaction. This body of research highlights the importance of the manager’s actions in creating conditions that can influence nurses’ responses to the workplace setting. A health care environment that supports healthier employees and diminishes work stress will culminate in improved organizational outcomes including improved patient care (Laschinger, 2008).

Minimal research exists on the outcomes of empowerment in the form of the leader’s innovative behaviour and managerial effectiveness in the business setting.
Spreitzer (1995a; 1995b) found that subordinates and superiors both see empowered middle managers as innovators, but only subordinates saw their managers as effective; the managers’ superior did not find them effective. Empowered middle managers who see themselves as competent and able to influence their jobs and work environment in meaningful ways are perceived by their subordinates as being proactive, high performers, and able to execute their job responsibilities effectively (Spreitzer et al., 1997).

There are two major findings from these studies. First, managers may not be willing to shift the balance of power to subordinates. Spreitzer (1995; 1995b) argues that superiors may feel threatened by empowered managers who appear to operate independently of the organization’s goals, and as such, the employees may become more a liability than an asset. This line of reasoning could suggest that superiors embrace empowerment in principle but not in practice. On the other hand, middle managers can be described as controlling and clinging to power because of deeply ingrained human needs manifested in control, achievement, and recognition needs (Forrester, 2000). From this standpoint, superiors may see these basic human needs as managers’ inability to share power with employees and, as such, do not believe managers are fulfilling their work role expectations.

The second finding is that different interests and values between managers and subordinates influence perceptions of empowerment (Spreitzer 1995a; 1995b). Individuals interpret empowerment from their own perspectives to best suit their needs. When expectations, intentions or goals are not met by managers or subordinates, feelings of distrust can occur on both sides (Fox, 1974). This acknowledges that managers and
subordinates assume their own definition of empowerment, highlighting the variation in attitudes and values which individuals bring to the workplace.

Less research can be found on the organizational outcomes of psychological empowerment. Researchers found psychological empowerment relates to work effectiveness (Koberg et al., 1999; Spreitzer et al., 1997) and quality improvement initiatives (Irvine et al., 1999). Psychological empowerment influences employee’s work satisfaction and ability to promote improvements in clinical practice contributing to organizational effectiveness. Consistent with the complexity of nurses’ work environments, Wall et al. (2002) suggest that under more complex and uncertain work conditions, managerial practices need to be aimed at providing employees increased decision making authority with respect to their primary work tasks. Managers who facilitate practices that are more flexible, decentralized, and informal influence employee empowerment and improve organizational performance. The link to psychological empowerment is consistent with Conger and Kanungo (1988) and Spreitzer’s (1995a; 1995b) contentions that when managers remove disempowering elements for the work setting, employees are more likely to find their work meaningful, have a greater sense of autonomy, and a strong belief they can have an impact on their work. Finally, a manager’s behaviour plays an essential role in creating the conditions for heightening an employee’s motivation for work effectiveness.

In summary, this body of literature suggests the importance of the manager in creating empowering conditions to influence employee cognitions and behaviours. Employees who are psychologically empowered value a manager who creates conditions for enhancing their motivation by removing disempowering organizational structures.
These studies suggest that personal factors in the environment such as personality, attitudes, demographics, and motivation enhance individual’s ability to meet work demands. A leadership style and a work context that reflects a participative work environment provide opportunities for individual to find their work more meaningful, have a greater sense of autonomy, and a strong belief in their ability to influence their work role and setting. However, a lack of trust in the nurse manager and a lack of participation in decision making regarding strategic and organizational influence appear to limit nurses’ ability to experience empowerment. These studies provide some support for nurses with a sense of satisfaction with a job well done, creates further motivation to achieve, recognition, and commitment to the job both employees and the organization.

Organizational Theory: The Structural Perspective

The management literature defines empowerment within the context of organizations (Bowen & Lawler, 1992; Kanter, 1977; 1993). Kanter postulates that work effectiveness occurs as a result of structural determinants, not personality characteristics or socialization.

According to Kanter (1977; 1993), employees with access to information necessary to carry out their jobs, resources in the form of rewards, support in the form of feedback from their superiors and peers, and the opportunity to develop their knowledge and skill in their work setting are empowered and able to accomplish organizational goals. Access to these empowering structures comes from the formal power system that includes job characteristics that are visible, flexible, and central to the organization’s goals. Informal power comes in the form of alliances with peers, superiors, and
subordinates that further influence empowerment through the cooperation needed to get things done. Therefore, access to information, resources, support, and opportunity is enhanced by job characteristics and interpersonal relationships that promote effective communication (Laschinger, Finegan, & Wilk, 2009).

According to Kanter (1977; 1993) the theory of structural empowerment places the focus of the employee’s behaviour entirely on the organization. Kanter suggests that managers who create equal opportunity by sharing information, resources, and support with their employees will increase their own power and empower staff members. Therefore, work environments that provide access to these structures empower individuals and result in increased levels of organizational commitment and feeling of autonomy. Consequently, employees experience an increase in productivity and work effectiveness in the organization.

For these reasons, Kanter’s model has been used extensively in Laschinger’s research investigating nurse empowerment and strategies for creating productive work environments that foster professional practice. Nurses from a variety of practice settings in Canadian institutions have participated in these studies (Beaulieau, Shamian, Donner, & Pringle, 1997; Faulkner & Laschinger, 2008; Greco, Laschinger, & Wong, 2006; Haugh & Laschinger, 1996; Laschinger & Finegan, 2005; Laschinger, Finegan, & Shamian, 2001a; Laschinger, Finegan, & Shamian, 2001b; Laschinger et al., 2009; Laschinger, Finegan, Shamian, & Casier, 2000; Laschinger & Havens, 1996; Laschinger & Shamian, 1994; Laschinger & Wong, 1999; Laschinger, Wong, McMahon, & Kaufmann, 1999; Lucas, Laschinger, & Wong, 2008; Kluska, Laschinger, & Kerr, 2004; Sabiston & Laschinger, 1995; Wilson & Laschinger, 1994). In all of these studies, the
Conditions for Work Effectiveness Questionnaire (CWEQ), based on Kanter’s theory of power, was used to measure job-related empowerment.

Some researchers have found that nurses perceive themselves as being only moderately empowered and suggest the need for more access to opportunity and to the power structures of resources, information, and support in nursing work environments (Laschinger & Finegan, 2005; Laschinger, Finegan, & Shamian, 2001a; Laschinger, Finegan, Shamian, & Casier, 2000; Sabiston & Laschinger, 1995). These studies provide evidence that access to power and opportunity lead nurses to accomplish their work more effectively. More specifically, an increase in nurse empowerment is likely to result in the delivery of high quality patient care when work environments are structured to promote maximum performance for professional nurses. The studies from this program of research discussed below illustrate how structural empowerment influences individual and organizational outcomes.

Relating Structural Empowerment to Organizational Factors

The discussion that follows will examine the influence of leadership and the social structural context of work affecting nurse empowerment. The nurse manager plays an instrumental role in facilitating the context for an empowering work environment for staff nurses. Numerous studies support a significant positive relationship between structural empowerment and psychological empowerment and their subscales for staff nurses and management (Kluska et al., 2004; Knol & van Linge, 2009; Laschinger et al., 2001c; Laschinger, Finegan, & Wilk, 2009; Laschinger, Purdy, & Almost, 2007; Manojlovich & Laschinger, 2002). These studies support Kanter’s (1977;1993) assertion of the importance nurse managers have on employees’ experiences at work. Identifying
and understanding the relationship between structural empowerment and psychological empowerment has assisted health care administrators to counter the impact of workplace related stressors in the health care organization and improve nurse, organizational, and patient outcomes.

First, I will review the literature by area of focus, as follows: i) the antecedents of staff nurses’ empowerment; ii) the differences between staff nurse and manager empowerment, and iii) managers’ empowerment. I will discuss the elements from this body of literature that apply to understanding staff nurse empowerment.

First, the literature suggests that the nurse manager’s leadership styles and behaviours influence staff nurses’ perceptions of their empowerment. Staff nurses in general have greater access to informal power than formal power in their work settings (Faulkner & Laschinger, 2008; Laschinger, Finegan, Shamian, & Casier, 2000; Laschinger, Finegan, Shamian, & Wilk, 2001c; Laschinger et al., 1999; Sabiston & Laschinger, 1995). The relationships nurses have with their superiors, peers, and subordinates provide greater access to information, resources, and support than do their jobs. These findings support Kanter’s (1977; 1993) contention that effective collaborative relationships with managers, colleagues, and subordinates foster nurses’ ability to get the cooperation needed to accomplish their work. Informal power can act to decrease barriers and facilitate alliances between nurses and their manager, and enable the disclosure of individual perceptions and ideas.

Several studies have linked leadership style to structural empowerment (Greco, Laschinger, & Wong, 2006; Laschinger et al., 1999). These findings suggest that staff nurses perceived their leader’s behaviour to be somewhat empowering and their work
environments to be moderately empowering. These results suggest that nurses felt more empowered when leader’s behaviour promoted autonomy, encouraged participative decision making, and displayed confidence in employees. The findings are consistent with a study by Upenieks (2003b) who found a manager’s participative leadership style and access to empowering structures facilitated nurses’ ability to accomplish their work.

Lucas et al. (2008) found that when nurse had access to empowering work structures they were more likely to report their manager had an emotional intelligence (EI) leadership style. More specifically, when nurses reported greater access to empowering work structures they were more likely to report that their managers had an EI leadership style. Cummings (2004) revealed that nurse leaders with high EI have an ability to develop positive relationships with staff nurses and were better able to manage emotions. A key finding of this study is that as the manager’s span of control increased, the manager’s ability to engage with nurses diminished and the effect of manager EI on nurse empowerment decreased. Given the demands in the manager role, leaders are challenged to connect meaningfully with their staff and provide the tools nurses require to respond effectively in their day-to-day activities. However, access to support, resources, and formal power were strongly related to manager EI suggesting that nurses were more empowered when the manager made time to engage meaningfully with staff, be present and visible on the unit, communicate, and control their emotions. This is an important finding because empowerment affects the quality of work life and leads to greater engagement of nurses in their work.

In a recent study, Laschinger and colleagues (2009) tested a multilevel model of organizational commitment demonstrating that structural empowerment and leader-
member exchange quality at the unit level positively influenced individual nurse perceptions of psychological empowerment. The quality of the nurse-manager relationship is vital in creating empowering work environments in units influencing nurses’ responses to workplace conditions.

Together the results by Laschinger et al. (1999; 2006; 2008; 2009) and Upenieks (2003b) suggest that nurse manager leadership styles are important for nurses’ perceptions to feel supported in their work. These studies reveal that when managers demonstrate leader characteristics and behaviours, nurses experience empowering work environments. These studies underscore the importance of unit leadership in countering the stressors of the work environment.

Second, some studies have focused on the differences between staff nurse and nurse manager empowerment. Nurse managers believe themselves to be more empowered than staff nurses because they had greater access to empowerment structures, and staff nurse empowerment relates to perceptions of their managers’ power in the organization (Beaulieu et al., 1997; Haugh & Laschinger, 1996; Laschinger & Shamian, 1994; Wilson & Laschinger, 1994). As a result, powerful managers empower staff members. Managers with access to power and opportunity structures are highly motivated and are able to motivate and empower nurses by sharing the sources of power.

Although studies reveal that nurse managers are more empowered than staff nurses, neither the managers nor the staff are highly empowered, thus raising the possibility that the powerless situations nurses believe they are in come as a result of the manager’s lack of power (Haugh & Laschinger, 1996). According to Kanter (1977; 1993), if managers have limited power to mobilize resources, it is unlikely that they will
be able to mobilize staff nurses, and hence, power is not shared in their chain of command.

Finally, some studies have focused specifically on managers’ empowerment. Self-efficacy contributes to nurse managers’ empowerment (Laschinger & Shamian, 1994). The greater the degree of access a nurse manager has to power and opportunity structures, the greater their confidence and their ability to perform their managerial role. Not surprisingly, managers were found to be significantly more empowered than front-line workers (Beaulieu et al., 1997; Haugh & Laschinger, 1996; Laschinger & Shamian, 1994). These findings are consistent with Upenieks (2003b) who suggests that nurse leaders must first access empowering work environment structures before offering these same empowering work conditions to their subordinates.

Further research at the manager level reveals a significant relationship between structural empowerment and psychological empowerment (Laschinger et al., 2007). When meaning, self-determination, and impact increase for the manager, it is more likely that their leadership actions will foster nurse empowerment, and hence positively influence outcomes. This line of research again supports Kanter’s (1977; 1993) contention that when managers feel confident in their managerial roles and have access to resources, information, support, and opportunity, they are more likely to be motivated and able to motivate and empower their staff by sharing power.

Relating Structural Empowerment to Work Outcomes

Laschinger’s program of research on nurse empowerment has generated an extensive body of literature supporting Kanter’s (1997;1993) theory of power focusing on individual and organizational outcomes. The nurse manager can facilitate access to
structural conditions leading to staff nurse empowerment, which ultimately shapes attitude and behaviour leading to job satisfaction, and work effectiveness.

**Individual Outcomes**

An extensive number of nursing studies have linked Kanter’s concept of power to individual outcomes. Nurse managers who have access to structural empowerment can empower staff nurses by sharing power and opportunity, which have led to nurses being accountable to each other for their practice, control over nursing practice, increased perceptions of autonomy, and contributed to job satisfaction, (Laschinger & Finegan, 2005; Laschinger & Havens, 1996; Laschinger & Sabiston, 2000; Laschinger & Wong, 1999; Sabiston & Laschinger, 1995; Upenieks, 2003b), professional nursing practice environment (Laschinger, 2008), and leadership effectiveness (Upenieks, 2003a). Therefore, when nurses have sufficient access to support, resources, information, and opportunity, they are more likely to feel accountable for client outcomes, have control over their practice, and more effectively accomplish their goals. In a systematic review examining the relationships between structural empowerment and psychological empowerment for registered nurses, Wagner et al. (2010) asserted that decentralizing formal power, or sharing power, from managers to registered nurses could culminate in positive long term workplace outcomes for both managers and registered nurses ultimately leading to improved patient outcomes.

Numerous studies have established positive relationships for structural empowerment and other important nurse outcomes. Relationships have been found between empowerment and lower levels of job stress and emotional exhaustion/burnout (Kluska et al, 2004; Laschinger, Finegan, & Shamian, 2001b; Laschinger Finegan,
Shamian, & Wilk, 2003). The results of these studies suggest that leadership practices that provide access to empowering working conditions are important to nurses’ sense of well being and their health in the work settings. Similar findings have been found in studies by Aiken and colleagues (2002) linking lower levels of burnout to work environments that provided autonomy and control over the practice environment. These results confirm the importance of the nurse manager in providing leadership practices in improving nurses work life and minimizing adverse effects, especially in light of nurse recruitment and retention issues and a critical nursing shortage.

In other studies structural empowerment is strongly associated with organizational commitment, organizational trust, respect, and job satisfaction (Beaulieu et al., 1997; Laschinger & Finegan, 2005; Laschinger, Finegan, & Shamian, 2001a; Wilson & Laschinger, 1994). In these studies, nurses felt they received the respect they deserved in the organization which increased their trust in management, and influenced their belief and acceptance of the organization’s goals and their willingness to exert effort at work and continue to work in the organization.

A closer examination of the findings reveals that nurses’ trust in their managers merits further exploration. Nurses reported low levels of trust in management’s honesty and concern for their needs, and felt they were not receiving the respect they deserved in the organization (Laschinger & Finegan, 2005). Instead, nurses reported a higher level of confidence and trust in their peers than in their leader. If we follow this line of logic, this study reveals that nurse outcomes are less than favourable in nurses’ work environments fuelled by low levels of trust between managers and their staff nurses. In this study, organizational trust is the belief that an employer will be straightforward and follow
through on commitments (Gilbert & Tang, 1998). Managerial trust is paramount for creating a nurturing environment in which employee empowerment is to occur (Hokanson Hawkes, 1992; Mishra & Spreitzer, 1998; Rogers, 2005). Trust between individuals develops from honesty, openness, and two-way communication and influences nurse empowerment (Hokanson Hawkes, 1992; Rogers, 2005). Other studies have indicated that given the majority of nurses are employed in the hospital sector, and individual nurses identified their managers as unsupportive, ineffective leaders, and disrespectful of the nurses speaks to the fragile relationship between staff nurses and their managers (O’Brien-Pallas et al., 2005; Priest, 2006). If there is a lack of trust between managers and staff nurses, and the structural conditions for creating productive work environments are limited for nurses to be effective in their practice roles, one can conclude that the working relationship nurses have with their nurse managers significantly influences staff nurse empowerment, and ultimately influences nurses’ job satisfaction.

Enhancing nurses’ trust in managers is necessary for nurses to actively participate in decisions that affect their practice to achieve important patient and organizational outcomes. Trust matters and nurse managers that are able to build, maintain, and repair it when broken, are better able to guide their nursing teams through organizational change and uncertainty in the workplace (Rogers, 2005). Laschinger and Finegan’s (2005) work is supported by Kanter’s (1977; 1993) contention that managers play a critical role in employee empowerment, and that as managers share power they increase nurses’ ability to effectively provide care consistent with the standards of professional practice.
These findings also highlight the importance between empowerment and respect (Faulkner & Laschinger, 2008). In this study, informal power and support were the most strongly related to nurses’ feelings of being respected. These findings are consistent with Diaski (2004) who asserts that respect is a key component of collaborative working relationships and a key feature of a productive work environment that promote high-quality patient care (Ulrich, Buerhaus, Donelan, & Dittus, 2005). These findings support Kanter’s (1977; 1993) contention that effective collaborative relationships with managers foster a feeling of respect and facilitate nurses’ ability to accomplish their work.

Important associations have been established with Kanter’s theory of structural empowerment and psychological empowerment. Structural empowerment and psychological empowerment have been positively associated with respect (Faulkner & Laschinger, 2008), job satisfaction, (Laschinger, Finegan, & Shamian, 2001b; Laschinger, Finegan, Shamian, & Wilk, 2004), job strain (Laschinger, Finegan, & Shamian, 2001b), lower job tension (Laschinger et al., 1999); effort-reward imbalance (Kluska et al., 2004), work effectiveness (Laschinger et al., 1999), and professional practice behaviours (Manojlovich, 2005). These studies employing an expanded model of empowerment supported the contention that nurses are more likely to feel autonomous, find a higher sense of meaning in their work and believe they can have an impact in their work role and work setting, when disempowering structures are removed by managers (Conger & Kanungo, 1988; Spreitzer, 1995). This heightened sense of psychological empowerment enhanced nurses’ ability to accomplish their work, have a more positive attitude toward their work, have a more favourable balance between their efforts and
perceived rewards, augmented nurses feelings of being respected in the workplace, and are able to enact professional standards of professional practice.

In addition, Laschinger et al. (2009) found that psychological empowerment mediated the relationships between unit level structural empowerment and nurses’ organizational commitment. These findings suggest a more engaged and committed workforce could influences nurses’ willingness to stay in their jobs, ultimately influencing the nursing shortage. Moreover, Wagner et al. (2010) recommend measuring the effect between structural empowerment and psychological empowerment not only at the unit level (Laschinger et al., 2009), but at the organizational, regional, provincial and international levels. Wagner et al. assert that decision making at various levels of the health care system interact and influence both nurse and patient outcomes.

Organizational Outcomes

Nursing studies have also linked Kanter’s concept of power to organizational outcomes, and are important for addressing the recruitment and retention of nurses, and ultimately addressing the nursing shortage. Nurse managers’ who have access to structural empowerment can empower staff nurses by sharing power and opportunity, which have led to improved productivity and perceived work effectiveness (Laschinger & Havens, 1996; Laschinger & Sabiston, 2000; Laschinger & Wong, 1999; Upenieks, 2003b). These findings support Kanter’s (1977; 1993) assertion that access to information, resources and support and opportunity have the potential to enhance work effectiveness and contribute to organizational and productivity goals as a result of nursing leadership.

Despite a significant research base in organizational empowerment a lack of
knowledge transfer may also be a contributing factor to nurses’ limited sense of work-related empowerment. Research thus far has found that managerial practices and programs can provide nurses with increased levels of power and control over their practice, yet effective change for staff nurse empowerment in practice settings has not been completely realized. Through translation research and the knowledge gained by studying nurse empowerment, it should be possible to increase the efficacy of nurses’ empowerment in practice by producing the desired outcomes of work effectiveness (Williams, 2004). The lack of research used in nurses’ practice may be due to lack of access to the evidence, unhelpful informational formats, and limited time for the comprehension and implementation of evidence (Thompson, McCaughan, Cullum, Sheldon, & Raynor, 2005). From the structural perspective, low organizational support and limited access to resources not only contribute to nurses’ experiences of powerlessness (Kanter, 1977; 1993), but also inhibit their ability to put evidence-based research into practice (Thompson et al., 2005). Therefore, it is not clear whether there is limited structural support or if the culture of the organization is not amenable to knowledge transfer by not viewing evidence based practice as a priority, limiting resources, or not facilitating skill development in nurses to understand and value evidenced based research (Udod & Care, 2004).

In summary, Kanter’s theory of structural power highlights the importance of the manager’s role in creating environments that provide access to structures that empower nurses to accomplish their work. Findings have also shown that by increasing access to power structures, nurses experience heightened levels of psychological empowerment that in turn increase their ability to more effectively practice according to professional
standards. Support for these studies is confirmed in Spreitzer’s (2008) review of empowerment research over the past two decades suggesting that structural empowerment and psychological empowerment are predictors of positive work behaviours and comprise the individual’s empowerment experience in organizations.

However, what we know from the literature on the structural theory of power is that nurses experience a limited ability to accomplish their work, which can be interpreted as nurse managers’ limited ability to facilitate the structural conditions required for organizational outcomes. The results of these studies are particularly salient for nurse managers who play a key role in creating positive responses to work by promoting collaborative working relationships. The literature also suggests that nurses trust relationships with their managers is less than favourable but is critical to patterns of nurse empowerment necessary for shaping and enhancing work experiences in nurses’ work life, and ultimately enhancing patient, nurse and organizational outcomes. In the following section, I explore how power is manifested in the nurse-manager relationship in more detail from a critical perspective.

**Critical Social Theory**

Critical theory is concerned with addressing the oppressive effects of power on disadvantaged and disenfranchised people (Applebaum, Hebert, & Leroux, 1999; Forbes, King, Kushner, Letourneau, Myrick, & Profetto-McGrath, 1999; Kincheloe & McLaren, 2005). There is not one critical theory but rather a school of interdisciplinary thought. In this broad sense, contemporary critical perspectives encompass different strands of theory developed by diverse theorists who emphasize communication (Habermas, 1984; 1987);
power/knowledge (Foucault, 1980); and habitus, capital, and field (Bourdieu, 1990; 1998). The many varieties of critical theory share the theory of false consciousness, an examination of a group’s dissatisfaction, the benefit from knowledge, and transformative action for change (Fay, 1987). The scholarship of critical science can orient research to questions relating to oppressive structural effects by uncovering relations of dominance that are potentially linked to practical interventions (Morrow, 1994). Boje and Rosalie (2001) contend that without employee ownership within the formal power structures actual power remains with administration in the organization. Empowerment, Jacques (1996) argues, means that “feeling [author emphasis] empowered is not the same as being [author emphasis] empowered” (p. 141). According to Jacques, being empowered suggests that unless power is granted to employees through ownership and participation in councils and committees, it is questionable to the extent in which empowerment interventions can be empowering for employees. For nursing, critical theory offers a research perspective that may help to “uncover the nature of enabling and/or restrictive practices, and thereby creates space for potential change and, ultimately, a better quality of care for patients” (Wells, 1995, p.52).

Critical and postmodern perspectives deconstruct the way power is embedded in nursing practice. Since the early 1990s there has been increasing interest in using critical approaches to inform nursing research (Ceci, 2003; Cheek, 1999; Cheek & Gibson, 1996; Cheek & Porter, 1997; Fahy, 2002; Fulton, 1997; Holmes, 2001; 2005; Manias & Street 2000). These approaches challenge the status quo, highlight the marginal voices in dominant discourses, and explore issues of power and knowledge in nursing. Nurse researchers have used critical social theory as a lens to promote consciousness-raising to
reconstruct power relations in nursing so that individuals can relate and act in more satisfying ways (Fay, 1987; Skeleton, 1994; Street, 1992).

More recently, a consensus seems to be emerging among critical theorists that power is a basic component of human existence that shapes the oppressive and productive nature of the individual (Foucault, 1995; Kincheloe & McLaren, 2005; Nicholson & Seidman, 1995). Re-conceptualized critical theory is intensely concerned with the need to understand the various and complex ways that power operates to dominate and shape consciousness (Kincheloe & McLaren, 2005). Moreover, critical theory can address relations of power that shape social reality, and develop knowledge that exposes inequities and emancipation for individuals (Browne, 2000; Campbell & Bunting, 1991). Finally, a critical perspective can reveal the ways power can be exercised in organizations, and seeks to release individuals from the constraints of unequal power relationships. In the following section, I examine the organization factors and characteristics of how power is exercised within the nurse-manager relationship from a critical perspective.

**Relating Critical Empowerment to Organizational Factors**

The discussion that follows will examine the influence of leadership and the social structural context of work affecting nurse empowerment from a critical perspective.

Rankin and Campbell (2006) conducted an institutional ethnography on the social relations of nurses’ work. In this study, nurses’ everyday work experiences are explored as a result of health care reform and the managerial practices that transform those settings. This research revealed that within a new leadership role, the focus for the
manager is on managerial concerns and rationing resources. Managers have become involved in specific text-based technologies of governance that include patient classification systems, quality assurance forms, bed maps, clinical pathways, and discharge planning forms, and focusing less on patients and their clinical conditions.

More importantly, the new technologies of management and governance have altered the work relations between managers and nurses (Rankin & Campbell, 2006). Nurse managers experience a disjuncture when differences surface between requisite patient care and actions needed to standardize health care with organizational management. Nurse managers use their nursing knowledge to rationalize and enforce nurses’ compliance, and nurses’ professional judgment and care activities are to be brought within the purview of authorized organizational goals.

Revising the first line nursing leadership job is part of broadening nurses’ responsibility for improving bed utilization, quality assurance, and effective nursing care. Nurses must subordinate competing clinical values and priorities to the managerial objectives of completing the necessary documentation to expedite discharge, attend to bed pressures, and increase the hospital’s productivity. As nurses engage with the various management technologies, they became subjects of strategic reform and are held to a new interpretation of nursing’s professional standards. Nurses assume a coordinating position within this reformed health care system meant to guide and support both therapeutic and organizational action. Rankin and Campbell (2006) explain:

Nurses themselves are being acted upon. They are being enrolled into the relations of ruling that are now being instituted in health care. Both nurses knowing and acting are reconstituted thereby. Their subjectivity is being restructured as they activate the text-
based and ideological practices of health care reform and hospital restructuring. We consider it important that nurses and others recognize that in activating the working texts, they absorb ruling ideas. Their place within the ruling agenda is crucial. (p. 168)

In essence, Rankin and Campbell (2006) found that the organization “hooks” nurses into textual based practices which frequently undermine nurses’ capacity to enact the care they deem necessary for safe, quality patient care. As such the standpoint of how nurses and managers relate to each other has eroded and changed from a collaborative and supervisory relationship (McGillis Hall & Donner, 1997) to a managerial relationship focused on the efficiency mandate of the reformed organization. This study identifies that the shift away from a collaborative relationship has limited the interaction between nurses and their manager, and may have negated the managerial influence necessary for organizational advancement and success (Bass, 1994; Gupta & Sharma, 2008; Yukl, 2009).

The focus of the poststructuralist perspective explores the gaps, silences, and ambiguities of power relations in social and health contexts (Cheek, 2000; Cheek & Rudge, 1994). One theorist whose work has been consistently associated with the poststructuralist perspective is the French social theorist Michel Foucault. From this viewpoint, Foucault (1982; 1995) argues that power can be productive and is viewed as being inadequate in capturing the complexity of power. The nature, existence and exercise of power have gained increasing importance within pediatric surgery, psychiatry and mental health (Ceci, 2003; Holmes, 2001; 2005; Holmes & Gastaldo, 2002). Holmes (2005) explored the coexistence of social control and psychiatric nursing care in a
correctional institution as part of a grounded theory doctoral study. A psychiatric hospital ward can be understood as employing a variety of Panoptic styles, including varying levels of patient observation, record keeping, ongoing assessments, planning, implementation and evaluation of nursing interventions, and it creates within nurses and patients an awareness of being continually monitored, and that any indiscretion will lead to corrective training. Such strategies can be understood as creating a state of “conscious and permanent visibility” (Foucault, 1995, p. 201), and thereby, ensures that nurses and patients are held within a power relation that seeks to ensure that they regulate their conduct according to the norms of the mental health setting. In this way, nurses and inmates are both subjects whereby nurses use power techniques to care for and control the mentally ill, and objects by which nurses and patients’ activities are dictated by rules of the penitentiary context. As such, nurses and inmates are caught in web of power relations that attempt to mold their behaviour through the technologies within the penitentiary setting. By using Foucault’s concepts in mental health nursing, Holmes’ work explicated how contemporary mental health settings predominantly characterized as caring, therapeutic and free from power are, paradoxically, also characterized by subtle relations of power.

Ceci (2003) explored nurses’ experiences in the events of an inquiry investigating the deaths of twelve children who died while undergoing or recovering from cardiac surgery at the Winnipeg Health Sciences Centre. Using Foucault as the conceptual framework, Ceci found that the gendering discourse and its practices constrained how nurses related to others and how they were able to conduct themselves, and in effect, limited their ability to advocate for safe patient care. Nurses exercised power in the
course of these events, yet the exercise of this power contributed to outcomes that were not desirable for the cardiac surgeon or for the hospital administration, thus making nurses subject to the control of others and their concerns were not heard.

**Characteristics of Critical Empowerment**

There is support for power relations in the nursing literature from the critical perspective. An emancipatory starting point by Fulton (1997) employed the critical social perspectives of Habermas (1971) and Friere (1972). Fulton (1997) described British nurses’ views of empowerment from a critical social perspective. The study was carried out prior to a course designed to empower nurses for practice.

According to Habermas (1971), individuals seek freedom from the constraints of domination and distorted communication, and it is through dialogue and self-reflection that individuals are liberated. In Fulton’s study (1997), nurses viewed empowerment as the freedom and authority to make decisions, to have choices, and to develop a knowledge base to be assertive; yet, nurses did not feel empowered. These findings correspond with the argument that nurses are an oppressed group (Diaski, 2004; Fletcher, 2006; Roberts, 1983). What is more, nurses believed their autonomy was circumscribed by doctors’ authority. Relationships among nurses are often hierarchical and competitive, and consistent with other oppressed groups, they exhibit subordination to those thought as more powerful (Diaski, 2004). In essence, the results of this study reinforced the idea that nurses are an oppressed group who desire a more positive self-concept, but trust in their ability for strategic action and change. However, British nurses did not allude to how or if their manager was instrumental in shaping or influencing their sense of empowerment.
In summary, a critical perspective provides some support for how nurses’ exercise power with managers, physicians, hospital administration, and patients, and how this governs and shapes their actions. More specifically, this critical perspective highlights how the manager exerts power over nurses, and how this governs and shapes nurses’ actions to influence their sense of empowerment, or lack thereof.

**Summary of State of Knowledge**

In this chapter, I review the organizational factors, characteristics, and work outcomes related to nurse empowerment located within the organizational and critical perspectives. The theoretical and empirical literature suggests that the majority of studies have reported on nurses’ belief in their ability to be empowered and the structural conditions promoting nurse empowerment. The critical perspective reveals nurses experience a subordinate position in their power relations with others. Overall, the literature suggests that nurses have limited interactions with their managers fuelled by low levels of trust, and this narrows the scope for positive outcomes for nurses. Based on this review, there is a lack of understanding of how nurses’ relationships with their managers facilitate nurses’ sense of power so they can assume greater control over their practice.

Largely absent from the nursing literature is a comprehensive theoretical understanding of the process in which power is exercised in the nurse-manager relationship and how this affects nurse empowerment. Specifically, there is lack of understanding of how the nurse-manager relationship influences nurses’ ability to get things done or when nurses perceive themselves as being made to do something they
would not otherwise do, foster or constrain staff nurse empowerment. We know that nurse empowerment has been explored from a subjective social position (psychosocial theory) and from an objective social position (structural theory) (Denham Lincoln et al., 2002), but has been less examined from a relational social position which is critical to power especially since power exists in relationships.

There are few studies examining nurse-manager relations and its link to nurse empowerment. Kanter’s work on structural empowerment has been applied to relationships in the workplace (Chandler, 1991; 1992; Roche, Morsi, & Chandler, 2009). The source of empowerment for nurses is their relationship with patients, colleagues, and mentors in the work setting (Chandler, 1992). The most common theme of nurses’ source of empowerment was their relationship with patients and families in which their empowering experiences came from teaching, counselling, and comforting. Building upon Chandler’s previous work, Roche et al. (2009) found that nurses’ relationships with patients, peers, and mentors are associated with nurses’ ability to perform at higher levels of expertise. This implies that staff nurses view the role of the nurse manager as providing them with the support, information, resources, and opportunity so they can develop the critical relationship with patients, peers, and mentors to develop and maintain expertise in their practice. Empowerment was derived from an interaction, yet nurses rarely reported experiencing empowerment from their superiors.

Klakovich (1996) found connective leadership was associated with nurse empowerment. Connective leaders are able to facilitate reciprocal communication and the creation of a shared vision toward the achievement of mutual goals by recognizing and nurturing strengths in others and bringing them into the leadership process. Nurses have
increased responsibility in the current health care environment as they are required to act rapidly and proactively in response to change. In this environment, nurses need to participate in reciprocal communication with their manager and develop cohesive work relationships which facilitate shared decision making. These study findings suggest that staff nurses perceive empowerment as increasing their capabilities and effectiveness to facilitate productive work behaviours. Consequently, it is important to further investigate the nurse-manager relationship as a source of nurse empowerment.

Consequently, there remains a need for research to examine how power is exercised between nurses and managers (relational social position) (Chandler, 1992; Fletcher, 2006; Manojlovich, 2007). How power is exercised in the relations between nurses and managers may have largely been taken for granted thus far, and therefore, may have contributed to the limited success in promoting nurses’ control over the content and context of their working conditions (Diaski, 2004; Manojlovich, 2005). A continued lack of control over nurses’ working conditions would suggest that power remains an elusive element for many nurses. Moreover, increasingly complex relationships are to be expected between nurses and their manager given the frequency of organizational changes, managerial turnover, large spans of control, a nursing shortage, and nursing layoffs in today’s competitive health care environment (Aiken et al., 2001a; McCutcheon et al., 2009). It is critical that the nurse-manager relationship be fostered to enhance nurses’ power so they have more control over their work, as well as the authority to deliver needed care on their own initiative and in a timely manner. Arguably this perspective may help make relations between nurses and their manager more explicit, more visible, and influence nurses’ ability to effect social change. More importantly, a
relational social perspective may facilitate nurses’ power to be exercised in more effective ways, and move our understanding of nurse empowerment forward.

Therefore, the directive I took from this literature review was the need for research to study the ways in which power is exercised that shape nurses’ experience in the workplace. The exercise of power in the nurse-manager relation reflects a process in a social setting (Glaser & Strauss, 1967; Strauss & Corbin, 1998). Specifically, research is needed to make visible the processes in which staff nurses and their managers exercise power in the hospital setting.

**Research Questions**

The major overarching research question guiding this study is “**What are the processes that shape how staff nurses and their nurse managers are situated in social relations of power that foster or constrain staff nurse empowerment?**” The following sub-questions offer direction to operationalizing the overall research question:

- How are staff nurses and their managers situated in social relations of power?
- What is the context in which these interactions occur?

**Summary**

In the next chapter, I outline the theoretical and methodological interpretation that will provide me with an interpretive lens that I will use throughout the research project and will shape the conclusions. Furthermore, in the next chapter I outline the methodological strategy, ethical considerations, and measures to ensure scientific quality.
CHAPTER THREE: METHODOLOGY AND METHODS

Introduction

This chapter details the methods and procedures used to conduct the study and will include: i) a brief overview of and rationale for grounded theory; ii) the study setting; iii) sampling and inclusion criteria; iv) data collection and analysis inherent in grounded theory; v) ethical considerations; and vi) measures to ensure scientific quality.

Grounded Theory Method: An Overview and Rationale

Grounded theory explores the richness and diversity of human behaviour and interaction in the natural setting (Chenitz & Swanson, 1986; Corbin & Strauss, 2008; Glaser & Strauss, 1967; Strauss & Corbin, 1998). The paramount goal in grounded theory is to discover the main problem and the basic social process, or core variable, to explain how people resolve problems in social life (Chenitz & Swanson, 1986; Corbin & Strauss, 2008; Glaser & Strauss, 1967; Strauss & Corbin, 1998). Grounded theory researchers examine social problems and the actions taken in response to these problems in light of social interaction and the context within which interactions take place. The conceptualization and theoretical description of a set of behaviours and social relations related to phenomenon will enable the identification of a basic social process (Corbin & Strauss, 2008; Strauss & Corbin, 1998).

The theoretical basis for grounded theory is symbolic interactionism (Corbin & Strauss, 2008; Creswell, 2007; Strauss & Corbin, 1998; Suddaby, 2006). Symbolic interactionism theory, described by George Herbert Mead (1934) and Herbert Blumer
(1969), is directly related to the grounded theory method (Chenitz & Swanson, 1986; Corbin & Strauss, 2008; Strauss & Corbin, 1998). Interactionism focuses on power relations and their enactment, and is not viewed as a static process or structure (Blumer, 1969; Dennis & Martin, 2005; Manias & Meltzer, 1967). The nature of human responses “create conditions that impact upon, restrict, limit, and contribute toward restructuring the variety of action/interaction” (Corbin & Strauss, 2008, p 6), and in turn, individuals shape the institutions where they work.

Mead (1934) postulated that the individual achieves a sense of self through social interactions. Blumer (1969) extended this social interactionist perspective by suggesting that phenomena are redefined through interactions, resulting in changes to self and, hence, changes in behaviour that occurs between individuals. More simply, in symbolic interactionism, meanings are derived from the social interaction or social relations one has with others. According to symbolic interactionism, people behave and interact based on the meaning of events to people in a natural setting. Because of this, individuals are always active participants in creating meaning through social interactions (Morse & Field, 1995; Stern, 1994). To understand human behaviour, the context, which includes rules, ideologies, and events illustrating shared meaning and that affect behaviour, are analyzed. In a typical symbolic interactionist approach, institutions are acknowledged as a backdrop for social interactions.

In qualitative research, grounded theory has been used extensively as a method important to the discipline of nursing (Chenitz & Swanson, 1986; Corbin & Strauss, 2008; Strauss & Corbin, 1998; Struebert Speziale & Rinaldi Carpenter, 2011). Grounded theory creates opportunities for nurses to develop substantive theories regarding
phenomena important to the clinical, administrative, and educative processes inherent to the discipline (Struebert Speziale & Rinaldi Carpenter, 2011). Examples of a social process in a grounded theory include: (i) relinquishing is a process of daughters letting go of a lifelong relationship, as they have known it with their parents, while adjusting to a new reality in a changed family structure (Read & Wuest, 2007); and (2) recognizing and responding to uncertainty is a process in medical-surgical intensive care nurses’ practice (Cranley, 2009). Consistent with grounded theory, these studies explain how the central problem in a study is resolved or processed.

I outline the following rationale for selecting grounded theory as a methodological approach for this study. First, an inherent assumption in using a grounded theory approach is that concepts relevant to the phenomenon are not fully developed, poorly understood, or conceptually underdeveloped and further exploration is necessary to increase understanding (Corbin & Strauss, 2008; Strauss & Corbin, 1998). Empowerment has been studied extensively from a management perspective, yet the concept remains poorly understood in terms of its link to power within relationships (Bradbury-Jones, Sambrook, & Irvine, 2008; Gilbert, 1995; Hardy & Leiba-O’Sullivan, 1998; Masteron & Owen, 2006; Rodwell, 1996; Ryles, 1999), and as such, existing power in the nurse-manager relationship have been under-investigated in the nurse empowerment literature.

Second, grounded theory is a particularly useful method in examining concepts that have been studied from a limited theoretical perspective (Ford-Gilboe, Wuest, & Merritt-Gray, 2005; Suddaby, 2006). Staff nurse empowerment has been researched primarily from a management perspective. Structural conditions and motivational approaches to improve self-efficacy provide an insufficient explanation of nurses’ ability
to be effective in their roles; this is compounded by their tenuous relationships with their managers. As such, the literature suggests that staff nurse empowerment continues to be highly problematic for staff nurses. Moreover, grounded theory is particularly useful in conceptualizing behaviour in complex situations, to understand unresolved social issues, and allows us to “understand behaviour in new and different ways” (Chenitz & Swanson, 1986, p. 5).

I used the grounded theory method to explain within a very precise context, the linking of categories to discover theoretically complete explanations about particular phenomenon. Symbolic interactionism is an appropriate framework for this study because it postulates that meaning is derived from a process of interaction with other individuals. The goal of this research was to examine the basic social processes of power within empowerment. The experiences of staff nurses are rooted in their unique perceptions and experiences of how power is exercised in the nurse-manager relationship. As such, the use of symbolic interactionism allows for an understanding of meaning produced by nurse-manager relations at work is important for empowering nurses to accomplish their work and achieve work effectiveness. For these reasons, a grounded theory method is appropriate to address how power is exercised within nurse-manager relations, and how this process fosters or constrains staff nurse empowerment. This study is a natural extension in building upon existing empowerment theory.
Setting of the Study

The site selection for the study and gaining entry to the setting are elaborated upon in this section.

Site Selection and Hospital Departments

The study was conducted within various departments in a western Canadian city. The selection of the sites for this research was guided by the following criteria:

(1) the hospital is a major teaching hospital in the province and was a reasonable distance from my home and was in close proximity to my workplace;

(2) entry was not difficult given the student-friendly environment;

(3) I am familiar with this facility, given my undergraduate clinical education and brief employment there; a considerable amount of time has elapsed since then (over 15 years), and it did not hinder my research.

I was able to maintain integrity to the primary goal of selecting units that represented different degrees of staff nurse specialization and different types of patient care. This allowed me to account for the peculiarities of different settings in which staff nurses complete their work.

Gaining Entry

Negotiating access for this study was a multi-layer process involving receiving ethical approval, gaining entry to the facility, and obtaining unit approval. After receiving approval from the University of Saskatchewan’s Ethical Behavioural Research Board and the Saskatoon Regional Health Authority, I obtained approval from the University of Toronto’s Ethical Review Committee. I formally contacted the Chief Nursing Officer of Hospital Services of the Saskatoon Regional Health Authority by
letter to request access to study participants in a tertiary hospital. A meeting was arranged at which time the Manager of Nursing Development agreed to provide a brief introduction of my research to the nurse managers in the identified areas. I negotiated and followed up on her suggestions for the best way to proceed in completing my research within the facility and in gaining access to potential participants.

Once I obtained agency approval, I negotiated entry with the nurse managers of the respective units. Nursing administration indicated that nurse managers were highly receptive to my research. While this served as a positive entry for my study, I needed to ensure that staff nurses did not feel pressured to participate. I met with nurse managers individually and stressed that participation by staff nurses was voluntary and that nurses may withdraw from the study at any time without negative repercussions. I provided copies of the relevant documents that reiterated my verbal statements, as well as provided my business cards should they need to contact me if they had further questions.

Following my meeting with the nurse managers, I held information sessions with staff nurses in the respective units to explain the study. The information session was to be scheduled once on each of three shifts, however in the end, only one scheduled information session was offered per unit. This occurred for two reasons: First, it was not always feasible to gather nurses as a group due to their workload. Second, nurses were willing and immediately consented to participate in the study when they heard of the study or when I approached them individually. Participants were informed both verbally and through documentation that participation in the study was voluntary and that they could withdraw at any time without consequences. Participants were given access to a written description of the research (Appendix A) outlining the purpose of the study, their
role in the study, methods of data collection, anticipated length of time required for participants, and ethical considerations. Staff nurses willing to participate were provided with a consent form for observations (Appendix B). A mutually agreed upon time and location was set up to conduct the observations. Following an observation, an interview was arranged at a mutually acceptable time and location. At the interview, staff nurses were provided with a consent form for the interview (Appendix C).

Gaining entry to the facility at the senior level of administration, and subsequently with staff nurses, involved initiating and maintaining trust and rapport (Morse & Field, 1995; Patton, 2002). Being sensitive to nurses’ willingness to participate in the study was a critical factor in gaining their support. Gaining trust and cooperation was essential to establishing reciprocity between staff nurses and me in order to ensure quality data (Patton, 2002). The entry period is also known to be the most uncomfortable stage of the research endeavour, because not only was I learning how to observe, I was also the observed (Patton, 2002). Upon beginning observations on the first unit, I was cognizant of others paying attention to what I said and watching my actions. I was aware that this was manifested through whom I spoke with, how I spoke with others, and generally, how I interacted with others. I spent considerable time particularly at the beginning of each set of observations on a unit but also during the time spent on each unit, to ensure my words and actions corresponded in order to develop and maintain trusting relationships with staff and administration. Gaining nurses’ trust increases the likelihood of the researcher to engage in conversations and observations that provide quality data.
Sampling and Inclusion Criteria

The sample recruited for the study, the rationale for obtaining an adequate sample, and the inclusion criteria are elaborated upon in this section.

Theoretical Sampling

Participants were chosen for the sample based on their experiences with the social process under investigation (Corbin & Strauss, 2008; Strauss & Corbin, 1998). Theoretical sampling involves gathering data driven by concepts derived from an emerging theory, and then determining the people, events, or places to go to maximize opportunities to discover variation among concepts (Corbin & Strauss, 2008; Glaser & Strauss, 1967; Strauss & Corbin, 1998). For example, many participants reported unsupportive relationships with their manager. In trying to find maximal variation of the phenomenon, I searched out contrary cases where nurses had more supportive relationships with their manager as a way to densify categories and denote a range of variability.

Later in the study, the idea of theoretical sampling took on a more prominent role in fleshing out the categories in terms of their properties and dimensions (Corbin & Strauss, 2008; Strauss & Corbin, 1998). Theoretical sampling involved returning to transcript data and gathering new data on categories in subsequent interviews. Moreover, sufficient sampling was achieved when the major categories revealed considerable breadth and depth in understanding the phenomenon and their relationships to other categories. Patton (2002) and Kuzel (1999) assert that there are no rules for sample size in qualitative inquiry but maintain that building rationale for a minimum number of participants addresses the adequacy of the sample size. The sample size in a qualitative
study is typically small — ranging anywhere from five to 30 units of analysis (Creswell, 1998; Kuzel, 1999). In this study, a purposeful sample of 30 registered nurses (10 registered nurses from each of the units) was expected to accomplish maximum sample variability. I continued theoretical sampling by going back to the original sample of nurses to explicate categories to the point of saturation and interpretations (Kuzel, 1999), and returning to previously collected data to see what was missed. Theoretical sampling became more purposeful and focused as the research progressed.

Two key elements are required for generating meaningful data in qualitative inquiry and supersede the need to use the large sample sizes associated with quantitative studies. First, nurses who were judged to have knowledge of the domain being studied were selected for the sample (Patton, 2002). In this study, nurses with a variety of viewpoints on their relationships with their manager were deliberately chosen to obtain perspectives from various age groups, diverse preparations, and practice experiences. Second, the observational and analytical capabilities of the researcher are critical to extracting rich and relevant data (Patton, 2002). Reflexivity is the complex relationship between the dynamic interaction of knowledge production and the investigator (Alvesson & Skoldberg, 2009). Briefly, this means that serious attention was given to stimulating critical reflection and awareness of my values and assumptions and how they affected the review of the literature, research design, data analysis, and interpretation in the research process. Reflexivity is expanded upon later in this chapter.

Inclusion Criteria

Inclusion criteria consisted of the following parameters: i) voluntary consent to participate in the study; ii) registered nurse status (this provided for a homogenous
professional designation); and iii) minimum one year’s experience on a respective unit. The last criterion was used to capture nurses who has been in the same or similar job situation for two to three years and allowed for a diversity of practice experiences of the phenomenon. I had chosen this criterion because novice nurses are focused on the objectifiable and measurable parameters of a patient’s condition (Benner, 1984) and typically have difficulty focusing on the contextual influences in the environment that impact their ability to provide patient care.

The final sample consisted of 26 nurses. I found that nurses were generally enthusiastic about participating in the study when the purpose of the study was clearly explained. I found also that because nurses were experiencing complex patient assignments while responding to organizational directives, I needed to be respectful of their time and effort directed towards my study. Consequently, I did not have difficulty recruiting nurses and was able to maintain positive and respectful relations with participants and other health care providers. In fact, a sizeable number of participants agreed to have their interviews conducted away from the unit before or after their shifts, and would occasionally meet in my office on their day off.

**Data Collection**

Grounded theory offers an approach to data collection and analysis from the empirical world of nursing practice. Data collected from interviews and observations are “grounded” in the actions, interactions, and processes of individuals (Chenitz & Swanson, 1986; Creswell, 1998; Morse & Field, 1995). The intent was to identify a basic social process to explain as close as possible the variation of phenomenon in a natural
setting. As such, I identified the behaviours and perspectives from staff nurses in the natural context of the hospital setting.

In this grounded theory study, I used three forms of data collection: observations, interviews, and field notes. New theory can be developed by allowing the theory to emerge from the data using a systematic data collection strategy to address the interpretive realities of actors in the social setting (Corbin & Strauss, 2008; Strauss & Corbin, 1998; Suddaby, 2006). These forms of data collection assisted in unveiling the theoretical underpinnings of the basic social process occurring in the hospital setting. Data collection took approximately 14 months - longer than anticipated. My commitment to professional and unplanned personal obligations significantly impacted and extended data collection and data analysis.

A pilot study with two participants from one unit was conducted to ascertain the efficacy of the research protocol. The purpose of the pilot study on a medical-surgical unit, in which I had no prior work experience, assisted me in gaining a better understanding of the nuances associated with carrying out my research with nurses in different work settings. Based on the data from the pilot study, it was determined that data collection methods were appropriate, and aided in finalizing the sequencing and wording of questions. Peer debriefing occurred with my committee where we discussed various aspects of the inquiry. We discussed initial themes and committee members raised relevant questions and comments that facilitated greater clarity surrounding how power was exercised in the nurse-manager relationship. Feedback provided from the committee aided my ability to ensure concepts were used appropriately in the analysis.

Participant Observation
Observations are a natural and effective technique for studying the actions and behaviour of people in enquiry that cannot be answered by interviews alone (Morse & Field, 1995; Robson, 2002). Observations were used to complement interview data, and to corroborate the messages obtained in the interviews (Patton, 2002; Robson, 2002). In this study, observations determine how closely participants’ narrative accounts of their experiences through semi-structured interviews paralleled their actual behaviour (Bogdewic, 1999; Patton, 2002). Observational fieldwork can also capture situations that may escape the awareness of those working in the setting and uncover things to which no one has previously paid attention (Patton, 2002).

Participant observation (Robson, 2002) was the method of choice to address my research question. Participant observation offers a balance on the continuum between being a non-participant and a complete participant; this role enabled me to interact with staff nurses by asking questions during the observation. Being a participant also offered a means of establishing rapport — an essential ingredient to the primary task of collecting data.

The hospital is the context in which staff nurses work. Observational fieldwork helped capture how power was exercised, and was a suitable method of data collection for this research. My goal during participant observations was to pay close attention to the design of the unit, the social relationships in the work environment, and the practices that shaped nurses conduct in critical consideration of how staff nurses and their manager exercised power. The ways of thinking and behaviours that were produced surrounding nurses’ ability to do their work illustrated the workings of power. For example, I observed staff nurse activities in clinical care (i.e., routine patient-care activities, change-
of-shift report), bed rounds, and one-on-one encounters. In addition, I attended to the purpose and frequency of informal staff discussions with managers, the extent to which staff nurses participated in decision-making affecting their professional practice, and management behaviours and practices that affirmed and negated staff nurse involvement. An observation guide (Appendix F) served as a template to begin the observations. Although the questions were broad, the themes that emerged allowed me to focus my observations (Taylor & Bogdan, 1998).

Studying power in the field provided the opportunity to move beyond the selective perceptions of participants, but simultaneously created another dilemma. Power can be overt or it can be masked in individual behaviour. I addressed this conundrum in two ways. First, observation enabled me to become familiar with the beliefs and rules that guided nurses’ thinking and actions in the social setting. Significant information can be illuminated from routine activities which nurses may not even be consciously aware of and therefore unable to recall in an interview. In other words, I was attentive to what was done as well as what was not done. Second, DeVault (1990) contends that researchers need to “develop ways of listening around and beyond words” (p.101) by attending to hesitancies, pauses, and fumbling for words. Following the suggestions by Opie (1992), I attempted to be a disciplined listener by noting the paradoxical and the contradictory, listening for what was said as much as what was not said. In one interview early on in the fieldwork, the nurse spoke at significant length regarding a lack of physician support in responding to critically ill patients. She spoke in a halting manner especially in the beginning of the interview with “um’s”, pauses, and chuckles that were inappropriate to the context of caring for critically ill patients and may have revealed her unease in
discussing the relationship with her nurse manager. As the interview progressed, the nurse talked about how inadequate staffing levels made her feel unsupported. I began to suspect there were dimensions of the nurse-manager relationship that might contribute to the nurse’s perspective in how nurses experienced their work life. The participant may have been reluctant to be direct in sharing, and so used this clinical situation to reveal how nurses experience their work without the support of the manager. Opie (1992) suggests that focusing on the differences in observing and interviewing participants is comparable to Glaser and Strauss’ (1967) constant comparative method.

Prior to beginning observations, I scheduled an initial site visit to the organization to familiarize myself with the units. This enhanced my ability to focus on the observations, rather than the surroundings, when I began data collection.

Staff were made aware that I was an observer from the beginning of the study. A verbal explanation of the study was provided to health-care providers encountered in the hospital during the investigation. I observed staff nurses on all three shifts (days, evenings, and nights). To ensure equal representation, staff nurses were observed over a three to four-hour period at various times during the day and on different days of the week. During the course of observations, I attempted to represent all shifts equally but this was not always possible, and observations conformed to the preference of the staff nurse. I observed nurses on their assigned shift while acting as their “shadow.” I blended into the clinical environment as best as I could in order to not draw undue attention to myself. Nonetheless, I spent eleven mornings, nine afternoons, and six evenings/nights on the unit for a total of 26 episodes of fieldwork. In total, 90 hours were spent in the field doing observations.
The participation aspect of observation assisted me in gaining trust and credibility with nurses. Patton (2002) recommends the researcher extend reciprocity to participants during observation as a way of valuing their participation in the study. Consistent with my role in participant observation, I assisted with simple tasks (i.e., making beds, obtaining supplies). I was always respectful and cognizant of the nurses and patients’ judgements regarding the appropriateness of my presence. In being the “gopher”, my actions facilitated obtaining quality data. I endeavoured to be flexible, sensitive, and adaptive regarding the degree of participation (Patton, 2002). More importantly, I made a concerted effort to participate appropriately as a means of gaining and maintaining trust and credibility with staff nurses (Morse & Field, 1995; Robson, 2002). As I worked alongside the nurse, trust quickly developed and nurses spoke freely to me. I paid significant attention to developing and maintaining positive relations by building on common experiences. For example, I listened to their experiences as a nurse, and provided empathy for their experiences (Hall & Callery, 2001). During observations, I was able to ask nurses to interpret and validate aspects of their interactions and behaviour that could potentially illuminate the research question.

Initially, the challenge was to identify the “big picture” while noting down copious amounts of detail in multiple and complex actions. Occasionally I was aware of the potential to miss observing and recording significant activities and actions in the clinical context. Participant observation was a selective process that involved writing about certain aspects of what I saw and heard that seemed significant and leaving out other matters that did not seem as significant (Emerson, Fretz, & Shaw, 2001). I was deliberate to focus on both action and dialogue in the social situation. It was difficult for
me to describe in detail both action and dialogue in the social setting, but Munhall (2003) asserts that doing so will enrich the subsequent account. Writing field notes was the most helpful strategy to systematically “unpack” my impressions and insights in a less taken for granted way (Bogdewic, 1999). At the conclusion of the observation with each nurse, arrangements were made for the interview with the voluntary participation of the staff nurse.

Semi-Structured Interviews

Interviews provide a unique “window” into participants’ subjective world as a means of understanding the thoughts behind their actions (Robson, 2002). It was anticipated that participant observations would help better formulate the interview questions and would provide a level of trust and cooperation for conducting the interviews. This strategy proved to be correct. The goal of open-ended, semi-structured interviews assisted me as the researcher to learn the participants’ language, capture how they view their world, and capture the complexities of individual perceptions and experiences within the context of the hospital setting (Patton, 2002).

I conducted all the interviews. Each interview was between 40 to 60 minutes, but I was cognizant of the energy level of staff nurse’s and tailored the length of the interview accordingly. I completed subsequent in-person and telephone interviews in situations where questions required further elaboration to address gaps in the emerging analysis. Subsequent interviews formed a stronger basis for understanding social processes by gaining depth, detail, and resonance that clarified and extended conceptual categories (Corbin & Strauss, 2008; Strauss & Corbin, 1998).
An interview guide (Appendix G) was developed in advance by preparing sensitizing questions gleaned from the literature and was “sharpened” as a result of participant observations. The interview guide served as a framework only, allowing me to pursue the data as they emerged during the interview. I was flexible in how and when the interview questions were asked in order to follow the logic of the staff nurse and capture significant data not developed in the interview guide. A flexible strategy also addressed my concern regarding the use of power in my role as researcher. Questions were revised based on emerging themes in the data and became more focused as the study proceeded. By keeping closely connected with the data, I was able to pursue additional questions that informed, extended, and refined emerging analytical themes (Corbin & Strauss, 2008; Strauss & Corbin, 1998). For example, additional questions arising from data analysis included: What does being supported by the manager mean? Why do nurses want the manager to be more available on the unit?

The semi-structured interview included a briefing session before the interview, the main body of the interview, and a debriefing session (Kvale, 1996). Interviews with staff nurses were conducted at mutually agreeable times and in mutually convenient and accessible locations (i.e., patient lounge, teaching room). Some participants preferred to be interviewed in my office where there was privacy and proceeded in a more relaxed atmosphere. In the briefing session, I explained the purpose of the interview and secured consent prior to beginning the interview. I assured the staff nurse of confidentiality and asked permission to tape and take notes during the interview.

Due to the nature of the relationship I established through observation, I was able to begin the interviews with a certain level of rapport and trust. I began by introducing the
key research themes designed to elicit staff nurses’ narratives in response to their relations with their manager. I facilitated this process by being an attentive listener, showing interest in them, and respecting their comments (Kvale, 1996). Miller and Crabtree (1999) suggest that the interviewer begin by asking rapport building biographical questions (Appendix D). The main body of the interview began once I sensed participants were comfortable.

The debriefing session signalled the interview was ending. This stage was identified when the interview was no longer productive and when the time had elapsed. I was cognizant that the staff nurse may feel vulnerable after sharing some personal experiences. I ended the interview by saying, “I have no further questions. Is there something you would like to ask before we finish the interview?” I trusted this statement served as an opportunity for the participants to find closure by sharing their feelings or thoughts. Once the staff nurse exited the room at the conclusion of the interview, I dedicated 10 to 15 minutes to reflect upon any significant occurrences during the interview such as nuances in the participants’ voice or facial and bodily expressions, and noted them down.

All interviews were tape recorded to preserve the authenticity of the interview and were then transcribed verbatim by a transcriptionist to facilitate a detailed narrative analysis. The transcriptionist was required to sign a consent form indicating a willingness to maintain confidentiality and was provided guidelines for transcribing (Appendix E). I listened to every taped interview to verify that the text “matches” the words and attended to the nuances of participants as a way of gaining a “feel” for the data. As I listened to the
Field Notes

Field notes were used for reflexivity, to reconstruct interactions observed in the setting, and described the physical setting and the activities that took place (Corbin & Strauss, 2008; Patton, 2002; Strauss & Corbin, 1998). Field notes also contained my impressions, insights, and interpretations of what was observed in the field but did not always answer or fit the research questions. Four types of field notes were used: i) condensed accounts; ii) expanded accounts; iii) a reflexive journal; and iv) analysis and interpretation of field notes.

I followed the framework by Spradley (1979) for documenting field notes. The first type of field notes were condensed accounts of the interviews and observations. A condensed account included phrases, conversational excerpts, single words, specific interactions, or salient incidents that resonated with me in the observation or interview as being pertinent to the phenomenon under study. I recorded data on a small note pad brought into the field. Attention to informal field notes was limited and was completed as discreetly as possible so the major focus was on observing or listening. I tried to slip away from an observation from time to time to a nearby conference room or lounge to expand my notes to include as many details as I could remember. I found that participants quickly grew accustomed to my note taking, and I was frequently able to jot down notes at the nursing station without drawing undue attention to myself.

The expanded account of field notes entailed elaborating on the condensed notes as quickly as possible after an observation. During this phase, the condensed
account of the observation or interview was expanded in a computer-based program, participants were identified by a code number, and sentences were expanded to elaborate on the meaning. These formal field notes were completed within 24 hours of the field session or before the next observation or interview occurred.

A third form of field notes was a reflexive journal. Reflexivity is the process of reflecting critically on the self as a human instrument in the research process (Guba & Lincoln, 1981). Attempts to eliminate all subjectivity on my part for the research would be naïve. I brought individual biases to this research study, as well as subconscious biases inherent to the concept of how power is exercised in social relations between nurses and their manager. Not surprisingly, these perspectives were likely “invisible” in shaping my research analysis and interpretations (Thorne, Reimer Kirkham, & MacDonald-Emes, 1997). It is difficult if not impossible to clarify my taken for granted assumptions; however, reflexivity meant paying attention to the construction of data, to myself as the human instrument, and to the social context, without letting any one of them dominate (Alvesson & Skoldberg, 2009). A more comprehensive discussion of reflexivity is expanded upon later in this chapter. Finally, I printed off copies of field notes and placed them in chronological order into file folders to maintain effective tracking.

The fourth type of field notes consisted of the analysis and interpretation of the data and served as the basis for writing my dissertation. These notes reflected my theoretical perspectives and the interpretations of the data. More specifically, these field notes included an analysis of social relations of power integral to staff nurse empowerment.
Data Management

Interview transcripts and field notes were password protected and stored on my computer (on a hard drive and on a flash drive) and arranged in chronological order in a set of coloured file folders. Two hard copies of interview transcripts were printed: a working copy for coding and a clean copy. All of the printed materials, the flash drive, and audio cassettes were stored in a secured filing cabinet. Consent forms were also secured and locked in a separate filing cabinet from the data. The data generated from the interviews, participant observations, and field notes were entered into the computer at regular intervals.

Data Analysis

In this study, I employed a grounded theory methodology using observations, interviews, and field notes to analyze data using constant comparative techniques (Corbin & Strauss, 2008; Strauss & Corbin, 1998). Sampling, data collection, and analysis are closely intertwined in grounded theory methodology (Corbin & Strauss, 2008; Strauss & Corbin, 1998). This methodology has been suggested to be linear and rigid, rather than a circular process (Charmaz, 2005). However, Strauss and Corbin (1998) assert that grounded theory “procedures were designed not to be followed dogmatically but rather to be used creatively and flexibly by researchers as they deem appropriate” (p. 13). Simply put, I attempted to strike a delicate balance between maintaining a degree of rigour by following the guidelines espoused by Strauss and Corbin, and by facilitating the necessary creativity to ask stimulating questions and make comparisons from a mass of unorganized raw data.
All interviews, observations, and field notes were transcribed and uploaded into a computer based program. As data were collected and generated, I simultaneously began coding data at all three levels of analysis (open, axial, and selective coding) (Corbin & Strauss, 2008; Strauss & Corbin, 1998). Each of these three levels of analysis is described in the following section.

In the first level of coding, *open coding*, I identified codes in the data and began to discover categories and their properties and dimensions (Corbin & Strauss, 2008; Strauss & Corbin, 1998). I began open coding by reading each piece of data (i.e., words, sentences) thoroughly to gain a sense of what the data were telling me before I attempted to make any comparisons. During this process, interview transcripts and observations were analyzed line by line, and descriptive code names were written in the margins. These descriptive code names assigned to each piece of data were words, phrases, and sentences contributed to “what is going on” in the data. For instance, with the in vivo code “not being accessible,” I questioned why it was so important that the manager be accessible? What did nurses need that they were not getting when the manager was inaccessible? In this phase of data interpretation, coding was based on facts (data) and as such limited my subjectivity, and strengthened the rigour of data interpretation. Each piece of data was coded into as many codes as possible to ensure comprehensive theoretical coverage.

The constant comparison method constitutes a central feature of grounded theory (Corbin & Strauss, 2008; Strauss & Corbin, 1998). This means that data were examined closely through a process of comparing new data with data already collected. This fine-tuning through constant comparisons facilitated the creation of new categories of
incoming data that did not fit existing categories, and resulted in the eventual emergence of a core process. This intellectual activity derived from such comparisons sensitized me to what was in the data, and enabled me to delineate the properties and dimensions that explicated the meaning of the phenomenon that gave rise to the specific theory (Corbin & Strauss, 2008; Strauss & Corbin, 1998).

Through the process of constant comparison, each of these codes had identifiable dimensions that lent themselves to a category. Hence, codes were grouped together into categories. Categories comprised concepts that represented the phenomenon and were grouped together because they had similar characteristics. Once I had some categories, I began to delineate the properties and dimensions of each category. The goal in this phase was to create as many categories as possible. Open coding ended when a core category was identified. Sampling at this level was open to participants that provided the greatest opportunity for relevant data about the phenomenon under the study (Corbin & Strauss, 2008; Strauss & Corbin, 1998).

In the second level of coding or axial coding, categories were related to sub-categories along the lines of properties and dimensions to form more precise and comprehensive explanations about phenomena (Corbin & Strauss, 2008; Strauss & Corbin, 1998). Conceptual categories comprised data-generated categories that accounted for most of the variation in patterns of behaviour and experiences. During this phase, I recoded as new interpretations were developed based on incoming data, additional categories were developed, and categories were combined. Categories were compared with every other category to ensure they were mutually exclusive.

The purpose of axial coding was accomplished using a coding paradigm in which
I identified a central category about the phenomenon, explored *causal conditions* (categories of conditions that influence the phenomenon), *actions/interactions* (responses manifested by individuals to issues or events that occur under those conditions), and *consequences* (outcomes of actions) (Corbin & Strauss, 2008; Strauss & Corbin, 1998).

For instance in thinking about conditions, I began to ask questions such as, “Under what conditions do nurses seek interaction with their manager?” In thinking about consequences, I began to ask questions such as: “What happens when nurses do not have contact with their manager?” This phase of analysis emphasized the interweaving of events. I was vigilant to the sequences that occurred in response to changes in conditions and the actions or interactions of individuals leading to consequences. The coding paradigm enabled me to sort and organize emerging connections among categories in building the theory. The significance of this analytic device served to help me understand how the categories relate to each other and proved to be valuable.

The most powerful support at this level was achieved through an analytic tool called diagramming to develop a visual model to show relationships between concepts. This tool elevated my thinking to a more abstract level, and after several iterations of the model, the diagram became more integrative as relationships among categories were substantiated.

The specific sampling technique advocated by Corbin and Strauss (1998) is called relational and variational sampling. The aim of theoretical sampling in axial coding is to seek out incidents that provide evidence of range in variation and dimension of a category and the relationships among categories. These specific sampling techniques enabled me to uncover and verify as many similarities and differences among the categories and sub-
categories as possible.

In the third level of coding, selective coding, I identified a core category, “seeking connectivity”, and systematically related it to other categories until a pattern among relationships was conceptualized, thus forming a substantive theory (Corbin & Strauss, 2008; Strauss & Corbin, 1998). Selective coding consists of several steps: i) selecting a central category; ii) organizing and relating categories around a central category; iii) validating those relationships; and iv) refining the theory by eliminating excess data not fitting the theory and densifying poorly developed categories. The emerging theory guided the process of data collection creating a tightening, spiral effect between data collection and theory development.

Poorly developed categories became more fully developed through further theoretical sampling. This process called discriminate sampling was more focused, and involved choosing the participants that maximized opportunities for comparative analysis and returning to transcript data to developed categories and validate relationships between categories.

Data collection continued until categories were saturated (Corbin & Strauss, 2008; Strauss & Corbin, 1998). Theoretical saturation was achieved when new data added only minor variations to categories. Theoretical saturation ensures the theory is uniformly developed, has density, and precision.

Two other fundamental characteristics that occur within a grounded theory inquiry are theoretical sensitivity and memos, which is addressed below.

**Theoretical Sensitivity**

Theoretical sensitivity is the ability to recognize what is important in the data and
to give it meaning (Corbin & Strauss, 2008; Strauss & Corbin, 1998). Theoretical sensitivity came from a continual interaction with data collection and analysis, and by being grounded in the literature. Becoming increasingly theoretical sensitive occurred as a result of prolonged engagement with the data. Concepts and relationships in the literature were selectively compared to data generated in the study to determine if they apply to the situation, and what form they take. However, concepts included in the theory were premised on what emerged from the data (Corbin & Strauss, 2008). Ongoing feedback with my doctoral committee during data collection and analysis challenged me to consider alternative interpretations and see concepts in new ways. Appendix J provides a sample of interview quotes with codes and memos related to *positioning to resist*. Memos became more precise over time leading to theoretical depth as I gained experience.

My experience as a registered nurse in an acute care setting was another potential source of sensitivity (Corbin & Strauss, 2008; Strauss & Corbin, 1998). My professional experience, prior knowledge, and perspectives were acknowledged as influential and offered a comparative base against which I measured the range of meaning in developing the properties and dimensions of the phenomenon. I was aware that my experience as a Clinical Coordinator might fold into my interpretations of the data, and I responded in two ways. First, I continually examined my own values and motivations through reflexivity in order to find contradictions to my assumptions in the data (elaborated more fully under reflexivity). Second, interview questions were guided by data analysis. At times, new questions were added to interviews to capitalize on emerging categories or concepts from the data.
Memos

Memos are the products of analysis done throughout the research process (Corbin & Strauss, 2008; Strauss & Corbin, 1998). Memos took several forms: code notes, theoretical notes, and operational notes (Corbin & Strauss, 2008; Strauss & Corbin, 1998). *Code notes* contained the actual products of open coding, axial coding, and selective coding. *Theoretical notes* summarized my thoughts and ideas about theoretical sampling and other issues. *Operational notes* are memos referring to procedural directions. Memos included my interpretations, questions, and directions gleaned from theoretical insights. Memos stimulated my analytic thought processes and provided direction for theoretical sampling. These memos enhanced the process of conceptualization and lent clarity and direction to the emerging theory.

Initially I found memo writing somewhat overwhelming in my quest to “get things right” in carrying out the analysis. As I disciplined myself and trusted in the procedures of the grounded theory method, I began to get a sense of what the data were telling me and how the social relations of power were manifest in participants work. I found that as the research progressed, memos supported, extended, and negated earlier memos. Memo writing grew in complexity, density, and clarity as the research progressed, and I was able to develop my own style knowing that the process was not always accomplished in an orderly fashion. This was affirmed by Corbin and Strauss (2008) who state that there are no rules governing memo writing, and the researcher develops his/her own style in the research process. Often times, discussions with my doctoral committee or the literature clarified earlier ideas and provided direction for the
ongoing research. Memo writing was an essential component of the research process in achieving conceptual density and integration.

**Ethical Considerations**

Ethical approval was obtained from the Research Ethics Board, University of Toronto, the Behavioural Research Ethics Board, University of Saskatchewan, as well as the Research Services Unit, Saskatoon Regional Health Authority. Due to the unknown nature of what could emerge during a grounded theory investigation, I employed a framework to deal with such ethical issues (Patton, 2002; Struebert Speziale & Rinaldi Carpenter, 2011). The ethical framework guiding this research included confidentiality and privacy, informed consents, freedom from harm and exploitation, reciprocity, and interventions.

Confidentiality of participants was assured by using numerical codes in data analysis and publications. I provided verbal assurance to participants of the confidential nature of their interviews and observations. All participants received a copy of the signed consent forms. Particular attention was paid to the privacy of health-care workers who, while working on the units, may believe they are uninvolved in the study (Robson, 2002). I offered verbal information about my research when health-care workers, but I was careful not to take notes of their behaviours if they did not wish to be included in the data, although most responded positively. Consideration was also extended to patients. In most cases, participants introduced me to the patient and explained the purpose of why I was “buddying” with his/her nurse. While informed consent was not required, all patients consented through a verbal agreement or an approving gesture. I separated documentation
that identified the agency, the names of individuals, or other indicators from the data (Christians, 2005).

Informed consents were obtained before any interview or participant observation. Most staff nurses I was in contact with voluntarily agreed to participate based on a full and open disclosure of the research objectives (Christians, 2005). I stressed that participation was voluntary and that participants may withdraw from the study at any time or stop the interview or observation. Several authors recommend ongoing consensual decision should be an ongoing process whereby consents are renegotiated as events and circumstances change (Munhall, 2012; Orb, Eisenhauer, & Wynaden, 2001; Richards & Schwartz, 2002). I was alert to any hesitation by staff nurses to continue in the study and offered them the chance to withdraw at any time during the study.

All participants have a right to freedom from harm and exploitation. The potential for participants to experience any adverse effects was minimal. I balanced the value of a potential response with the potential distress it could cause the participant (Patton, 2002). On one occasion, a participant had difficulty responding to an upsetting situation regarding an experience with the manager. I provided the opportunity for the participant not to pursue this situation, but without hesitation, she explained how the manager inappropriately disciplined her. I did not witness any significant breaches of unethical conduct, but at times, I felt uncomfortable with the way nurses spoke to patients. During one observation, my buddy nurse noted that although a bath/shower was not possible for an elderly woman, the patient still required peri-care. The nurse announced loudly and within ear-shot of other patients in the room by stating, “You are stinky…we can wash your privates…” I felt uncomfortable with the way the nurse handled the situation and
her choice of words. I did not respond, but tried to model appropriate behaviour by promptly filling the washbasin with water and soap. I further closed the curtains in attempting to provide some dignity as we assisted the woman with morning care.

Reciprocity is a process that involves issues of compensating participants for their role in the study (Patton, 2002). Participants provided me with highly valuable information through the sharing of their experiences and by allowing me to observe them in the clinical setting. Contractual obligations within the health region prohibited me from carrying meal trays or hot beverages to patients because of risk management issues. Yet I found ways to express my gratitude to nurses for their participation in the study by assisting in simple tasks such as obtaining linen, patient charts, or being a “gopher.” These gestures constituted acts of good will and appreciation on my part, and enhanced the development of a trusting relationship. Participants were also included in verifying the findings and were offered summaries of research findings.

I was cognizant going into the field of the possibility of being asked to provide professional guidance for a nursing intervention. Patton (2002) asserts that it is common for the researcher to be asked advice because of their “expertise.” Staff nurses can view a nurse researcher or PhD student as an “expert.” I did not encounter any specific situations of this nature, yet I was prepared to engage in a delicate balancing of listening and being supportive while not offering any false reassurance or advice.

**Ensuring Scientific Quality**

The standards applicable to judging qualitative research are in sharp contrast to the criteria required to judge quantitative research. Goodness criteria are rooted in the assumptions of the paradigm for which they are designed, and one cannot expect the
criteria of one to fit another (Guba & Lincoln, 1989). Multiple criteria for evaluating qualitative research exist, but there is “no single interpretive truth” (Denzin & Lincoln, 2005, p. 26). As explained by Sandelowski (1993), “trustworthiness becomes a matter of persuasion… it is less a matter of claiming to be right about a phenomenon than of having practiced good science” (p. 2).

This discussion of the evolving conception of criteria for ensuring scientific quality led me to select standards that fit with this particular study. First, principles guiding qualitative sampling were applied to this study to ensure credibility. Second, Corbin and Strauss (2008) suggest that the researcher use their own criteria for evaluation to determine “quality”. This has prompted scholars to argue that researchers need to describe the standards by which the qualitative study is judged, and abandon the notion of a generic framework for assessing the quality of qualitative research (Corbin & Strauss, 2008; Rolfe, 2006b). I selected verification techniques espoused by Morse and colleagues (2002) to place the responsibility of the rigour for the study on the researcher. Finally, I added reflexivity and relationality to create a more rigorous form of grounded theory research (Hall & Callery, 2001). In providing the standards for this study, the reader will be able to judge the analytic logic and overall adequacy of the research process in uncovering the processes of how staff nurses exercise power in social relations with their manager.

Principles of Sampling

The rationale for evaluating sampling methods is based on appropriateness and adequacy (Morse, 1991; Morse & Field, 1995). Appropriateness evaluates participants’ ability to inform the research question under study. A purposive sample acknowledges
that staff nurses were the individuals best suited to answer the research question of how power is exercised with their managers. Consistent with grounded theory, sampling began more broadly, and became more deliberate and focused after concepts and relationships begin to emerge from the data. After the initial major categories emerged from analysis, theoretical sampling was carried out by going back to the staff nurses who could best fill gaps in the theoretical constructs and returning to existing transcript data.

Second, the adequacy of the sample was fulfilled when the data allowed for a full and rich description of how power is exercised between staff nurses and their managers. This occurred when there were not any significant additions to the data and the theory “made sense,” thus achieving saturation (Morse & Field, 1995). For these reasons, my sample size met the principles for sampling in this qualitative study.

**Verification Strategies**

Verification strategies help to modify or re-direct the research process in order to manage threats to reliability and validity (Morse, Barrett, Mayan, Olson, & Spiers, 2002). As a novice researcher, having the ability to re-direct the analysis and the development of the theory was a self-correcting mechanism designed to attain a quality product (Morse et al., 2002).

Verification strategies included i) methodological coherence; ii) appropriate sample; iii) collecting and analyzing data concurrently; iv) thinking theoretically; and v) theory development. First, methodological coherence was evident in the fit between the research question and the grounded theory methodology. For example, the processes that shape how staff nurses exercise power with their managers provided a clear and direct link to a grounded theory approach that links the constant comparative method of data
analysis, theoretical sampling, analytic tools, and coding in an interconnected manner (Corbin & Strauss, 2008; Strauss & Corbin, 1998). As the study progressed and was influenced by the data collection and analysis, the sample size changed slightly – from 30 proposed at the beginning of data collection to 26 participants when saturation was achieved.

Second, the appropriateness of the sample was critical because staff nurses who are most knowledgeable about the phenomenon were sampled. For this criterion to be met, I ensured that sufficient data were obtained to account for all categories. I did this by returning to the original sample and interviewing and/or observing participants for the purpose for increasing scope, adequacy, and addressing gaps, thus achieving saturation (see principles of sampling discussed above).

Third, collecting and analyzing data simultaneously comprised the iterative interaction between what is known and what needs to be known. In other words, this strategy paralleled theoretical sampling, the constant comparative analysis, and coding associated with grounded theory (Corbin & Strauss, 2008; Strauss & Corbin, 1998). Analysis was driven by the data emerging from the research, but staying closely connected with the literature enabled me to understand concepts more clearly and sharpened my ability to be sensitive to what was in the data. For example, data collection and analysis were systematic and sequential beginning with data collection, followed by analysis, and further data collection until theoretical saturation occurred (Corbin & Strauss, 2008).

Fourth, I was diligent in moving carefully and methodically back and forth between ideas, emerging from data analysis and verifying it with new data collected in
the field. This strategy was reinforced by comparing the emerging findings to the literature. For example, acts of resistance delineated in the data were more easily distinguished as a consequence of my immersion in the literature. This strategy was further enhanced by diligence in analyzing new data and verifying it with data already collected in building a solid foundation for the theory of seeking connectivity.

Finally, theory development has a double-pronged outcome for ensuring reliability and validity. First, the findings of this study attest to the logical, comprehensive, and parsimonious nature of this research endeavour. To achieve this goal, I sorted through memos to look for cues on how all the categories could easily fit together. Rereading memos, developing several iterations of the model, and critically thinking about how the pieces could fit together were the techniques used to arrive at the final integration of the theory. Second, I linked this newly developed theory to the existing theory on staff nurse empowerment. This theory further provides a template for comparison and further development of the theory for future investigations. I address how the theory of seeking connectivity extends the theory of nurse empowerment and elaborate more fully on this point in Chapter Seven. Collectively, these verification strategies contributed to the reliability and validity of this research, and ensured rigour.

**Reflexivity**

Reflexivity was a major part of the study, and was a means to reflect critically upon how I participated in creating and interpreting research data. This section involves reflexivity of myself as the researcher and of the research process in maintaining my integrity as researcher and author of this thesis.
Rather than engaging in attempts to eliminate the effects of the researcher, I engaged in as honest an examination of the values and interests as I could that impinged upon my research, but I also acknowledged the potential to influence the perspective of staff nurses (Alvesson & Skoldberg, 2009; Patton, 2002; Porter, 1993). That is, as the researcher, I am a product of the social, cultural, and historical positioning of the nursing discourse because my perspective is shaped by the nursing knowledge in which I was and am embedded. I acknowledge that there were situations where I may have made inferences, judgments, or constructed knowledge from a social position of privilege as a middle-class White researcher at a university. For example, I was attentive to my past experience as a Clinical Coordinator and nurses perceptions that I needed to have had clinical experience on the unit on which I worked. As I listened to the stories of nurses’ experiences with their manager, my position of researcher became evident as the following excerpt of an interview demonstrates:

R: What kind of things can she [manager] provide for you to facilitate your work?

P: I guess one of the main…..things I guess is just advocating for your staff. Like backing them up no matter what situation they’re in….I don’t know, new staff coming up against aggressive physicians or families, that kind of thing. I don’t know, there’s so many obstacles…And I guess someone who knows, like has some background knowledge about the area they are dealing with.

R: The literature says that the manager doesn’t have to be the expert…..some of these articles read that the manager needs to be able to manage and lead.

In retrospect, this participant was particularly forthcoming about her experiences with the manager, and I was dismayed at my apparent digression from her train of thought, yet this excerpt revealed a response consistent with a researcher familiar with the nurse manager literature. My experience in an administrative role led me to believe that nurses wanted me to be on the unit and also to have clinical experience and expertise in this specialty
area. As the research progressed, the self-sight about my position of privilege led me to see that my ability to analyze data was less about my social identity, but rather the interpretative lens with which I approached this research. Alvesson and Skoldberg (2009) describe reflexivity as not only minimizing problem areas but in seeing alternative perspectives and “re-balancing and re-framing voices to interrogate and vary data” (p. 313) to arrive at new constructions of the phenomenon.

Yet, through reflexivity, I attempted to address some of my preconceptions of nurses’ experience in their workplace. Reflexivity challenged and opened up to scrutiny the taken-for-granted aspects of the research process and the discourses shaping nurses’ practices conveyed to me in the collection of data in this research undertaking. By dialoguing through reflexivity, I was able to become aware of established ways of thinking so that I could listen to research participants more openly. As such, I spent considerable time examining values, assumptions, and motivation to determine how this may have impacted my research. I was acutely aware of my influence on the research to ensure I collected “valid” data and to enhance the trustworthiness of the results (Lipson, 1991). In my personal accounts, I was keenly aware of how my past experience as a Clinical Coordinator in a large tertiary teaching hospital affected my perspective. This was evident in my reflexivity journal as I chronicled how the structures and processes inherent in the hospital in which I worked operated, and the ways nurses conveyed how the unit needed to be governed by myself as the leader. As a Clinical Coordinator I was acutely aware that nurses under my supervision were insistent I be physically present on the unit, and their comments reflected their displeasure when I spent time away from the unit especially if I were in my office. I felt confident nurses could provide safe, quality
patient care without me “hovering” as most nurses had significant experience in the specialty and I had none. The challenge in reflexivity is to break away from a way of thinking and “look at the situation at what it is not [authors’ emphasis] capable of saying” (Alvesson, & Skoldberg, 2009, p. 270). However, Angrosino (2007) maintains that field work is highly political and a researcher does not enter the field in a bland and neutral state. But rather, the researcher is a “real historical individual with concrete specific desires, and interests –and ones that are sometimes in tension with each other” (Harding, 1987, p. 32). Reflexivity helped me to see other worldviews while placing my own lived experience in context. In order to achieve scientific quality, I checked with participants to ensure I captured and understood their perceptions. Focusing on participant’s views as the ‘truth” could inhibit me from moving beyond the perceptions of the participant. This was an ongoing exercise throughout the research process, and I made an extra effort to interrogate the reality of nurses’ work to show how their perspectives and practices were shaped by the discourses operating in the hospital.

Despite my reflexive preparation, there were instances where my desire to help participants feel comfortable and safe during the interview resulted in awkward responses on my part. In one interview early on in the fieldwork, a participant began by explaining how difficult it was to secure medical intervention for a critically ill patient. She chuckled at inappropriate times, and there seemed to be long awkward silences where she was not commenting. After listening for about 20 minutes and due to my inexperience, I asked several questions at once in response to the situation she was describing. An excerpt of my responses demonstrates this situation:
So what did the doctor come back to you and say should have been handled differently? Were you supported by nursing management? Did they understand the acuity of that situation or nothing was done?

As I reviewed the transcript, I was dismayed at how quickly I interrupted the participant by asking several questions, rather than pacing probing questions and allowing silences to occur. I realized through reflexivity that my motivation was to ensure the participant was comfortable and prove myself as a trustworthy and credible researcher. Through reflexivity, this realization prompted me to be more mindful of pauses and silences in subsequent interviews and allow participants time to respond to questions in their own time.

Finally, and equally important, as researcher I was influenced by engaging in the research (Dowling, 2006). Undertaking a study of this nature necessarily required a thorough and critical analysis of the power and empowerment literature. This scholarly journey could not have been possible without critically reflecting on the conceptual and emotive elements of power. This caused me to further reflect on how power has been exerted over me personally and professionally, and how I may have participated, knowingly and unknowingly, in the use of power over others. Without a doubt, a highly charged concept such as power stimulated an active engagement in my own personal power issues. Above all, reflexivity proved to be a useful tool in critically analyzing my own writings, thereby shedding valuable perspectives on the research process in which I was engaged.

Reflexivity was facilitated through writing field notes, conversations with colleagues, and guidance from my doctoral committee throughout the study. A questioning perspective during data collection and analysis enhanced transparency.
Developing appropriate self-awareness through reflexivity provided information about myself as a human instrument to enhance the rigour of the study (Hall & Callery, 2001; Patton, 2002). Nonetheless, the resultant theory remains a human construction in analyzing and interpreting the data even though great strides were taken to ensure rigorous treatment of data.

**Relationality**

Attention to power dynamics is a central feature of critical inquiry, and is worthy in enhancing the quality of this study. Relationality recognizes and validates the researcher’s “moral obligation to emphasize equality in their power relationships with participants” (Hall & Callery, 2001, p. 266), especially where relationships are built on trust and mutuality. Relationality and its outcomes of reciprocity, equity, and social action are supported by the symbolic interactionist’s acknowledgement of power relations around the process for change in the human experience (Hall & Callery, 2001).

I engaged in several strategies to account for power differences inherent in the researcher-participant interaction, one of which was reflexivity through journaling and memo writing. Through reflexivity, I engaged in an ongoing, reflective, and critical evaluation of how my position of power as a researcher influenced my interactions with participants. Yet there were instances when my interactions revealed a more shared relational power by engaging participants in what would emerge from the data. I engaged nurses by paraphrasing their comments during interviews, and I involved nurses in member checks by using a diagram of the theoretical model in discussing the analysis of the findings.
Another strategy consisted of member checking where participants were asked to comment and validate the representation of phenomenon. Lincoln and Guba (1989) suggest that participants be offered the chance to reflect on their experience and provide additional information that may further illuminate the theoretical conceptualization. Member checks were completed in two ways: First, during data collection I verified what I noted down was in fact what the participant intended to communicate (Lincoln & Guba, 1989). Second, I asked participants to comment on emerging theoretical conceptualizations throughout the research process (Lincoln & Guba, 1989; Thorne, Reimer Kirkham, & MacDonald-Emes, 1997). Although member checks occurred throughout fieldwork, three participants, one from each of the three units accepted the invitation to participate in validating the final theoretical construction. Each of these three participants had achieved a level of competency as a nurse on the unit (Lincoln & Guba, 1989). This formal process gave participants the opportunity to correct errors, make suggestions, and provide additional comments. I met with each of these participants separately. In each session, I explained that although the participants may not see themselves in the model, I required their assistance to determine if the interpretation of the model “made sense” to them. Generally, I found the explanation of the model engendered agreement from participant’s affirming, clarifying, and enriching my understanding of the phenomenon through either verbal agreements or gestures. Frequently our conversation was interspersed by participants elaborating on a specific portion of the model that provided further information and confirmation of my interpretation of data. I deliberately allowed participants time to pursue their thoughts in
order to determine if there was information not captured in the model. This served as a mechanism to allow participants to explore aspects of the model.

There are debates around the usefulness of member checks in confirming research findings (Morse et al., 2002; Thorne, 2008; Thorne & Darbyshire, 2005; Sandelowski, 1993). The problem with member checks from the authors’ perspectives is that participants may not recognize their experiences, and the researcher may be compelled to provide a more descriptive presentation of the analysis in order to address participants’ concerns. Consequently, this may limit the theoretical depth of the findings and minimize or invalidate the researcher’s level of analysis. I nevertheless did member checks with three participants who were presented with the model to determine if the model “made sense.” The final analysis remains my interpretation of the findings.

While I did not encounter any disagreements, I was prepared to integrate different viewpoints by providing each other “interpretive space” in striving to understand the participant’s perspective in the fieldwork exchange (Borland, 1991). The openness of the process provides a mechanism for assuring participants that the study is carried out with integrity, and is the single most crucial technique for establishing credibility (Guba & Lincoln, 1989). While co-authorship was not possible, liberal use of narratives and member checks balanced nurses’ perspectives with mine. Following the member check, each participant was provided with a coffee voucher at Starbuck’s in the hospital mall as a token of my appreciation for their time (one participant came to work earlier than necessary, and one participant met with me on her day off in my office).

I was acutely aware that I was not attempting to find the ‘truth’, but I was verifying the accuracy of my understanding of participant’s meanings and if the model
“made sense” to them. To this end, the findings seem to be a reasonable interpretation of participant observations and interviews (Thorne & Darbyshire, 2005). The rigour of a grounded theory study increases when theoretical sensitivity, reflexivity, and relationality are combined (Hall & Callery, 2001).

Summary

This chapter provided a description of the methods and procedures used in conducting this study. A brief overview and rationale for grounded theory methodology was offered. Further, the location for the setting of the study was outlined. Approaches to sampling, data collection, and analysis specific for a grounded theory approach were detailed. Ethical considerations were also examined. Steps to ensure the rigour of the study were elaborated upon. A grounded perspective emphasizes knowledge generation that contributed to a meaningful explanation of how staff nurses exercise power in social relations with their manager.
CHAPTER FOUR:
ORGANIZATIONAL CONTEXT

Introduction

In the following three chapters, I present a detailed examination of the model’s component parts. In this chapter, I present the results of the data analysis for the organizational context in order to reveal the conditions and their relationship to the processes that shape how staff nurses and managers exercise power. The substantive theory that emerged from this investigation evolved from Strauss and Corbin’s (1998) grounded theory approach. I make use of direct quotations to reflect the voices of participants while locating data in a higher conceptual analysis (Corbin & Strauss, 2008; Creswell, 2007; Strauss & Corbin, 1998) resulting from inductive analysis.

In this chapter, I begin by offering a brief overview of the sample followed by an introduction to the organizational context revealing how the nurse manager influences work conditions. I also describe the roles of head nurse and nurse manager, setting the stage for exploring nurse-manager relations. I present research findings, more specifically themes and sub-themes to reveal the ways the organizational context shaped nurses’ relationships with their managers, and how these relationships manifested the way nurses experienced power – how they were able to get things done or when they participated in situations that were not preferable to accomplishing their work. These themes are (i) Relating through Disconnecting and Connecting. In Chapter 5, I present a range of consequences for nurses as a result of being situated in social relations of power with their manager. More specifically social relations of power are exercised either when nurses perceive themselves as able to get things done or when they participated in
situations they would not ordinarily do in carrying out their work. These themes are: (i) Positioning to Resist, and (ii) Experiencing the Potentiality of Enabling. In Chapter 6, I offer an overview of the theoretical model, and theorize the substantive theory emerging from the data, *process of seeking connectivity*. 
### Figure 1 Process of Seeking Connectivity: The Expanded Model

#### A Depiction of the Process of Seeking Connectivity

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<tr>
<th>Organizational Context</th>
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<th>Nurse Responses</th>
<th>Power/Empowerment</th>
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### Conditions

- The Budget
- Working Short
- Contradicting Demands & Interruptions
- Being Controlled by Policies Jeopardizing Patient Safety
Characteristics of the Sample

The final study sample consisted of 26 registered nurses who consented to being observed and interviewed. Nurses ranged in age from 20 to 25 years of age to over 50 years of age. Forty percent of the sample was 26 to 30 years of age. The majority of nurses were female (88%), and the majority of nurses had a nursing degree or a nursing degree in progress (64%). The length of time nurses worked on their respective units ranged from seven months to 24.5 years, with a mean of 7.5 years on their respective units.

The total number of years as a registered nurse ranged from less than one year to 30 years, with a mean of 10 years. One registered nurse I observed did not complete the interview portion of the study because she assumed a staff position on another unit, and despite several attempts to contact her, I was unable to complete an interview. See Appendix I for the demographic profile of participants.

Organizational Context

To understand how power was exercised in the nurse-manager relationship, I began by asking nurses to talk about what it was like to work on their respective units and how the manager’s role affected their ability to do their work. The important contribution I make here is to situate the nurse and nurse manager relationships in context, and thereby demonstrate how complex structures and processes in the environment mediate these interactions in the organization. Their description of the units and the hospital context serves as an entrée into the larger research investigation and reveal a number of key contextual factors that are foundational to the entire investigation. This study builds upon
a program of research on nurse empowerment. Therefore, Kanter’s Theory of Structural Power in Organizations (1977;1993) provides insight and direction to this study, but I endeavored to remain open to new ideas and concepts emerging from the data (Corbin & Strauss, 2008; Strauss & Corbin, 1998). Nurses’ constructions of these structural factors locate power in its larger context to show how this context shapes the day-to-day nurse and manager encounters. Specifically, nurses’ constructions of the organizational context are instructive in providing initial understandings of the power dynamics between nurses and managers that serve as the basis for the rest of the study.

This section is organized around the key contextual factors in the hospital emerging from the data: i) “the budget”; ii) “working short”; iii) contradicting demands and interruptions; iv) being controlled by policies; and v) jeopardizing patient safety. Specifically, my aim is to explicate how the nature of factors, or lack thereof, came to shape nurses’ thinking and their practice and delivery of patient care.

“The Budget”

A function of the nurse manager role is to be responsible for the fiscal and operational management of the unit. In this study, nurses perceived that managers’ preoccupation with the budget, and the associated fiscal and human resource cutbacks and shortages, frequently fell short of the requirements for patient care activities on the units. Although nurses understood that fiscal management was a priority, they took exception to managers who seemed to focus primarily on the budget. One nurse suggested, “I think that a new initiative here in the unit is that they’re trying to cut the budget” (#11, p. 6). From this nurse’s perspective, financial cutbacks and constraint appeared to be a central focus for the manager of the patient care unit.
Nurses commented on “having to do more with less” and adjusting their practice accordingly because of inadequate staffing. On occasion, the manager conveyed to nurses that the budget assumed primary importance when nurses were considering the number of nurses needed on a particular shift, while on another occasion a manager denied having made staffing cuts. On one unit, budgetary restrictions were evident prompting one nurse to state the manager emphasized, “…cutting vacation, cutting staff, cutting overtime, that kind of thing which I understand…she’s got a boss as well and so she has to kind of stick within her limits…” (#18, p. 6-7). This quotation illustrates that this nurse perceived the manager as prioritizing the budget and simultaneously meeting management’s goals, while not appearing to be as concerned about nurses’ ability to deliver patient care with limited resources. This finding is consistent with Blythe et al. (2001) who found that restructuring intensifies structural weaknesses, and although nurses agreed that financial restraints were necessary and inevitable, standards of care were affected.

Nurses perceived that managers won favour with senior management who were being diligent in meeting performance indicators and focusing on the budget. As one nurse pointed out, the manager’s preoccupation with the budget originated from pressures from upper management and the purpose of one manager being hired was to bring the budget under control and to “…straighten us out …” (#19, p. 6) by decreasing the budget by 20% and bringing the budget under control. In this way, nurses came to view fiscal priorities as replacing safe patient care as the hospital’s mission. These findings are consistent with other studies that suggest management’s primary focus was on the financial bottom line, and manager’s effectiveness in their jobs depended upon learning
to manage their unit budgets more effectively (Laschinger, Finegan, & Shamian, 2001a; Rankin & Campbell, 2006).

In summary, the budget was incorporated as part of nurses’ everyday language and came to govern nurses’ work. Fiscal restraint led nurses to view their patients and their care as a cost-conscious activity driven by economic efficiency and resource constraints. The ultimate aim was to highlight for nurses the importance of financial restraint to the operation of the unit, and force them to participate in reducing expenditures.

“Working Short”

The nursing shortage was defined as working short either because there were not enough nursing personnel or because managers sometimes would not fill sick time in order to save money, and influenced how nurses managed their workloads. For example, nurses voiced their concern over providing only “the basics” of patient care when they experienced a shortage of professional nursing staff. Nurses indicated that they found the work environment stressful, with one nurse stating, “…we’re all kind of snapping at each other near the end [of the day]…it’s hard to work in that environment...” (#2, p. 28). Nurses on another unit stated that they were anxious about the quality and safety of patient care when they perceived organizational support for staffing was lower than expected. One nurse explained:

P: ….we don’t get people coming in sometimes….overtime is refused….

R: So how often are you short [staffed]?

P: About three-quarters of the time…its’ really bad. It’s really bad. Like every night we’re short…. (#11, p. 7)
Another nurse on this unit indicated that a vicious cycle of nurses working beyond full-time hours in order to cover significant staffing shortages resulted in an increase in sick time as she explained, “…everybody’s working overtime on top of overtime…then you’re taking your sick time [and] somebody else has to work in the meantime…” (#13, p. 3). On another unit, nurses were called routinely if they could work on their days off, as one nurse explained:

P: Like I’ll get called every day here, every morning at 6:00 in the morning when the staffing office opens, you know.

R: On your days off?

P: Mmmhmmm. Yup, ‘cause [unit] is always short – they just phone everybody on the [number] floor just to see if someone can come so that’s stressful. …when you start you think oh yeah, I can…you know, we can squeak by but then…you can only do that for so long” (#2, p. 28-29)

These excerpts illustrate that under-staffing and management’s request for nurses to work overtime led nurses’ to be desensitized to manager’s efforts to resolve the nurse shortage. These working conditions also led nurses to experience low morale. When nurses worked extra hours, the ratio of nurse-to-patient was not consistently alleviated. Research findings report work pressures such as nurse shortages and high workloads can be detrimental to patient care (Baumann et al., 2001; Priest, 2006). Nurses did not refer to any form of patient classification system guiding appropriate staff mix or staffing decisions.

Nurses on yet another unit explained how staffing levels were inappropriate in their specialty unit. In this situation, the shift from a medical unit to a highly specialized unit had resulted in caring for a more complex patient receiving more advanced treatments and medications requiring close monitoring. Research has suggested that an
inadequate number of nurses employed in acute care hospitals provide the increased intensity of care required to meet patient needs (O’Brien-Pallas et al., 2005; Priest, 2006). Other researchers suggest that quality practice environments are those with adequate staffing and increasing the number of registered nurses can be expected to reduce the number of negative patient outcomes (Aiken, Clarke, & Sloane, 2002; Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2002).

In my observations, I noted nurses were generally able to complete their patient care activities without being harried. For example, one participant had seven patients on a weekend shift and was able to respond to several personal calls while commenting that not having a health care aide on their unit would create extra work for the nurses (Field notes #7, p. 46-48). On another unit, a senior nurse was paired with a junior nurse in caring for eight patients, and during this observation, I did not notice any staff member rushing to complete patient care. The nurse further explained that “today is not a good day because it is quiet” (Field notes, #11, p. 14 and p.17). In most observations, I had time to ask the nurse questions, and I spent considerable time at the desk while the nurse charted.

In summary, nurses’ perceptions of working short regarding a lack of staffing resources affected the way they viewed the quality of their work. Work activities became less controllable as a result of inadequate staffing, and compromised nurses’ ability to deliver patient care.

Contradicting Demands and Interruptions

All nurses expressed their concern over the frequency with which they were “pulled away” by competing organizational priorities resulting in nurses having to re-
adjust their patient care priorities. Nurses described competing organizational priorities as needing to temporarily stop direct patient activities and responding immediately to overcapacity alerts, prompt documentation of patient activities as they occurred, time pressures related to dispensing medications at the designated time, while also responding to a myriad of non-nursing duties. Nurses’ comments reflected a practice reflective of a specialized body of nursing knowledge requiring expertise and unique care requirements, as one nurse stated:

P: “...we had [specialized] patients, but we weren’t doing, the heavy [specialized treatments], that we are now –we weren’t looking after the heavy [specialized] patients that we are, we weren’t doing a lot of [specialized surgeries]. There was a change of physicians...they started to bring in more patients, more acutely ill patients for [specialized surgery], but the medications, the treatments and are just so more advanced....you couldn’t work with those people [patients] with the staffing level...It’s not attainable.” (#17, p. 24)

Nurses described re-prioritizing care as responding to the most pressing patient care issues such as preparing patients for tests, preparing patients for discharge, and providing medications. However, an element of unpredictability such as patient discharges, transfers, or admissions from the emergency department could arise demanding nurses’ complete attention. When this occurred, nurses were often required to re-prioritize by focusing on the most pressing and urgent tasks amidst a large number of patient care activities to enhance the manageability of their workloads. One senior nurse explained how she came to manage her workday without regular breaks:

P: “...you have no choice. ...I’ve done it for so long it doesn’t so really affect me now....I do watch it affect other people...[they] get a bit flustered and a bit short tempered....its just the stress of trying to manage everything. But if you prioritize, I think you probably, you may not feel like you’ve managed it well but at the end of the day you can look back and say I did manage that well. Everybody got their treatments, everybody got what they needed…and nobody was harmed.” (#10, pp. 2-3)
In some of these instances, I observed nurses carried out their work with limited support from a ward clerk, laundry personnel, or housekeeping. For example, on one unit, nurses were required to respond to several telephones: the regular telephone, telemetry telephone, and emergency department telephone. In some cases, there were more phones than staff, as nurses coped with multiple demands and disruptions resonated with what nurses said about the strained conditions of their work. Consequently, some of the emotional and psychological care nurses could have provided to patients was superseded by other demands, as one nurse explained:

P: “We do a lot of non-nursing tasks. A lot…if I were to write everything down and you could see…and its hard actually because you’re wanting to be with the patients more….but the phone is taking you away. You want to educate your patients more but sometimes you’re just speeding through the nursing tasks that you have to do in order to do the non-nursing stuff and I know a lot of staff members have, have voiced this, saying you know that stupid phone rings all the time and I can’t, I can’t be there to answer it. That’s not my priority when I’m dealing with chest pains, it’s not my priority when somebody really needs to talk to me or somebody is upset. I can’t go running to that phone. Just recently they’ve now added an extra phone to Unit 1 and Unit 2, so when you’re on the phone…on one of the phones and it’s busy the other phone rings, but sometimes you’re the only one at the desk…it’s just non-stop, right? Instead of getting us somebody to help answer that phone that keeps ringing, they’ve added another phone but not the actual person to answer the phone…Now we have three phones plus the call bell to answer…and sometimes all three of them can ring at once and you only have three people that can help you – it’s a lot.” (#3, p. 3-5)

This nurse is pointing out the frustration of having to respond to the telephone while also responding to the more complex patient care issues that arise. Many nurses echoed this concern suggesting that such disruptions fragmented their patient care especially given the more in-depth knowledge and skill required of a registered nurse.
Nurses spoke at considerable lengths about documentation and charting associated with new policy initiatives, patient safety and risk management. Such documentation altered nurses’ recording practices and established additional responsibilities. This prompted one nurse to state, “…your time is….mostly eaten up by….paperwork.” (#6, p.2). Another nurse indicated that “double charting or triple charting” occurred and that, in his view, the focus of nurses’ work had shifted from patient care to paper care (Field notes, #7 p. 51). In other words, nurses were required to document the same patient information on more than one form for quality improvement or risk management purposes, as one nurse stated:

P: I think that’s the main thing – the paperwork…we’re overloaded with…documenting stuff and charting and, which is very important as well, but…maybe that patient ratio, nurse to patient is…a little bit too high for doing all that stuff…basically every month it’s just getting more and more and more… (#7, p 6)

In summary, the complexity and diversity of competing priorities within the institution such as documentation responsibilities, adhering to policy regarding patient transfers, and non-nursing tasks occasionally overshadowed nurses’ time for direct patient care. Nurses learned to focus on the most pressing patient care activities in order to meet organizational efficiencies, thus contributing to disjunctures in patient care.

Being Controlled by Policies

Nurses participating in this study responded to organizational and unit policies during the course of their workday. First, nurses responded to overcapacity alerts (organizational policies) and to changes in the patient care delivery model (unit policies); second, nurses responded to work situation reports.

The organizational policy termed “overcapacity alerts” was something all nurses were required to respond to in the course of their shift. The overcapacity alert policy is a
mechanism the hospital implemented to ensure efficient bed utilization and cost-effectiveness of hospital beds. Overcapacity alert signals that the emergency department is filled to capacity and temporary bed spaces are created on units called “99 beds” as a way to redistribute and house more patients. What is significant is that these beds do not have the same access to call systems or equipment as patients in designated beds. The overcapacity alerts policy originally intended as a temporary measure had become routine. Nurses needed to accommodate the incoming patient regardless of what they were doing, and they frequently felt the distractions could undermine their full attention to patient safety. When an overcapacity alert was put into motion it was not unusual to observe, within minutes of the nurse receiving report, the patient already at the desk for admission to the unit and promptly taken to the designated bed. In this way, priority was given to bed space in the emergency department while other units, deemed to have lower acuity and more manageable workloads, were given patients without always checking with nurses to determine if they could safely accept a patient. One nurse described the situation:

P: ….So they…basically they announce it through the hospital and the discharges, we have to get patients out of here as fast as we can, um, get them discharged but half the time the physician isn’t even on the floor and you know you’ve got discharges so at that point, you may need to phone the residents and find out you need to discharge this patient, um, because we’re at overcapacity… (#3, p. 15)

This quotation illustrates that nurses were required to comply by responding promptly to organizational directives surrounding overcapacity alerts and bed management. When this occurred, nurses believed their patient care activities on the unit were temporarily suspended to support managerial goals and hospital efficiencies.
The purpose of daily “bed rounds” was to facilitate patient movement through the system to ensure bed space was used effectively. During one observation, the coordinator received a text message indicating that patients in other acute care hospitals in western Canada were waiting to be transferred to this location (Field notes #10, p.3-4). This suggests that there were forces beyond the unit and organizational levels over which management may have had little control with respect to bed management. Bed rounds were another form of organizational restructuring that was played out at the unit level, and for which nurses were responsible for integrating into their work. The literature on nurses’ work environments report hospitals support the policy of bed reductions while striving to meet the needs of more acutely ill patients despite having fewer nurses (O’Brien-Pallas et al., 2005). However, Blythe et al. (2001) reported that restructuring polices led to decreasing integration and ultimately to disempowerment for nurses, including a loss of control over work.

Nurses on one unit responded to changes in unit policies when they were required to switch from team nursing to primary care nursing as the new mode of patient care delivery, and respond to changes in documentation. It was difficult for nurses not to comply with these policy directives, as one senior nurse explained:

P: I told C [manager] that people were looking at policy changes and primary care and it was all lumped together because there’s so much going on…I think people were overwhelmed and I said, there’s a risk of people worrying, or putting the blame on primary care whereas they’re two separate things, so by dealing with one issue…it would have been less stressful for everyone and I think a smoother transition. But unfortunately it was sort of like…this is the way the policy is and, she was getting pressure to the primary care [model] so everything kind of bang at one time…I hope we don’t have to go through a period like this again… (#25, p. 24)
Nurses talked about work situation reports. When working conditions were unfavourable, nurses completed work situation reports highlighting what was happening on the unit that could potentially lead to patient safety issues. Work situation reports were submitted to the manager and to the Saskatchewan Union of Nurses (SUN). According to one participant, the committee was a year behind in processing work situation reports. Kanter (1977;1993) asserts that powerlessness results from not having powerful alliances to help individuals manage institutional bureaucracy. Although nurses had peer connections with the union, they remained dependent on formal procedures that flowed through a multi-layered chain of command within the institution. This may suggest that timely decisions necessary to alleviate some of the repressive working conditions were not attended to, and nurses remained in a cycle of powerlessness illustrated by their comments that completing work situation reports was commonplace.

The work situation report served to protect the nurses should a patient incident, medication error, or patient complaint occur. When nurses’ workloads were unmanageable and there was inadequate staffing or an influx of patients from the emergency department, nurses completed work situation reports because these events often impinged upon his/her ability to manage workload demands. Work situation reports served to make visible to the manager and administration the conditions in which nurses’ worked and how adhering to policies could affect nurses’ ability to safely manage patient care.

In summary, the nature of policies appeared as an organizing and dominant feature in nurses’ work. Policy decisions made elsewhere in the organization re-organized nurses’ judgment and actions in line with managerial imperatives, and occasionally
undermined nurses’ capacity to enact patient care they deemed necessary due to the
nature of juggling patient care and organizational demands.

Jeopardizing Patient Safety

In this study, organizational priorities influenced nurses’ agendas and increased
the scope of their workloads, and they lived with the ever-present threat of jeopardizing
patient safety and their professional licenses. Nurses unanimously described the notion of
being on constant alert to not jeopardize patient safety nor jeopardize their professional
license, as one nurse explained:

P: …maybe I’m just realizing it more because I’m feeling more overwhelmed and
stressed and tired, but I’m hearing it too from the senior staff that the patients are
getting sicker, and the staffing hasn’t changed….I’m noticing that people are
getting burnt out….I’m noticing patients saying to me, ‘You look so busy. Like
I don’t want to tell you this or, you know, you, you just, you don’t seem like you
have a lot of time’…

R: So what does short staffed mean here?

P: Patient safety is compromised – bottom line…you’re just being pulled in every
direction so how can you possibly be working 100%? Like you can’t be…you
cannot be…working at a good…mind level I guess. You’re tired, you’re being
pulled at every direction, the phone is ringing, you’ve got orders that needs to be
checked, you’re got charting you need to do, you’ve got a bunch of different
things and you’re multi-tasking…I don’t care who you are, you can’t multi-task
all the time and be perfect at doing it. You’re going to make mistakes. (#3, p. 8-9)

In the majority of interviews, nurses spoke matter-of-factly about not having choices or
control over situations influencing their workloads, as one nurse explained regarding a
patient being directed to her unit because of an overcapacity alert:

P: You have to take that patient from emerg because emerg is in the situation its not
safe downstairs…

R: Is it safe for you?

P: Nope. Not necessarily…its one of those [situations] where you feel that you don’t
have the rights, because you can’t…we’ve tried, we’ve tried to say no, we’re too
busy...we’re told we absolutely have to take that patient, no ands, ifs, or buts, we are bringing up that patient now, they will be up in five minutes....we always get told ‘Oh you’ll manage, you’ll manage, you’ll manage’, and you know, you just say why? Why do we have to manage? Could you not just give me five minutes and if you could just give me five minutes then it would be so much safer. (#5, p. 24-25)

These excerpts illustrate that although it was sometimes unsafe for patients to be received onto the unit, overcapacity alerts did not preclude the re-distribution of patients from the emergency department to their units, thus potentially compromising patient safety but also nurses’ licensure. When individuals do not have access to resources, information or support they experience powerlessness (Kanter, 1977; 1993). These individuals may feel excluded from organizational decision-making, and are accountable without power.

That nurses seemed not to have any apparent control over limited resources and policy directives while being held responsible and accountable for providing safe patient care caused nurses to be in a state of hyper-vigilance, as one nurse explained:

P: Somebody fell because you were just so preoccupied with other things that something happened and perhaps an occurrence report was written…Well I almost gave the wrong pills to the wrong person ‘cause it was like ten call bells ringing like constantly. You know, like what I mean is like you got distracted because the call bells [are] ringing constantly …and just like well, I almost give the wrong pill to the wrong person but yeah, like you know, there’s a lot of near misses like oh my gosh….. (#11, pp. 18-19)

Nurses were constrained by a myriad of interruptions and demands in their practice. Although less obvious, nurses frequently found themselves distracted by numerous demands while simultaneously keeping track of multiple details in their minds. When policy directives, limited resources, and workloads were added to nurses’ workdays, nurses became more fearful they would endanger patient safety and/or put their own professional license at risk. These findings are consistent with previous research that
suggests that overworked nurses and work pressures could jeopardize patient care (Baumann et al., 2001). In addition, changes in work patterns where nurses have fewer breaks, less time to recover before returning to work as a result of inadequate human resources, combined with increasingly demanding workloads challenged nurses ability to provide safe patient care and may increase the risk of making errors (Rogers, Hwang, Scott, Aiken, & Dinges, 2004).

In summary, nurses complied with organizational demands but experienced unease and an undertone of vigilance over their ability to provide safe patient care while not jeopardizing their licenses. Nurses frequently found themselves re-prioritizing patient care amidst a myriad of non-direct patient care priorities for which they were responsible and accountable while staying alert for patient safety.

Section Summary

In this section, I have described how the environment within the unit/organization influenced nurses’ ability to carry out patient care activities. For the most part, the unpredictability, constancy and immediacy of nurses’ work were influenced by the efficiency mandate of the hospital. Organizational imperatives hooked nurses into incorporating its mandate, practices, and efficiencies into their work. The regulating features of resource constraints, policies, and contradicting demands and disruptions led to less integration of patient care. These contextual factors increased nurses’ vigilance over patient safety and served to re-organize nurses’ professional judgment and the nature of nurses’ work surrounding their patient care practices.
In the following section, I shift the focus from policies, financial practices, and other contextual factors to nurses’ relationships with their managers. I locate the head nurse role in a socio-historical context and compare it to the contemporary nurse manager role laying the foundation for the further explication of nurses and nurse managers relations that follow.

**Acknowledging the Restructured Role of the Head Nurse**

Prior to health care reform and the transition of the head nurse to the manager role, a head nurses’ proficiency was judged through relationships with staff and clinical expertise to support the operation of the unit. The traditional head nurse responsibilities included staff scheduling, work supervision, and mentoring nurses in their practice (Fullerton, 1993; Rankin, 2003). The head nurse was viewed as a highly visible clinical expert and served as an adjunct to patient care when nurses’ workload became heavy (Rankin, 2003). Among other things, the head nurse focused on patient care by attending shift report, was knowledgeable about patient conditions, and served as a pivotal point of communication between physicians and nurses by updating physicians on patient conditions and acting as a liaison (Fullerton, 1993; Rankin & Campbell, 2006).

Prior to health care reform, patient care was not dependent on critical pathways to expedite patient discharge from the hospital. There was less sophisticated technology and less complex therapy, and nurses did not need to contend with the intensity of highly regulated work environments (Rankin & Campbell, 2006). Financial and human resource issues, although important to the successful viability of the organization, were not something the head nurse was directly responsible for and did not enter nurses’
consciousness at the bedside (Fullerton, 1993). Nurses could focus their energies on what they believed was their role: providing individualized patient care.

The sociopolitical environment in which the head nurse enacted the role was also different from the resource driven environment today (McGillis Hall & Donner, 1997). Throughout the 1990’s, health care was fuelled by interest in improving efficiencies in Canada’s health care system as the government sought to improve and sustain services (Kirby, 2002; Romanow, 2002). The contemporary role, under the official title of nurse manager, is to ensure the effective operation of a defined service unit in an organization and the quality of care by working through others (McGillis Hall & Donner, 1997; Nicklin, 1995). In accordance with this title, the nurse manager’s role focuses more on managing resources and maintaining efficiency than on caring for patients. Nurse managers frequently have responsibility for more than one unit, and as a result, have more people directly reporting to them, which determines the number of interactions expected of them (Counsell, Gilbert, & McCain, 2001; Lucas, Laschinger, & Wong, 2008; McCutcheon et al., 2009). In this study, nurses characterized the nurse manager’s role as focused on attending meetings, responding to the budget, and responding to paperwork, while the clinical aspect took a secondary role.

Although it is not my intent to construct a romanticized version of the past, the role of the head nurse and his/her association with direct patient care facilitated more collaborative relationships with staff with regard to the common goal of supporting patient care. This was possible because head nurses did not need to contend with contemporary corporate practices. Health care restructuring has shifted the mechanisms of power for nurses. The discourse of efficiency has resulted in an increased emphasis on
text-based practices such as charting, clinical pathways, and discharge planning for nurses (Rankin & Campbell, 2006). These textual practices have assumed some supervisory responsibilities that facilitate nurses’ ability to do their work more effectively and efficiently, thus distancing the manager from the supervisory role.

I now make visible the contextual factors that mediate the relationships between nurses and their managers, and how this shaped nurses and managers’ judgments, actions or inactions. Nurses experienced a range of both positive and negative aspects of power depending on the situations they found themselves in with their manager.

There were three factors related to the managerial role that influenced relations with nurses. First, there was lack of nurse manager visibility because of frequent managerial turnover, which I have labeled a “revolving door” syndrome. During the course of this fieldwork, contact was made with five nurse managers from three units. At the beginning of data collection, the tenure of nurse managers ranged from two weeks to 18 months in duration. On one unit, two managers occupied the manager role during my 12-month fieldwork experience. On this unit, the nurse manager arrived two weeks after data collection started and resigned two months later. Nurses did not have an opportunity to get to know their manager and her expectations before she left her role.

Second, the majority of nurses referred to “management” throughout their interviews as the individuals responsible for making decisions on the unit. When I would ask for clarification as to whom management was, nurses sometimes were reluctant to identify whom they were referring to for fear of retribution. One nurse cited her fear that her vacation may be withheld but could not provide evidence to support her claim. Some nurses would identify whom they were talking about but would quickly revert to using
the term interchangeably when referring to the middle manager, first-line nurse manager, coordinator, or nurse educator. The gulf between managers and nurses was evident as nurses’ speech reflected inferences of “nurses versus management.” Nurses in this study had difficulty forming meaningful relationships with their managers because of the turnover of managers. Manager turnover contributed to nurses’ sense of estrangement or disconnection to those in positions of authority and created a barrier between the manager and nurses.

Third, each unit had an assistant to the manager whose title was clinical coordinator. The coordinator functioned more like the traditional head nurse and was described as being on the unit at all times and serving as a clinical resource for nurses. Like the traditional head nurse, the coordinator was committed to clinical practice as evidenced by making patient rounds and personally assessing all patients under her care. The coordinators were described as focusing on patient care, being more hands-on, not focusing on the budget, and offering assistance either by obtaining extra staff or by physically assisting nurses in patient care. While the differences between the coordinator and former head nurse role appear negligible, health care restructuring has lead to new accountability structures related to programs, protocols, and policies for managers (Rankin, 2003). New ways of working for nurse managers has led them to distance themselves from patient care and nurses’ work on the units, and actively engage in the discourse of efficiency and productivity in meeting authorized organizational goals. In turn, this causes nurses to participate in efficiency discourses whereby they maintain their practice in correspondence with the organization’s restructuring mandate (Rankin & Campbell, 2006).
Relating through Disconnecting and Connecting

In this section, I explore how interactions and communication influence the way nurses relate through: i) disconnecting in their relationships with their manager, and ii) connecting in their relationships with their manager. First, I begin by demonstrating how disconnecting explained how working without an anchor and how silencing forms of communication compromised nurses’ ability to meaningfully engage with their manager. Most notably, the analysis of the research data reveals that nurses were directed by bureaucratic policies and practices of the organization in the absence of the manager. This was made worse when communication with the manager was flawed as a consequence of nurses having fewer avenues for transmitting concerns to their manager. More specifically, as relationships between nurses and managers grew distant the more isolated and powerless nurses became, and power was maintained over nurses. Second, I explore how connecting illustrates how the manager’s behaviour and communication style facilitated the stepping up of power and influenced nurses’ ability to more successfully manage patient care.

Working Without an Anchor

In this category, nurses described engaging in their work without the consistent and reliable support of their manager, however, the extent to which this occurred for each nurses varied. Nurses characterized the manager as subordinating nursing and patient care practices in favour of the managerial imperatives of the organization. Nurses further characterized these work environments as working in isolation from the manager, having limited trust and confidence to act based on the decisions and actions of the manager. Nurses’ conceptualizations of working without an anchor were comprised of three main
sub-categories: (i) being out of sight and mind; (ii) encountering limited know how; and (iii) sealing unease.

Being Out of Sight and Mind

Nurses described the managers’ lack of visibility and accessibility on the unit as shaping their practice. The manager’s lack of visibility and nurses’ inability to interact in a regular and consistent manner exacerbated nurses perceptions of working in isolation, and adversely affected their access to knowledge and engagement in decision making.

Nurses believed the nurse manager needed to be visible on the unit to understand patient needs, to understand the work and time constraints nurses faced, and to deal with patient and family issues beyond nurses’ control. At times, the manager’s lack of availability impacted the ways in which care was provided. For example, patient admissions during an overcapacity alert made it difficult for nurses to respond effectively to other nursing activities. Nurses perceived the nurse manager’s lack of awareness of what was happening on the unit as a dissonance between the needs of patients and the manageability of nurse’ work:

P: …she never came for report – like the charge nurse report, she wasn’t there and so she didn’t really get to know the patient and understand…our acuity situation, therefore…before she was going to even withdraw some of the staff from some of the night shift staff…(#15, p. 8)

Because the manager was physically not visible and maintained limited contact, some nurses did not find the manager approachable nor did they believe the manager was willing to engage with nurses. Limited interactions between nurses and their manager impacted the quality and quantity of information exchanged. Therefore, nurses were not comfortable discussing issues or concerns that were important to them. One nurse explained:

...
P: …the first thing I noticed for sure was that she, there was a lack of approachability and personability. Like she….she was never, almost never accessible to anyone on the floor like for any reason whether it was to do with staffing issues, workload issues, with the basic needs, applying for vacation I guess – just things that a day to day manager should be able to…She just wasn’t ever willing to…discuss anything. Like it seemed like there was always something more…pressing that always took her away from the floor and I think…yeah, if they’re not someone that you feel like you can approach and someone that you can talk to it’s a big barrier between…between the staff and that I guess. It’s, it’s a huge thing to have someone that you can approach… (#18, p. 2)

In summary, nurses perceived the manager’s lack of perceived interest in patient care situations and a lack of visibility as a barrier to meaningful engagement, exacerbating a lack of trust in their manager. Kanter (1977;1993) identified support and positive feedback from a manager as a key function to maximize employee effectiveness and the opportunity to exercise discretion in one’s job as important components of the organizational source of power. Nurses in this study indicated they experienced a sense of isolation without the guidance of their manager as they struggled to merge safe patient care practices with institutional demands that interfered with quality patient care.

Encountering Limited Know How

This sub-category describes nurses’ accounts illustrating their perception of the manager’s insufficient clinical knowledge and experience for their designated unit, and insufficient managerial experience. In nurses’ views the manager had limited clinical knowledge and experience which constrained her ability to understand the complexities of nurses’ work and advocate in the best interests of nurses’ and patients’ well being, as one nurse noted:

P: She needs to be involved in…in day to day, like the ward and I find she…she came in, she started at the top going to meetings, um, not really on the ward, she doesn’t have a very a….broad knowledge base for nursing. (#14, p. 20)
Nurses on one unit viewed the manager as being ‘closed off’ to learning when nurses perceived a lack of motivation and willingness to learn about patient diseases and conditions relevant to the patient population of the unit, as one nurse explained:

P: …but she’d also made a remark that she wanted to read some…you know, some…documents that he [physician] had to further her knowledge in the area and he’d offered her whatever and she said, “Oh, you know, maybe not.” Like…and sort of backed off again… (#17, p. 23)

Two nurses believed they were delegated disciplinary responsibilities when the manager appeared to be unable or unwilling to respond to employee performance issues. In this situation, the manager asked the nurse to speak to a patient because of that patient’s complaint lodged against another nurse. Assigning a performance issue to a nurse signaled that the manager may have had limited ability to intervene in an effective manner and was deemed an inappropriate delegation of a manager’s duties. One nurse explained:

P: …she’s asking us to do manager things….not realizing that I’m a regular staff nurse – I can’t do that….You know, I can’t….talk to a staff member about something that they’ve done – that’s your job…..to reprimand them. (#13, p. 26)

On another occasion, nurses’ perceptions of the manager’s limited managerial knowledge and experience were evident when it came to budgetary management. In this situation, the manager approached a senior nurse for guidance in trying to clarify how the budget worked on the unit. In this nurse’s view, the manager’s lack of knowledge in managing a budget was evident:

P: …I lost that, that feeling with her ‘cause I just felt that really she, she didn’t have as much of a background in [the unit specialty] that she’d been made out to have – like it was very lacking….Within the first week of working with her…she…would come up to me during shift and, and ask some really strange questions like how is the…the budget worked out for, you know, staffing like the lines that were still open needed positions filled or who was funding them – was it the health region or was it…the extra money coming on or is that our base? Was
the positions vacant, was that our baseline or was that what we need to achieve to get to our goal… (#17, p. 4)

In summary, nurses viewed the manager as having limited clinical knowledge and experience as constraining the manager’s ability to act as a resource and advocate for nurses’ ability to deliver safe, quality patient care. Nurses described this as not feeling confident in the manager’s ability to effectively lead and manage the unit in light of multiple and competing organizational demands influencing nurses’ work. Laschinger and Shamian (1994) found managers that have organizational power can create work environments that allow subordinates increased access to the resources necessary to achieve organizational goals. Yet in this study, nurses did not perceive the manager as being consistently and effectively getting things done in the organization, suggesting that managers’ limited power shaped nurses’ sense of power. Nonetheless, a lack of common ground regarding clinical knowledge increased the gap between nurses and their manager and the relationships became more distant. Moreover, Roche et al. (2009) found that the role of the acute care nurse requires complex clinical decision-making skills to respond to the increased patient acuity, decreased length of stay, and the need to monitor patient safety. In their study, nurses viewed the role of the manager as providing them with support, opportunity, resources, and information and they credit the work relationship with the manager as enabling them to perform at a higher level of expertise, ultimately enhancing critical relationships with patients and their families.

From another perspective, Lukes’ (2005) three-dimensional view of power describes power that can be hidden by manipulating roles and identities. This could be interpreted as nurses’ participation in using covert expressions of power to remove the manager from her role. More specifically, this could be viewed as nurses’ unwillingness
to accept the authority of the manager giving them the right to assess their manager’s ability to lead the unit. Undermining the manager’s experience may have been a way for the nurses on this unit to conceal their desire to maintain control of the unit.

Sealing Unease

A third sub-category was described as the manager interacting with nurses in inappropriate and demeaning ways, exacerbating strained relationships and reinforcing distrust in their leader. Nurses described this as a lack of regard by the manager especially when such situations occurred in front of coworkers and/or patients and their families that aggravated the nurse-manager relationship. In the limited interactions nurses had with their managers, nurses would sometimes report being “grilled” as to why they required extra human resources to facilitate patient care. One nurse explained:

P: …there’s a lot of questions about if you did ask for a sitter to come in…she’d a, you know, really grill you about why are you doing this? ….is this really appropriate…It was just that, you know, she’s looking at the dollar figure more than…how stressed we were at work or what our work environment was…and lots of questions about do we really need two RN’s in this area? You know, can we get away with an RN/LPN type thing? And, you know, we’re, we’re short everyday as it is so…it really puts a lot of stress on you to hear that… (#16, p. 3)

This quotation illustrates the nurse perceived the manager as using the authority of her role to interrogate the nurse regarding the financial implications of securing additional staff. In this nurse’s view, the manager sidestepped the issue of trying to discern what prompted the nurse to seek assistance in the first place. This excerpt suggests that power was used to shape the nurse’s perceptions in such a way that the nurse was to accept her responsibility in not being able to satisfactorily meet her workload (Lukes, 2005). This was a way for the nurse to accept her role in this situation without questioning the real reason for acquiring additional staffing.
Nurses perceived the manager or coordinator sometimes labeled them as “lazy” or “good” nurses, and this label seemed to be related to the level of support received. According to one nurse, the nature of a good nurse was perceived as someone whose request for support or resources was deemed credible and valuable by the manager, and assistance was rendered. Judgments of a lazy nurse by the manager was perceived as someone who could be accomplishing more than they were and was not worthy of being afforded assistance to facilitate patient care. How each of these labels were determined was not clear. In this nurse’s view, she believed her professional judgment was not seen as credible and valid when she requested extra support. She stated:

P: …why can’t you just listen to me the first time when I tell you I need help. It seems like you have to do a big production to get more help and it shouldn’t be like that. And then they question….what kind of nurse is that nurse? Is she a good nurse? Can she handle this? …if she’s a good nurse, then maybe…she does need help because she’s telling me this but if she’s a lazy nurse, then maybe she doesn’t really need help…So it, who it’s coming from to say you need help, I think that’s evaluated sometimes before they even get help but…why wouldn’t you just get help if the nurse is saying I need help?... But when you’re not being listened to, you get frustrated and it’s like people don’t care….you don’t feel very good.” (#3, p. 21 and p.23)

This quotation suggests that this nurse perceived she was being judged and labeled based on her motivation or competence, or lack thereof, by the manager when asking for assistance. This nurse did not perceive herself as being able to perform her work nor did she have a sense of control over how she carried out her job without the support of the manager to accomplish her work (Kanter, 1977; 1993; Spreitzer, 1995).

In another situation, a senior nurse expressed her dissatisfaction with a manager who judged nurses’ inability to complete their work in a predetermined time. This nurse explained how the manager’s random attention to nurses’ work highlighted the manager’s
lack of understanding of the complexity and circumstances surrounding patient care and the contextual demands on nurses’ practice. She explained:

P: …On the other hand, if they’re [manager], if they’re constantly off the ward…and leaving it all to the staff and the charge nurse to do and never really knowing what’s going on with these people, except for to go on rounds…and then go to meetings, meetings, meetings, then I think that affects us as a person ‘cause then…they come and say, ‘Well why isn’t this done, why is…’, and you go, ‘Well where were you today?….‘If you were here more…it wouldn’t be so stressful for us… (#10, p. 54)

This nurse experienced a lack of recognition from the manager for the work accomplished, a lack of support from the manager, and perceived herself to have a lower level of competence as a result (Kanter, 1977; 1993; Spreitzer, 1995).

At times, nurses perceived a high level of stress on the unit evoked inappropriate and critical responses from the manager toward them. One nurse explained how she experienced feeling degraded by the manager in front of a co-worker after pointing out that as charge nurse she noted a high number of nurses on vacation on the staffing schedule while the unit could not meet appropriate staffing levels. She explained:

P: ….I was in her office one morning for something and she was talking with another staff member and she told me that…she didn’t appreciate that…when I say things like that [highlighting a lack of staffing in a document that others could view] that makes her feel like not coming to work, very petty….then continued to go up one side of me and down the other about everything, really everything…I felt that was really inappropriate, she never apologized to me but she apologized to the co-worker who was….in the room… (#24, p. 31)

This excerpt illustrates that the nurse perceived she lacked support from her manager, which may have contributed to the nurse’s sense of powerlessness. In addition, the nurse was not able to establish positive relations with her superior and may not have been able to accomplish her work in a meaningful way. The hierarchical nature of nurses’ work environments reveals the manager has more access to support, information, and resources.
than staff nurses, but if the manager is unwilling to share power, the situation may de-motivate nurses (Kanter, 1977; 1993). The manager may have perceived herself to be disempowered and demonstrated a controlling demeanour in an attempt to maintain what little control she may have had (Kanter, 1977; 1993). The manager’s behaviour prevented a climate of trust and respect from developing fundamental to innovative and creative work practices (Knol & van Linge, 2009; Sofarelli & Brown, 1998).

In summary, nurses experienced a sense of unease and vulnerability when he/she was the target of the manager’s frustrations and inappropriate remarks. Nurses believed they did not consistently have the support, autonomy in determining how they would accomplish their work, and they felt they were not consistently listened to (Casey, Saunders, & O’Hara, 2010; Kanter, 1977; 1993; Spreitzer, 1995). These strained relationships intensified nurses’ sense of being undervalued and resulted in disengagement with their manager. Creating work environments that encourage professional practice by empowering nurses to act on their expertise is an essential strategy for fostering trust within organizations (Laschinger, Finegan, & Shamian, 2001a).

To sum up, working without an anchor accentuated the tension nurses experienced between meeting organizational imperatives while providing patient care, without the consistent and active engagement of the manager to facilitate and guide professional responsibilities. Some nurses experienced distant and strained relationships and a sense of vulnerability in their encounters with the manager. Taken together, nurses perceived a sense of isolation and lack of support from their leader and lack of recognition; hence, they experienced a sense of powerlessness in their work efforts.
Silencing Forms of Communication

Silencing forms of communication refers to how communication patterns between managers and nurses were circumscribed reinforcing the isolation nurses experienced. Nurses’ lack of ability to form connections with the manager was underscored by limited and/or a lack of a forum for communication. Silencing forms of communication occurred within individual nurses and within an interpersonal interaction. As sub-categories, silencing communication included: i) communicating and enforcing policies; ii) assuming a silent role; and iii) being trapped.

Communicating and Enforcing Policies

Nurses’ input into the policy changes implemented on the unit and affecting their work was either circumscribed or non-existent. Nurses were frequently forced to comply with the manager and/or management’s policy changes without face-to-face dialogue or collaboration that solicited their viewpoints. Nurses described policy decisions focusing on changes to staffing levels, changes to the patient delivery model and documentation, and adjustments to the timing for clearing of intravenous machines.

Nurses on one unit talked about the absence of a mechanism for two-way communication between staff and the manager especially regarding the implementation of a new patient delivery model – from team nursing to primary care nursing. Nurses received notification of the policy change, along with other less significant policies via electronic mail and a memo posted on the staff bulletin board. The manner in which the policies were imparted from the manager gave the impression of a non-negotiable edict, as one nurse noted: “Talking to C [manager] she says we’ll use it as a guideline but everything seems to be kind of set in stone…” (#25, p. 3). Another nurse described the
lack of input into the changes to the patient care delivery model on one unit in the following manner: “It [patient delivery model] kind of came out of left field and just kind of landed and we were told to scurry away and do it” (#20, p. 29). Associated with critical social empowerment, nurses did not perceive themselves as being involved in decisions affecting their work in the organization (Casey et al., 2010). From Kanter’s perspective (1977; 1993), nurses did not perceive there were rewards for innovative work because decisions made by those higher in the managerial hierarchy reduced nurses’ autonomy.

Nurses expressed strong sentiments regarding the changes the patient delivery model had on their work. For example, one senior nurse affected by this unit policy change reacted negatively by stating: “Some of the girls have said, they feel more like they’re nursing policies right now…” (#25, p. 16). Nurses were not able to describe neither how primary care nursing was to be implemented nor how it would result in better patient and nurse outcomes. Nonetheless, these excerpts illustrate that nurses perceived the switch to primary care as a non-negotiable edict.

A lack of clear and direct expectations created confusion about the chosen patient delivery model in the absence of a forum for meaningful communication. To compensate for a lack of formal meeting opportunities regarding the implementation of the patient delivery model, the educator scheduled brief meetings prior to the day shift for one week as the policy change was being implemented. One senior nurse explained:

P: And I know there was some meetings just prior to doing this to discuss staff concerns…was sent out in an e-mail and I’m probably the only person on the ward that doesn’t have a computer or an e-mail…I didn’t know anything about it but…people told me it was like from 7:25 to 7:30 which I don’t feel was much time to address any…So just before shift change. (#25, p. 9)
This excerpt illustrates that time was made for staff nurses to ask questions regarding the new patient model, yet, the quality and quantity of the exchange between the nurses and the educator was circumscribed by time allotted for discussions, and by nurses’ likely preoccupation with beginning their shift. The social interaction between nurses and the educator limited the opportunity for meaningful information and support to be communicated, and hindered nurses access to knowledge and feedback necessary to carry out their job (Kanter, 1977; 1993).

In summary, limited opportunities to communicate with their manager left nurses with minimal understanding of and participation in policy decisions affecting their work for which they were responsible for implementing. These findings suggest that managers who promote opportunities for nurses to participate in decision making by communicating openly and providing support enhance perceptions of empowerment (Casey et al., 2010; Kanter, 1977;1993). Nurses who feel they have a sense of control over what happens in their workplace often have managers who value their decisions, leading to a sense of control on the part of nurses (Spreitzer, 1995a; 1995b). The process of information sharing can facilitate nurses’ understanding of organizational needs and establish the foundation for more trusting relationships (Blanchard, Carlos, & Randolph, 1999; Laschinger et al., 2001a).

Assuming a Silent Role

Rather than assuming a leadership role in executing a change process by preparing and meeting with staff, the manager assumed a “silent role,” and let the educator assume the role of “pushing” the policies, as one nurse explained:

P: …from what I see, just my general view of being full-time, just a general staff member here…she [manager] …has a very…silen, it’s almost, not like a silent
role but through this whole thing I, she never discussed…I’ve never actually heard her discuss any of the changes that have recently happened with any of the staff except on a one-on-one. If you approach her and have a conversation with her, then she’ll explain to you the reasoning and, you know, sit down with you and talk to you but…she’s not one to approach a whole, like have staff meetings and hold staff meetings – she’s never done that. (#23, p. 3)

Despite a number of one-to-one conversations between nurses and their manager signaling nurses had concerns and reservations about implementing the model, action was not taken to provide a forum for discussion, as one nurse stated:

P: They were kind of closed minded about the issue [patient deliver model]…I know people did raise concerns to C [manager]. I don’t think many of peoples concerns that were brought up were addressed…until we got into it…I guess they listened to peoples concerns but didn’t do much about it. (#22, p. 14)

A lack of substantive action by the manager may have intensified the silence on issues she was not willing to negotiate. In the manager agreeing to meet one-on-one with staff, the manager held the balance of power, which may have shaped nurse’s responses and actions. One nurse explained:

P: What’s, what’s the fear of having…staff input? ..That, that your idea won’t automatically be agreed with?

R: So why do you think it [no forum for communication] was done that way?

P: Because of the idea that we would buck change. That we would…not embrace that idea. (#24, p. 39)

In contrast, another nurse disagreed with the notion that the educator was responsible for “pushing the policies”. She suggested that the educator became the target of pushing policies because nurses resented her lack of experience as a staff nurse on the unit. Hence, the educator became the voice for driving the policies forward, but the manager was complicit in the change by not restricting the educator’s actions. This nurse explained:
P: …I think that there’s… I think there’s this real feeling that a lot of it [pushing policies] comes from her [educator] but I don’t know that it definitely does… people don’t like her period… (#24, p. 37)

This excerpt illustrates that nurses came to unleash their frustration on the person most vocal in driving the policy agenda for nurses. Through the educator, nurses were being acted upon to carry out a practice required by management, which they resisted (explained more fully in a subsequent section). The educator became the scapegoat - the individual responsible for nurses’ frustration because she was viewed as less powerful than the manager was. To that end, the majority of nurses on the unit experienced contempt for the educator and categorized her as inexperienced and not having the qualifications to support such a change. The educator did not have authority over nurses to actively engage them in enacting the unit policy. In turn, nurses may have used the educator’s lack of formal role, to resist (Kanter, 1977; 1993). Nurses’ perceptions of a lack of support from their manager may have contributed to the fragile relationship between nurses and their manager.

Due to the lack of a forum for nurses to engage with their manager, one of the nurses in the study, who was also the union representative for the unit, met with the clinical coordinator and the educator to discuss nurses’ concerns with the patient delivery model. She explained:

P: She [manager] wasn’t at that meeting… she was ill at the time… But I know there is some resentment there because of it… Which actually, the union lady told me, my boss as well as another one [manager] that are new managers, and don’t have a lot of experience, are very angry about it but other ones [managers] that have the experience just think it’s part of the process and this is… what your staff needs… (#24, p. 15)

This quotation suggests that although nurses had a forum to voice their concerns about issues of importance, nurses were required to take the initiative to meet with the manager.
Because this forum allowed nurses’ voices to be heard by union leaders and senior management, the optics of this strategy may have had negative implications for how the manager could be viewed by senior management. Access to managerial support, regular feedback, and information to discuss concerns is crucial to empower staff (Kanter, 1977; 1993).

**Being Trapped**

Nurses recognized that managers had demands and constraints that affected nurses’ work, even though they were not always clear what those demands entailed. One nurse pointed out that the reason why nurse managers may have limited an exchange with nurses was that managers were sandwiched between meeting their superiors’ expectations and contending with nurses’ defiance to proposed changes. Because the manager had limited maneuverability to execute certain courses of action, obtaining input from nurses may have been deemed futile. Nurses described minimal support from their manager in receiving feedback or guidance, which limited their ability to be involved and provide suggestions for improving the delivery of care (Casey et al., 2010; Kanter, 1977; 1993).

However, a junior nurse highlighted a reason why the manager was not able to provide a satisfying workplace for nurses:

P: Their hands, everyone’s hands are tied and we’re all standing looking at each other with our hands bound behind our backs because…

R: So whose hands are tied?

P: I think the managers. (#5, p. 29)

Limiting communication with the nurses seemed to be a natural outcome of nurse managers’ own pressures. So because the nurse manager had pressure to facilitate
change, holding information sessions and fostering communication consisting of face-to-face dialogues where nurses could ask questions and express their frustrations may have only added to nurse managers’ own pressures from hospital administrators. In this way, the manager could remain focused on ensuring organizational priorities without engaging in dialogue with nurses that would deter their course of action.

To sum up, *silencing forms of communication* that would foster dialogue between the manager and staff nurses were frequently circumscribed or rendered inactive. Promoting a one-way form of communication where there is a limited forum to exchange ideas or provide feedback was a way for managers to decrease their vulnerability by silencing nurses, reducing conflict, and maintaining power over them to advance organizational directives. Lukes (2005) describes institutional power as most effective when it is maintained by socially structured and culturally patterned practices within an organization to secure compliance to domination. This renders an individual unable to take action, and as such is effective within a bureaucratic structure. This was a way for the manager to maintain control over a polarized situation between herself and the nurses as each struggled for control in how contextual factors would influence nurses’ work.

**Stepping Up of Power**

Nurses also described positive interactions with their nurse managers. Nurses characterized the manager’s supportive attitudes and behaviours as a greater ability to meet professional standards of practice ultimately enhancing control over their work despite the contextual demands in the workplace. Nurses identified the manager’s willingness to interface with nurses by communicating and supporting them as creating the conditions for fostering nurses’ trust in their manager. As sub-categories, stepping up
of power included: (i) advocating and backing nurses; (iii) demonstrating nurses’ worth; and (iv) re-adjusting the mindset to nursing.

**Advocating and Backing Nurses**

Nurses described advocating and backing nurses as the manager acting as a liaison to support and/or resolve conflict between nurses and patients, their families, or other health professionals in the organizational hierarchy, especially when there was a power differential. One nurse described the manager as being a “higher source of power” who could advocate and support nurses in ways that facilitated their patient care activities. Nursing is practiced within the power of hierarchical structures suggesting there is widespread acceptance that nurses are in a subservient position to administrators and physicians who may demonstrate controlling behaviour (Kincheloe & McLaren, 2005; Lewis & Urmston, 2000). One nurse shared the following experience:

P: …I guess just a higher source of power. ..often on this unit we’ve had troubles with the physicians and …we ask them like something for the patient care needs and they don’t…agree with it or whatever so we’ll go to her [manager] with that but…a lot of our problems are with the physicians…I would say and then you kind of need someone at a higher source of power because there’s too much of a power space between the nurses and physicians. (#22, p. 3)

This quotation suggests that nurses constructed themselves as being situated in a power gradient where they frequently experienced themselves in subordinate positions and unable to take effective action on their own. On this particular unit, nurses viewed their limited nursing experience as a constraining factor in successfully advocating with physicians for the care of patients. When the manager intervened on their behalf and communicated with physicians, nurses viewed this act as an extension of their own success.
In another situation, a junior nurse explained how a manager affirmed her professional judgment and made her feel valued. The manager included the nurse in taking action, and the nurse felt supported and validated, as she explained:

P: …one day I had an interaction with the [nurse specialist] and it was a negative interaction for me – she made me very upset, I felt I was verbally attacked, I went right to my manager… I sat down in her chair and…rehashed what just happened…and she was great with that. She was so good with that. She validated my concern, she made me feel like… absolutely I was the right person to come to, absolutely I need to know about this. We need to write it down, we need to send a memo to her manager, they need to know about this – she made me feel really good about coming to her, that I had taken the right channels, everything. (#20, p. 20)

This quotation illustrates that the nurse identified herself as more powerful and able to take action with the guidance of the manager. These findings support the conceptualization of psychological empowerment by Spreitzer (1995) that suggest the nurse perceived she was capable of performing a task and believed she could make a difference to the outcome of the situation with the reliable support of the manager. In this sense, the manager may have replicated the traditional hierarchical structure within the organization accentuating the power differential existing between nurses, clinical nurse specialists (CNS), and their managers, by intervening on the nurse’s behalf rather than coaching the nurse to confront the CNS herself. This situation may demonstrate that nurses remain in a subordinated position by those considered more powerful who interfere either favourably or unfavourably into nurses issues. These power differentials for nurses with respect to others more powerful may weaken and perpetuate the domination of hierarchical nurse-manager relationships (Daiski, 2004).

Nurses also spoke about the manager who responded to staffing issues and did not hesitate to approve additional human resource personnel to help nurses do their work.
While this level of support was rare, nurses valued when the manager focused less on the budget and provided the extra human resources. One nurse explained how a nurse manager advocated for more nurses to hospital administration, and the unit received additional human resources to support patient care activities, as she explained:

P: …for year and years the manager had to argue, argue with upper management that, we’re not medicine. We need to be staffed appropriately …and finally….we finally got to a point where they started to listen…She broke the ice, now government’s listening… (#17, p. 25)

In summary, when the manager would advocate for nurses, this facilitated their ability to accomplish their work. From a critical perspective, nurses in this study perceived themselves in a “step-down” position (Kincheloe & McLaren, 2005; Kuhse, 1997), whereby they were not consistently able to take effective action with others without the “higher source of power” of the manager. These findings also support studies suggesting that access to structural empowerment affected nurses’ feelings of psychological empowerment leading to job satisfaction (Laschinger et al., 2004).

Demonstrating Nurses’ Worth

Nurses suggested the manager who actively listened and collaborated with nurses valued their professional judgment. Nurses expressed a sense of being heard when the manager demonstrated such behaviour, as one nurse explained:

P: ….and A [manager] seems to be, you know, she just started so she’s…brand new…Yeah, just getting to learn what we do up here and how we are but she seems very…very helpful like you know, we need new flashlights, she got us new flashlights. You know, like if we…ask for something it seems like within reason, she…she, you know, really understands it so…I think it’ll be good with her. (#2, p. 22)

This quotation illustrates that the manager’s interest in this nurse’s practice enabled her to feel supported by the manager. In this nurse’s view, access to the manager’s authority and
receptivity to the nurse’s request, enabled her to feel heard and enhanced her ability to provide patient care.

When the manager engaged with nurses, solicited feedback, and was receptive to their opinions and professional judgment in decisions affecting their work, nurses responded favourably:

P: ...when H [nurse manager] started for example, I was really impressed in the fact that she came around every day and introduced herself...until she had met everybody...for a few minutes, you know, on a day that you were working, just grabbed you for maybe ten or fifteen minutes and just asked you what you, you know, in her office so no one could listen or, you know, so you...free to say what you wanted...what would you do to improve the place or, you know, what do you think we need...what everyone’s concerns were...She really wanted to...to know what was going on... (#2, pp. 37-38)

This excerpt illustrates that the manager valued and encouraged nurses’ input into the decision-making processes on the unit and possibly the organization. The findings in this sub-category are similar to results by Laschinger and Finegan (2005) who found that nurse empowerment had an impact on feelings of being respected in their work and trust in management influencing job satisfaction. Aiken et al. (2001a) found that nurses who were involved in decisions affecting their work, had more autonomy and control over their practice. These organizational characteristics are consistent with the empowering environments described by Kanter (1977; 1993).

Nurses perceived the nurse manager understood the challenges they faced on the front lines when they were acknowledged and recognized for their efforts despite pressures and resource constraints. Nurses described experiences such as being told “thank you” for coming into work and for managing heavy workloads as the manager recognizing and responding to the challenges in their work situations, as one nurse reported:
P: “…just acknowledging and showing that something is going to be done and just sort of giving power back to the staff…just a little bit more, feeling like more power that we can actually talk to this person and get this addressed….a big issue with B [previous manager] was they didn’t feel they could approach her and when they did she had something that was more important on her mind”. (#16, pp. 17-18)

This quotation illustrates that the manager appeared to understand the stressors and limitations of nurses’ work. Attempts by the manager to secure additional human resources to alleviate nurses’ workloads and expressed sentiments of appreciation of their commitment made a difference to nurses’ job satisfaction. Similar to findings in this study, Laschinger et al. (2001a) found that nurse empowerment was associated with job satisfaction. Nurses felt their concerns for a more appropriately staffed unit were supported by the manager consistent with Kanter’s (1977; 1993) conception of structural empowerment.

In summary, nurses valued when the manager respected and encouraged their professional judgment, asked for their input on patient and unit matters, and recognized and acknowledged nurses’ contributions. Nurses perceived themselves as being collaborators, influential, and having control over their work when power was shared with them by their manager (Kanter, 1977;1993).

Re-adjusting the Mindset to Nursing

Nurses described readjusting the mindset to nursing as a cognitive approach the manager used to subordinate organizational priorities in favour of re-directing the focus to nurses’ work and patient care. This was characterized by the manager’s ability to redirect her judgments and activities from an organizational consciousness to the traditional expression of facilitating nurses’ work. When working together, this bridged
the nurse-manager relationship and created a more conducive work environment for nurses despite contextual pressures.

Nurses valued the visibility and accessibility of the manager on the unit and/or in her office for a variety of reasons. First, when the manager was on the unit, she could meet the nurses and be accessible as a resource or guide in resolving complex care issues. Nurses reported that the manager’s ability to control the flow of patient admissions and discharges, made their workloads more manageable. When managers were on the unit, they were able to gain a better grasp of nurses’ workload and of patient acuity, which facilitated their ability to understand nurses’ work, as one nurse implied:

P: …like today she was in [sub-unit] already just seeing how our day was and seeing if we needed help with anything um, and told us what we’d be getting from the operating room, what surgeries there would be and what movements we have…like who would move out of [sub unit] and who would come in…and she’s…in her office most of the day so anytime you really wanted to you could either leave a message with her in her office or…just go in and see her. (#22, p. 15)

Manager’s accessibility became especially important because of a large proportion of novice nurses who did not have the clinical experience needed to make complex care decisions. On one unit, nurses valued the manager’s presence because the majority of nurses had only two to three years of experience, as one novice nurse stated:

P: ….it makes my work easier and it makes you feel better too, she just comes…into like obs. [observation unit] for today if we had any problems we could just let her know when she was in there instead sometimes the little problems would get missed I guess because you forget about them and then…she’s not around to tell about them….I think…it’s better to be visible as a manager than not be around. (#22, p. 17)

Second, the manager’s accessibility to support nurses’ practice facilitated the manager’s approachability and enabled communication. There were a few situations provided in which managers assisted in patient care, and this reinforced nurses’
perceptions that the manager’s first obligation should be to patient care, as one nurse stated:

P: I think it was actually one of those days when we were short staffed and we just had no, no time to make transfers to take this patient from emerg and I was talking to B [manager] and she’s like do you want me to call the CPAS [patient/bed management] and let them know where you’re at because I will definitely do that for you- like I’ll let them know there’s no way we can take anymore [patients] right now. (#18, p.12)

This excerpt illustrates that this nurse viewed the manager’s presence as an opportunity to find common ground with their leader who could provide direction and support to nurses. In such circumstances, nurses got to know and trust their manager, were comfortable sharing their concerns, and nurses gained a sense of the manager valuing their work. In this study, the manager’s behaviour is consistent with Ergeneli et al. (2007) and Koberg et al. (1999) who report that trust enhances communication and provides opportunities for effective problem solving. When the belief in the manager’s reliability, dependability, and competence increases, overall psychological empowerment increases as well (Ergeneli et al., 2007). The manager who listens, supports, and recognizes nurses’ suggestions increases nurses’ sense of critical social empowerment (Casey et al., 2010).

To sum up, stepping up of power was characterized by the manager’s accessibility on the unit offering managers a close-up view of the demands of nurses’ work, and revealed the manager re-directing her activities and involvement to patient care. This facilitated nurses’ receptivity and comfort level in interacting with the manager, improved communication, and contributed to nurses’ trust in their manager. The findings suggest that trust influences psychological empowerment (Ergeneli et al., 2007; Koberg et al., 1999). Consistent with Spreitzer (1995), this result might mean that nurses feel more confident as they become aware their goals are attainable with the cooperation of
the manager and believe the manager is reliable and dependable, thereby increasing perceptions of psychological empowerment.

Conclusion

In this chapter, I have examined how the environment within the unit/organization influenced nurses’ ability to carry out patient care activities. For the most part, nurses’ ability to have control over their practice was constrained by organizational efficiencies and practices, hence, nurses experienced a disempowering work environment. Then, I explored how these contextual factors surface in nurses relationships with their managers and show how power is exercised in these relationships.

First, nurses in this study expressed limited support from their manager hindering nurses’ relations with their managers, and communication was used as the mechanism of control, either knowingly or unknowingly. In the absence of a mechanism for information sharing with the manager, managerial priorities dominated nurses’ judgments and actions. Nurses experienced a repressive work situation when they did not have an advocate in the person of the manager whom they could consistently rely on to assist in navigating the competing challenges, and nurses experienced “power over” them.

Second, in contrast to nurses’ sense of powerlessness, when managers shared power by providing guidance in resolving complex situations on the unit, advocated for nurses, engaged nurses as co-collaborators by shifting their focus to nursing, nurses perceived themselves as being able to more successfully carry out their duties. When managers demonstrated support for nurses, these strategies served to alleviate the tensions sustained through constant exposure to oppressive managerial practices. As a
consequence, this process relegated managerial practices to a less prominent role in
nurses’ work life, and nurses viewed themselves as being able to accomplish their patient
care more confidently when these leadership practices were put into effect; hence, nurses
experienced “power to”, engendering trust in the manager’s ability to lead the unit.

In the subsequent chapter, I reveal the enactment of resistance strategies by nurses
over their managers. Specifically, I will show how nurses used a range of resistance
strategies in response to the frustrations and tensions they experienced to managerial
practices. I also illustrate how managers shared power with nurses and facilitated nurses’
ability to accomplish safe, quality patient care.
CHAPTER FIVE: NURSE EFFECTS

Introduction

I begin this chapter by delineating a range of positive and negative consequences for nurses as a result of being situated in social relations of power with their manager. First, I demonstrate how *positioning to resist* explained how in a more oppressive work context nurses’ level of resistance intensified when the manager prioritized managerial imperatives and limited communication with nurses. Second, I demonstrate how *experiencing the potentiality of enabling* facilitated nurses’ work when the manager shared power. This action by the manager fostered positive interpersonal relationships, and nurses were able to meet their work responsibilities in a less resistive fashion.

Positioning to Resist

Nurses’ resistance strategies were intermittent and occurred at multiple points along a continuum to challenge the existing power imbalances. Nurses were most articulate about the relationships between themselves and nursing administration. These relationships were the key areas where their oppression was most explicit and where they demonstrated acts of resistance. Nurses did not employ an “all or nothing” approach to resistance towards their managers and role responsibilities. A close reading of the data in this study suggests that there were deep-rooted resistances at play that were not always visible or easily discernible. For instance, my observations revealed that nurses did not consistently report all medication errors, made minimal effort to clear intravenous lines regularly, and at times, made minimal effort to respond to morning care. Yet at other times, the resistance nurses demonstrated was easily visible and overt. For example,
nurses’ active and collective resistance against the manager on one unit demonstrated nurses’ sensitivity to patient safety and concern for nurses’ professional licensures.

In this section, I reveal how resistance strategies reflected an array of nurses’ expression of their oppression. The categories include: (i) setting limits flexibly; (ii) redefining behaviour; (iii) attending to one’s voice; (iv) running interference by not doing; and (v) battling back with supportive others.

Setting Limits Flexibly

Nurses described setting limits flexibly as a means by which they allowed their manager a trial period to ascertain her fitness for the role of manager. Early on in the study, nurses dropped hints about a manager’s trial period, but it was never clear how long a manager’s probationary period was, what exactly she needed to achieve, and when the learning curve expired. As the study progressed, one nurse explained the time limit being afforded to a new manager was about six months. I sensed the participant’s generosity in affording the manager a grace period so she could learn and understand her role, as the nurse stated:

P: ….A [manager], is still new so we’re [nurses] still giving her a year or two grace kind of thing but …K [clinical coordinator] has directly worked on the ward so we know that she understands….we sometimes wish A [manager] would give the ward a whirl for, for a little bit to see what it’s like and…but we’re giving her certainly a, a grace period… (#9, p.19)

Nurses on another unit were less tolerant of the manager’s learning curve even though some of the nurses had been on the selection committee and supported the manager’s hiring. As the fieldwork experience continued on this unit, it became evident that setting time limits on the manager’s learning curve was the beginning of more overt forms of resistance, as this senior nurse stated:
P: Yeah, you [nurses] give her [manager] time to learn, you give her time to grow, you give her, you know… but… there’s a time when that has to stop, you know, because… is it going to be that she’s here a year and she still doesn’t want to even try?.. How long is, how long do you, how long is too long to wait before you actually nip it in the bud? (#13, p. 30)

Another nurse shared her perceptions about a manager’s performance, as she explained:

P: …. are you actually saying that things are going to move forward and she’s like yeah, it definitely will- we, all felt OK, we’ll at least give, it some time to see if it actually comes through, like if she actually follows up on anything…” (#18, p. 14)

These excerpts suggest that nurses used subtle expressions of resistance by placing unspecified parameters around the manager’s probationary period. This was characterized by nurses’ expending energy challenging the manager’s readiness and abilities for the position, rather than challenging the basis upon which the decision was made and their involvement in the decision making process. From Kanter’s perspective (1977; 1993), individuals with less access to organizational resources, less support from managers, and less influence in the informal power structure, use various strategies to maintain control over their work. This could have been a way for nurses to maintain power by serving as a reminder to the manager that their perspectives needed to be taken into account because they were closely associated with patient care. In this instance, nurses were pessimistic about the manager’s abilities to exercise her own power to effectively access resources to support nurses in their work. What was not apparent is when and how nurses came together to determine the expiration of the manager’s probationary period, or how senior management supported managers in the probationary period.
In summary, nurses’ perceptions reflected an uncritical characterization of the manager’s ability and were manifested as setting undefined limits to the probationary period.

Redefining Behaviour

Nurses described redefining behaviour as knowing how the manager should perform her role and how she needed to improve, despite not knowing the scope of the manager’s job description. Nurses used subtle and not so subtle strategies to get the manager to conform to their preferred ways of how the manager should function. In informal meetings with one manager, nurses used a variety of strategies or suggestions to persuade the manager to change her behaviour, as one nurse explained:

P: …well I think there was…maybe a handful of senior staff – I wasn’t included in that but there was nurses who’d had 20+ years experience just felt they had a lot to teach her and so…they could kind of, like they could see that she was struggling and so…not that they would physically take her aside but in the mornings like they would just have suggestions like if you came to report you would know, you kind of know what was happening not only with patients but with the staff….I told her again, I said if you had come to report, you’d kind of know what…the floor looks like – if we’re over census who we can take, and who our pre-books are, that kind of thing and she said…’I know what your previous manager’s job was,’ and she’s like I’m not going to take that on – that’s not my responsibility and I don’t really know what she meant by that. Like if she felt we were asking her to do more than we should be asking her to do I guess, if it was out of her realm? ..I’m not sure what she thought her scope of practice was and all that. (#18, pp. 4-5)

This quotation illustrates that, under the guise of helping the manager do her job more effectively, these nurses took it upon themselves to admonish the manager for not attending morning report, yet it was not clear why the manager was not present. Nurses engaged in a power struggle to bring the manager’s actions in line with their expectations.
Despite not knowing the scope, the complexities, or demands of the manager’s job responsibilities, nurses were not deterred from judging the manager’s actions, as this nurse stated:

P …I think if you…do kind of get too focused on the other areas of things. You know what I mean? With…patient placement and the budget and staffing and that kind of thing. Like I agree that’s part of the job as well but I just feel like to be more of a holistic manager…I guess. (#18, p. 26)

When nurses became less tolerant about the manager’s performance, they became more direct and assertive in their approach, as another nurse stated:

P: And we [nurses] had actually spoken to B [nurse manager] on a couple of occasions outside of the meeting, you know, like…you need to focus on doing this because you’re not and so B [nurse manager] had had some things brought to her attention before we went too, as far as…as doing that meeting…. (#17, p. 15)

This excerpt illustrates that as managers diverted their attention from focusing more directly on the nature of nurses’ work, their opposition to the manager’s action increased.

On this unit, nurses’ seniority and experience may have threatened the informal system of management nurses had come to assume in the manager’s absence. Specifically, nurses may have gained power and made some of the necessary decisions in the manager’s absence. Whenever a new manager assumed the role with her own style and goal of managing a unit, nurses colluded and did not willingly shift the reins of power to the manager. When individuals lack power more constructively, there is a displacement of control over others (Kanter, 1977; 1993). According to Kanter, individuals who lack control over their work when they are dependent on others but are accountable experience disempowerment.

In summary, nurses took an active role in not playing the role of the oppressed, but were still not able to examine critically the reason for the manager’s actions. Nurses
chose to use direct and assertive tactics to “punish” the manager for focusing on organizational priorities, all the while believing that they knew ‘best’ how the manager’s role should be defined and how the unit was to be managed.

*Attending to One’s Voice*

Nurses described attending to one’s voice as speaking up to the nurse manager, middle manager, clinical coordinator, or educator when they lacked support or resources affecting their ability to provide patient care. It was at the nurse-manager interchange that individual nurses began to actively create and advocate in protecting the quality of patient care. Lukes (2005) describes institutionalized power as effective when it is least visible and when it is maintained by socially structured and culturally patterned behaviours and practices. In such cases, the consequence for those in subordinated positions is that it results in their domination either through their consent or through adaptation to power, yet not complain about power itself, but only how it is oppressively exercised (Lukes, 2005). As such, nurses viewed the manager’s focus on organizational priorities as undermining patient care practices (Rankin & Campbell, 2006), while failing to recognize structural constraints as a source of domination. Resistance to the manager’s actions was borne out of nurses’ knowledge and proximity to patient care giving them a sense of competency derived from their work. In this way, nurses had formal power in the form of a highly visible job associated with caring for patients (Kanter, 1977; 1993).

The act of speaking up for nurses was accomplished in several ways. When nurses were unable to meet as a group with the manager, they attempted to discuss issues on a one-to-one with the manager. At times, nurses perceived that the manager’s ability to listen receptively to what nurses were saying only went so far. As an example, one
participant tried to discuss nurses’ concerns with the manager regarding the new patient
delivery model and the implications for the staffing shortage, as the senior nurse
explained:

P: …..I finally did go talk to C [manager]…she clarified a lot of things but
then…some of the things still weren’t quite…up to, you know…the way she was
describing it ‘cause she had told me oh no, like don’t worry about, like there,
there’s going to be a…an RN, an LPN and a special care aide in every unit and
a…a special care aide would be doing baths and stuff like that and helping, you
know, ambulate people and…I thought well I would love to see that but I can’t,
with the staffing levels…when we’re lucky if we can get two people in a unit, I
can’t see us getting three um, at this point so some of the things were still kind of
vague in my head after…talking to her…(#25, pp. 25-26)

Another tangible form of nurses speaking up to the manager occurred at a staff
meeting where the hiring of licensed practical nurses (LPN’s) was perceived as
threatening the quality of care. Despite nurses having expressed reservations about the
quality of care and shouldering additional work responsibilities, the manager stated
nurses were “getting LPN’s whether they liked it or not.” This statement by the manager
suggests that although nurses could express their concerns, the manager could and did
over ride their concerns. Not engaging nurses in a collaborative process was a way for the
manager to maintain a top down management approach leaving little or no space for
collective discussion, or deviation from organizational priorities. The manager may have
been responding to the restrictiveness of her own situation by controlling nurses’
behaviour as a result of the dominating, bureaucratic structure that maintain power
relations (Kanter, 1977; 1993; Lewis & Urmston, 2000). This managerial ethos shapes
nurses’ perceptions, cognitions, and preferences in such a way that they are to accept
their role and practice as normal and therefore beyond question (Gilbert, 1995; Lukes,
2005), yet nurses resisted.
One nurse attempted to advocate for increased time for patient care by informing the manager that the telephone was disruptive without adequate clerical support, as the nurse explained:

P: …because we’re so busy on the phone and so they [management] said, OK, well we’ll add another phone but by adding another phone, it just has added an extra phone to ring for us to…pick up… (#3, p. 5)

This same nurse believed that in order to be heard by the manager she needed to be persistent in making her point in unconventional ways, as she explained:

P: …I don’t know but it does seem like you have to jump up and down some, some days before you’ll even get somebody to listen to you that you need help.

R: So what does jumping up and down mean?

P: *chuckles* Saying over probably five times that you need help…It’s, it doesn’t seem like it’s heard or it’s kind of just…blown….like they’re not, maybe they just pretend they didn’t even hear that and just…getting on with the day. (#3, p. 22)

These quotations illustrate that in order to be heard by the manager the nurse resorted to more overt measures, and even then, felt dismissed. There is some argument that nurses as an oppressed group tend to feel powerless (Diaski, 2004; Fletcher, 2006; Fulton, 1997). The psychological empowerment literature suggests individuals are empowered when they find meaning in their work and are able to influence outcomes (Spreitzer, 1995). Yet nurses’ resistance to managerial imperatives could be explained by a desire to achieve positive patient outcomes (Quinn & Spreitzer, 1997; Spreitzer & Doneson, 2005).

In summary, nurses’ active resistance aimed at redirecting the manager’s focus to nurses’ work and patient care, was suggestive of their advocacy for patient care. However, when communicating directly with the manager did not get the expected
results, nurses’ frustration escalated into more overt and tangible forms of resistance, as the following sections reveal.

*Running Interference by Not Doing*

Nurses described running interference by not doing as a more tangible but indirect form of resistance against their manager. Nurses determined for themselves which activities they deemed appropriate not to carry out when workloads became unmanageable. Nurses demonstrated more overt forms of resistance than previously described and it was particularly evident in the actions related to policies, such as: not consistently adhering to the new patient care delivery model, not clearing IVAC machines at designated times to signify a patient’s fluid intake, not documenting immediately after administering medications or completing a patient assessment, and not reporting all medication errors. Nurses did not consider making beds, providing morning care, or patient teaching as critical especially when they perceived themselves as over burdened. In response to managerial imperatives, nurses silently yet defiantly demonstrated resistance by documenting when it was convenient, charting the time the medication was to be administered rather the time the medication was provided, and making minimal effort to clear the IVAC machine and implement the patient care model. Nurses indicated they worked diligently to meet patient needs as they juggled competing demands, but were involved in fewer patient-nurse interactions. At times, doing the bare minimum was one way nurses coped with “doing more with less”, and they learned to re-prioritize patient care, as one nurse noted:

P: …and, you know, you need to sometimes just…step away for a few minutes….patients not getting, you know, washed or something ‘cause there’s not, you know, like you kind of have to…weigh the, what’s the most important right…now….Prioritize things so maybe someone will get washed up before they
go home ‘cause it was more important, you know, to get their discharge stuff ready. (#2, p. 25)

This quotation illustrates how organizational demands vied for this nurse’s attention requiring her to re-adjust aspects of patient care in order to maintain workload manageability. This sentiment was expressed in a number of interviews.

On one unit, nurses refused to comply with the new patient delivery model, as one nurse stated, “everybody was kind of digging their heels in” (#23, p. 5). Six months later the model was re-introduced, placing pressure on nurses to incorporate it into their practice. This change was not perceived as important to nurses so they justified their actions by indicating they were not consulted in developing the policy on the model, didn’t understand the model of care, and the model may not work in their setting as reasons for noncompliance, as one nurse explained:

P: …Basically I think most nurses now are doing it when they have time and when they’re not, we’re not, which isn’t the best thing but that’s just the way our unit goes. (#22, p. 9)

A culture of silence existed among nurses when they actively concealed their own or others’ medication errors. Nurses believed it was defensible not to report certain medication errors especially when they experienced working conditions beyond their control while working with limited resources, and therefore, were reluctant to complete a form that highlighted their culpability for a medication error. Unethical practices such as not reporting all medication errors could compromise patient care (Kuhse, 1997). Kanter (1997; 1993) suggests that the effective mobilization of resources by nurses at the point of care is likely to result in better outcomes. By increasing the level of nurses’ structural
empowerment through increased access to information and resources, the manager helps support patient care with fewer errors (Armstrong & Laschinger, 2006).

In summary, faced with competing priorities and the manager’s lack of involvement in patient care, nurses attempted to assume control over their work through acts of passive resistance. When nurses did not follow ethical practice guidelines by not reporting all medication errors, they may have created unsafe practice situations themselves.

*Battling Back with Supportive Others*

As a last resort, nurses demonstrated the most overt and assertive forms of resistance when they perceived themselves as not having choices and having minimal control in the workplace. Nurses described battling back as a critical analysis of and sensitivity to advocating for patients and taking collective critical action. Nurses described how they joined forces and implemented a variety of strategies such as documenting, threatening to resign, going to a higher authority, forming a group of unit representatives, beginning a petition, and organizing meetings. Initially, some of the strategies were more closely aligned with manipulation (i.e., beginning a petition) when nurses anticipated resistance from their manager (Fulton, 1997). However, positive resistance was demonstrated (i.e., group of representatives) when nurses’ took a risk and exercised collective action because of their desire to advocate for their patients (Spreitzer & Doneson, 2005).

Nurses’ acts of negative or unproductive resistance were predicated on becoming increasingly “fired up” about the pressures and demands of the unit, but they were unable to take their concerns to someone who could actively address their concerns. As nurses
became increasingly frustrated, they became more militant by threatening to leave the
unit, as one nurse pointed out:

P: …like we were so fired about the situation with the way…the work place was
going and that people were threatening to leave – like it was just such a high
stress…environment…(#18, p. 14)

Documentation was used as an instrument of nurses’ resistance towards the nurse
manager when nurses’ workloads and organizational demands became unwieldy.

Documentation legitimized nurses’ frustrations and was a way to call attention to the
powerlessness they experienced. One nurse stated:

P: …we’re trying to…document a lot of our, a lot of what’s happening on the day
and we have something on paper…to actually bring forth and say no, it’s not just
us complaining…So that’s because we’re tired, we’re frustrated, we’re mad,
we’re…whatever, this is legitimate complaints. If they’re on paper…then you
have somewhere to go with that. (#13, p. 34)

This excerpt illustrates that documenting provided evidence to the manager and the union
of nurses’ resistance. Yet nurses’ intent on transforming their practice was hindered by
the practices and polices within the institution (Lukes, 2005) which often delay resolution
of issues important to nurses’ work, as this study revealed.

Nurses gauged their resistance to the manager’s actions by completing workplace
safety reports, especially if they believed the manager was intentionally scaling back
staffing for designated shifts, as one nurse explained:

P: …You know, because with B [manager] you knew that she was out to under staff
you so you would intentionally fill them out whereas with D [coordinator]
when…you are short staffed, you might fill them out or you might let it pass and
just get by the best you can because you know the requests were put out for the
extra staff. (#19, pp. 11-12)

This excerpt illustrates that documentation was a tool nurses used to convey to those in
authority that the manager was not supporting their ability to provide safe, quality care.
Structured resistance is built into bureaucratic organizations (Lukes, 2005), nonetheless, nurses used their expert power of patient care as leverage in exposing the manager’s responses, or lack thereof, by completing work situation reports in response to the powerlessness they experienced. Rankin and Campbell (2006) assert that text-based practices appear to help nurses get their work done effectively and efficiently. Conversely, textual based practices also reduce nurses’ ability to have face-to-face dialogues with the manager where they may have more opportunities to actively participate in decisions affecting their practice.

Nurses’ acts of positive resistance (Spreitzer & Doneson, 2005; Street, 1992) prompted them to meet with the manager’s superior in securing guidance to take collective action against the manager. It was under such conditions that nurses took calculated risks to focus on the primary object of their care – the individual patient. Nurses determined amongst themselves that those with seniority, education specific to the patient population, experience, and an ability to remain neutral during conflict be designated as group representatives. The goal of the meeting was to advance the proposal for the new unit, and to have the manager adjust her managerial style, as one nurse noted:

P: …but we wanted to do it in a way that would be…a two-way conversation – like a dialogue. Like she, we could express our concerns but we could also…let her have her say and explain to us like what her plan was, like why were things not being done rather than just attack…and so that’s how it was set up. (#18, p. 15)

Involving senior management in the meeting served to call attention to the challenges and frustrations nurses encountered in their daily work enabling nurses concerns to be heard and hence, experience a sense of control over their practice. A nurse explained how the meeting sanctioned by the senior manager proceeded:
P: …the meeting started and everyone kind of went around and A [nurse] was kind of the spokesperson and she said...just so you know, this meeting isn’t to attack you [manager]. We’re not...trying to sit here and point out all your faults, we just really want this to be a positive ward and we think there are such good things that could be done… when it [meeting] was done it was B’s [manager] time to speak and...she had got the impression from somewhere and no one really knows where but she said that she had been told that this meeting had been set up because we were going to ask her to resign which kind of set the tone...she was already highly...stressed...and we couldn’t have stressed more, like no, that’s not our intent. Like if that was what we wanted we would have just...you know...just went to S [manager’s superior] again and said we can’t take it but we...set it up to have a chance for everyone to...kind of say what needs to be done and for things to change...We weren’t hoping for her to go...But that’s, yeah, that’s what happened shortly thereafter the meeting… (#18, p.18)

These quotes serve to illustrate that underlying this collaborative approach was a covert agenda geared toward resisting organizational practices and modifying the manager’s activities to suit nurses’ expectations. Nurses may have manipulated the situation to preserve power within the unit because the manager did not occupy the position for any length of time before leaving. Soon thereafter, the manager resigned and nurses were able to maintain the status quo by preserving their power.

The disempowerment nurses and the manager experienced may have been due to the restrictive control operating within the oppressive nature of the institutional structure of the hospital (Lewis & Urmston, 2000; Lukes, 2005). Consistent with Haugh and Laschinger (1996), the manager may have had limited access to power and may not have been able to share power with subordinates. According to Kanter (1977;1993), managers who perceive themselves to be disempowered are more likely to adhere to rules and regulations and withhold information in order to preserve what little power they possess.

In summary, nurses employed unproductive acts of resistance, yet the most successful acts of resistance were the result of nurses’ collective action to act as patient
advocates (Spreitzer & Doneson, 2005). Nurses’ ability to create change was premised on dialogues of protest and collective, liberating actions for the sake of patient care.

**Experiencing the Potentiality of Enabling**

Nurses experienced the potentiality of enabling as advocating for the quality of patient care when the manager was supportive of nurses in their practice environments. When the manager minimized the demands of the organization, this enabled nurses to believe in the manager’s reliability and dependability that increased nurses’ psychological empowerment (Ergeneli et al., 2007; Spreitzer, 1995). Nurses were then able to provide the quality of care they believed necessary to promote and enhance patients’ health and well-being, thus making a difference to the trajectory of the patient’s recovery. The sub-category is “acting with and for patients”.

**Acting With and For Patients**

Nurses described acting with and for patients as the ability to recognize, promote, and enhance patient care outcomes. Patients came to the tertiary hospital with serious medical conditions, concerns and anxiety about their course of recovery. Some nurses described the paralyzing fears patients faced as they underwent advanced medical therapies or life-threatening surgeries as one nurse explained, “….you go in there and hang the chemotherapy and they’re like deer caught in the headlights and they’re absolutely frightened.” (#13, p. 18). Nurses described patients as being attentive, listening, and valuing the confidence of the nurse in making a difference to the patient’s recovery and well-being. One nurse explained:

P: I have always done my medicine in totality. Like I pray for my patients. I am able to talk, I have had some patients tell me because they had time to talk with me, even though they felt so down, they were able to get up and do stuff…(#15, p. 2)
These excerpts illustrate that nurses were aware of the anxieties patient’s experience, and that attending to the psychosocial and spiritual dimensions of patient care facilitated patient’s well-being. Therapeutic communication skills such as listening, empathizing and providing information are needed in order to share power and enter into an equal relationship with patients (Finfgeld, 2004). Nurses bring expert knowledge and skills and when communication is caring, respectful, and carried out in a mutual satisfying and collaborative manner in the nurse-patient interaction, empowerment can occur (Ellis-Stoll & Popkess, 1998; Gibson, 1991; Hokanson Hawks, 1991; Rodwell, 1996).

Although nurses did not use the language of “meeting professional competencies” associated with professional standards, their descriptions of having time with patients lent credence to their ability to address physical, psychosocial and spiritual aspects of patient care, and that the overall health of patients was served by this pattern of practice. One senior nurse indicated she responded to patient requests by providing holistic care:

P: And psychologically comfortable as well as physically –it doesn’t really make a difference. You want both. ‘Cause if they’re not psychologically comfortable, they won’t be physically comfortable. (#10, pp. 17-18)

I observed a nurse demonstrating compassion and concern in caring for a dying patient in the observation unit. As the nurse was caring for the patient, the patient was the focus of her attention, as my field notes indicated:

B [nurse] was gentle with R [patient] and took her time bathing him, and cared for him in a gentle manner. She was focused entirely on the patient and spoke to only him and when necessary. B easily assisted him to the chair so he could sit in the chair. We straightened his bed and I changed the pillow cases...We returned to the desk to where L, the other nurse, was sitting and doing paperwork...Soon thereafter, R signaled that he was ready to go back to bed, and B assisted him to bed. As B was straightening the covers and he was making himself comfortable in bed she said in a comforting manner, "you did good-I'm proud of you." (Field notes #13, p. 21)
Despite serious illnesses, patients sometimes chose not to reveal to nurses they were in physical distress, potentially intensifying or worsening their condition. A nurse explains why acting on a patient’s behalf is critical to their recovery:

P: …if you’re rushed, rushed and you try to do something else while you’re talking to them and not making eye contact, they get kind of…you know, they feel inconvenienced…or they don’t want to bug you…and they don’t tell you when they’re having chest pains, and they say,’Oh you were busy and …then you give them heck”. (#2, pp. 10-11)

This excerpt illustrates that the nurse served to advocate and mobilize resources so the patient could have access to the required cardiac care. Advocating, supporting, and facilitating resources for patients can result in the promotion and maintenance of personal empowerment (Falk-Rafael, 1995; Gibson, 1991; Kieffer, 1984). As such, nurses’ personal value and worth are acknowledged and nurse empowerment can occur (Gibson, 1991; Hokanson Hawks, 1991; Rodwell, 1996). Empowered nurses are able to develop nursing care that increases self-confidence, personal competency, and autonomy in decision making thus allowing for more freedom of action, and the potential for achieving goals (Hokanson Hawks, 1991; Kuokkanen & Leino-Kilpi, 2000; Spreitzer, 1995).

Nurses indicated that caring, comforting and reassuring patients undergoing procedures or surgery could result in positive patient outcomes. Nurses spoke about providing comfort through empathy and silence and being trusted by patients. When nurses were not juggling multiple demands they were able to take the time to think clearly and focus on the patient-nurse relationship. When nurses took time with their patients, they found the patient calm and more relaxed, as one nurse stated:
This excerpt illustrates that one of the ways this nurse assisted in facilitating patient education was by creating a receptive environment whereby she could respond to patient questions. In contrast, one nurse stated that the frequencies with which patients were re-admitted to the hospital increase when patient education is not provided. Nurses indicated that patient teaching was critical to preventative care. The promotion of health behaviours is an outcome of attempts to empower patients and families (Ellis-Stoll & Popkess-Vawter, 1998) which in turn can improve an individual’s quality of life (Gibson, 1991).

In summary, nurses believed they were psychologically empowered to focus on direct patient care when the manager intervened to regulate organizational processes and practices. Nurses were then able to use their expert knowledge and expertise to engage with the patient for the purpose of promoting health behaviours and health outcomes.

Conclusion

In this chapter, I have delineated the consequences of how power is exercised in nurses’ social relations with their manager. First, nurses’ increasingly overt resistance toward the manager characterized *positioning to resist*. Power imbalances, precarious relationships, and a lack of support for nurses’ concerns reinforced nurses’ feelings of powerlessness as nurses engaged in a serious of unproductive strategies. This kept nurses from engaging in more productive and creative forms of problem solving, and detracted from their ability to experience a sense of control over their work. These resistance strategies were nurses’ exercise of power over their manager in order to disrupt
organizational practices and manager behaviours. Yet, when nurses collaborated with each other, they exercised power through dialogues of protest and actions to act as advocates of patient care, and they experienced empowerment.

Second, managers relinquishing control and cooperating to share power with nurses characterized *experiencing the potentiality of enabling*. This suggests that nurses had a sense of purpose and meaning and they were able to influence patient outcomes. This in turn engendered trust in the manager’s ability to maintain a nursing perspective and to effectively lead and manage the patient care unit, and nurses experienced empowerment.

Having described the findings related to nurses’ effects of how power is exercised in nurses’ relationships with their manager; I now turn to explicating the theory. In the following chapter, I extend the substantive theory on nurse empowerment in a manner that explains the relationships between the categories. I also theorize how power is exercised in the nurse-manager relationship thereby increasing the theory’s depth, scope, and level of abstraction.
CHAPTER SIX:
THE SUBSTANTIVE THEORY: PROCESS OF SEEKING CONNECTIVITY

Introduction

This chapter addresses how the substantive theory that emerged from the data, *process of seeking connectivity*, is further highlighted and theorized. Theorizing is the act of constructing from data an explanatory scheme that systematically integrates various concepts through statements of relationships to extend theory (Strauss & Corbin, 1998).

The purpose of this chapter is to highlight the theory, by explicating relationships between the ten main categories that comprise the theory. The conditions, actions/inactions, and consequences constitute the paradigm for discovering how categories relate to each other (Strauss & Corbin, 1998). Five categories of contextual factors represented the conditions in which nurse and manager relations were situated. The three categories of nurse and manager relations represent the actions and inactions involved in responding to the organizational context. The two categories of consequences represent the outcomes of nurse and manager relations.

Conditions, actions and inactions, and consequences formed the theory of seeking connectivity as an extension of nurse empowerment theory. The overarching finding is that the manager plays a critical role in modifying the work environment for nurses and as such, nurses seek connection with their manager. More specifically, nurses require the manager to enhance their ability to share power with them. The results of this study are understood by drawing upon three theoretical approaches: organizational theory, psychological theory, and critical social theory. The results of this study extend the body of knowledge on power and empowerment as stemming respectively from: provide more
open forums to enhance information flow and exchange vital information between nurses and their manager; increase nurses’ autonomy within prescribed boundaries to enhance their ability to influence work activities and outcomes; and facilitate nurses desire for shared decision making to enhance a more democratic workplace. Each component of the paradigm is explained in more detail to advance the research findings in extending the theory of empowerment.

Seeking Connectivity: An Overview of the Model

During the course of data collection and analysis, it became evident that the basic social problem in this study was that nurses’ work was carried out within an institutional structure that incorporated patterns of practice and that the absence of consistent and reliable support of the manager influenced nurses’ ability to provide patient care.

The basic social process that emerged in response to this problem was that of seeking connectivity, and was selected as the core variable in this grounded theory study (Corbin & Strauss, 2008; Strauss & Corbin, 1998). Seeking connectivity was the process in which nurses strived to connect with their manager to create a workable partnership in the provision of quality patient care while responding to the demands in the organizational context. An overview of the theoretical model is presented in Figure 1. The theory of seeking connectivity provides an explanatory framework of how social relations of power are exercised between nurses and managers. This conceptualization seemed to explain much of the variation of how nurses and their manager’s exercised power, and how seeking connectivity either hindered or fostered nurses’ ability to feel empowered in the work setting. The ways in which nurses came to think and take action
as a consequence of the power relationships with their manager confirms the complexity and interactivity of the process of seeking connectivity.

Conditions

Five categories were interrelated as causal conditions that influenced nurses’ relationships with the managers in seeking connectivity. Causal conditions represent the events or happenings that influence a phenomenon (Strauss & Corbin, 1998). The important issue is not so much identifying and listing the type of condition, but rather, the analyst should focus on the complex interweaving of events leading up to a problem to which individuals are responding (Strauss & Corbin, 1998). The five categories were: i) “the budget”; ii) “working short”; iii) contradicting demands and interruptions; iv) being controlled by policies; and v) jeopardizing patient safety. Table 1 highlights the categories.

From an institutional framework, managerial priorities in the form of budgetary priorities and policies combined in various ways to influence nurses’ thinking and shaped their actions. Amidst physical and human resource constraints, nurses frequently found their nursing activities interrupted and re-directed because of multitude demands. Nurses’ work was disrupted by hospital alerts, swift patient discharges and transfers, making a “99 bed”, and responding to numerous tasks as a result of diminished support from hospital departments. Nurses assumed some of the tasks that are not traditionally those of nurses to accomplish the goals of the hospital, reducing their ability to act on their own professional judgment as a competent registered nurse. Nurses’ work was infiltrated by numerous efficiency-oriented interruptions that distracted them and left
them vulnerable to make mistakes. For example, expediting patients establishes faster and prompt admission and discharge to minimize existing bed capacity. In such situations, nurses’ work was fragmented as nurses readjusted and re-prioritized patient care practices. Work pressures caused nurses to focus on “the basics of care” as a result of not having time to care for patients as individuals with needs beyond what is measurable and necessary for organizational efficiency. Nurses’ work became less controllable as organizational demands increased, compromising nurses’ ability to consistently maintain and deliver acceptable levels of patient care. Because of these contextual circumstances, fear for patient safety and for nurses’ liability for potential mishaps frequently surfaced.

Though categories were distinct, nurses could experience more than one causal condition but not necessarily all conditions. For instance, a nurse could experience both working short and being controlled by policies. Managerial priorities effected through the power of the institution served to reorganize nurses’ work by shaping the perceptions of their practice as acceptable and natural. That is, nurses experienced power over them embedded in and reinforced by the institutional structure and its practices. How nurses came to know and enact their work was constructed as a repressive mode of practice, often overshadowing direct patient care priorities. As such, these conditions shaped the actions and inactions of nurse-manager relations in seeking connectivity.
Category

<table>
<thead>
<tr>
<th>The budget</th>
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<tr>
<td>Working short</td>
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<tr>
<td>Contradicting demands and interruptions</td>
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<tr>
<td>Being controlled by policies</td>
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<tr>
<td>Jeopardizing patient safety</td>
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Table 1  Five categories of contextual factors in relation to the conditions in which nurse and manager relations were situated.

**Actions and Consequences**

In response to the causal conditions, there were three main categories of nurse-manager relationships to seeking connectivity. The process of seeking connectivity is explained by patterns in the interactions between nurses and their managers. Strauss and Corbin (1998) state that a grounded theory study represents “multiple and diverse patterns” (p. 188) that shift over time, thus making the term pattern a logical fit in conceptualizing how nurses and their manager relate through actions/interactions and their consequences.

Therefore, the first pattern of the process is characterized by nurses situated in a state of disconnect with the manager as a result of being situated in a more oppressive work context, comprising several categories. The category working without an anchor had three sub-categories. These included: (i) being out of sight and mind; (ii) encountering limited know how; and (iii) sealing unease. The category silencing forms of
communication had three sub-categories. These included: (i) communicating and enforcing policies; (ii) assuming a silent role; and (iii) being trapped. Sub-categories are concepts that pertain to a category, giving it further specificity and dimensionalizing the characteristics of the category (Strauss & Corbin, 1998). Though distinct, there was overlap in that a nurse could encounter a manager’s limited clinical knowledge and be controlled by policies.

The first pattern suggests that in the absence of meaningful engagement with the manager, power was held over nurses through institutional patterns of behaviour and practices. In *working without an anchor*, nurses perceived themselves as being isolated from the manager’s guidance, support, and access to resources, which served as deterrents to meaningful interaction. Without the active engagement of the manager, nurses experienced the added pressure of meeting organizational imperatives while also providing patient care. *Silencing forms of communication* represent the mechanism that circumscribed or restricted dialogue and support between nurses and the manager. Unresponsive institutional structures, practices, and fragile nurse-manager relations conveyed a nurse-manager relationship devoid of shared power, potentially creating a cycle of nurse inaction, maintaining the status quo and resulting in nurses’ powerlessness. Power was held over nurses restricting discussion with the manager, compelling nurses to participate in managerial priorities without input into organizational decision-making. Taken together, nurses experienced a low level of trust in their manager and power over them, prompting them to take resistive forms of action against the manager.

A third category, *positioning to resist*, served as the consequence of the disconnect nurses experienced with their manager. This category had the following five
sub-categories: (i) setting limits flexibly; (ii) redefining behaviour; (iii) attending to one’s voice; (iv) running interference by not doing; and (v) battling back with supportive others. Consequences or outcomes represent an action or lack of it, taken in response to manage or maintain a certain situation (Strauss & Corbin, 1998; Corbin & Strauss, 2008).

In response to the disempowerment nurses experienced, nurses employed a variety of resistance strategies that were selective and occurred at multiple points along a continuum depending on the degree of oppression they experienced within a particular context. The subcategories of *positioning to resist* (setting limits flexibly, redefining behaviour, attending to one’s voice, and running interference) highlighted how nurses experienced instances of oppression in the relationships with their manager (working without an anchor, silencing forms of communication). Nurses’ acts of resistance demonstrated a lack of supportive strategies by the manager to intervene and moderate the power of institutional practices held over nurses, constraining their ability to provide safe, quality care. For instance, nurses’ level of resistance intensified in a corresponding fashion when meaningful interaction and communication with nurses was circumvented. Resistance strategies ranged from subtle verbal comments regarding the manager’s ability to remain in the role to the most assertive forms of resistance that included joining forces as a collective of nurses. As such, some of nurses’ resistance was manipulative and unproductive (i.e., being pessimistic about the manager’s ability to meet job requirements). Thus, these consequence sub-categories manifested how seeking connectivity was manifested, and how nurses exercised power over their managers when they were not able to connect with them.
However, the path of this feedback loop altered the situation when the sub-category of *positioning to resist* (battling back with supportive others) occurred, as nurses exercised collaborative power to engage the manager. These strategies were productive and aimed at increasing meaningful interaction and involvement in decision-making to enhance nurses’ control over their work and their ability to support patient care practices. By actively collaborating, nurses asserted responsibility for their own empowerment, and nurtured it by collective action to promote change. Thus, battling back modified how seeking connectivity was manifested, and how nurses experienced power to when they connected with their manager, and nurses experienced empowerment.

How nurses employed resistance was dependent on the manager’s actions and inactions as well as the nature of contextual factors. Table 2 highlights the categories and sub-categories when nurses were situated in a state of disconnect with the manager.

<table>
<thead>
<tr>
<th>Categories and Sub-categories</th>
<th>Categories and Sub-categories</th>
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<tr>
<td>Working without an anchor</td>
<td>Positioning to Resist</td>
</tr>
<tr>
<td>- Being out of sight and mind</td>
<td>- Setting limits flexibly</td>
</tr>
<tr>
<td>- Encountering limited know how</td>
<td>- Attending to one’s voice</td>
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<tr>
<td>- Sealing unease</td>
<td>- Running interference by not doing</td>
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<tr>
<td>Silencing forms of communication</td>
<td>- Battling back with supportive others</td>
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<tr>
<td>- Communicating and enforcing policies</td>
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<td>- Assuming a silent role</td>
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<td>- Being trapped</td>
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Table 2 Categories and sub-categories representing the first pattern of the process when nurses were situated in a state of disconnect with the manager.
The second pattern of the process is characterized by nurses as being connected with their manager as a result of being situated in a more supportive context. The two patterns in this process are artificially separated in order to present the emerging model as clearly as possible. There is considerable interplay in this process suggesting that nurses can experience both patterns of social relations with their manager. The category stepping up of power had three sub-categories. These included: (i) advocating and backing nurses; (iii) demonstrating nurses’ worth; and (iv) re-adjusting the mindset to nursing.

The second pattern suggests that when managers provided guidance, advocated for nurses, and engaged nurses as co-collaborators by shifting their focus from organizational priorities, such as the budget to nursing, nurses’ perceived themselves as having more control over their practice. Nurses viewed themselves as being able to accomplish their patient care more confidently when such leadership practices were put into effect.

A second category in this pattern, experiencing the potentiality of enabling, served as the consequence of the connection nurses experienced with their manager. This category had one sub-category: (i) acting with and for patients.

This supportive context is illustrated by the re-establishment of a network of relationships among nurses and the manager suggesting that nurses relied on the manager in assisting them to alter their work environment. Experiencing the potentiality of enabling also initiated a feedback loop, as managers created an environment that enabled nurses to practice according to professional standards of practice and provide safe, quality patient care. When nurses were able to acquire knowledge, and have the manager
advocate for and support them in securing resources, they experienced a sense of meaning as well as self-efficacy. In response, nurses had the capacity to communicate with the manager, problem solve, and make decisions to positively influence patient outcomes. The manager’s ability to share power and focus on nurses’ work and patient care created conditions that fostered nurses’ trust in management and enabled them to experience a sense of empowerment.

The categories, *positioning to resist* and *experiencing the potentiality of enabling*, are consequences in the process of seeking connectivity, because they are outcomes of the process. Either one of these consequence categories initiated a feedback loop to nurse-manager relations. Moreover, either of these categories reinforced the importance of the nurse-manager relationship for the staff nurse to accomplish their work in satisfying ways.

These consequence categories highlight the evolving and dynamic nature of nurses seeking connection with their manager. Through encounters with contextual factors (conditions), and as a result of the nurse-manager actions and interactions, nurses responded to and shaped the situations in which they found themselves in order to provide patient care in satisfying ways. The process of seeking connectivity is present in the organizational context and continually evolving. Thus, conditions, action, and consequences of seeking connectivity continue to evolve.

Table 3 highlights the categories and sub-categories when nurses were situated in a state of connection with the manager.
Table 3 Categories and sub-categories representing the second pattern of the process when nurses were connected with the manager.

Therefore, a widening focus embracing an organizational, psychological, and critical social approach is necessary for nurse empowerment. Helping nurses feel more self- efficacious will have a limited effect without providing access to information, support, and resources necessary to accomplish work and allow that power to be exercised. Likewise, social change will not be empowering if nurses perceive themselves as unable to make use of those changes. Nurse’s individual perceptions and abilities in shaping his/her work role are foundational to promoting change through collective action.
Figure 1 Process of Seeking Connectivity: The Expanded Model
Summary of the Theory: Process of Seeking Connectivity

Findings from this study, revealed a grounded theory seeking connectivity (see Figure 1). The ten main categories of conditions, actions and inactions, and consequences were interrelated and connected through statements of relationships. Together, these conceptual relationships extended the substantive theory on nurse empowerment of how staff nurses experienced power in their relationships with their manager. In the following chapter, I provide further interpretation of the study findings in the context of existing literature, and highlight the theory’s unique theoretical contribution to nursing knowledge and re-examine the concept of power to reveal the multi-faceted nature in which empowerment is conceptualized. I also discuss the limitations of the present study. The chapter concludes with directions for future research, and implications for practice, administration, and policy.
CHAPTER SEVEN:
DISCUSSION

Introduction

To better understand what fosters nurse empowerment, this study looks at how power is exercised in the nurse-manager relationship in a hospital setting. Using a grounded theory methodology, I have extended existing knowledge on staff nurse empowerment, which may contribute to a more comprehensive understanding of empowerment. Specifically, I have shed light on how power is exercised in the nurse-manager relationship; and how these relations facilitate or constrain nurses’ ability to provide patient care. My findings provide new insights and understanding about how nurses seek connectivity with their managers as a result of individual, structural, and social empowering practices that complement and widen the focus of nurse empowerment. Through the research process, I have come to better understand the complex and multi-faceted nature of empowerment and its inextricable link to power.

In this final chapter, I further interpret the study findings by describing the new knowledge uncovered in this research and its contribution to the discipline of nursing. I compare study findings to relevant literature with regard to the categories comprising the theory of *seeking connectivity*. I then discuss the implications of this study for theorizing power and empowerment; I address the limitations of this study and offer recommendations for future research. Finally, I outline implications for practice, policy, and administration.
Conditions to Seeking Connectivity: Relationship to the Literature

Nurses identified a number of contextual factors that affected seeking connectivity with their manager. These factors were categorized into five conditions within the organizational context: “the budget,” “working short,” contradicting demands and interruptions, being controlled by policies, and jeopardizing patient safety.

The hospital in this study sought to maintain power through a series of mechanisms affecting the way in which nurses worked. With these managerial imperatives in place, nursing work was actively organized, structured, and circumscribed in line with centrally determined policies and practices that downplayed nurses’ professional judgment about patient care. At times, a nurse could encounter more than one contextual factor at a time. For the most part, the demands upon nurses fragmented care, increased nurses’ vigilance over patient safety and served to re-organize nurses’ professional judgment surrounding their patient care practices.

“The Budget”

Nurses described the budget as a discourse of cost-consciousness infiltrating their day-to-day work. It was commonplace to hear a nurse use terms such as “the budget” and “working short” in interactions with others, thus incorporating management’s language and objectives. The ultimate aim of management was to highlight for nurses the importance of financial restraint and force them to participate in reducing expenditures.

“Working Short”

Nurses described working short as a lack of nursing personnel, whether intentional or not, and this practice exploited nurses’ sense of duty to care for their patients and served as a mechanism regulating nurses’ work. The cost-conscious
discourse, a staff shortage, and a focus on minimizing overtime compounded the stressors associated with patient care, profoundly affecting nurses’ work. Nurses adjusted their practice by working within the parameters of fiscal and human resource constraints by adopting a “doing the best I can” philosophy. In conversations with nurses, I found they often had difficulty articulating their frustrations into meaningful and discernible statements that exposed the struggles they encountered in providing care.

Contradicting Demands and Interruptions

Nurses described their experience of contradicting demands and interruptions as a complexity and diversity of competing priorities ranging from adhering to policies regarding bed management, increasing documentation responsibilities, and non-nursing tasks that occasionally overshadowed nurses’ time for direct patient care. Nurses learned to focus on the most pressing patient care activities in order to meet organizational efficiencies, and they experienced a disjuncture in patient care resulting from their inability to provide continuous, holistic care.

These three categories of conditions in seeking connectivity - the budget, working short and contradicting demands and interruptions - were consistent with previous studies in the nursing literature. Studies reported similar results in terms of an inadequate number of nurses in acute care hospitals providing an increased intensity of care to support the policy of bed reductions while striving to meet patient health care needs (O’Brien-Pallas et al., 2005; Priest, 2006). When hospitals want to decrease the amount of money spent on nursing personnel, they reduce the paid time available for all nursing care (Rankin & Campbell, 2006). Cost containment and efficiencies have curtailed the range of services and attention to patients (Rankin & Campbell). As early as 1981,
hospitals set presumptive productivity expectations for nurses that increased the pressure to work harder, increase their pace of work and work on unpaid time (Rankin & Campbell). Nurses respond by completing their assigned patient care when less time is allocated, and in this manner, nurses’ work is treated as expendable.

Sandhu et al. (1992) were among the first to articulate that nurses’ work encompasses a blended concept of efficiency. These authors asserted the necessity of adapting nursing practices to correspond with the then current expectations of cost containment in organizations. Viewed from this perspective, cost containment was normalized and naturalized as “how things are.” Nurses’ work that produce a blended concept of efficiency has become almost invisible and is a taken-for-granted aspect of contemporary nursing practice.

In a study by Blythe et al. (2001), work activities became less controllable and compromised nurses’ ability to deliver effective care during restructuring. Although nurses in this study were not involved in restructuring, nonetheless, budget cutbacks and nursing shortages, as well as other managerial imperatives directed substantial energy, time and resources away from nurses’ regular patient activities and caused a decline in the quality of patient care.

Being Controlled by Policies

Nurses described being controlled by policies as a dominant and organizing aspect of their work that influenced patient care. The context of nurses’ work is situated in the organizational structure, practices, and policies of the health care setting. Hence, nurses’ practice is undertaken in a heavily regulated work environment characterized by fiscal restraint and limited human resources.
Policies represent a sophisticated form of power exercised over nurses and their work (Rankin & Campbell, 2006). Patient safety required nurses to participate in substantial charting to support the work of administration even though their interests differ from nurses. In effect, the organization was enforcing policies and regulations designated to safeguard the interests of the patients and enhance operational efficiency, but seemingly without regard to how such activities, at times, hindered nurses’ ability to provide safe quality patient care. Nurses in this study reconfigured their activities to accommodate and advance managerial directives as an extension of the efficiency mandate of the hospital.

Bed policies served as a symbol of power, and controlled nurses work (Wong, 2004). Because nurses oversee the well-being of patients, it was natural that the responsibility for bed monitoring was integrated into their practice. The priorities of the hospital included a continuous need to create extra beds, so nurses were caught in the management of beds, admissions, and discharges to expedite the movement of patients from the emergency department to less resource intensive units. Again, it was commonplace for nurses to use terms such as “99 beds” and “alerts,” reflecting how the corporate commitment to bed utilization policies was readily integrated into everyday interactions. Such situations illustrated how nurses’ practice had broadened and become regulated.

According to Rankin and Campbell (2006), nurses’ use of the language of efficiency has a dual purpose. On one hand, nurses retain their traditional understanding of their responsibility to be efficient in order to attend to individual patient needs. Conversely, the efficiency of managerial imperatives dominates nurses’ thinking and
influences their actions. Storch (1996), in noting the pressure to promote the business nature of health care practices states, “the influence of language in shaping thinking and instilling a gradual acceptance of ideas and approaches formerly not viewed as applicable to health care should never be underestimated” (p. 24). This dual approach to the language of efficiency “shapes nurses’ understanding of restructuring as their own professional responsibility [authors’ emphasis]” (Rankin & Campbell, 2006, p. 146).

Similarly, Blythe et al. (2001) found that policies led to work activities that became less controllable, decreased integration of patient care, and ultimately led to nurse disempowerment.

Policies and protocols simultaneously enable and constrain nurses care’ activities (Manias & Street, 2000). First, policies enable nurses to recognize expected standards of care. In effect, policies provide an additional way for nurses to legitimize their care practices and presumably demonstrate safe practice. Policies offer nurses the ability to validate their decisions and assert their power in achieving a sense of control over their work. When nurses communicate their knowledge of policies and protocols, this provides a legitimate and valuable way to assert their power in decision-making processes.

Second, policies at times constrained nurses’ actions by limiting their ability to care for patients in ways that would optimize their health unencumbered by policy discourses (Manias & Street, 2000). The manager scrutinized nurses’ activities to ensure they demonstrated desirable and expected practices by following policy directives. In this way, administrative personnel, including the manager, upheld the value of organizational and unit policies in the organization. The need to take account of the context is noted by Hart (1993) who indicates that policies and protocols are generally too firm and inflexible
for the dynamic nature of clinical work. All too often administration develop policies and protocols in isolation from the realities of those providing care at the bedside and therefore fail to address the potential difficulties confronting clinical nurses (Blythe et al., 2001). To illustrate, policies were perceived by nurses as an added layer of bureaucracy, and their ability to make decisions was deemed less autonomous and less flexible in responding to required patient care services. Power over nurses created new ways of thinking and acting for nurses, causing them to divide their energies between organizational priorities and nursing care practices. As such, nurses’ work included responsibilities for enacting objective, text-based policies into the local setting. Nurses were held accountable for implementing policies into their day-to-day practices of managing patients because their actions could be scrutinized and judged according to established standards and produced their work reality.

**Jeopardizing Patient Safety**

Nurses described this category as their hyper-vigilance to the pervasive threat of unintended injuries or complications to patients as a result of responding to a myriad of competing priorities. The dissatisfaction among nurses as they grappled with fragmented care and unwieldy workloads ultimately led to fears of not being able to provide safe, quality care, and risking their professional licenses. Nurses frequently found themselves re-prioritizing patient care amidst numerous priorities for which they were responsible and accountable in addition to staying alert for patient safety. It is noteworthy that patient safety and risk management were high-level priorities in the hospital as evidenced by the existence of a risk management department.
Page (2004) identified organizational factors as important predictors of patient safety. Previous research suggested that the nursing shortage creates a stressful work environment, compromises patient care delivery, and impinges on the smooth functioning of the organization (O’Brien-Pallas et al., 2005; Priest, 2006). Specifically, job stress increases the risk of injury and accidents and compromises patient safety on short-staffed units. Other studies found evidence to support the relationship among adequate staffing levels, lower hospital mortality levels, and shorter patient length of stay (Aiken et al., 2002; Lang, Hodge, Olson, Romano, & Kravitz, 2004). Research into adverse events among patients in Canadian acute care hospitals suggests that the greatest gain in improving patient safety will come from modifying the work environment of health professionals thus creating better defenses towards mitigating or averting adverse events (Baker, Norton, Flintoft, Blais, Brown, Cox, et al., 2004).

Actions and Consequences for Seeking Connectivity: Relationship to the Literature

In this section, I consider the extent to which managerial imperatives shaped the nurse-manager relationship. I divide this section into two sequences 1) relating through disconnecting, and 2) relating through connecting.

Relating through Disconnecting

The first pattern of the process is characterized by nurses situated in a state of disconnect with the manager in an oppressive work context. This stage is comprised of three categories each with its own set of sub-categories. First, the category working
without an anchor has three sub-categories: (i) being out of sight and mind; (ii) encountering limited know how; and (iii) sealing unease. Second, the category silencing forms of communication has three sub-categories: (i) communicating and enforcing policies; (ii) assuming a silent role; and (iii) being trapped.

Third, the category positioning to resist has five sub-categories: (i) setting limits flexibly; (ii) redefining behaviour; (iii) attending to one’s voice; (iv) running interference by not doing; and (v) battling back with supportive others. Each of these is discussed separately within the context of related nursing literature.

Working Without an Anchor

Working without an anchor accentuated the tension nurses experienced between meeting organizational imperatives without the support and active engagement of the manager. A wide array of managerial practices within the organization influenced nurses’ perceptions. Nurses came to view the manager as aligning with administration’s cost-containment goal of efficiency in work, in the use of resources, and in adherence to policies. Nurses viewed the manager as a tangible and visible form of power and the primary architect of their job dissatisfaction.

Being Out of Sight and Mind

Being out of sight and mind describes the manager’s lack of visibility and accessibility on the unit, which shaped nurses practice and is congruent with other studies in the nursing literature. Rankin and Campbell (2006) reported that nurse leaders learn to apply text–based methods of managing nurses, which include assessing workload, allocating staff, and ensuring documentation standards are met. Such management technologies are expressed in policies and strategies designed to make efficient use of
nurses’ time and of other resources (Rankin & Campbell). Monitoring and enforcing of policies by managers achieves the desired level of involvement of nurses. Consequently, nurses at the front-line are accountable for their practice and are judged “rather forcefully” (p. 103) by nurse leaders to comply with managerial objectives. These authors further assert that managers’ attention to the nursing staff increasingly focuses on how nurses fulfill the requirements of the efficiency mandate, and the nurse-manager relationship has changed from a collaborative and supervisory relationship to a managerial relationship. Others report similar findings, emphasizing that organizational processes and practices used by management regulate nursing work (Wong, 2004). In the present study, terms such as “beds,” “admissions,” and “discharges” were used by nurses to achieve the turnover demanded by the hospital, and regulated the conduct of the nurse-manager relationship according to the norms of the hospital setting.

New governance models have radically changed nursing leadership structures. Studies found nurse managers have increased spans of control (Doran et al., 2004; Laschinger et al., 2008; McCutcheon et al., 2009), and decreased visibility and availability for mentoring and support (CNAC, 2002). Managers with increased responsibilities may have less time to develop, implement, and evaluate systems and processes that enhance patient care (McCutcheon et al., 2009). Transformational leaders exert a positive impact on staff satisfaction by providing support, positive feedback, encouragement, and individual consideration, and transactional leaders assign tasks, specify procedures and clarify expectations. However, the positive effects of transformational and transactional leadership styles on nurses’ job satisfaction were significantly decreased in units where managers had wide spans of control limiting their
ability to provide effective leadership support (McCutcheon et al., 2009). In the present study, because the manager was less visible on the unit due to organizational responsibilities, nurses gradually assumed increasing responsibility for the management of the unit. Nurses perceived themselves to be scrutinized by their manager through incident reports and surveillance of documentation. The fact that nurses could be observed, judged, and evaluated at any time revealed the discreet form of power operating within the organization.

Sealing Unease

Sealing unease describes the manager as interacting with nurses in demeaning ways, which exacerbated strained relationships and reinforced distrust in the manager. Several studies have found that many practicing nurses do not feel respected in their workplace (Buerhaus, Donelan, Norman, & Dittus, 2005; Laschinger, 2004; Laschinger, Finegan, & Shamian, 2001b). Lack of respect is identified as a core value that reflects an organization’s culture, is a key factor that affects the quality of nurses’ work life, and is instrumental to the overall success of an organization (Faulkner & Laschinger, 2008; Laschinger & Finegan, 2005; Laschinger, 2004). Respect is associated with organizational trust and perceived organizational support (Laschinger & Finegan, 2005; Laschinger Purdy, Cho, & Almost, 2006). On the contrary, a lack of respect is linked to personal stress (Boyle & Kochinda, 2004) and disrespected individuals are less committed to the group’s goals and less likely to identify with the group (Faulkner & Laschinger, 2008). The negative consequences of lack of respect include emotional exhaustion, a depressive state of mind, and turnover intentions (Ulrich et al., 2005). In this study, the surveillance of nurses’ work allowed for intervention if the nurse was in
breach of organizational policies (i.e. not complying with documentation, not participating in bed movement), and nurses learned to comply with managerial practices to avoid reprimand. As a result, nurses participated in self-correcting behaviours to achieve managerial objectives.

**Silencing Forms of Communication**

Silencing forms of communication describes a pattern of communication between nurses and their manager that circumscribed and reinforced the isolation nurses experienced in addressing the complexities of their practice. Communication, or lack thereof, was used to exercise power and to restrict and alter information needs between nurses and their manager. For example, nurses had limited opportunities to participate in forums with the manager that affected their work within the organization. The effect of silencing communication was that nurses’ were only minimally involved in decision making and policy development denoting their invisibility in influencing patient care.

These findings, congruent with other studies in the nursing literature, describe nurses’ limited ability to negotiate or contribute to decisions affecting their practice. Daiski (2004) found that nurse disempowerment resulted from nursing leadership aligning with hospital administrators, from nurses receiving little respect from managers, and from nurses being excluded from decision-making processes. Cheek and Gibson (1996) reported nurses were found to be an oppressed group and the privileging of other voices, namely physicians and nursing management, intruded into nursing issues and affected nurses’ lives favourably or unfavourably. Nurses navigated institutional practices as effective and obedient employees but with limited guidance from the manager (Daiski, 2004).
Blythe et al. (2001) reported nurses had no input into restructuring policies and had little opportunity to contribute to unit-level change because even when meetings were open, they were usually not able to attend. Other researchers suggest that nurses’ exclusion by managers from decision-making processes affecting their work fails to acknowledge nurses’ professional judgment based on their close contact and observation of the patient (Cheek & Rudge, 1994; Peter, Lunardi, & Macfarlene, 2004).

Findings related to limited communication patterns in the current study are congruent with other literature that reports organizational factors affect nurse-manager interactions. Some suggest that a manager’s expanding responsibility for other disciplines diminishes communication links between them and nursing personnel at lower levels (CNAC, 2002). Similarly, other studies found that the manager’s time constraints, demands, and increased span of control results in nurses communicating less frequently and more formally with the manager (Blythe, et al., 2001; McCutcheon et al., 2009). Hence, nurses’ dissatisfaction was often exacerbated by flawed communication, insufficient support, and distrust (Blythe et al., 2001). As a result, hostility arose and rumours about nurses’ deployment decreased morale (Blythe et al., 2001). Limited communication may impede the development of the high-quality relationships that are essential to implement systems and processes that enhance patient care and facilitate a high-quality work environment for nurses.

Positioning to Resist

A third category, positioning to resist, resulted from the disconnect nurses experienced with their manager. This category has five sub-categories: (i) setting limits flexibly; (ii) redefining behaviour; (iii) attending to one’s voice; (iv) running interference
by not doing; and (v) battling back with supportive others. The existence of power revealed multiple points of resistance where nurses played the role of adversary when nurses exercised power in relations with their manager, opening up the possibility for change by disrupting the managerial imperative. Nurses’ acts of resistance to the oppressive nature of the managerial imperative ultimately brought about change to nurses’ practice through individual reflection, dialogues of protest, and collective action.

Research has explored the concept of resistance in the context of the nurse-manager relationship. Peter et al. (2004) employed a Foucauldian notion of power relations and feminist ethics and found that nurses resist in situations where they experience moral conflicts in relation to the actions of health professionals. The importance of maintaining the nurse-patient relationship was found to be a central moral value in the descriptions of moral conflict. The majority of conflicts and disagreements were with physicians. Other Foucauldian researchers suggest that nurses can identify points of resistance to develop alternative discourses for medication administration (Cheek and Gibson, 1996) and improve the quality of nurses’ work life (Udod, 2008). Using an ethnographic approach, Street (1992) suggests that nurses must be made aware of the ways in which they are oppressed, of their role in oppression and of how such awareness can lead to resistance. Together, these authors challenge nurses to identify points of resistance and develop alternative discourses leading to improved patient and nurse outcomes.

Setting Limits Flexibly

Setting limits flexibly describes a form of undermining in which nurses made disparaging and judgmental remarks to each other about the manager’s performance,
while covertly setting time restrictions to the probationary period. This finding is congruent with an ethnographic study by Street (1992) suggesting that nurses are most articulate about their relationship between themselves and nursing administration where their oppression is most explicit and where they are most active in acts of resistance. Street described the first stage of resistance as characterized by situations where nurses expend significant energy challenging the mechanics of an administrative decision rather than challenging the basis upon which the decision is made. Nurses in the present study expended significant energy supporting or hindering the manager based on their perceptions of whether the manager was fulfilling her job responsibilities as they saw fit. In this way, rather than challenging the basis of the manager’s pressures and domination by critically examining the rules of the system that propel managers to make specific administrative decisions, nurses believed the manager was largely at fault for their oppression. Hence, nurses questioned the manager’s ability to meet performance expectations. This process reveals the inequality of the nurse manager-nurse relationship and maintains the hegemonic oppressive relationship prevalent in bureaucratic structures.

*Attending to One’s Voice*

Attending to one’s voice is speaking up to the nurse manager, middle manager, clinical coordinator, or educator when nurses lack support or resources. Previous studies report speaking up and confronting as acts of resistance and that nurses spoke up in response to moral distress and ethical concerns (Peter, et al., 2004; Sundin-Huard & Fahy, 1999; Wurzbach, 1999). In my study, if nurses were uncomfortable with a patient care decision, they engaged in patient advocacy.

*Running Interference by Not Doing*
Running interference by not doing describes how nurses determined what tasks or activities they would not carry out. Silent protests were particularly evident when nurses ignored or modified instructions to appear that nurses were responding to managerial directives. This finding is congruent with other studies that report instances of passive resistance when nurses ignored charts or made minimal effort to record information (Street, 1992). In another study, nurses exhibited an indirect form of resistance labeled responsible subversion aimed at bending rules (Hutchinson, 1990), in which nurses used different strategies aimed at stalling or pretending not to notice events in order to advocate for patient care. The present study extends these findings as nurses manipulated their practice as one of the ways they assumed power and control over their work. Nurses made decisions alone or in consultation with one another to advocate for patient care and safety and to reduce nurses’ stress.

Battling Back with Supportive Others

Battling back with supportive others describes how nurses demonstrated the most overt and assertive forms of resistance when they perceived themselves as having minimal control over their work. Nurses described battling back as taking collective action through dialogue and debate in advocating for safer, high-quality patient care. Previous studies do report resistance as emancipatory action when nurses spoke up to protect the quality of care for patients (Peter et al., 2004; Schroeter, 1999; Street, 1992). Nurses’ most assertive acts of resistance rely on their professional knowledge of patient care that include documentation and going to a higher authority (Peter et al., 2004; Schroeter, 1999). Nurses’ primary conviction was to comfort patients and families, which led to their struggles with their managers to ensure that patients did not experience
distress. These acts of resistance call for patient advocacy and demonstrate nurses’ sensitivity to their patient’s vulnerability and oppression. They provide opportunities for nurses to exercise power through the expression and enactment of nursing values (Peter et al., 2004).

Findings from the current study surrounding nurses’ resistance to their manager confirm and extend the work by Street (1992). Nurses in the present study were also able to resist oppressive situations and become effective advocates for their patients through a process of collective consciousness-raising, which came about in critical moments of oppressive leadership. A decision was made to act in a manner that would more effectively meet patient care needs. Nurses’ claim to authority is derived from their experience and knowledge of patient care. Street (1992) asserts that all oppositional behaviour needs to become a focal point for dialogue and critical analysis. At this level of resistance, nurses began to share concerns with each other and became collectively aware of how oppressive the managerial expectations had become. In this way, nurses’ social relations of power with their manager were made explicit, and the oppression they experienced in the workplace was made visible.

In response to nurses’ actions, nursing administration held several meetings with the manager. In these meetings, nurses were able to move beyond oppression by engaging with the manager in discussion about work issues. Power struggles between nurses and managers represented their struggle for autonomy to support quality patient care.

In the present study, dialogues of protest did not, however cause nurses to explore the basis of their oppression in-depth nor their role in their oppression. Daiski (2004) demonstrated insight into nursing hierarchies and non-supportive relationships
that sustained nurses’ oppression. Nurses expressed ideas about how to promote mutually supportive relationships that included, for example, respecting and praising each other for jobs well done and building a community of “sharing and caring.” In the present study, nurses were unable to express more fully elements of a managerial imperative at play that limited the manager’s ability to more effectively facilitate nurses’ work. While one manager’s resignation was a “relief,” some nurses were taken aback by this turn of events, yet other nurses indicated this process affirmed their power in being able to effect change. Some nurses alluded to the fact that the manager may have been “a scapegoat” for senior administration, but nurses were reluctant to explore the expectations on the manager to meet administrative goals. Rather they chose to focus on her unsuitability for the role.

Further exploration of the scapegoat theory by nurses would have required more of their time and energy to determine the amount of control over policies and staffing requirements the manager realistically had in operating the unit (Street, 1992). Exploring the issue in depth would have taken additional energy causing nurses to potentially experience higher levels of stress and may have diverted them from their primary aim of providing patient care. Street (1992) reveals that nurses’ resistance may be halted if they experience too much dissonance with their professional image as caring nurses; however, I speculate this was not the case in this study. These disempowering situations for nurses will not change until they are able to critically examine the rules and social practices within the hospital bureaucracy that ultimately have a bearing on how and why certain actions are taken or not taken by managers and to explore their role in their own oppression (Street, 1992). Daiki (2004) affirms that effective and appropriate change
“needs to come from within nursing, be brought about by nurses themselves, and be achieved through greater advocacy for the profession” (p. 48).

**Relating through Connecting**

The *second pattern* of the process is characterized by nurses situated in a state of connection with the manager in a supportive work environment. Findings from this study highlight two major categories. First, *stepping up of power*, has three sub-categories: i) advocating and backing nurses; ii) demonstrating nurses’ worth; and iii) readjusting the mindset to nursing. Second, *experiencing the potentiality of enabling*, has one sub-category: i) acting with and for patients.

**Stepping Up of Power**

When managers were accessible, advocated for nurses, engaged and supported nurses in patient care, nurses were able to practice according to professional standards of practice. The manager’s behaviour enabled nurses to practice more autonomously despite the organizational context. In this study, nurses came to identify themselves as being situated in a positive relationship with their manager, albeit less frequently, when she exhibited certain attitudes and behaviours that nurses found conducive to facilitating their practice.

**Advocating and Backing Nurses**

This sub-category describes the manager acting as a liaison to guide, support and/or resolve conflict between nurses and others. More specifically, the manager’s supportive interventions occurred when conflict occurred between nurses and patients, their families, or other health professionals in the organizational hierarchy, especially
when there was a power differential, and when administrative interests superseded nursing care decisions.

Supportive leader behaviour was manifested as being accessible to communicate and exchange information, exhibiting a positive management style, providing feedback, and providing expressions of caring (Corbally, Scott, Matthews, Gabhann, & Murphy, 2007; Faulkner & Laschinger, 2008; Kuokkanen & Leoni-Kilpi, 2001). This finding is also congruent with previous research that suggests leader empowering behavior, such as facilitating goal accomplishment, being visible, and providing autonomy from bureaucratic constraints, was associated with workplace empowerment leading to decreased tension and increased work effectiveness (Greco, Laschinger, & Wong, 2006; Kuokkanen, Suominen, Harkonen, Kukkurainen, & Doran, 2009; Laschinger et al., 1999; Upenieks, 2003b). Blythe et al. (2001) reported, when managers clearly communicate critical information to nurses, nurses place less blame on the organization thus mitigating distrust. This present study extends these findings as nurses felt empowered to take on tasks facing them in their workplace despite the contextual demands when the manager employed leader empowering behaviours. The manager’s presence on the unit provided opportunities for nurses to dialogue with her about their concerns. For example, they felt that her presence facilitated her ability to see first hand the pressures nurses faced in their everyday workload. In addition, the manager was better able to regulate the flow of patients onto the unit, act as a resource, and secure more staff. As a result, nurses were able to dedicate themselves to patient care, and this enhanced the meaningfulness of their work and aided their ability to accomplish patient care.
Demonstrating Nurses’ Worth

Demonstrating nurses’ worth describes the manager as respecting and encouraging nurses’ professional judgment, asking for their input on patient and unit matters, and recognizing and acknowledging nurses’ contributions. When this occurred, nurses experienced a sense of respect from their manager. Furthermore, they felt it demonstrated her commitment to patient care.

Studies report similar findings in terms of the relationship between nurse empowerment and trust in management (Corbally et al., 2007; Kuokkanen & Leino-Kilpi, 2001; Laschinger & Finegan, 2005; Laschinger, Finegan, Shamian, & Wilk, 2001c). Although Corbally et al. found that professional respect was a belief inherent in empowerment, Laschinger and Finegan (2005) found empowerment had a direct effect on respect. Laschinger and Finegan’s study revealed nurses were more likely to trust managers who provided the necessary resources for them to accomplish their work. As Laschinger and Finegan (2005) found, nurses in the present study expressed low levels of trust in their manager’s concern for their needs. I speculate that manager’s actual care and concern for the staff’s ability to provide quality care was higher than staff recognized. I argue that managers may have been “sandwiched” between meeting staff needs and demonstrating to their superiors’ their ability to meet organizational expectations.

On occasion, managers empowered their staff by encouraging a sense of autonomy and control over practice. Nurses described this as being able to use their skills and judgment to their full scope of practice in caring for patients and as being capable of successfully responding to patient care. Similar research in the nursing population has found autonomy to be an important predictor for empowerment (Corbally et al., 2007;
Part of nurses’ ability to secure control over their practice was predicated on the manager’s ability to procure physical and human resources for patient care. This was particularly evident when physicians on one unit would not respond to answer a nurse’s call concerning a patient having an episode of tachycardia. Nurses felt powerless to help the patient despite repeatedly calling for medical intervention. Having exhausted their options, they informed their manager of the critical nature of the patient’s status. The manager promptly secured a physician from the cardiac care unit (CCU), and the patient was immediately transferred and received medical intervention in CCU. Although events such as this were rare in nurses’ testimonies, they elicited respect and confidence of nurses in the manager as a consequence of her support in obtaining medical intervention.

What is noteworthy is that nurses in the present study reported minimal involvement in participatory decision making at the unit and organizational levels, although they desired further involvement. Being involved in decision making is an effective leader empowering strategy in nurse empowerment (Greco et al., 2006; Laschinger et al., 1999). The present study’s findings are consistent with Greco et al. (2006) who found participatory decision making was the least used leader empowering behaviour. I offer two reasons why managers in this study may have minimally used this strategy. First, being involved in unit or organizational decision making necessarily requires time and commitment away from patient care to attend meetings. Given nurses’ often-hectic workdays, managers may have opted to not actively involve nurses in decision-making processes in order to minimize their stress. Secondly, involving nurses
in decision-making may have been futile if choices had been made by administration and were not amenable to discussion.

Yet other studies confirmed the importance of participatory decision making. Nurses expressed job satisfaction in workplaces where they participated in hospital and unit committees (Daiski, 2004). More specifically, Peter et al. (2004) affirm the necessity of nurses to be involved in decision making at the level of institutional priority setting, engaging in resource allocation, and in decisions affecting patient care at the bedside. Moreover, nurses in this present study reported instances where policies and procedures directly affecting their practice were developed by others in authority and passed on to nurses to implement. Nurses would have valued an opportunity to participate on committees where their professional viewpoints could have aided in examining organizational contingencies and problems affecting their practice. Albeit time consuming, having nurses involved in some of the major decisions affecting their practice may lead to a sense of being valued as collaborators in patient care. Nonetheless, nurses described situations in which the manager recognized and acknowledged nurses’ contribution to patient care, thus suggesting that promoting professional and supportive relationships is particularly important for building nurses’ worth.

**Readjusting the Mindset to Nursing**

Readjusting the mindset to nursing is a cognitive approach characterized by the manager’s ability to redirect her judgments and activities from an organizational consciousness to a nursing consciousness. This strategy bridged the nurse-manager relationship creating a work environment more conducive to respect by the manager and trust in the manager when she demonstrated support and commitment to patient care.
Little research has explored the concept of readjusting the mindset to nursing in
the health care literature. However, Rankin and Campbell (2006) provided an account of
the changing work of front-line nurse managers within a new public management model,
which links to the present study. Rankin and Campbell’s work about the public
responsibility for funding health care puts a strong focus on its proper administration.
Public administrators must maintain an efficient, effective, and equitable system of
delivering health care. The new leadership role for the nurse manager is organized in
relation to the technologies of management (i.e., clinical pathways, computerized
program for keeping track of admissions, discharges, etc.) and on textual activities to
make therapeutic practices of patient care more efficient. Work requirement for both
managers and nurses can create tension and conflict when patient care is subordinated to
policy objectives.

**Experiencing the Potentiality of Enabling.**

Experiencing the potentiality of enabling resulted when nurses experienced a
connection with their manager. This category had one sub-category: (i) acting with and
for patients. The consequences of connecting highlight nurses’ ability to practice
according to professional standards and to provide high-quality care when the manager
was visible, advocated for nurses, and was supportive of nurses in their practice
environments.

*Acting With and For Patients*

Acting with and for patients includes nurses’ ability to enhance patient care when
the manager intervenes to regulate organizational processes and practices. Underlying
this sub-category is nurses’ ability to use their expert knowledge to engage in promoting
patient care. High-quality practice environments that provide adequate support services to allow nurses to spend time with patients produce better patient outcomes (Aiken et al., 2002; Laschinger & Armstrong, 2006). Similarly, Laschinger et al. (2001d) found that nurses’ perceptions of a positive work environment had an impact on nurses’ trust in management and ultimately influenced their job satisfaction and their perceptions of quality of patient care. Armstrong and Laschinger (2006) conclude that a manager’s leadership practices creates positive working conditions, and nurses feel more able to have an impact on how they provide care in the workplace which contribute to their ability to provide safe, high-quality care.

Nurses feel more empowered when the manager promotes professional behaviours and supportive relationships, which ultimately has an impact on patient safety, on the quality of patient care, and on the quality of nurses’ work life in their work environment (Boyle & Kochinda, 2004; Laschinger et al., 2004; Ulrich, et al., 2005). Moreover, satisfied nurses are more likely to respond to the challenge of organizational restructuring, affecting patient satisfaction, and ultimately, improving patient outcomes (Manojlovich & Laschinger, 2002).

**Linking Power and Nurse Empowerment in Three Theoretical Perspectives**

In this section, I revisit the various theoretical approaches outlined in the Literature Review in Chapter 2. First, I suggest how these approaches are useful in understanding power and its link to nurse empowerment by situating my findings in the three different theoretical perspectives.

Data support findings from previous studies on nurse empowerment, namely,
structural empowerment, psychological empowerment, and critical social empowerment. This section highlights the way power operates from each of these theoretical perspectives and clarifies how the theory of seeking connectivity advances nurse empowerment theory. Power is central to understanding nursing practice and we need to understand how power operates for nurses within their work environment (Bradbury et al., 2008; Denham Lincoln et al., 2002; Hardy & Leiba-O’Sullivan, 1998). The next section describes how power is mobilized by nurses and managers to advance nurse empowerment in the context of other theoretical work in each of the following perspectives: i) structural, ii) psychosocial, and iii) critical social.

Organizational Theory: Structural Perspective

Power, according to Kanter (1977; 1993), is associated with the ability to mobilize resources to get things done. Accordingly, work environments that provide access to resources, support, and information empower nurses to accomplish their work in meaningful ways (Kanter, 1977; 1993). From this perspective, power is associated with granting or bestowing power; it is legitimate and shared for everyone’s benefit. Power is associated with autonomy and mastery, not domination and control, and it affects organizational productivity. Kanter argues, and Laschinger (1996; 1999; 2006) research confirms that managers play a key role in ensuring access to sources of nurses’ empowerment in work settings. Empowerment is a tool used to motivate nurses to achieve organizational goals. Empowerment enables nurses to have autonomy and control over practice. It is manifested by a degree of clinical judgment within one’s scope of practice in caring for patients.
In the present study, as in Kanter’s (1977;1993), organizational conditions of support, information, and resources, and managers’ stepping up of power, characterized by behaviours such as being accessible, advocating, and supporting, enabled nurses to practice more autonomously. The present study demonstrated a strong relationship between informal power and support that was closely related to nurses’ feelings of being respected as did Faulkner and Laschinger (2008). This supports Kanter’s (1977; 1993) contention that effective collaborative relationships with managers and colleagues foster a feeling of respect in the worker and a sense of being valued in the organization, as well as a sense of achieving professional autonomy.

This study revealed, from a structural perspective, that nurses frequently lacked resources, information, and access to opportunities to accomplish their work. Reasonable workloads and time (Kanter, 1993) are essential for nurse empowerment. The study findings also indicated that nurses felt they did not always have the necessary information to complete their work effectively. Consistent with findings by Faulkner and Laschinger (2008), the findings in the present study revealed access to learning opportunities and career advancement maybe viewed as counterproductive during a nursing shortage or corporate reorganization given the constraints in the workplace and increased demands on nurses’ time.

In the present study, the theoretical concepts of sealing unease and experiencing the potentiality of enabling confirm that nurses who have access to empowerment have a more positive attitude toward work and feelings of respect. Findings from the present study confirm that structurally empowered work environments are the outcome of leadership practices that foster employee feelings of respect and organizational trust.
(Laschinger & Finegan, 2005; Laschinger et al., 2004) and job satisfaction (Laschinger et al., 2001b). Moreover, respect is aligned closely with leadership practices that empower nurses to practice autonomously within interdisciplinary teams in today’s dramatically restructured work settings (Laschinger & Finegan, 2005). The findings in the present study support Kanter’s contention (1977; 1993) that effective collaborative relationships with managers increase access to empowerment structures and facilitate the accomplishment of goals.

Finally, the ultimate control rests with the manager who modifies and changes the parameters of the work environment within which nurses operate. The present study reveals there is a greater need for decentralization of power at the unit level. The act of managers controlling resources and information implies that power remains with management, thus creating a “dependency relationship” (Hardy & Leiba-O’Sullivan, 1998, p. 469). From this perspective, the relationship can be viewed as disempowering particularly when the empowerer (manager) has significant power over the empoweree (nurse). There is a need to work with the managers to enhance their ability to share power with staff nurses. Leaders who demonstrate power sharing through participation and involvement are more likely to engender reciprocal feelings of power among their subordinates.

Organizational Theory: Psychosocial Perspective

Theorists who assume the psychosocial perspective downplay changes in working conditions, choosing rather to focus on empowerment as a motivational construct that supports individuals’ self-efficacy beliefs and in doing so, improves productivity.
Spreitzer (1996) theorized that an employee’s perceptions of the work environment shape feelings of empowerment and those structural empowering conditions cannot be fully realized unless the individual is psychologically receptive. The motivational approach to empowerment involves sharing power and information to provide nurses with added conviction in their own effectiveness. By helping nurses feel they have power over significant aspects of their work, and by enabling them to develop a sense of ownership in their work and the organization, empowerment is thought to increase nurses’ commitment and involvement, ability to cope with adversity and willingness to perform independently and responsibly (Conger & Kanungo, 1988; Thomas & Velthouse, 1990).

In the present study, as in Spreitzer’s (1995) concept of psychological empowerment, *stepping up of power* characterized nurses as being able to practice more autonomously despite the demands of the organizational environment. Data in the present study identified factors such as autonomy and self-determination as important for empowerment. The theoretical concept of *jeopardizing patient safety* characterized nurses as responding to fragmented care and being vigilant in ensuring safe patient care. Nurses in the present study did not consistently perceive they were able to complete their work effectively. They believed the fit between their behaviour and the requirements for professional nursing practice was not always aligned.

The theoretical concept of *working without an anchor* characterized nurses as working without the support and guidance of the manager but being governed by managerial practices and policies. Laschinger and Finegan (2005) emphasized the importance placed on autonomy by professional nurses, yet nurses in this study reported deficits in autonomy. Laschinger and Finegan (2005) report significant relationship
between autonomy, empowerment, and job satisfaction given the importance of professional decision making required in patient centered care. Nurses also reported not having significant impact over unit activities. Again, research has found a strong correlation among impact, empowerment, and job satisfaction (Manojlovich & Laschinger, 2002).

In the present study, similar to Spreitzer’s (1995) construct of competence, experiencing the potentiality of enabling was characterized as nurses’ ability to practice according to professional standards of practice. Data identified nurses’ knowledge, expert judgment, and professional skills as important for empowerment. Laschinger et al. (2001c) found nurses who experienced a high degree of control in their jobs, however psychologically demanding, were more psychologically empowered as measured on Spreitzer’s (1995) scale. These findings support Spreitzer’s (1995) contention that managers who facilitate meaningful work and provide autonomy in accomplishing nurses’ work play a role in heightening nurses’ motivation in completing a task through a sense of personal self–efficacy. These findings confirm that managers should create conditions that optimize nurses’ autonomy to use their knowledge and expert judgment in providing patient care. Managers must let go of control, focus on clear goals, and give nurses a degree of freedom within agreed upon boundaries.

Findings of my study provide some support for leader empowering behaviours as reported by Laschinger et al. (1999) and Greco et al. (2006). The results of these studies reveal that leader behaviours are important for nurses to feel supported and are consistent with the theoretical concept of stepping up of power. Results of the present study suggest that nurses are empowered when the leader’s behaviour encourages
autonomy, displays confidence and respect’s nurses’ professional judgment. However, nurses in the present study did not consistently perceive themselves as being involved in participatory decision making. The literature supports the importance of the manager using a more inclusive, participatory style in which a concerted effort is made to seek nurses’ input into decision-making processes (Laschinger et al., 1999; Upenieks, 2003b). These findings support Conger and Kanungo’s contention (1988) that managers play a role in heightening nurses’ motivation. Although the psychosocial perspective acknowledges the individuals’ perceptions of their own power and self-efficacy, external agents, such as the manager, have a role to play in fostering empowerment through the utilization of motivational techniques.

The present study supports Kanter (1977;1993) and Conger and Kanungo (1988) and highlights the key role of leader behaviour in creating positive responses to work. Taken together, the structural and psychosocial perspectives suggest that nurse empowerment is both a process and a goal that acts at the individual level to increase self-efficacy. It will be important for current and future nurse managers to learn new ways of leading that include participatory decision making to empower nurses to engage in providing the high-quality care their patients deserve. The sharing of power from the manager to the nurse increases nurses’ sense of self-efficacy, enhances nurses’ empowerment, and improves organizational success.

Critical Theory

Examined from the critical theory perspective, power and empowerment are social and political phenomena. Critical theory is based on the premise that certain groups
are in a subordinated position. In critical theory, power means that an increase in power is compensated by someone else surrendering part of their power (Kuokkanen & Leino-Kilpi, 2000). Critical social empowerment depends on countering the existing power relations that result in the domination of subordinate groups by more powerful ones (Hardy & Leiba-O’Sullivan, 1998). The common denominator in critical social empowerment is a process whereby disenfranchised members of a group become aware of the forces that oppress them and take action by changing their work conditions. The political dynamic of critical social empowerment is a more radical form of empowerment and is quite different from organizational empowerment.

To strengthen this discussion of power requires an examination of seminal work by Lukes (2005). Lukes proposed a three-dimensional view of power. Lukes’ first model of power describes the one dimensional view. Here power involves a focus on behaviour through the observation of conflict. For example, those successful in the conflict are those considered to have power. The second model of power describes the two dimensional view. Here the focus on both decision-making and non-decision making are of analytical importance. This typology of power embraces coercion and manipulation by controlling agendas so that particular options are not considered.

Lukes’ (2005) third model of power, the three dimensional view, is most relevant to this dissertation because it is characteristic of critical theory. He introduces the idea of the subject, which is of central importance to the discussion of power. Lukes asserts that power is produced to shape individuals’ perceptions and cognitions in such a way that they accept social practices and their role as inevitable. Critical theorists are interested in exposing how power concealed in the organization’s structure, rules and
culture prevents conflicts from arising. Therefore, conflict does not arise because people fail to consider alternatives to the present way of doing things. From this perspective, managers use power to prevent nurses from challenging existing power positions by portraying nurses’ positions as beneficial, acceptable, or inevitable (Hardy & Leiba-O’Sullivan, 1998). Power in this way produces consensus and acquiescence, replacing visible controls with hidden cultural forms of domination.

The present study expands our understanding of empowerment by including a third perspective, the critical social perspective. In the present study, silencing forms of communication were characterized by communication patterns that restricted and altered communication and information needs between nurses and their manager. Casey et al.’s (2010) findings reveal respondents reported a moderate level of critical social empowerment when they felt involved in decisions affecting them and the organization. On the contrary, nurses in the present study, reported minimal opportunities to be involved in situations in which others listened to them about decisions affecting them or the organization. In addition, nurses did not consistently feel recognized, did not receive the requisite information required for patient care, and did not believe their work environment constituted a democratic workplace in which their voices could be heard.

Critical social empowerment reveals nurses need to have an equal voice in decision-making and be collaborators with their manager to recognize their potential in contributing to the organization (Casey et al, 2010). In my study, nurses found value and power in the nurse-patient relationship but did not always believe they were recognized for their knowledge and expertise and its potential contributions for patient centered care.

Collaboration between nurses and other groups within an organization can enable
nurses to have access to additional information and support to facilitate goal achievement (Sieloff, 2004). Through such collaborations, other groups can become more aware of nursing’s expertise and hence, nurses can increase their power and influence within the organization.

By seeking a redistribution of economic and political power, critical social empowerment often involves conflict and resistance with the governance structures that influence individuals’ work lives (Alvesson & Willmott, 1992; Hardy & Leib-O’Sullivan, 1998). The emphasis is on participation of the subordinated group who organize themselves on their own behalf and for their own benefit (Hardy & Leib-O’Sullivan, 1998). In the present study, nurses’ resistance to the oppressive nature of the managerial imperative characterized *positioning to resist*, and this resistance ultimately brought about change to nurses’ practice. Street (1992) works within a critical and feminist pedagogy to provide a detailed analysis of how nurses critique themselves and contest medical domination, administrative structures, gender politics, and the hierarchies of power and privilege that devalue their clinical knowledge and practice. The present study parallels Street’s concepts of nurses’ acts of passive and active resistance and extends knowledge of how resistance can be enacted in the clinical setting. Resistance was especially evident in areas where nurses objected to the bureaucratic processes and policies that had been instigated and/or reinforced by others in responding to nursing and patient issues.

In summary, the discourse of nurse empowerment was prompted by a reconsideration of how the concept of power is constructed and negotiated, and ultimately how it influences nurses’ work and provision of care. The nurse manager plays a critical
role in modifying the work environment to increase all three dimensions of empowerment. All three dimensions are important for advancing nurse empowerment. I elaborate more specifically on how these theoretical perspectives advance nurse empowerment theory later in the following section.

Advancing Theoretical Contributions to Nursing Knowledge

In this section, I clarify how the theory of seeking connectivity advances nurse empowerment theory. The substantive theory that emerged from this study explained the processes of how nurses are situated in social relations of power with their manager. Studies have not fully explicated the processes underlying the nurse-manager relationship that contribute to nurses’ power and the ways in which empowerment is conceptualized. More recently, Spreitzer (2008) affirms the integration of the social-structural and psychological perspectives in empowerment have highlighted the need to develop a more comprehensive theory of empowerment. Specifically, Spreitzer suggests a theory to identify the “mechanisms and processes of empowerment” (p. 68) would facilitate our understanding of a more holistic theory of work empowerment.

I begin by revealing how the concepts emerging from the data advance theoretical thinking, describe propositions emerging from this study, and conclude with how the theory of seeking connectivity advances theoretical understanding of nurse empowerment. I believe this study clarifies how we might advance our theorizing in order to bring about transformative knowledge and practice to nurses’ work.
Concept Definitions in the Process of Seeking Connectivity

Seeking connectivity is the process in which nurses strive to connect with their manager to create a workable partnership in the provision of high-quality patient care while responding to the demands of the organizational context.

The budget is a discourse of cost-consciousness infiltrating the day-to-day operations of nurses’ work. This concept highlights the importance of access to funds, additional health personnel, and supplies in order for nurses to meet their job demands. When nurses do not have access to the resources required to accomplish their work, they are accountable without power creating feelings of frustration and failure. When nurses have control over resources, they can achieve successful patient care.

Working short is lack of nursing personnel, whether intentional or not, which appeals to nurses’ duty to care for their patients and serves as a mechanism to regulate nurses’ work. When nurses do not have access to personnel, they are unable to achieve job demands.

Contradicting demands and interruptions involves a complexity and diversity of competing priorities ranging from non-nursing tasks to implementing various policies that occasionally overshadowed nurses’ time for direct patient care. This concept illustrates self-determination reflecting nurses’ autonomy and choice in making decisions about work behaviour, the pace at which they are able to respond appropriately to work demands, and the effort needed to accomplish work (Spreitzer, 1995b).

Being controlled by policies is the context of nurses’ work situated in the organizational structure, protocols, and practices characterized by fiscal restraint and limited human resources. This concept illustrates power as a three dimensional model
(Lukes, 2005). It is key to analyzing nurses’ power relations with their manager. Power shapes individual perceptions and cognitions in such a way that they accept social practices and their role as inevitable, and it prevents nurses, “…to whatever degree, from having grievances by shaping their perceptions, cognitions and preferences in such a way they accept their role…” (Lukes, 2005, p.11). As a result, nurses believe their work environment is normal and natural and hence, they participate in adapting and/or being dominated by institutional practices in their work setting.

*Jeopardizing patient safety* is nurses’ hyper-vigilance to the threat of unintended injuries or complications to patients as a result of nurses responding to a myriad of competing priorities. This concept illustrates that inadequate and ineffective mobilization of resources by managers for nurses, at the point of care, negatively influence the delivery of safe patient care. Nurses were less likely to believe in their ability to perform their work activities skillfully when they did not have the requisite resources. What is more, nurses were held accountable for decisions made by managers affecting the delivery of patient care they had minimal input in defining. Nurses lacked consistent control over the delivery of safe patient care and were dependent on others above them, while being expected by virtue of their position to provide safe, quality patient care.

*Working without an anchor* is the tension nurses experienced without the support, and active engagement, of the manager to facilitate and guide nurses’ professional responsibilities. Without support of their manager, nurses relied upon formal procedures and policies, communication that flowed through a multi-layered chain of command, and conformity to the rules of the organization. This concept illustrates that nurses
experienced power over them when the leader was not available to promote autonomy, encourage participatory decision making and display confidence in staff nurses.

*Silencing forms of communication* represents communication patterns between nurses and their manager that circumscribed and reinforced the isolation nurses experienced creating an obstacle for nurses’ practice. This concept illustrates nurses perceived they did not have consistent forums, either collectively or individually, to have a voice in decision-making processes and practices affecting their work. With less access to the organization’s resources and limited support and communication with their managers, nurses relied heavily on the policies and practices of the organization to guide their day-to-day work activities and to translate general guidelines into specific directives. Involving nurses in decisions affecting their practice could possibly achieve a more engaged innovative staff.

*Stepping up of power* illustrates that when managers were accessible, advocated for nurses, and engaged and supported nurses in patient care; nurses were able to practice according to professional standards of practice. This concept illustrates that when nurses have access to additional health care members, they have time to complete their work in a non-harried fashion. In addition, when nurses have access to guidance, knowledge and awareness of unit and organizational goals from their manager, nurses have access to power and are able to practice according to professional standards.

*Positioning to resist* represents how nurses played the role of adversary with their manager, which occurred through individual reflection, dialogues of protest, and collective action, and which opened up the possibility for change to nurses’ practice.
Experiencing the potentiality of enabling highlights nurses’ ability to practice according to professional standards of practice and provide safe, quality care. Managers who adopt a participatory style, in which they shared information, advocated for nurses, facilitated autonomy, and were supportive of nurses illustrate this concept. The nurse manager role is critical in establishing the conditions for professional nursing practice that support a culture of patient safety and high-quality patient care.

A Model of Seeking Connectivity: Theoretical Propositions and Rationale

The relationships in the model of seeking connectivity are stated as a logic diagram and a series of propositions (Corbin & Strauss, 2008; Strauss & Corbin, 1998). As shown in Figure 1, the model was designed using the terms of axial coding: conditions, actions/strategies, and outcomes. The central logic of the model of seeking connectivity suggests that when certain conditions exist (organizational/unit/individual context) the strategies employed (nurse and nurse manager engage in select actions) contribute to a specific outcome (ability to deliver patient care).

This logic leads to several propositions and sub-propositions for future testing. The first proposition focuses on the staff nurse role, whereas the second proposition focuses on the nurse manager role. The first proposition and sub-propositions include:

1.0 The nature and number of contextual conditions in the hospital environment and the state of the nurse-manager relationship influences the strategies in which nurses engage to deliver patient care (Laschinger, 2008; Laschinger et al., 2009; Wagner et al., 2010).
1.1 The greater the perceived connection between the nurse and nurse manager, the more frequently nurses will act with and for patients to provide safe, high-quality patient care.

1.2 The greater the perceived disconnection between nurses and the nurse manager, the more frequently nurses will increase the level of resistance towards the nurse manager to act with and for patients to provide safe, high-quality patient care.

1.3 The greater the nature and number of contextual conditions in which a problem or event arises in the hospital environment, the more frequently nurses’ will increase the level of resistance towards the nurse manager.

1.4 The more frequently nurses take collective counter measures in objection to managerial policies, the more likely nurse administrators will readjust nurses’ perceived obstacles in their work environment.

1.5 The more frequently nurses take collective counter measures in objection to managerial policies, the more frequently the nurse manager will advocate, engage, and support nurses in patient care.

These sub-propositions suggest that the organizational context, nurse and nurse manager relations, and the effect on nurses are interrelated. The literature confirms this interrelationship (Faulkner & Laschinger, 2008; Laschinger et al., 2004; Laschinger et al., 1999). These studies suggest that employees who have access to these empowerment structures are more likely to be motivated, accomplish their work in meaningful ways, and be more committed to the organization. These studies also support the contention
that employees are more likely to feel autonomous, find meaning in their work, and believe they can have an impact when managers remove disempowering structures (Conger & Kanungo, 1988).

Less clear from the literature is how and to what extent the nature and conditions of the organizational context affect nurses’ performance. The present study addresses this gap by identifying that nurses’ level of resistance is accentuated correspondingly to the number and nature of organizational imperatives that focus on efficiencies that at times disrupt nurses’ ability to satisfactorily care for patients, and is compounded by a perceived disconnection in the nurse-manager relationship. The theory of seeking connectivity sensitizes managers to the contextual realities at the unit level which undermine nurses’ ability to enact the patient care they judge is required. The findings from this study employing organizational and critical perspectives, which have not been explored to date, have relevance in fostering a level of synergy and cohesion between nurses and their manager, better enabling nurses to achieve their goals and experience empowerment.

Additional studies related to propositions 1.4 and 1.5 provide opportunity to advance nurse empowerment theory. Our current understanding of nurse managers’ response to nurses’ collective counter measures in objection to managerial policies is limited. Exploring the circumstances in which managers readjust the work environment or advocate and support nurses in patient care when nurses resist could provide important information about the challenges managers face in their work. This could inform senior nursing leadership of the quality of care challenges occurring at the point of care that need to be addressed. Testing these propositions could enhance the nurse empowerment
literature and also provide better clues about re-configuring socially structured policies and practices to facilitate nurses’ ability to enhance patient care.

The second proposition and sub-propositions focus on the nurse manager role, and include:

2.0 The nature and number of contextual conditions that arise in the hospital environment influence nurse-manager relations.

2.1 The greater the nature and number of contextual conditions that arise in the hospital environment, the more frequently the nurse manager will likely not actively engage with nurses.

2.2 The greater the nature and number of contextual conditions in which a problem or event arises in the hospital environment, the more frequently silencing forms of communication with nurses will occur.

This proposition and its sub-propositions represent findings not expected in this study. From the interviews, I gained a greater appreciation of the complexity of issues facing nurse managers. Studies have suggested that our knowledge of structurally empowering work environments and leader empowering behaviours provide conditions that promote meaningful engagement of nurses in organizational life. Moreover, the results of a study by Lashinger et al. (2008) suggest that nurse leaders in Canada view themselves as an empowered and influential group within their organization. First-line managers reported that large spans of control resulted in greater job dissatisfaction, and less ability to influence budgetary allocations, but more influence in staff and policy decisions. Laschinger et al.’s (2008) findings appear to contradict the current study that suggests managers have limited ability to influence systemic and policy decisions, but
confirms that managers have limited ability to influence budgetary allocations. In any case, these sub-propositions focus attention on increased organizational complexity, level of administrative demand, time and fiscal constraints, and work environments that increasingly focus on policies and protocols underpinning nurses’ work. These contextual factors challenge managers’ ability to carry out their role that Laschinger et al. reminds us needs to be examined in more detail.

**Advancing Theoretical Contributions to Nurse Empowerment Theory**

Broadening the scope of this theoretical contribution is valuable to advancing nurse empowerment, which addresses a problem of direct relevance to practice. Corley and Gioia (2011) argue for an orientation towards prescience, and define it as a “process of discerning what we need to know and influencing the intellectual framing of what we need to know…” (p. 23). These authors state that prescience accentuates the notion that leading-edge thinkers should not only become oriented towards advancing the field’s relevance to future scholarship, but also more importantly, concerned more directly with organizational practice concerning problems that matter (Corley & Gioia). Above all, this study has provided a theoretical framework with pragmatic relevance by addressing the long-standing problem of nurses’ lack of empowerment in their work environments.

The theory of seeking connectivity advances nurse empowerment through the processes by which nurses strive to connect with their manager to create a workable partnership in the provision of high-quality patient care while responding to the demands of the organizational context. The model of seeking connectivity has implications for each of the dominant theoretical paradigms but rests most strongly in the structural
perspective, and secondarily with the critical social perspective. The conceptualization of critical social empowerment is at an early stage of development (Casey et al., 2010; Spreitzer & Doneson, 2005; Kuokkanen & Leino-Kilpi, 2000); however, the results of this study provide further direction for advancing nurse empowerment theory.

First, the theory of seeking connectivity supports Kanter’s theory of workplace empowerment (1977; 1993). Managers can create empowering work conditions that result in feelings of personal empowerment for nurses. This study demonstrates that:

- Nurses had a greater ability to accomplish their work when the manager provided access to resources in the form of additional health workers, thereby contributing to more reasonable workloads and giving nurses time to complete their work in a less harried fashion, which may have provided time for more effective communication (“the budget”, “working short”, stepping up of power);

- When managers were accessible, advocated for nurses, and engaged and supported nurses in patient care, nurses were better able to practice according to professional standards of practice (stepping up of power);

- When managers provided access to resources, information, and support, thus sharing power, nurses were better able to provide safe, quality patient care (experiencing the potentiality of enabling).

The theory of seeking connectivity confirms and reinforces the importance of the manager’s role in creating positive work conditions in nurses’ work experiences. When the manager provided access to resources, information, and support, this created
conditions for nurses to accomplish their work in meaningful ways. Control over working conditions facilitated nurses’ ability to focus on safe, quality patient care.

This study further supports Kanter’s (1977;1993) contention that managers who create empowering work conditions can promote collaborative work relationships. These findings highlight the importance of the manager making time to meaningfully engage with nurses and be physically present as a way to nurture the nurse-manager relationship. Investing time and making relationships work is a priority that may promote collaboration and reduce conflict in the workplace (Lucas, Laschinger, & Wong, 2008). Nurses who have access to these power structures are more likely to feel valued, be motivated, and engender feelings of trust in the manager, thus affecting nurses experiences in their work.

Second, the theory of seeking connectivity supports the psychosocial perspective in understanding the cognitive and behavioural factors affecting nurses’ work. The psychosocial perspective on empowerment reveals manager actions that increase nurses’ feelings of self-efficacy and control over their work (Conger & Kanungo, 1998). The findings in this study support Conger and Kanungo’s conceptualization of empowerment in the following ways:

- Nurses did not consistently perceive themselves as being involved in unit participatory decision-making, but they were able to practice more autonomously when the manager advocated for and supported nurses’ ability to improve patient care (stepping up of power and experiencing the potentiality of enabling);
• Managers who facilitate meaningful work and increase nurses’ autonomy increase their ability to practice according to professional standards (experiencing the potentiality of enabling);

• Without the manager’s active engagement and guidance, nurses were governed by managerial practices and policies and their ability to effectively achieve patient care was hampered (contradicting demands and interruptions and working without an anchor);

• Nurses described their inability to consistently doing meaningful work competently when care was fragmented and they became hyper-vigilant for patient safety (jeopardizing patient safety).

The theory of seeking connectivity confirms nurse managers have a role as advocates for and facilitators of high-quality care. Managers need to be mindful that nurse empowerment may function to mitigate the effects of organizational complexities that negatively influence patient care. Managers who promote collaborative working relationships and provide support to nurses, thereby foster a sense of meaningful work and autonomy in initiating and regulating work actions and ultimately enhance nurses’ perceptions of control over their work.

This research supports Conger and Kanungo (1998) suggesting that the nurse-manager relationship is strengthened when managers engage in open communication. By communicating openly, managers can facilitate nurses’ understanding of the organization and its needs, and nurses can share the impact of management practices on patient care, thereby enabling responsible decision-making. Managers’ ability to provide
information and support through various communication strategies optimizes nurses’ autonomy to use their knowledge and expert judgment in providing patient care.

Third, the critical perspective of empowerment discloses power relations that perpetuate oppressive and hierarchical structures in nursing practice and uncovers the ways in which these power relations affect the daily lives of clinical nurses. This study demonstrates that:

- Nurses’ work is situated in institutional structures, practices, and policies characterized by resource constraints (being controlled by policies);
- Nurses perceived they did not have consistent forums to have a voice in decision-making processes at the unit and organizational level (silencing forms of communication);
- Resistance was observed to increase nurses’ power and influence within the organization (positioning to resist).

The theory of seeking connectivity advances our understanding of the institutional practices affecting nurses’ work. Organizational structures, practices, and policies compel nurses to complete activities they would not typically do or constrain nurses’ professional practice and expert judgment.

The theory of seeking connectivity reveals ways in which managers can engage with staff through opening communication channels and creating opportunities to participate in decision making. Such engagement could enhance the exchange of information flow and provide opportunities for nurses to contribute to and influence unit and organizational directives affecting their work. By working together, nurses and
managers have the potential to achieve their goals in the delivery of high-quality, cost effective health care.

The theory of seeking connectivity reveals how conflict and resistance brings about change to nurses’ practice providing an alternative and more productive way to improve patient care. Nurses affirmed their professional judgment and assumed responsibility for resisting organizational practices that constrained their ability to practice safely. Nurses’ collective action was a local act of resistance to the domination of institutional power in order to facilitate improved patient outcomes.

Okhuysen and Bonardi (2011) argue that management issues often require explanations developed from a combination of perspective to provide answers to complex questions. Understanding and integrating the organizational and critical social perspectives from the current study has implications for a multi-faceted approach that may facilitate more effective empowerment strategies for nurses.

**Study Limitations**

There were a number of limitations in this study. One was the small sample size, which in qualitative research often raises concerns about the generalizability of the findings to other groups of nurses, situations, or settings. The intent of this qualitative study was not to generalize findings, but to advance theory (Corbin & Strauss, 2008; Strauss & Corbin, 1998). Seeking connectivity was the theory developed in this study to explain how nurses exercised power in social relations with their manager and how this affected their sense of empowerment.
Another limitation was the exclusion of managers from this study. Locating both nurses and their managers in this study may have provided a more balanced perspective in exploring this research question. This may have been especially helpful given the high turnover of managers encountered in this hospital particularly on one unit. Findings of this study do not reflect findings in a national study of nurse leaders (Laschinger et al., 2008). The findings revealed first-line managers perceive themselves as empowered, feel satisfied with their job, and are not intending to leave their positions. Involving managers in the current study may have added valuable insights to the research question in this investigation and shed light on their sense of empowerment, and lent greater clarity and understanding of the nature of the manager’s work in an acute care setting. I speculate that, although nurses may have had more ability to engage in resistive strategies in the current study, the manager may have had less ability to resist, which may account for the “revolving door” syndrome attributed to the manager role.

I also sensed some participants used this research study as an avenue “to get back at” their manager and/or release some of their pent-up frustrations regarding their practice. Some of the nurses who willingly came forward to volunteer for the study could be described as dissatisfied in their workplace and/or with the manager. For example, one nurse boldly told me, “I am a disgruntled nurse and I want to be in your study.” In such cases, my self-awareness was heightened in order to maintain data quality through the critical application of methods (Corbin & Strauss, 2008). Fendt and Sachs (2008) argue that the “first requirement of qualitative research is faithfulness to the phenomena under study” (p. 450). I have engaged in the research process to lend insight and show sensitivity to the phenomena, while also demonstrating empathy and respect to accurately
capture the essence of what participants were telling me (Corbin & Strauss, 2008). With this in mind, these findings are limited to the experience of nurses who participated in this study; therefore, caution must be exercised when considering how relevant the findings may be for other staff nurses.

**Directions for Future Research**

The theory of *seeking connectivity* points to the complex and dynamic nature of how power is exercised in nurse-manager relations and reveals the challenges inherent in theorizing empowerment. This theory suggests the need for further investigation, but the multi-faceted nature of empowerment should not deter further investigations. I offer ideas about avenues for further research.

First, this study has generated a theoretical model of how power is exercised in nurse-manager relations and has provided a theoretical foundation for further research to extend, test and refine the theory of seeking connectivity. The most apparent research imperative is to assess the usefulness of this model by further testing with nurses in a variety of contexts that include other hospitals and health care facilities, both rural and urban. Further testing could confirm whether the concepts illuminated in the model, generated from the data in this study, are transferable to other settings. In addition, further research could extend various aspects of seeking connectivity to provide additional insight. For example, there may be aspects of seeking connectivity that are antecedent conditions in the organizational context, and additional actions or interactions nurses and manager engage in while seeking connectivity. Testing the propositions generated from this study could also provide better clues about enhancing nurses’ ability to accomplish
their work. Therefore, this theory could be extended to explore other structures and processes that examine power in the nurse-manager relationship, and ultimately enhance nurse empowerment.

Second, as an extension of this research, managers need to be included in future research. The results of such a study could create space for exchanges between managers and nurses to more positively respond to the effects of power. Collaborative efforts between nurses and managers could focus on the power afforded to nurses in their interactions with patients and their role in making a difference to patients’ recovery.

Third, further empirical evidence is needed to more fully explore how institutional discourses shape patient care, particularly in relation to patient safety. Patient outcomes, which include patient safety, are an important source of evidence in determining the consequences of nursing care (Doran et al., 2006). More specifically, how does nursing care constituted within organizational imperatives of efficiencies shape nurses’ understandings of how patient care is delivered? What are those effects? This type of research supports the arguments that work environments that empower nurses to practice according to professional standards are more likely to support a culture of patient safety. By ensuring nurses’ access to empowering work environments, leaders will not only work towards a culture of patient safety that supports high quality patient care but also increase the organization’s ability to attract and retain nurses (Armstrong & Laschinger, 2006; Wagner et al., 2010).

Fourth, approaches like Habermas’ may be relevant for understanding power and could bring another theoretical lens to advancing nurse empowerment research through exploration of communicative action and public discourse (Huntington &
Gilmour, 2001; Kemmis & McTaggert, 2005). A critical social perspective unpacks how gender, class, and power intersect to affect staff nurses and managers’ work life (Olesen, 2005; Weedon, 1987). A critical social approach raises questions about the prevailing power structures by revealing what Smith (1987) cogently describes as relations of ruling inherent in complex institutions like healthcare organizations. Gender analysis may contribute to examining front-line nurses and nurse managers’ struggles in specific contexts to realize social justice, or present new ideas about their oppression (Olesen, 2005). Thus, a focus on gender could represent an essential approach to understanding how power found in the processes and social relations within the institution influences nurses’ work. This lens can also reveal how relations of ruling and domination ideologies are mediated and replicated in the workplace to shape policies, guidelines and other discourses that impact on nursing practice and styles of leadership. Even though a critical perspective may not directly relieve nurses’ struggle in the organizational context, further research may contribute to achieving, at least modestly, some transformation in nurse’s lives that re-frame policies and adjust the organization’s actions (Maynard, 1994; Olesen, 2008).

The notion of consciousness-raising is the primary motivator of feminist research (Henderson, 1995). The use of focus groups in consciousness-raising activities within a feminist tradition has often been empowering for women of colour (Kamberelis & Dimitriadis, 2005). It is reasonable then to expect that consciousness-raising as a form of a collective testimony could provide nurses a nurturing context to connect with each other and share their experiences and struggles. In consciousness-raising, a major breakthrough for nurses could be the possibility of interpreting difficulties and
inadequacies not as the effect of the individual nurse’s personal failings, but as the result of socially produced structures that maintain a division of labour by gender, together with particular norms of femininity and masculinity, which maintain nurses’ subordination. Consciousness-raising could extend nurses’ capacity to actively resist oppressive work expectations.

Finally, methodological issues examined earlier in the thesis warrant further consideration. My experience challenged how I, as the researcher, was positioned with respect to the power dynamics encountered in the field. A condition of conducting high-quality research is sensitivity to the topic, to the participants, and to the research. To do a high-quality analysis requires the researcher to “step into the shoes of participants” (Corbin & Strauss, 2008, p. 304), otherwise the researcher may lose some of the richness and depth of the data. This was particularly challenging on one unit, where I found that the power dynamics between the manager and staff were highly charged. These methodological challenges will demand careful consideration for related research on the topic of power and will push our discussions to new levels.

In considering the implications for future research, my recommendations have provided a general direction to address the theoretical and methodological challenges inherent in an empowerment research agenda. I have included several pointed research questions derived directly from this study. Taken together, these recommendations serve as a template for my own research program as well as for investigative directions for other nurse researchers.
Implications for Practice and Policy

The research findings yield insights that have implications for practice, administration, and policy and that stimulate thinking about the manager’s use of communication as a venue when the manager engages with nurses. In this section, I provide direction for administration and for nurses in addressing practice and policy implications.

Manager Role

This study clearly identified the centrality of the manager’s support and engagement with nurses specifically and managerial imperative generally, in shaping the nurses’ relationships with the manager. This is consistent with Laschinger’s (1999) program of research that highlights the importance of leader empowering behaviour influencing nurses’ ability to achieve work effectiveness. Managers must more fully engage nurses as active participants in developing practices and policies that underpin patient care activities and influence nurses’ job satisfaction. Research confirms effective leadership is an integral component of retention (Kleinman, 2004; VanOyen Force, 2005), however, a large span of control reduces the effects of transformational and transactional leadership styles (Doran et al., 2004; McCutcheon et al., 2009). Nevertheless, managers need to consider ways of leading that in collaboration with nurses, result in modifying procedures and practices located in the structure of the health care setting to better facilitate patient care.

Several recommendations advance the manager’s role and its implications for practice and policy. First, given the argument developed in this thesis that managers’ engagement in a reciprocal forum for communication is a way to create a workable
partnership in the provision of quality care, managers need to consider how to create spaces to identify practice concerns with nurses. The interpretation of data suggests a call to managers to seek connections, individually and collectively, with nurses that affirm nurses’ sense of power by (a) being available to advocate for nurses (b) respecting nurses’ professional judgment and (c) valuing nurses as collaborators in care. In this way, the manager’s behaviour communicates the value of the nurse’s contribution to patient care, engages nurses in decision-making, and unites the manager with nurses in a common goal of patient care.

It would be beneficial for managers to shift to a more inclusive, participative decision-making style, as this could have a more positive effect on maintaining safe, high-quality care. A considerable number of participants indicated that they felt removed from decision making in the organization and on the unit. One participant stated that “[policies] come automatic[ally]” suggesting a fairly centralized decision-making process in which policies are generated and implemented by others.

My recommendation would therefore be to enhance representation of nurses (perhaps informal nurse leaders) on key unit and organizational committees affecting nurses’ practice. The effect of these strategies would be to actively promote nurses’ professional role and support their ability to participate in decisions affecting the care they provide (Casey et al., 2010; Riley & Manias, 2002).

Second, I suggest clinical support be available to facilitate nurses’ work. It would be helpful to enlist the clinical coordinator or educator to provide novice nurses, especially, with immediate clinical support and education, and it would lighten the workload of senior nurses. In this study, senior nurses maintained that they typically
carried a heavier patient load than junior nurses did. On one occasion, I witnessed a senior nurse’s patient care disrupted several times during the course of a couple of hours because novice nurses had questions or another patient needed his nursing expertise. My observations and conversations with senior nurses indicated that heavy and complex workloads and the intensity of nurses’ work challenged novice nurses ability to respond as quickly to patient care situations as more experienced nurses. Having immediate assistance for novice nurses would permit senior nurses to continue their patient care uninterrupted and would likely result in safer and less fragmented care. Having access to support and information would enable both novice and senior nurses to find their work environments more empowering, which could lead to greater job satisfaction and the delivery of higher quality nursing care (Armstrong & Laschinger, 2006).

Third, senior nurse administrators at the meso and macro levels need to involve nurses meaningfully in processes of defining and supporting patient care practices that could enhance patient safety. Nursing leadership needs to facilitate nurses’ ability to have a greater voice in organizational decision making so they can achieve an engaged, motivated, innovative, and productive staff. Administrators who develop policies need to reconsider how nurses’ work is shaped and constrained within particular clinical and political contexts by such policies (Polzer, 2006).

Nurses should become involved in policy development that is foundational to building nurse capacity at the point of patient care (Borthwick & Galbally, 2001; Hewison, 1995). Having nurses participate in some of the policy changes, such as the overcapacity alert policy, would move nurses towards a sense of participation in and control over their practice. Facilitating nurse involvement at the practice level may equip
nurses with skills in advocacy and political action and enable them to influence practice and policy directions that improve patient and nurse outcomes. In essence, the practice-policy gap (Reimer Kirkham, 2000) might narrow by paying closer attention to where and how decisions are made and the extent to which nurses are involved.

To this end, strengthening nurses’ ability to engage in decision making in their practice may cause a re-alignment of organizational priorities and practices to enhance nurses’ ability to provide safe, high-quality patient care, as reflected in the governance, the resource allocation, and the policy statements of the organization.

Nurse Role

Nurses are not without responsibility, and I outline possibilities for nurses to resist oppressive managerial situations and become effective advocates for their patients. Thus, a nursing perspective opens up ways of thinking and acting that enable nurses to uphold a focus on patient care (Street, 1992).

First and most importantly, nurses can challenge their own practice by actively examining managerial practices for themselves (Knol & van Linge, 2009). Nurses can explore the assumptions and understandings implicit within their practice. For nurses to empower themselves, they need to develop an understanding of the way present managerial imperatives are produced and dominate their work. More specifically, nurses need to consider how their work is observed, how they conform to practice, and how their practice is evaluated through socially structured processes within the institution. Together these mechanisms may highlight how nurses have accepted taken-for-granted aspects of their practice, which divert them from the primary aim of direct patient care (Casey et al., 2010; Lukes, 2005; Riley & Manias, 2000).
I recommend that nurses collaboratively examine the basis of some of the benign practices that include, for example, bed management and documentation protocols that support patient care. For example, the present notion of reviewing nurses’ documentation for quality improvement or patient safety has limited nurses’ autonomy through the imposition of rules (Doering, 1992). Although compliance to standards of practice is necessary to ensure specified outcomes, nurses in this study spent considerable time doing “papercare.” Such demands siphon nurses’ time and energy away from more direct forms of patient care. Therefore, the challenge for nurses is to share understanding with each other and with nursing leadership through communication forums that are mutually beneficial to ultimately reshape their roles and build supportive institutional practices. Thinking critically about managerial imperatives may encourage nurses to recognize how their work is constrained making it possible for other ways of thinking in which nurses can be more proactive in governing their own practice. Nurses can move from a position of passive resistance to a proactive, informed and participatory position leading to the development of new practices and the advancement of nursing knowledge.

Second, there is evidence to suggest nurses have the ability to resist. By working together and fostering open and respectful channels of communication, both nurses and managers may increase their ability and effectiveness to set and improve patient care. Nurses can take action by voicing their concerns to the manager and take responsibility by valuing their leaders, fostering respect, and engaging in courteous behaviour (Hokanson Hawkes, 1992). For example, nurses could consider supporting each other in advocating to their manager in a respectful and collegial manner for alternate policies or protocols that could benefit the patient’s recovery process.
Finally, I need to acknowledge that while empowerment is the topic under study in this thesis, I am mindful that a blanket effort “to empower” nurses may not work for everyone, since not all nurses desire a greater sense of empowerment (Moores, 1993). For managers, empowering strategies in the practice arena are associated with a loosening of control, which may adversely affect some managers by removing some of their control (Spreitzer, 2008). Because managers’ sense of identity and authority is premised on traditional management practices, managers may experience distress and alienation as a consequence of empowering initiatives. Unless the culture of the hospital is amenable and administration is willing to make changes, nurse empowerment efforts will not be successful (Foster-Fishman et al., 1998).

In summary, taken together, these recommendations for managers and nurses have implications that enhance nurse empowerment and that foster safe, high-quality patient care. Managers and administrators must carefully consider their priorities and involve nurses in more participatory and active forms of collaborating in organizational initiatives and practices. Nurses must attend to their professional obligations by examining taken-for-granted practices and be willing participants in organizational governance as it pertains to their practice. An improved practice environment will ultimately have a beneficial effect on the quality of nurses’ work life, on nurse retention, and of patient care.

**Conclusion**

This study brings new knowledge to nurse empowerment literature by examining the complexities and processes of how power is exercised in nurse-manager relations.
Nurses confront the task of contending with power in an organizational environment, which historically has enforced oppression, and which continues its active and implicit attempts at subverting constructive change (Keiffer, 1984). Empowerment for nurses is linked to understanding how power is exercised in the nurse-manager relationship and its effect on patient care quality and patient outcomes. Antecedents, actions and interactions, and consequences that comprised this theory were conceptually related to form an explanatory scheme of how nurses and managers were situated in social relations of power. An important first step in this program of research was careful theorizing about the organizational context, nurse and manager relations and their effect on nurses’ practice. Findings from this study advance nurse empowerment largely from a structural perspective, and secondarily from a critical social perspective. Ultimately, the study’s findings reveal that nurses strive to create a workable and sustainable partnership with their manager in the provision of care while responding to the demands of the organizational context. The study thus provides direction for promoting relationships marked by connectedness and communication between nurses and their managers and offers the possibility of exploring nurses’ resistance. This study provides direction to begin to explore resistance and create a space for possible change by allowing nurses to problematize managerial practices. These transformative transitions can only be constructed through action at the micro level and can only grow from long-term engagement.

The current study reveals seeking connectivity as a dynamic transforming process of creating a power-sharing partnership between nurses and their manager - vital to achieving successful outcomes. Practice sites and policy formulations with nurses’ active
and direct participation create space where changes can be addressed at a more tangible level. I agree with Skelton (1994) and Bradbury et al. (2008) who suggest that nurses must adopt a critical stance in relation to the notion of empowerment. If we fail to be active participants in our own inquiry, “if we continue to speak this sameness, if we speak to each other as men have spoken for centuries, as they taught us to speak, we will fail each other” (Irigaray, 1980, p. 69). To this end, nurses must question the truth of dominant discourses and participate in shaping their own practice destiny.
REFERENCES


and physician leadership in two intensive care units. *Journal of Nursing Administration, 34* (2), 60-70.


Philosophy, 4, 61-76.


reflexivity and relationality. *Qualitative Health Research, 11*, 257-272.


Huntington, A.D. & Gilmour, J.A. (2001). Re-thinking representations, re-writing nursing texts: possibilities through feminist and Foucauldian thought. *Journal of*
Advanced Nursing, 35 (6), 902-908.


Moores, P. B. (1993). *Becoming empowered: A grounded theory study of staff nurse


Polzer, J. (2006). From active participant in health to (pro)active manager of genetic risk: (Re)making the ethical subject of risk in the age of genetics. Unpublished doctoral dissertation, University of Toronto, Toronto, ON.


Richards, H.M., & Schwartz, L. J. (2002). Ethics of qualitative research: are there special issues for health services research? *Family Practice, 19* (2), 135-139.

Riley, R., & Manias, E. (2002). Foucault could have been an operating room nurse. *Journal of Advanced Nursing, 39* (4), 316-324.


Advancing the human imperative (5th. ed.). Philadelphia: Lippincott, Williams, & Wilkins.


Appendix A

The Nurse Manager’s Role in Staff Nurses Work

Researcher: Sonia A. Udod, RN, MS
PhD Student, University of Toronto, Faculty of Nursing (416-978-2392)
Supervisor: Dr. Diane Doran
Associate Dean & Professor (416-978-2866)

Information to Nurses

Dear Colleagues:

I am a registered nurse with a background in med-surgical nursing and an interest in the quality of nurses’ worklife. I am also a PhD student in the doctoral program at the University of Toronto. I am beginning my data collection for my research called “The Nurse Managers Role in Staff Nurses Work”. This qualitative study proposes to examine the relationships between staff nurses and their nurse managers, and how this affects nurses’ ability to complete their work. I hope this research will serve as a basis for improving staff nurses’ autonomy and their involvement in decision making affecting the workplace. Ultimately, nurses’ ability to complete their work more effectively will contribute to their quality of worklife, enhance recruitment and retention, enhance patient safety, and positively affect the quality of patient care.

I am interested in what factors influence nurses’ ability to do their work. These factors might be related to how procedures or policies govern nurses’ actions, and in how decisions are made by nurse managers that influence nurses’ practice. These factors may be positive or negative. I am planning to observe how staff nurse interactions occur in the acute care settings. I hope to accomplish this fieldwork experience in the surgery-orthopedic unit, intensive care unit, and the post-partum unit. I also plan on following up on observations by interviewing nurses regarding how factors in the work environment and the interactions with nurse managers influence nurses’ ability to complete their work more effectively.

I will be on your unit from ?? to ?? at various hours of the day and on various days of the week. I am seeking the participation of nurses in the following ways:

Observations:

- If you agree to participate in the study, I will be “buddied” with you on the unit for a maximum period of 4 hours. The buddy system is similar to having a student nurse “buddied” with you. Being a buddy will help me understand how factors on the unit affect your ability to do your work.
- I will make notes based on the tasks and interactions you are involved in to learn more about how you complete your work. YOU HAVE THE RIGHT TO REQUEST I NOT OBSERVE OR MAKE NOTES ON WHAT I OBSERVE. You may tell me at the time or phone me at 966-4783.
This should not take extra time nor interfere with your practice. Under your direction, I will assist you in non-complex nursing activities such as making beds and delivering trays. I will be making notes in an unobtrusive manner about my observations.

Interview:
- I will interview you following the observation regarding what factors in the work environment and how interactions with your nurse manager influence your ability to complete your work. If you consent to be interviewed following the observation, I will talk with you at a mutually agreed upon location and at a time convenient to you. Each interview will last about one hour, and you may be interviewed a second time but at a later date. In order to collect accurate information, I will audiotape the interview and have it transcribed. If you feel uncomfortable being audiotaped during a portion of the interview, I will turn off the tape recorder at your request.

The decision to participate in this study is entirely voluntary. YOU ARE UNDER NO OBLIGATION TO PARTICIPATE. YOU CAN WITHDRAW FROM THE STUDY AT ANY TIME, AND CAN REFUSE TO HAVE YOUR NURSING PRACTICE OBSERVED AND REFUSE TO ANSWER ANY QUESTIONS.

Confidentiality:
Confidentiality will be maintained throughout the study. Your name will not be on any forms or notes, and will not be identified in any paper or presentation that may arise from this study. Data from the interviews and observations will be kept in a locked filing cabinet in my office. Research material will be used strictly for the purpose of this dissertation research, future publications, and presentations. Only selected sections of the data that will not compromise confidentiality will be shared with my dissertation committee. A transcriptionist who will agree to maintain confidentiality will have access to the data.

Risks and Benefits:
I am not aware of any risks to your participation in this study. Benefits include:
- gain a greater awareness in how you can improve your practice
- enhance nurse administrators’ ability to improve the quality of nurses’ worklife, and improve the recruitment and retention of nurses

I hope you will consider participation in this study. If you have any questions, or if you would like to participate in this study, please call me at 966-4783 or call my supervisor, Dr. Diane Doran at 416-978-2866. Thank you for your time and consideration of my request.

Sincerely,

Sonia A. Udod
Appendix B

The Nurse Manager’s Role in Staff Nurses Work

Researcher: Sonia A. Udod, RN, MS
PhD Student, University of Toronto, Faculty of Nursing (416-978-2392)
Supervisor: Dr. Diane Doran
Associate Dean & Professor (416-978-2866)

Consent for Nurses: Observation

I have read Sonia Udod’s information letter about the above named study and understand Sonia is interested in learning more about how the relationships between staff nurses and their nurse managers foster or constrain staff nurses’ ability to complete their work.

I understand that:
1. Sonia Udod, the researcher, will observe me as I carry out some nursing functions;
2. Sonia will talk to me about factors in the work environment and the interactions with my nurse manager that influence my ability to complete my work.

I understand that “buddying” will involve Sonia observing me in interaction with patients and other staff, as well as observing other nursing functions. Sonia will buddy with me for 3-4 hour periods on 1-2 occasions. She may assist me with non-complex nursing activities such as making beds and delivering trays. I understand her presence will not interfere with my ability to provide patient care nor compromise patient safety. She will stop observations when it infringes upon privacy or causes discomfort to those being observed.

I understand that Sonia will be writing field notes about her observations. I know that I can ask her not to write field notes on her observations of me or can have the field notes destroyed if I feel uncomfortable with what is in them.

I understand that Sonia and her supervisor will have access to the field notes. I understand that my identity will be protected throughout the study as my name will not be found on any written material, and the research materials will be kept in a secure location.

I understand that I can ask Sonia questions throughout the study and that the results of the study will be shared with me. I also know that I can speak to Sonia about what it is like to participate in this research project. I also understand that the results will be reported in Sonia’s doctoral dissertation, in professional publications, and at professional conferences.

I am aware that I can withdraw from the study at any time and can refuse to answer any questions, or can refuse to have my nursing practice observed. I understand participation in this project is voluntary.
I also understand if I have any concerns about my rights or treatment as a research participant, I may contact Dr. Diane Doran (416-978-2866), University of Toronto.

My signature below shows that I have agreed to be in the study, and that I have received a copy of the consent and the “Information to Nurses” letter.

Date: ________________

Participant Signature______________________________________

Researcher: _______________________________________________

Sonia A. Udod
Appendix C

The Nurse Manager’s Role in Staff Nurses Work

Researcher: Sonia A. Udod, RN, MS
PhD Student, University of Toronto, Faculty of Nursing (416-978-2392)
Supervisor: Dr. Diane Doran
Associate Dean & Professor (416-978-2866)

Consent for Nurses: Interviews

I have read Sonia Udod’s information letter about the above named study and understand Sonia is interested in learning more about the factors in the work environment and the nature of interactions with my nurse manager that influences my ability to complete my work. Sonia is recruiting registered nurses who have been employed on the unit for a minimum of one year.

I understand that:
1. Sonia Udod, the researcher, will ask certain demographic information from me regarding my education, employment, age, and address.
2. Sonia will talk to me about factors in the work environment and the nature of interactions with my nurse manager that influences my ability to complete my work.

I understand that the interview will be approximately one hour in length at a place and time convenient for me. I consent to having these interviews tape recorded and transcribed by a typist. I know that I can ask for the tape recorder to be turned off at any point in our conversation, can have the tape erased, or can have the interview notes destroyed if I feel uncomfortable with what is on the tape or in the notes.

I understand that Sonia and her supervisor and a typist will have access to the tapes. I understand that my identity will be protected throughout the study as my name will not be mentioned on the tape or written material, and the tapes will be kept in a secure location.

I know that I can ask questions of Sonia throughout the study and that the results will be shared with me. I also know that I can speak to Sonia about what it is like to be a research participant. I also understand that the results will be reported in Sonia’s doctoral dissertation, in professional publications, and at professional conferences. I know that my name will not be disclosed on any notes, and that I will not be identified in any paper or presentation that may arise from this study.

I am aware that I can withdraw from the study at any time and can refuse to answer any questions. I understand participation in this project is voluntary.
I also understand if I have any concerns about my rights or treatment as a research participant, I may contact Dr. Diane Doran (416-978-2866), University of Toronto.

My signature below shows that I have agreed to be in the study, and that I have received a copy of the consent and the “Information to Nurses” letter.

Date:_________________

Participant Signature________________________________________________

Researcher ________________________________________________________

Sonia A. Udod
Appendix D

Nurse Biographic Form

CONFIDENTIAL

1. Code #:_____________________

2. Unit:________________________________ Code #:___________

3. Age: 20-25_____ 26-30_____ 31-40_____ 41-50_____ Over 50_____ 

4. Gender: Female_____ Male_____

5. a) Nursing Education: Diploma _____ Degree_____

   School/College of Nursing ______________________________________

   Graduate Degree_________________________________________________

   b) Non-Nursing: (degree, diploma, certificate) ______________________________

6. Previous experience in Nursing: < 5 years_____ 5-9 years_______ 10-14 years_____

   15-19 years_______ 20-35 years_______

How long have you been a nurse on your current unit? ________ Total Years:_________

7. Mailing Address and Telephone: ___________________________________________

   ____________________________________________________________________
Appendix E

The Nurse Manager’s Role in Staff Nurses’ Work

Transcriptionist’s Consent Form

Researcher: Sonia A. Udod, RN, MS
PhD Student, University of Toronto, Faculty of Nursing (416-978-2392)
Supervisor: Dr. Diane Doran
Associate Dean & Professor (416-978-2866)

I agree to participate in this study by transcribing interview materials.

I will protect the confidentiality in this study by translating any names of persons or institutions I encounter during transcription to Speaker 1, Speaker 2, etc. As well, I will not disclose any information from the research materials to any persons or agencies. The confidential/personal information generated from this research is the property of Sonia Udod.

All research materials will be kept secure in a locked filing cabinet or drawer while in my possession. Once I have completed each transcription, I will return all tapes, the flash drive, and print outs to the researcher. I will erase all transcription materials from the hard drive of the computer I am using.

I have discussed these requirements with the researcher, Sonia Udod, and have received a copy of the consent form.

Date__________________________

Transcriptionist___________________________________________________

Researcher______________________________________________________

Sonia A. Udod
Appendix F

Observation Guide

All participant observations take place in social situations. Questions for the observations stem from the major dimensions common to a social situation: place, actors, and activities (Spradley, 1980). These elements serve as a springboard for understanding the meaning of a social situation. Place refers to the people who are engaged in activities in a specific location (i.e. hospital units). Actors refer to the people who are engaging in some kind of activity (i.e. staff nurses, other health care providers, patients). Activities refer to the behaviour or things people do in a specific location (i.e. professional nursing practice). As I become more immersed in the observations, the behaviour of nurses on the hospital units will become clearer.

Observations will be informed by sensitizing concepts according to Foucault. The central focus of Foucault’s theory of power lies in the anterior power relations that shape, constrain, and constitute staff nurses’ thoughts and actions (Weberman, 1995). Foucault’s interpretation of where power resides will provide direction to the processes that shape how staff nurses are situated in relations of power in the hospital setting.

The following checklist of where power resides will serve to ensure the concepts relevant to this research will be addressed. These concepts and sub-themes are based on a precise framework so that I may obtain the necessary information to address the research question.

1. Environment of the Hospital
   a) Characteristics and Description of the Unit
      -physical organization and design of the unit
      -nursing staff to patient ratio
      -availability of equipment and supplies
      -patient beds
      -unit’s role within the organization
   b) Staff Environment
      -effects of the environment on nurses’ ability to carry out nursing care
      -difficulties experienced by staff nurses at the professional level
      -relationships between and among staff nurses
      -relationships between staff nurses and their nurse managers
      -expressions of a supportive and/or non-supportive culture
2. Governmentality

Government is not associated with the notion of sovereign rule and the workings of the state. Rather, Foucault conceives of governmentality as the “activity aiming to shape, guide or affect the conduct of some person or persons” (Gordon, 1991, p.2). More specifically, governmentality includes a set of practices, both subtle and overt, that are pivotal in directing and shaping the conduct of nurses (Polzer, 2006).

- relationships between staff nurses
- relationships between staff nurses and nurse managers
- implementation of specific nursing and non-nursing tasks
- practice according to professional standards of nursing practice

3. Nurse-Patient Relationships
- description of staff nurse and patient relationships
- characteristics of nurse-patient relationships

4. Power

Foucault’s notion of power is not concerned with structural or centralized forms of power found in institutions. Discipline is a type of power comprising a whole set of instruments, techniques, and procedures. This discipline of power is the “anatomy” of power, or more simply, illustrates how power operates in the hospital setting (Rabinow, 1984).

The demonstrations of power/forces may be enacted (both subtle and overt) in the following ways:

- rules and regulations (ie. hierarchical structure, following safety principles, agency policy and legal requirements, occurrence reports)

- instruments (ie. education, care plans, hierarchy of information and decision making practices directing patient care, clinical ladders, staff mix, chart documentation)

- practices/activities (ie. following orders, coded signs of obedience, “value” of the nurse, rewards and punishment, supervision of staff nurses’ work)
Appendix G

Interview Guide

1. Can you tell me about how your work environment affects your ability to provide patient care? Walk me through a specific patient situation you encountered that affected your ability to provide quality patient care.

2. How do the practices on your unit influence your ability to do your job? What helps? What makes it difficult?

3. How do policies and rules influence your ability to provide patient care?

4. How much control do you think you have to practice according to professional standards of practice?

5. How do you get what you need to provide patient care?

6. How does the larger hospital environment influence your ability to do your work?

7. Tell me a bit about how nurses work together on your unit in providing patient care.

8. Tell me a bit about how your unit manager helps or hinders your ability to provide patient care.

9. How does the work environment affect the nurse-patient relationship on this unit?

Closing Question

Is there anything else that you think would be helpful for me to know about your ability to provide patient care that we haven’t talked about?

Prompts:

Can you tell me more about…….
In what way…….
So what you’re saying is…….
What were you thinking when that happened…….
What was that like for you…….
Appendix H

Process of Understanding What Constrains and Fosters Staff Nurses Work

Researcher: Sonia A. Udod, RN, PhD (c )
University of Toronto, Faculty of Nursing (966-4783)
Supervisor: Dr. Diane Doran
Professor (416-978-2866)

Transcript Release Form

I, __________________________, have reviewed the complete transcript of my personal interview and observation in this study, and have been provided with the opportunity to add, alter, and delete information from the transcript as appropriate. I acknowledge that the transcript accurately reflects what I said in my personal interview and observation with Sonia Udod. I hereby authorize the release of this transcript to Sonia Udod to be used in the manner described in the consent forms. I have received a copy of this Data/Transcript Release Form for my own records.

__________________________  _________________________
Name of Participant    Date

__________________________  __________________________
Signature of Participant    Signature of Researcher
### Appendix I

#### Demographic Profile of Participants

<table>
<thead>
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<th>Age</th>
<th>Count</th>
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<td>26-30</td>
<td>10</td>
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<tr>
<td>31-40</td>
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<tr>
<td>41-50</td>
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<td>Over 50</td>
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<table>
<thead>
<tr>
<th>Gender</th>
<th>Count</th>
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<tr>
<td>Male</td>
<td>3</td>
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<table>
<thead>
<tr>
<th>Nursing Education</th>
<th>Count</th>
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</tr>
<tr>
<td>Degree</td>
<td>15 (1 degree in progress)</td>
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<td>Graduate Degree</td>
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<th>Count</th>
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</tr>
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<td>Diploma</td>
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</tr>
<tr>
<td>Degree</td>
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<table>
<thead>
<tr>
<th>Previous Experience in Nursing</th>
<th>Count</th>
</tr>
</thead>
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<tr>
<td>&lt; 5 years</td>
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</tr>
<tr>
<td>5-9 years</td>
<td>8</td>
</tr>
<tr>
<td>10-14 years</td>
<td>1</td>
</tr>
<tr>
<td>15-19 years</td>
<td>3</td>
</tr>
<tr>
<td>20-35 years</td>
<td>6</td>
</tr>
</tbody>
</table>

**How long have you been a nurse on your unit?** 7 months - 24.5 years (Mean = 7.5 years)

**Total years as a nurse:** 7 months - 30 years (Mean = 10 years)
## Appendix J

### Example of Data Analysis with Codes and Memos: Positioning to Resist

<table>
<thead>
<tr>
<th>Interview</th>
<th>Code</th>
<th>Memo</th>
</tr>
</thead>
<tbody>
<tr>
<td>I want to help these new kids [nurses] out a bit but they need more staff. Whether it be an LPN or...just an SCA or just somebody helping them out.</td>
<td>Setting limits flexibly</td>
<td>As a senior nurse B appears to have the experience (power) and knowledge (power) because the manager is not on the unit with any degree of consistency. Perhaps she feels an additional responsibility to help junior nurses become accustomed to their new work role. B expressed a subtle nuance or put up roadblocks to ideas proposed by the manager. Were these subtle nuances aimed at resisting the manager’s ability to operate the unit?</td>
</tr>
</tbody>
</table>

R: And is she [manager] receptive to your request.

P: At that time she did but until I see it on the ward, I am skeptical. I do want to see if these LPN’s are going to...um, augment our staff or if they’re going to be used as replacement for our RN’s. The jury is still out on that (#9, p. 33-34).

<table>
<thead>
<tr>
<th>Interview</th>
<th>Code</th>
<th>Memo</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the interviewing process she was...she was just a totally different person and [we] actually told her that at the meeting – like if you could be more...like you were at the interview, you know, like really open and asking questions and just really involved. But it seemed to just disappear as soon as she hit the floor. Like come have coffee with us, like come and meet your patients, you know, like they’re your patients too (#18, p. 19).</td>
<td>Redefining behaviour</td>
<td>S seems to know how the manager should be implementing her role- how she should be interacting, how she should be involved with patient care - presuming to know. This could be a way of having the manager adhere to the previous role of head nurse. It could also be a way of maintaining power of how nurses want the manager to act/behave without understanding the scope of her managerial responsibilities. There is evidence of subtle power techniques at play in the</td>
</tr>
</tbody>
</table>
Like myself I told M[educator] that we are busy enough unit as it is, we don’t have time to do that sort of stuff but she, all she said was, ‘Well its your license on the line so if you do it, good, if you don’t - if something ever comes up its your own problem’ (#22, p. 9).

Attending to one’s voice

This nurse spoke up to the educator about her reluctance to follow policies. The educator was not willing to listen and used power over the nurse to get the nurse to adhere to the new policies. The nurse’s view was brushed aside. Why are nurses views not heard? Perhaps the manager doesn’t know what to do in light of the staffing shortage and they are strapped themselves. Could it be that the manager doesn’t know what to do either and the educator serves as the conduit between nurses and the manager?

You need to step away for a few minutes... Patients not getting washed cause there’s not... you have to weigh the most important [things] right now.... Prioritize things so maybe someone will get washed up before they go home cause it was more important to get their discharge stuff ready (#2, p. 25).

Running interference by not doing

This nurse is saying that nurses sometimes do not do am care because of time constraints and that she often felt overwhelmed by the intensity of the workload (stepping away). This nurse learned to prioritize patient care by providing the most necessary patient interventions because of competing demands. This was a way to maintain some control over their work.
<table>
<thead>
<tr>
<th>So basically we chose a person from each rotation. Someone who had strong opinions but someone, like I don’t know, I don’t want to say it in a way that singles anyone out as being this kind of person but every ward has one I guess ….there’s people who are assertive about their views and can put it out in a way that not going to make someone defensive…. (#18, p. 14).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Battling back with supportive others</td>
</tr>
<tr>
<td>When nurses became angry and disenfranchised they protected one another and joined forces/banned together against the manager. I can’t help but wonder that when nurses get a manager who does not communicate with them in ways that they find conducive, they will resist until they get an audience with her even if it means confronting and meeting in an adversarial manner? There is a need to connect with the manager/leader of the unit. Nurses may be powerless in that if the manager is not supporting them in their care that supporting and uniting with each other enables them to have power.</td>
</tr>
</tbody>
</table>