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Nursing Participation in Hospital Decision-Making

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NURSING PARTICIPATION IN HOSPITAL DECISION-MAKING

By

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ABSTRACT

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Nurse administrators may participate in predicting organizational trends and planning at various organizational levels, however, the degree of actual participation of the nurse administrator in hospital decision-making is a relatively new area of investigation. A descriptive cross-sectional research design was used to investigate the differences between nurse administrators' actual and preferred participation in hospital decision-making. A stratified random sample of 60 nurse executives and 60 nurse managers was selected from the Michigan Organization of Nurse Executives' membership list. The overall response rate was 67% (N = 81). Data were obtained from individual nurses by questionnaires. The responses from the nurse administrators indicated that they desired greater participation and that their expectations for participation in hospital decision-making are not being met. Significant differences were found between nurse administrators' actual and preferred participation in hospital decision-making (t = 10.50, $p<.01$). Preferred participation in hospital decision-making was positively associated with perceived actual participation (r = .73). As might be expected nurse executives had significantly greater participation in hospital decision-making than did nurse managers (t = 10.18, $p<.01$).

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Chapter One

Introduction

The nation's healthcare delivery system is undergoing rapid redefinition and change. Some recent developments include an aging population, changing lifestyle, rapidly advancing technology, emphasis on outpatient medical care, and issues surrounding reimbursement by the government and other third party payors. Hospitals no longer have unending access to resources but instead face a challenging and uncertain future. Obviously hospitals must review and redefine their organizational function and structure in order to survive in this era of cost containment.

Hospitals and their internal decision-making structures are subject to increasing public scrutiny (Weisman, Alexander & Morlock, 1981). Decision-making on the part of hospital management is a mechanism for achieving a desired level of organizational performance (Charns & Schaefer, 1983). Nurse administrators are a part of the management team and the quality of the decisions they make is directly linked to the quality of information on which those decisions are based. Conway (1978) defines decision-making as the process through which the values of an organization are identified and the means for achieving its goals are prescribed. Three issues motivate current investigations of hospital decision-making:

the efficient allocation of scarce resources within and between hospitals, the development of effective control systems to monitor quality of care, and the ability of hospitals to adapt to environmental changes through technological or social innovations (Weisman et al., 1981). Though these issues were identified nine years ago their relevance applies to healthcare in the 1990s. Effective planning for distribution of resources can no longer be the sole concern of boards of directors and hospital administrators.

To effectively influence decision-making, nurse administrators must be versatile in the exercise of multiple forms of power. Researchers who study decision-making within organizations are concerned with distribution and application of power across positions or levels. Power is the ability to exert influence, to compel others to do what they may or may not want to do, or to persuade others in ways that may further one's own interest (Dennis, 1983). It is the capacity to affect the behavior of others and to control valuable resources. In the past, power bases among nurses, physicians, and hospital administrators have been grossly unequal, with the nursing profession having the least interest or perceived need in acquiring power. Physicians and hospital administrators have been perceived as possessing unlimited power. Typically, a nurse administrator's control is perceived at the level of patient care units but not at the organizational level. In order to effectively

participate in hospital decision-making, nurse administrators must establish power bases that legitimize their position and authority within the organization.

Nurse administrators assume major responsibility in hospitals and are usually responsible for the single largest cost center. Thus, they must be able to make effective decisions quickly and efficiently. Nurse administrators must be able to make appropriate and rational decisions that move their organization in the right direction and enable it to meet its objectives. These decisions are based on patient care needs, rules, regulations, and circumstances that are constantly changing. Nurses must help determine organizational goals and decide which activities are desirable and critical to the organization (Stuart, 1985). The Nursing Service standards of the Joint Commission on Accreditation of Health Care Organizations (JCAHO) requires "an established mechanism for the nursing department/service to communicate with those levels of management involved in policy decisions affecting patient care services in the hospital" (Accreditation Manual for Hospitals, 1990, p. 134). However, nurse administrators must go a step further and seek direct representation with voting privileges on organizational decision-making bodies. Participation in decision-making processes at the organizational level will allow nurse administrators to gain control over standards of professional practice and influence those policy decisions that directly or indirectly affect patient care within the

hospital system.

Problem Statement

Greater knowledge of nurse administrators' participation in hospital decision-making is relevant not only to understanding the many dimensions of the hospital's decision-making process, but also to specific outcomes that affect the viability of hospitals as organizations. Most of the research has focused on the structure and influence of medical staff and boards of trustees (Weisman et al., 1981; Perrow, 1961; Kotter, 1977). Other studies have attempted to relate medical and administrative decision-making to quality of care in hospitals. The nursing profession remains committed to the provision of quality nursing care, however the practice of nursing seems to be shaped more and more by organizational decisions in which many nurse administrators feel they have little opportunity to participate. To effectively influence quality patient outcomes, nursing must be directly involved in hospital level decision-making processes, including representation on governing boards. Investigation of the nurse administrator's role within this context is important not only to a broader understanding of hospital decision-making, but also to the development of nursing as a profession. Specifically, this study seeks to answer the question what are the differences between nurse administrators' actual and preferred degree of involvement in decision-making in hospital settings? For the purpose of this study, the term "nurse administrator" refers to nurses

in management level positions. Nurse administrators include those nurses who contribute to the nursing profession by directing and coordinating the work of others. The Michigan Organization of Nurse Executives identifies two categories of nurse administrators: (a) nurse executive defined as a nurse who has total administrative responsibility for nursing in the hospital and (b) nurse manager defined as a nurse holding a line management position with operational responsibility that includes patient care management, human resource management, and fiscal and material resource management, who has 24 hour accountability for patient care units and who may or may not report directly to the nurse executive. These definitions will be utilized in this study.

Using the strategic contingencies theory of intraorganizational power developed by Hickson, Hinings, Lee, Schneck, and Pennings (1971), this study aims to identify the actual and preferred degree of nurse administrator participation in the decision-making processes at all organizational levels. Specifically, the participation of nurse executives and nurse managers in hospital decision-making will be elicited to determine the extent of nurse administrators' participation. This study will partially replicate and extend the findings of Stuart (1985).

Chapter Two

Literature Review and Conceptual Framework

Literature Review

The review of literature included studies of power in nursing that have concentrated primarily on interpersonal power such as leadership styles, bases of power, and the perceived role of the nurse administrator. In addition, studies have focused on the power structures of hospitals, participation in decision-making as power sharing and nursing's role in hospital decision-making.

Power may be defined as the capacity or ability to do or accomplish something. It is the capacity to influence the behavior of others and to control valuable resources. These definitions imply a cause-and-effect element to power that takes place within an interpersonal or social situation.

Because the term "power" with its dominance-submission implications conjures up images of manipulation, coercion, and exploitation, it is often referred to in a negative sense (Dennis, 1983). However, it is also something that can be used in a positive and constructive manner. The negative connotations of the word have resulted in reluctance to openly admit a desire to want, seek or use power. It wasn't until the 1970s that nurses began to consider some of their dynamic interrelationships in terms of power, viewing power

from both a positive as well as negative perspective within the professional context.

Analysis of power sources within organizations have been studied by both sociologists and social psychologists. Zey-Ferrell (1979) summarized the sources of power as positional, knowledge, personal attribute, and traditional values. Positional and knowledge power have received significant attention.

Larsen (1982) studied the nature of power in terms of political and organizational power. Organizational power refers to the power that exists within hospitals and other healthcare organizations. This kind of power is in the decision-making process of organizations. It is organizational power that nurse administrators need to influence nursing practice in the workplace. Larsen (1982) further contended that authors seem to agree that major sources of organizational power and influence are:

1. reward power: the power to reward behavior, give positive opportunities or remove negative effects;
2. coercive power: the ability to impose penalties for nonconformity;
3. legitimate power: power based on internalized norms, beliefs, roles and values of those being influenced;
4. referent power: the power based on identifying with other people who have power;
5. expert power: the power deriving from the knowledge, abilities and credibility of the person exerting

influence; and

6. informational power: the power arising from the ability and opportunities of an individual to gain and share valuable information (pp. 76-77).

But having power is not itself sufficient to make individuals powerful, their sources of power must be used as resources to achieve desired goals. Increasing nurse administrators' power has to do with defining goals and learning political structures within organizations.

Hoelzel (1989) asserted that to be more effective in the healthcare system of the 1990s, nurse administrators must understand organizational sources of structural power. The author explored three sources of structural power: centrality, control of uncertainty, and control over resources, and analyzed their relevance for nurse administrators. The findings contend that nurse administrators must first understand power and willingly "acquire and use it, like it, and most of all admit they like it" (Booth, 1983, p. 20). By applying structural and behavioral sources of power, nurse administrators can then "act rather than react, proceed rather than retreat, direct rather than be directed" (Hoezel, 1989, p. 14).

Booth (1983) defined power as a concept that is present in all relationships, yet it is often viewed as a negative tactic instead of a positive and productive one. As relationships become more complex, the need to build strong social power relationships increases. In the face of

challenging changes in the healthcare system including advanced technology, increased consumer expectations and diminishing resources, nurses, physicians, and hospital administrators must integrate their collective resources and expertise in order to survive and be able to communicate with each other's jargon, assumptions, and goals. The underlying foundation for all productive power relationships consists of reciprocity in benefits and rewards as well as equitable exchange between individuals and groups.

The literature is rich with articles about what nurse administrators should do to be powerful. Recurring themes include power struggles (Brown, Polk & Brown, 1986), knowledge as power (Martin, 1988), women in power (Muller & Cocotas, 1988), how to acquire and use power (del Bueno, 1987; Willey, 1987), empowering nurses in decision-making (Harrison & Roth, 1987), and types of power, power tools, and power strategies (Cochran, 1982; Levenstein, 1981; Peterson, 1979; Shiflett & McFarland, 1978). The purpose of reporting these themes is to increase political effectiveness of nurse administrators within hospital organizations. However, empirical data to substantiate these power strategies is lacking in nursing literature. Also little is found regarding equality of power in hospital organizations.

Though power may be difficult to measure, it is not difficult to recognize. Powerful individuals achieve the outcomes they desire. It is also obvious that power requires a relationship. Pfeffer (1981) suggested that the power of

one individual is contingent on the other actors in a social relationship. An organization or the subunits of an organization may represent the social relationship.

According to Kanter (1977), power at the top is contingent on conformity. Nurse administrators may find social acceptance into the inner circle of the power elite difficult if they dress in a different manner (white uniform versus business attire) and seemingly refuse to accept the concept of the hospital as a business organization (Johnson, 1989). Social approval is deemed a type of social reward, as is admiration and praise. Leaders who are considered powerful have the ability to obtain for their group of subordinates or followers a share of the resources, opportunities, and rewards within the organization. To be viewed as powerful one must have access to power resources of the organization and must fully use those resources. Parenti (1978) described power resources as "organization, social prestige, social legitimacy, number of adherents, various kinds of knowledgeability and leadership skills, technological skills, control of jobs, control of information, ability to manipulate the symbolic environment, and ability to apply force and violence" (p. 63).

Brooks (1982) examined nurse managers' perceptions of nurse executives' access to power resources. In a study of 802 nurse managers and 52 nurse executives, Brooks found that in small hospitals, nurse managers perceived nurse executives as having sufficient power resources to satisfy their goals.

In large hospitals, Brooks found an inverse relationship between nurse managers and nurse executives, which was attributed to the nurse executives' lack of knowledge and understanding of management and organizational theory. This study suggested nurse educators might better prepare nurse administrators in areas of management and organizational theory to better prepare them to deal with the complexities of larger institutions.

Stuart (1985) surveyed 606 nurse administrators to determine nursing participation in hospital decision-making. She proposed four principles for empowering nurse administrators within an organization, based on the strategic contingencies theory of intraorganizational power developed by Hickson et al. (1971). To maximize power, Stuart asserted that nurse administrators increase connections with other subunits, create conditions that make them irreplaceable, demonstrate nursing assets, and participate in high level decision-making. Strategies for maximizing nursing participation in high level decision-making included: (a) assisting with the determination of organizational goals, (b) deciding which activities are desirable and critical to the organization and (c) obtaining direct representation with voting privileges on organizational decision-making bodies.

Stuart's study examined the nature of nursing participation in hospital decision-making and how various attributes of hospital organizations, nursing departments and individual nurses influenced the extent of nurse

administrators' participation and related outcomes of job satisfaction and commitment to the hospital organization. A cross-sectional survey research design was used in this study, conducted in 24 general hospitals in an East coast metropolitan city. The subjects included full-time registered nurses employed as executive, middle, and first-line nurse administrators (N = 606) with an overall response rate of 87%. Data were obtained from individual nurse administrators by questionnaires and from documents supplied by hospitals and the American Hospital Association. The response from nurse administrators indicated that they desired a greater participative role and that their expectations for participation in hospital decision-making were not being met, particularly in the areas of budget and planning. The findings from Stuart's study suggested that predictors of participative power among hospital nurse administrators included a combination of individual, hospital, and nursing department variables. In addition, participation in hospital decision-making and work autonomy measures were found to be significant predictors of job satisfaction and organizational commitment of each group of nurse administrators.

In a study of 206 nurse administrators in multihospital systems, Harrison and Roth (1987) found nurses had considerable power in decisions related to nursing operations yet had less influence in strategic and financial planning decisions. A questionnaire comprised of 11 decision areas

was developed and piloted. Respondents were requested to indicate perceptions of their actual and preferred degree of involvement in decision-making for each decision area (0 = none, 1 = minimum, 2 = moderate, 3 = maximum). The first four decision areas pertained to hospital operations and the remaining seven to nursing department operations, thus creating two subscales. For those decision areas related more to hospital operations than nursing operations, nurse administrators indicated lesser involvement. Appointment and performance appraisal of the hospital administrator were areas of minimal to no involvement for the majority of nurse administrators, although they preferred to be moderately or maximally involved. Seventy-two percent were moderately or maximally involved in formulating the hospital strategic plans, but 97% preferred that degree of involvement. Although 85% of nurse administrators were moderately or maximally involved in decisions concerning the addition or deletion of patient care services, 98% preferred that degree of involvement.

The majority of nurse administrators were maximally involved in those decison areas directly related to the delivery of nursing services, including budget, structure, standards, and staffing. In summary, the authors contended that nurse administrators could choose to become more influential in strategic and financial planning by operationalizing the four principles advocated by Stuart (1985) for empowering nursing within an organization: (a)

increase connections, (b) become irreplaceable, (c) demonstrate nursing assets, and (d) participate in high-level decision-making.

The nursing subunit must increase its connections with other organizational units striving for high levels of workflow pervasiveness and immediacy. A high degree of centrality often exists in hospitals and clinical nursing because of the nature of nurses' work and their coordinating functions. Centrality is the degree to which activities are connected within a system (Hickson, et al., 1971). A subunit is seen as central if the activities performed are linked with other activities of the organization (workflow pervasiveness) and if the activities performed by that subunit are critical to the workflow of the organization (workflow immediacy).

It is hypothesized that the higher the pervasiveness and immediacy of workflow of a subunit, the greater the subunit's power within the organization (Hickson, et al., 1971). Nursing has a high degree of centrality within hospital organizations. As Ashley (1973) stated, "without the pooled energies of individual nurses, healthcare facilities across the nation would be forced to shut down or offer a far different kind of service than they do at present" (p. 639). If members of nursing departments ceased to function, the effect would be immediately evident and would substantially impede the workflow of hospital organizations. Because nursing participates in all aspects of patient care, the

nursing department is centrally linked with other hospital departments and is critical to the workflow of the organization. Nurse administrators must demonstrate to their organizations that they can manage organizational problems and uncertainties through prevention, information, or assimilation (Stuart, 1986).

Nurse administrators must help determine organizational goals and decide which activities are desirable and critical to the organization. Input into these decisions, whether related to patient care, administrative policies and programs, or hospitals' strategic plans for the future, provides nurse administrators with a sense of control over their work and a stake in the success and wellbeing of the organization as a whole.

A study by Johnson (1989) sought to determine if there was a significant difference in the equality of power of nurse administrators and other executives with similar titles in a hospital organization. A 36 item Power Assessment Inventory was used to collect data from 96 nurse administrators and 147 other executives in the same institution. The tool measured the amount of self-perceived power that one possesses in the organization and was comprised of 36 objective statements regarding symbols of power, prestige, esteem, and legitimacy.

The normative power of the nurse administrator group and the normative power of the other executive group was determined by the total score on the Power Assessment

Inventory. The findings indicated that nurse administrators were more powerful in overall normative power, prestige, and esteem, as well as legitimacy of position. It also revealed that nurse administrators participate actively in the management of the hospital and function more that adequately in a executive position. The findings also support Kalisch's (1978) prediction that by the year 2003 nurses will yield considerable power from top-level administrative positions. The study also supports Stuart's (1985) belief that nurse administrators were more likely to be involved in hospital decision-making when they were members of powerful committees and the nursing director was a vice president of the hospital. In addition, the findings supported the American Nurses' Association (1969), and the American Hospital Association's (1972) recommendation that nurse administrators be members of top management. In summary, Johnson (1989) concluded that nurse administrators are having a significant impact on the business of healthcare and healthcare administration and imply that nurse administrators should stop referring to themselves and their profession as powerless.

Some nurse administrators feel that in the caring and supporting world of nursing, power is an alien concept (Hoelzel, 1989). Others assert, however, that power is an essential component of effective managerial behavior (Booth, 1983). Access to and willingness to use power increases a nurse administrator's ability to acquire resources needed

to improve patient care (Carter, 1988). This idea is not new: Peterson (1979) said if nurse administrators do not seek and use power effectively "the nursing department, at best, maintains status quo, and the sphere of influence of the nurse administrator diminishes." Registered nurses prefer to work with nurse administrators who get things done and who have influence both upward and outward. Nurse administrators who understand and use power tend to improve their effectiveness within the nursing department and the hospital organization.

In most hospitals, nurse executives have not had equal status with other hospital managers with comparable responsibilities (Kusserow, 1988). In January 1988, the Wisconsin Organization of Nurse Executives surveyed its membership to determine the extent of nursing input to hospital boards. The survey found that 37% of nurse executives were expected to attend board meetings regularly and 41% were expected to attend some or all hospital board committee meetings. Other factors influencing nursing's role in hospital organizations have also been considered. At a hearing on the Nursing Shortage held by the Senate Finance Committee's Subcommittee on Health in October 1987, witnesses cited low pay, unsatisfactory working conditions, and lack of input in managerial decisions as issues faced by the nursing profession. Some healthcare professionals believe that representation of nurse executives on hospital governing bodies and key hospital committees may

have a positive effect on nurse recruitment and retention (Kusserow, 1988).

In December 1987, Otis Bowen, MD, Secretary for the United States Department of Health and Human Services appointed a special Commission to study the nursing shortage and provide a report and corrective action plan. The Commission was headed by Carolyne K. Davis, PhD, RN, former administrator of the Health Care Financing Administration. The purpose of this inspection was to: (a) determine the extent to which nurses were represented on governing bodies and policy-making committees in hospitals around the country, and (b) describe strategies and techniques used by hospitals to recruit and retain nurses. The Commission found that while most nurse administrators participated to some degree in hospital governing body meetings, very few had a vote. However it did not appear that they had been singled out for exclusion from governing body deliberations, because other hospital management staff (except Chief Executive Officers) were rarely voting members. The study also indicated that nurse administrators were seldom represented on executive and finance committees, but did participate on planning committees. The status, autonomy, and span of control of today's nurse administrators appeared to be greater than in years past (Kusserow, 1988). It was thought that these improvements in status may have reflected hospitals' increased awareness of the critical role of nursing departments, but may also be the result of efforts of a more

sophisticated, better educated, and better organized nursing profession.

Henry and Moody (1986) designed a research project to describe and analyze the contextual elements and the administrative behaviors of nurse administrators. The researchers observed that the most productive nurse administrators used networking to build and maintain relationships as described by Kotter (1974) in order to accomplish tasks. They negotiated and coerced, they set goals and built coalitions, they used the authority of their formal positions to influence others, and appealed to others through friendship. The study also recognized the challenges and demands of nurse administrators and their need to understand the complexity of decisions and actions, whether in small organizations or in large multi-institutional systems comprising hospitals of varying size. Furthermore they stated the strongest, largest, most diverse networks were developed by nurse administrators with the strongest sense of their hospital's history and with the shrewdest sense of what was negotiable. Finally these networks were established by nurse administrators who were the most visionary about future roles their hospital could play, by those who had patience and stamina to wear down whatever resistance others might proffer, and by those who were most inspiring, charismatic, and trusted (Henry & Moody, 1986). In summary, nurses must participate in the determination of organizational goals and help decide which activities are

desirable and critical to the organization. In nursing, attainment of control or autonomy is directed primarily toward obtaining better care for patients (Stuart, 1981). To accomplish this nursing must exercise control over the conditions of practice.

Within hospitals, decisions about patient care are often more influenced by authority structures than by patients' needs. The authority of hospitals rests primarily in the hands of hospital administrators, physicians, and trustees; regulations are formulated by this group without consulting nurses and with little priority given to providing quality nursing care (Roemer & Friedman, 1971). In 1983, the National Commission on Nursing recommended that:

> Nursing should be recognized as a clinical practice discipline that needs to have authority over its management process. Nurse executives and nurse managers of patient care units should be qualified by education and experience to promote, develop, and maintain an organizational climate conducive to quality nursing practice and effective management of nursing resources (p.3).

In order to accomplish this task, nurse administrators must actively participate in the decision-making process at all levels of the organization. Increasing nursing participation in decision-making can be viewed as a necessary component of an organizational approach to healthcare planning. Regional, state, community, and institutional planning organizations

require leadership capabilities of many health professionals, including nursing (Nagy & Galimore, 1979). Because of increasing costs, maldistribution of healthcare services, and emphasis on quality of care issues, the planning of healthcare is of critical importance. Nursing has an identified role and a responsibility in healthcare planning. However the full implementation of participation by nursing at an organizational level has yet to be realized.

Conceptual Framework

The literature review provided an historical analysis of nurses' involvement in decision-making within hospital organizations. From this review it can be concluded that power is a multidimensional concept that can be applied to individuals and groups within organizations. Power can be acquired in various ways that incorporate interpersonal skills as well as structural and political dimensions. Participation in decison-making can be viewed as one mechanism for power sharing within organizations, but antecedents and outcomes of participation vary, depending on one's perspective of organizational theory (Stuart, 1985).

The strategic contingencies theory of intraorganizational power developed by Hickson et al. (1971) provides the conceptual framework for this study. Their contingencies model hypothesizes that three variables govern the degree of the subunit's interdependence with other subunits: (a) centrality is the degree of the subunit's interdependence with other subunits; (b) substitutability is

the possibility of replacement by others; and (c) coping with uncertainty is the ability to handle, through a variety of mechanisms, inevitable but unpredictable occurrences (Hickson et al., 1971). The theory relates the power of a subunit to its coping with centrality, substitutability, and uncertainty, through the control of strategic contingencies for other dependent activities, the control resulting from a combination of these variables. The more contingencies are controlled by a subunit, the greater its power within the organization. Nurse administrators' participation in hospital decision-making enables nursing to cope with uncertainties and control contingencies that may have a negative impact on nursing practice. Maximizing nurse administrator participation in hospital decision-making is related to corresponding power to influence decision-making at all levels and to control the deployment of those services critical to the care and safety of patients.

For the organization to operate, each subunit naturally possesses a minimal amount of centrality, but a subunit's relative centrality and indispensability affect the extent of its power. The ideas of workflow pervasiveness and immediacy derive from the centrality concept. The more a group's functions are related with other functions in an organization, the more pervasive its workflow and the greater its power. Workflow immediacy (the speed and severity with which the subunit's tasks affect the final output of the organization) suggests that a subunit is powerful if stopping

a subunit's activities would quickly and substantially interrupt the organization's primary workflow. A subunit that is difficult to replace will have greater power than one easily replaced by other members of the organization or by personnel from outside the organization. Acquiring resources and data and processing or disposing of a product can all involve uncertainties. Effectively coping with uncertainties yields power.

Subunits can utilize several coping strategies. They may anticipate a problem and prevent its occurrence within the organization. Or a group may advise the organization of a predicted uncertainty. Lastly, the subunit may acknowledge and assimilate an uncertainty within the organization itself. Efficient coping with uncertainty places a subunit in a position of power, creating dependency in other subunits, and allowing the organization to undertake new ventures or use new technologies. The amount of uncertainty a group assumes and the certainty with which it continues to perform its activities is an indicator of how well it copes.

A final, critical component of strategic contingencies theory relates to the identification of "critical contingencies" and to the dependence of that identification process on the three preceding power variables. Critical organizational contingencies are problems and uncertainties that can originate either within the organization or from the external environment. The ability to determine organizational goals and define what is critical to the

organization is essential for a subunit's acquisition and exercise of power. Nurse administrators must help determine organizational goals and decide which activities are desirable and critical to hospital organizations. The more an organization controls critical contingencies, the greater its power. If a subunit can successfully identify and contribute resources critical to the organization's survival (such as skills, knowledge, prestige, money, materials, equipment, customers, or clients) (White, 1974), it will achieve influence and power proportionate to the resource's importance and its relative success in obtaining the resources. The subunit's power will also affect the filling of key leadership roles and the internal allocation of money and resources. Thus power generates power, and power becomes institutionalized as structures and policies favoring the continued influence of a particular subunit are established in the organization (Salancik & Pfeffer, 1977).

To maximize power, Stuart (1986) advocated that nurse administrators must increase connections with other subunits, create conditions that make them irreplaceable, demonstrate nursing assets, and participate in high level decision-making. The strategic contingencies theory hypothesizes that increasing workflow centrality, reducing substitutability, and coping with uncertainty allows control of strategic contingencies thus enabling a subunit to acquire power. For nursing this power involves participation in hospital decision-making. Stuart maintained that nurse administrators

must be involved in decision-making at all organizational levels if they are to balance their subunit's power with that of other subunits and ultimately achieve the goals of quality healthcare and control over nursing practice. Participation in hospital decision-making at all organizational levels will allow nurse administrators' power to balance with other subunits and allow nursing to contribute fully to the organization. The degree of nurse administrators' participation in key decisions at the organizational level provides the primary focus for this investigation. Thus this study brings an eclectic approach to the study of the nurse administrator's role in hospital decision-making.

Summary

In summary, little empirical evidence exists regarding nursing involvement in key decisions in hospital organizations. Nor is there adequate research to guide nurse administrators in attaining decision-making authority and influence in organizational settings. Nursing's role in healthcare has a direct impact on patient outcomes as well as determining the utilization of valuable and scarce resources. Nurses will gain control over standards of professional practice and influence those policy decisions that directly or indirectly affect patient care in hospital systems only if nurse administrators participate in decision-making processes at all organizational levels.

Implications for the Study

Although much is known about decision-making as one aspect of leadership, the actual and preferred degree of nursing involvement in hospital decision-making is unclear. Hospital decision-making is receiving much attention, however nursing's role in decision-making at the hospital level is a relatively new area of investigation. A starting point for researchers and nurse administrators alike is the documentation and expansion of nursing's sphere of influence in hospitals. Though nursing's power may be perceived by physicians, administrators, and trustees as most legitimate in areas directly related to nursing practice and staffing, it is clear that in today's environment nursing cannot make major or long-range decisions for itself independent of considerations of overall hospital costs, quality, and services. To effectively initiate needed nursing innovations (such as career ladders or flexible scheduling), nurse administrators must be directly involved in hospital level decision-making processes including, in some cases, memberships on governing bodies. Investigation of nursing's role within this context is important not only to a broader understanding of hospital decision-making, but also to the development of nursing as a profession.

Research Question

The following research question and hypotheses were developed from review of the literature and the strategic contingencies theory of intraorganizational power:

1) What are the differences between nurse administrators' actual and preferred degree of involvement in decision-making in hospital organizations?

Hypotheses

1) Preferred participation in hospital decision-making of nurse administrators will be positively associated with actual nursing participation in hospital decision-making.

2) Nurse executives will have greater actual participation in hospital decision-making than nurse managers.

Theoretical Definitions

The degree of nurse administrators' participation in hospital decision-making provided the primary focus for this investigation. To understand the phenomenon of participation in decision-making and how the nurse administrator fits into this realm, it is necessary to consider the following theoretical definitions.

Participation: To take part; join or share in an undertaking.

Decision-making: The process through which the values of an organization are identified and the means for achieving its goals are prescribed (Conway, 1978).

Actual participation: behaviors such as the nurse administrator's direct involvement in budget, planning, personnel, and work-context decision areas.

Preferred participation: the nurse administrator desire for greater involvement in budget, planning,

personnel, and work-context decision areas.

Chapter Three

Methodology

Study Design

A descriptive cross-sectional research design was used to investigate nurse administrators' participation in hospital decision-making in Michigan hospitals. This study examined the differences between nurse administrators' actual and preferred participation in hospital decision-making. Psychiatric, geriatric, and nursing home institutions were excluded from the study population. This study partially replicated the research of Stuart (1985).

Random selection of the sample is a major strength of this study, thus findings can be generalized to other nurse administrators in hospitals who are members of the Michigan Organization of Nurse Executives. Furthermore, the naturalistic setting and random selection of nurse administrators from hospitals across Michigan make the findings more likely to be applicable to other nurse administrators practicing in similar settings in Michigan. Since a cross-sectional design obtains data from one point in time, mortality was not a threat to internal validity. In order to measure nurse administrators' perceptions of their participation in hospital decision-making a rather lengthy questionnaire was utilized which could have been a threat to

internal validity, however a 67% response rate was achieved. A number of relatively enduring characteristics of the respondents can interfere with accurate measures of the target attribute. Social desirability, extreme responses, and acquiescence are potential problems in self-report measures.

Population and Sample

The Michigan Organization of Nurse Executives' (MONE) membership directory was used to randomly select 60 nurse executives and 60 nurse managers for participation in the study. The selection criteria was that the nurse administrator had a title of nurse executive or nurse manager as defined by MONE. The nurse administrator at the executive level was responsible for the nursing division and managed from the perspective of the chief nurse executive of the organization as a whole. The nurse functioning at the nurse manager level was accountable to the nurse executive of the employing hospital and was responsible for the delivery of nursing care at the nursing unit level.

Characteristics of participants

A total of 81 nurse administrators comprised of 40 nurse executives and 41 nurse managers constituted the sample. Tables 1 provides demographic and professional data by position, age, gender, years as a nurse, initial educational preparation, and highest educational degree. The general profile of the nurse executive was a female between 40 to 59 years of age (82.50%). As indicated in Table 1, 50% had been

Table 1.

Demographic and Professional Data for 81 Nurse Administrators

	Nurse Executive (n = 40)		Nurse Manager (n = 41)	
	n	%	n	%
Age				
27 - 29	--	--	2	4.80
30 - 39	7	17.50	16	38.40
40 - 49	19	47.50	17	40.80
50 - 59	14	35.00	5	12.00
60 - 61	--	--	1	2.40
Gender				
female	40	100.00	39	95.10
male	--	--	2	4.90
Years as Nurse				
0 to 5	1	2.50	2	4.90
6 to 10	1	2.50	7	17.00
11 to 15	6	15.00	17	41.30
16 to 20	8	20.00	7	17.00
21 to 25	11	27.50	3	7.30
26 to 30	9	22.50	4	9.60
31 to 35	3	7.50	--	--
36 to 39	1	2.50	1	2.40
Initial educational preparation				
LPN certificate	2	5.00	4	9.80
Associate degree	4	10.00	11	26.80
Diploma	21	52.50	11	26.80
BSN degree	12	30.00	14	34.10
No response	1	2.50	1	2.40
Highest educational preparation				
Associate degree	2	5.00	2	4.90
Diploma	5	12.50	6	14.60
BSN degree	5	12.50	9	22.00
Baccalaureate, other	4	10.00	4	9.80
MSN degree	9	22.50	9	22.00
Master's, other	15	37.50	10	24.40
Doctoral, nursing	--	--	1	2.40

practicing nursing between 21 and 30 years, while 5% indicated 10 or less years, 15% indicated 11 to 15 years, and 10% indicated 31 to 39 years. The majority of nurse executives (67.50%) entered nursing with less than a baccalaureate in nursing degree, 12.50% now hold baccalaureate in nursing degrees and 22.50% now possess a master's in nursing degrees. The general profile of the nurse manager was a female (95.10%) between 30 to 49 years of age (79.20%). The majority (41.30%) of the nurse managers had been practicing 11 to 15 years, while 21.90% indicated 10 or less years, 24.30% indicated 16 to 25 years, 9.60% indicated 26 to 30 years, and 2.40% indicated 36 to 39 years. The majority of nurse managers (63.40%) entered nursing with less than a baccalaureate in nursing degree, 22% now hold baccalaureate in nursing degrees and 22% now possess master's in nursing degrees with one respondent (2.40%) indicating a nursing doctorate. The emphasis on advanced educational preparation in nursing was evident in both nurse administrator groups.

Table 2 provides employment data by position, tenure in hospital nursing, tenure in current position, and total hours per week spent working on the job. The majority of nurse executives (47.50%) had been employed in the present organization for 10 or less years, with 30% indicating 11 to 20 years, and 32.50% indicating 21 to 32 years. The general profile of the nurse executive also revealed that they had been in their present position no more than 5 years (65%),

Table 2.

Employment Data by Position for 81 Nurse Administrators

	Nurse Executive (n = 40)		Nurse Manager (n = 41)	
	n	%	n	%
Years in present organization				
0 to 5	13	32.50	10	24.20
6 to 10	6	15.00	9	21.90
11 to 15	6	15.00	12	29.30
16 to 20	6	15.00	6	14.70
21 to 25	7	17.50	3	7.20
26 to 30	1	2.50	1	2.40
30 to 32	1	2.50	-	--
Years in present position				
0 to 5	26	65.00	31	75.70
6 to 10	8	20.00	8	19.40
11 to 15	3	7.50	2	4.90
16 to 20	1	2.50	-	--
20 to 25	2	5.00	-	--
Total hours per week spent on job				
30 to 40	2	5.00	8	19.50
41 to 45	7	17.50	5	12.20
46 to 50	17	42.50	20	48.70
51 to 60	14	35.00	8	19.50

with 20% indicating 6 to 10 years, 10% indicating 11 to 15 years, and 7.50% indicating 16 to 25 years. Over 40% of the nurse executives spent 46 to 50 hours per week working on the job while 22.50% indicated spending 45 or less hours, and 35% spent between 51 to 60 hours.

The majority (46.10%) of nurse managers had been employed in the present organization for 10 or less years, with 29.30% indicating 11 to 15 years, 21.90% indicating 16 to 25 years, and 2.40% indicated 26 to 30 years in the same organization. The general profile of nurse managers also revealed that they were relatively new to their position, (95.10%) with no more than 10 years; 4.90% indicating 11 to 15 years. Over 48% of the respondents spent 46 to 50 hours per week working on the job; 19.50% indicated 51 to 60 hours per week.

Instrument

A questionnaire comprised of four decision areas was developed from a portion of Stuart's instrument. Respondents were requested to indicate their actual and preferred degree of participation in decision-making for each decision area utilizing a summated rating scale (0 = never, 1 = seldom, 2 = sometimes, 3 = often, 4 = always). Participative behavior was defined as a nurse administrator's actual involvement in hospital decision-making in four areas: budget, personnel, planning, and work-context. A total mean score was computed for all decision areas combined, thus creating an indicator of actual participation at an interval level of measurement.

A higher value represented a greater degree of actual involvement in hospital decision-making. The specific items were selected based upon a review of the theoretical and empirical literature.

The budget decision area included 13 items such as generating hospital income and resources, purchasing new equipment, evaluating cost-containment proposals, allocation of nursing budget, and salaries of hospital administrators. The personnel decision areas included 20 items such as manpower needs of nursing staff, recruitment and hiring of hospital administrators, promotion of nursing staff, discipline and discharge of physicians and work strikes, stoppages, and union demands. The planning decision areas included 13 items such as formulating long-term goals of the hospital, evaluating nursing department goal achievement, the expansion, renovation, opening, or closing of hospital facilities, organizational structure of the hospital, and meeting the demands of governmental regulatory bodies. The work-context decision areas included eight items such as career ladders for nursing staff, work schedules of nursing staff, type of nursing care organization, use of support services by nursing staff, nurse-physician collaborative relationships, and conflict resolution.

In addition to reporting one's actual participation, the nurse administrators' similarly recorded their preferred participation in each of these decision areas. Incongruence in participation was defined as the discrepancy between one's

preferred and actual participation in hospital decision-making. It was computed as the difference between the total mean values of one's preferred and actual participation measures. A higher value indicated a greater discrepancy or incongruence between the nurse administrator's desired and actual degree of participation.

Since Stuart was unable to find an instrument to measure participation or classify decision areas in the literature, she developed the participation in hospital decision-making scale. A panel of experts determined the list of decision areas as a means of establishing content validity (G. W. Stuart, personal communication, July 25, 1990). Cronbach's Alpha was not determined for the portion of the instrument designed to measure nursing participation in hospital decision-making (G. W. Stuart, personal communication, July 25, 1990).

Nurse administrators were asked to indicate their opinion on overall nursing participation in hospital decision-making as less than adequate, adequate, or more than adequate. Also nurse administrators were asked to indicate their perceptions of opportunity to participate in decision-making as very much so, often, seldom, or not at all. Data were also obtained on the perceptions of nurse administrators with regard to the relative frequency of participation in decision-making by hospital administrators, physicians, and the board of trustees as compared to nurse administrators. The nurse administrators' perceptions of the

relative involvement of nurses, hospital administrators, physicians, and board of trustees in the four steps of the decision-making process were also examined. The four steps include initiating issues, providing data, deciding solutions, and implementing actions. Information regarding demographic, professional, career, and length of employment was also collected as part of this study.

Procedure

A descriptive cross-sectional survey research design was utilized in this study. Grand Valley State University Human Research Review Committee approved the study per the expedited review criteria. Since the focus of this study was nursing participation in hospital decision-making, the data collection activities faced the challenge of obtaining participation of nurse administrators.

A random sample of 60 nurse executives and 60 nurse managers was selected from the Michigan Organization of Nurse Executives' membership list. The instrument, a cover letter explaining the purpose of this study, and a postcard were mailed to potential participants. Respondents were asked to return the postcard indicating their decision to participate in this study and their desire for an abstract of findings separate from their completed questionnaires. This approach enabled the researcher to identify overall response while maintaining anonymity of the participants. An attempt to reach non-respondents was not necessary due to a 67% response rate. The cover letter and questionnaire employed in this

study are reproduced in Appendices A and B.

Chapter Four

Data Analysis

Data Preparation and Analysis

The data collection records were reviewed to ensure that all data entered into the analysis phase were consistent with the selection criteria previously described. In preparation for computer analysis the questionnaires were precoded. All data collected was entered onto a coding sheet as they appeared on the questionnaire. Coded data were analyzed according to the research question and hypotheses using the Statistical Package for the Social Sciences. Preferred participation in hospital decision-making of nurse administrators will be positively associated with actual nursing participation in hospital decision-making and nurse executives will have greater actual participation in hospital decision-making than nurse managers were the hypotheses considered in this study.

Results

The research question that asked "what are the differences between nurse administrators' actual and preferred degree of involvement in decision-making in hospital organizations" was answered. Total mean scores were calculated, thus creating indicators of actual and preferred participation. The difference between actual and preferred

participation in hospital decision-making for all nurse administrators was calculated as presented in Table 3 using paired t-tests.

Table 3. Comparison of Nurse Administrators' Actual and Preferred Participation in Hospital Decision-making (N = 79).

	M	SD	t
Actual Participation	124.19	36.84	10.50
Preferred Participation	154.88	32.45	df = 78

(one-tailed) p<.01.

The preferred degree of participation in decision-making by nurse administrators (M = 154.88, SD = 32.45) exceeded the amount actually perceived to be the case (M = 124.19, SD = 36.84), (t = 10.50, df = 78, p<.01). Two cases were missing for this analysis. The differences between actual and preferred degree of participation were also compared for nurse executives and nurse managers. These comparisons are shown in Table 4.

Table 4. Intragroup Comparison of Actual and Preferred Participation in Hospital Decision-making

	Nurse Executive (n = 40)			Nurse Manager (n = 41)		
	M	SD	t	M	SD	t
Actual Participation	152.64	24.20	5.19	97.58	24.15	10.62
Preferred Participation	175.42	24.04	df = 37	135.56	26.68	df = 40

(one-tailed) p<.01.

The preferred degree of involvement in decision-making by nurse executives (M = 175.42, SD = 24.04) was significantly greater than the amount actually perceived to be the case (M = 152.64, SD = 24.20), (t = 5.19, df = 37, $p<.01$). The mean for nurse managers' preferred degree of involvement (M = 135.56, SD = 26.68) also exceeded the amount actually perceived to be the case (M = 97.58, SD = 24.16), (t = 10.62, df = 40, $p<.01$). The findings suggested that nurse managers identify a desire for greater participation in hospital decision-making than do nurse executives.

The hypothesis stating that preferred participation in hospital decision-making will be positively associated with actual nursing participation was supported. In other words, nurse administrators who preferred greater participation in hospital decision-making indicated more involvement in actual participation. Pearson r correlations between actual and preferred participation were calculated using a one-tailed test of significance. A high correlation of .73 was noted for the total sample. Nurse executives indicated a low correlation of .38 and nurse managers indicated a moderate correlation of .60.

The hypothesis that stated nurse executives will have greater actual participation in hospital decision-making than nurse managers was also supported. The group mean for the nurse executives' participation was 152.64; for the nurse managers', 97.58, (t = 10.18, df = 78, $p<.01$).

Other Findings of Interest

Nurse administrators were also asked to indicate their opinion on overall nursing participation in hospital decision-making. Most (53.80%) nurse executives indicated that nursing had more than adequate overall participation in hospital decision-making. The majority of nurse managers (58.50%) identified nursing's overall participation as adequate.

Table 5. Perceptions of Amount of Overall Participation by Nursing in Hospital Decision-making

	Nurse Executive (n = 40)	Nurse Manager (n = 41)
	%	%
Less than adequate	2.60	31.70
Adequate	43.60	58.50
More than adequate	53.80	9.80

Nurse administrators' perceptions of opportunity to participate in hospital decision-making was also identified (Table 6).

Table 6. Perceptions of Opportunity to Participate in Hospital Decision-making

	Nurse Executive (n = 40)	Nurse Manager (n = 41)
	%	%
Very much so	67.50	7.50
Often	32.50	55.00
Seldom	--	37.50
Not at all	--	--

The majority (67.50%) of nurse executives identified their opportunity to participate in hospital decision-making as very much involved, while 55% of the nurse managers indicated their involvement as often.

Data were also obtained on the perceptions of nurse administrators with regard to the relative frequency of participation in decision-making by hospital administrators, physicians, and the board of trustees as compared to nurse administrators' participation (Table 7). Nurse executives and nurse managers identified hospital administrators involvement in decision-making as most frequent (M = 3.80, M = 3.81). Nurse executives ranked nurses as second (M = 3.23), the board of trustees next (M = 3.05), and least involved in decision-making were physicians (M = 2.83). Nurse managers identified nurses (M = 2.85) and physicians (M = 2.85) as equally involved, with the board of trustees as least involved (M = 2.75) in hospital decision-making.

Table 7. Comparison of Nurse Administrators' Perceptions of Frequency of Key Groups' Participation in Decision-making

	Nurse Executive (n = 40)		Nurse Manager (n = 41)	
	M	SD	M	SD
Key Groups:				
Nurses	3.23	.62	2.85	.57
Hospital Administrators	3.80	.41	3.81	.46
Physicians	2.83	.55	2.85	.62
Board of Trustees	3.05	.76	2.75	1.08

The nurse administrators' perceptions of the relative involvement of each of the four groups in the four steps of the decision-making process were also examined (Table 8).

Table 8. Comparison of Nurse Administrators' Perceptions of Key Groups' Participation in the Decision-making Process (N = 81).

	Nurses	Administrators	Physicians	Trustee
Implementing actions				
Mean (SD)	.94 (.25)	.68 (.47)	.30 (.46)	.25 (.43)
Deciding solutions				
Mean (SD)	.85 (.36)	.92 (.27)	.65 (.48)	.74 (.44)
Providing data				
Mean (SD)	.95 (.22)	.51 (.50)	.54 (.50)	.07 (.25)
Initiating issues				
Mean (SD)	.89 (.32)	.67 (.47)	.82 (.39)	.44 (.50)

Nurse administrators saw nurses as most frequently

providing data and implementing actions, followed by about equal involvement in initiating issues and deciding solutions. In contrast, hospital administrators were perceived as most often involved in deciding solutions, followed by implementing actions, initiating issues, and providing data. Physicians were seen as most often initiating issues while trustees were viewed as deciding solutions.

Participation of nurse executives and nurse managers in this study provided the researcher with an excellent opportunity to evaluate nursing's involvement in hospital decision-making. It appears that the topic was of interest and timely to issues affecting the roles of nurse administrators.

Chapter Five

Discussion and Implications

Discussion

The major focus of this study was to examine nursing participation in hospital decision-making. In addressing this issue, the study generated a data base that included a 67% response rate from nurse administrators practicing in Michigan hospitals. The definitions of both nurse administrator groups were derived from the Michigan Organization of Nurse Executives (MONE). This derivation may allow the findings to be somewhat generalizable to nurse administrators in similar settings across Michigan. Such generalizations, however, should be made with caution until more is known about nurse administrators who do not belong to MONE and the characteristics of other hospitals. Similarly, since little is known about nurse administrators on a national scale, this study should be considered as providing preliminary data with regard to that population. Therefore, the findings of this study may be assumed to have potential importance for the nursing profession, future nursing research, and hospital organizations.

The primary objective of this study was to describe the extent of nursing's involvement in hospital decision-making as perceived by nurse administrators. However, this study

did not assume that nurse administrators desired a highly participative role. Therefore, their preference for participation in all decision areas was assessed along with their actual participation. A measure of incongruence was defined as the discrepancy between one's preferred and actual participation in the decision areas. All of the nurse administrators desired a greater participative role than they had in the hospital. Despite the advances made by the nursing profession in more recent years, these data suggest that nurse administrators prefer more involvement in hospital decision-making.

The responses from nurse administrators indicate that they desire a greater participative role and that their expectations for participation in hospital decision-making are not being met. Stuart (1985) found that almost all nurse administrators (98.50%) desired a greater participative role than they presently had in the hospital. These results shed some light on, not only the nature of nursing participation, but also on the expectations nurse administrators have with regard to their involvement in decision-making in hospital organizations. The findings from this study suggest that the preference for participation and position level may be important factors influencing nurse administrators' participation in hospital decision-making.

The conceptual framework used for this study proposed that three variables govern a subunit's power within an organization. These variables are the subunit's centrality

or interdependence with other subunits, vulnerability to replacement from within or outside the organization, and ability to cope with natural and inevitable organizational uncertainties. To maximize power, Stuart (1985) advocated that nurses increase connections with other subunits, create conditions that make them irreplaceable, demonstrate nursing assets, and participate in high level decision-making. The more critical contingencies nursing controls, the greater is its organizational power.

Nurse executives were found to have greater participation in hospital decision-making than nurse managers which supports Kalisch's (1978) prediction that by the year 2003 nurses will yield considerable power from top-level administrative positions. The findings indicate that nurse executives have acquired greater participation associated with decision-making processes within hospital organizations than do nurse managers. The majority of nurse executives identified their opportunity to participate in hospital decision-making as very much involved, while the majority of nurse managers indicated their involvement as often. Also nurse managers identified the board of trustees as least involved in hospital decision-making while nurse executives' response reflected the board's influence in decision-making. Perhaps nurse managers are not familiar with the role of boards in hospital organizations. Nurse executives are usually expected to attend governing body meetings regularly therefore are more aware of the board's influence on hospital

management and planning.

Preferred participation in hospital decision-making of nurse administrators was positively associated with actual nursing participation in hospital decision-making. In other words, many nurse administrators are becoming more involved in decision-making by operationalizing the four principles advocated by Stuart (1985) to maximize nursing's power within an organization. The results of this study indicate that many nurse administrators are choosing to take a more active role in hospital decision-making at both nurse manager and nurse executive levels.

In summary, then, the results of this study support Stuart's (1985) findings that nurse administrators want to be more involved in decision-making. To effectively influence decision-making, nurse administrators must be versatile in the exercise of multiple forms of power. Today's healthcare environment requires that nurse administrators' reliance on position power alone is insufficient. In order to advance nursing's role in hospital decision-making, innovative and creative nursing leaders must position themselves strategically within hospital organizations and actively participate in decision-making at the organizational level.

Implications for Nursing and Hospital Organizations

The findings regarding the participative power of nurse administrators have implications for both nurses and hospital organizations. For the nursing profession a trend toward increasing levels of education emerged from the data with

a greater percentage of respondents holding a baccalaureate in nursing and higher degrees. However, at both the baccalaureate and master's levels, nurse administrators are continuing to seek educational preparation in non-nursing programs. This trend may reflect the unavailability of nursing education programs that accommodate the working nurse administrator or the perception of the greater marketability of degrees in other fields (such as business or healthcare management) in healthcare administration. Most respondents were fairly young in their career trajectories with less than five years in their current position and less than five years tenure with their hospital. Likewise, the large representation of nurse managers under 49 years of age may indicate a trend towards earlier and more definite career planning. Judging from the characteristics of this sample, opportunities exist for nurse administrators to gain entry into new administrative roles and enjoy challenges in more than one setting during their career. The majority of nurse executives were between 40 and 59 years old and had been practicing 21 to 30 years with five or less years in their present position. Results from this study support the findings of Poulin (1984) who reported a college-educated, older population (50 to 59 years) in the nurse executive role who had been in their present positions an average of 5.3 years.

Hospitals face the challenge of competing for highly qualified nurse administrators who will commit to their

organizations. Nurse administrators desire more involvement in the decision-making process, therefore if a hospital organization provides greater opportunities for participation related to hospital operations, nurse administrators' long-term commitment to the organization may be enhanced. The increasing complexity of hospital organizations may create the need for an organizational structure that favors the less centralized forms of governance that will foster an environment conducive to increased nursing participation in decision-making. Hospital administrators and boards will need to consider the role of the nurse executive at all organizational levels and provide opportunities to exchange perspectives, delineate mutual goals, and establish coalitions for influencing decision-making. Furthermore, nurse executives should facilitate opportunities to advance the role of nurse managers within the nursing organization.

Limitations

One limitation of this study is that these findings are based on nurse administrators' perceptions of their participation in hospital decision-making. Their perceptions could be different than other nurse administrators who are not members of the Michigan Organization of Nurse Executives and may not be representative of other nurse administrators in Michigan or across the United States. Another limitation is that this study involved participation of nurse administrators in hospital settings only. Data from nurse administrators in other practice settings may yield different

results. The instrument used to measure participation in decision-making may also be a limitation to this study. Since respondents provided self-report data by means of a questionnaire, threats to validity and reliability of the instrument exist.

Recommendations

This study suggests some recommendations for future research that can serve to expand the level of present knowledge in the areas addressed. Primary among them would be the need for exploring the extent of nursing participation in hospital decision-making among nurse administrators other than those who are members of the Michigan Organization of Nurse Executives and in other states. What characteristics of hospitals and nurse administrators are associated with greater nursing participation? How does size of the hospital influence the role of the nurse administrator? Do reporting relationships affect nursing participation in decision-making? What are the consequences of higher levels of nursing participation for nursing staff, medical staff, and the quality of care? Does greater nursing participation result in successful nursing innovation? Replication of this study in other settings is also encouraged.

Research into the organization and characteristics of hospitals should also be considered. Primary among them would be the need to study both the determinants and outcomes of nursing participation in hospital decision-making at a hospital level of analysis. Here the outcomes could include

indicators of hospital effectiveness and efficiency as represented in measures of costs, quality of care, and adoption of innovations. It would similarly be important to include other influential groups (physicians, hospital administrators, and trustees) in an examination of relative participative power. One could also test the theories of power distribution and power sharing among these groups.

Finally, additional research is needed on nurse administrators. Surprisingly little is known about this important group of nursing professionals. Further research could help to define more precisely their role and the structures and processes that can best maximize nursing's contribution.

Appendices

Appendix A

Cover Letter

Sylvia Simons, BSN, RN
3129 Dumont Road
Allegan, MI 49010

Dear Colleague:

Although much is known about decision-making as one aspect of leadership, the actual and preferred degree of nursing involvement in hospital decision-making is unclear. Hospital decision-making is receiving much attention, however nursing's role in this process is a relatively new area of investigation. I am conducting a study of nursing participation in hospital decision-making and have randomly selected Nurse Executives and Nurse Managers who are members of the Michigan Organization of Nurse Executives as participants in this survey.

Enclosed you will find a short questionnaire that will take approximately 20 minutes to complete. To insure confidentiality of your responses please do not place your name on the questionnaire. All data will be reported as aggregate statistics only, so that no individual nor hospital will be recognizable in any results I may report. The completion of this questionnaire and the return of it to me signifies your consent to participate in this study. Please return your completed questionnaire in the self-addressed, stamped envelope by November 20th.

This study is being undertaken as part of my graduate work at Grand Valley State University, Kirkhof School of Nursing in Allendale, Michigan. Please return the enclosed postcard separate from the questionnaire. This will enable me to monitor overall response to this study and provide you with an abstract of my findings if requested. If you have any questions, please feel free to contact me at 616-673-7130. Thank you for your professional support and assistance.

Sincerely,

Sylvia Simons, BSN, RN

ID _____ (1-3)

Record 01 (4-5)

1. Please respond to the following questions.

a. How long have you been employed in this hospital in any position?

_____Years _____Months

(6) (7) (8) (9)

b. How long have you been employed in this hospital in your present position?

_____Years _____Months

(10) (11) (12) (13)

c. How many years altogether have you been employed in hospital nursing in any hospital?

_____Years _____Months

(14) (15) (16) (17)

d. At which level of nursing administration is your present position in this hospital?
(Check only one box.)

_____ Nurse Executive (nurse administrator position responsible for the nursing department and manages from the perspective of the chief nursing administrator of the organization as a whole)

_____ Nurse Manager (nurse functioning at the level of nursing administra--tion accountable to the nurse executive of the employing hospital and is responsible for the individual nursing unit and the delivery of nursing care)

(18)

e. On the average, approximately how many hours per week do you spend working on your job?

_____Hours per week

(19) (20)

In hospitals, many different groups make the important decisions on how hospitals will be run. Some examples of these decisions include when units are to be closed, what new equipment should be purchased, and how resources should be allocated. In this section, I will be asking questions about how these kinds of decisions are made in your hospital.

2. Overall, how frequently do you think the following groups usually participate in making the important decisions of this hospital? (Check only one box for each group.)

CIRCLE THE NUMBER THAT CORRESPONDS WITH YOUR RESPONSE

	Always	Often	Sometimes	Seldom	Never	
a. Nurses (including nurse administrators)	4	3	2	1	0	_____ (21)
b. Hospital administrators	4	3	2	1	0	_____ (22)
c. Physicians (including physician administrators)	4	3	2	1	0	_____ (23)
d. Trustees	4	3	2	1	0	_____ (24)

3. In what way do the following groups usually participate in making the important decisions of this hospital? (Check as many boxes as you feel apply to each group.)

	Implement Actions	Decide Solutions	Provide Data	Initiate Issues	No Input	
a. Nurses (including nurse administrators)	4	3	2	1	0	_____ (25)
b. Hospital administrators	4	3	2	1	0	_____ (26)
c. Physicians (including physician administrators)	4	3	2	1	0	_____ (27)
d. Trustees	4	3	2	1	0	_____ (28)

A number of important decision areas considered in this hospital are listed on the left hand side of the page below. For each identified decision area, indicate (first) how frequently you actually participate in it, and then how frequently you prefer to participate in it. (Circle one response per decision area for actual participation and one response for preferred participation.)

ID ____ (1-3)
Record 02 (4-5)

Decision Area	Your Actual Participation					Your Preferred Participation						
Budget	Always	Often	Sometimes	Seldom	Never	Always	Often	Sometimes	Seldom	Never		
1. Generating hospital income and resources	4	3	2	1	0	4	3	2	1	0	____ (6)	____ (7)
2. Determining level of hospital charges	4	3	2	1	0	4	3	2	1	0	____ (8)	____ (9)
3. Purchasing new equipment	4	3	2	1	0	4	3	2	1	0	____ (10)	____ (11)
4. Negotiating third-party reimbursement	4	3	2	1	0	4	3	2	1	0	____ (12)	____ (13)
5. Evaluating cost-containment proposals	4	3	2	1	0	4	3	2	1	0	____ (14)	____ (15)
6. Amount of nursing department budget	4	3	2	1	0	4	3	2	1	0	____ (16)	____ (17)
7. Amount of medical department budget	4	3	2	1	0	4	3	2	1	0	____ (18)	____ (19)
8. Amount of hospital administration budget	4	3	2	1	0	4	3	2	1	0	____ (20)	____ (21)
9. Allocation of nursing budget	4	3	2	1	0	4	3	2	1	0	____ (22)	____ (23)
10. Salaries of nursing staff	4	3	2	1	0	4	3	2	1	0	____ (24)	____ (25)
11. Salaries of medical staff	4	3	2	1	0	4	3	2	1	0	____ (26)	____ (27)
12. Salaries of hospital administrators	4	3	2	1	0	4	3	2	1	0	____ (28)	____ (29)
13. Individual billing for nursing services	4	3	2	1	0	4	3	2	1	0	____ (30)	____ (31)

Decision Area	Your Actual Participation					Your Preferred Participation						
Personnel	Always	Often	Sometimes	Seldom	Never	Always	Often	Sometimes	Seldom	Never		
14. Granting clinical privileges to nurses	4	3	2	1	0	4	3	2	1	0	(32)	(33)
15. Granting clinical privi--leges to medical staff	4	3	2	1	0	4	3	2	1	0	(34)	(35)
16. Manpower needs of nursing staff	4	3	2	1	0	4	3	2	1	0	(36)	(37)
17. Manpower needs of medical staff	4	3	2	1	0	4	3	2	1	0	(38)	(39)
18. Manpower needs of hospital administration	4	3	2	1	0	4	3	2	1	0	(40)	(41)
19. Recruitment and hiring of nursing staff	4	3	2	1	0	4	3	2	1	0	(42)	(43)
20. Recruitment and hiring of medical staff	4	3	2	1	0	4	3	2	1	0	(44)	(45)
21. Recruitment and hiring of hospital administrators	4	3	2	1	0	4	3	2	1	0	(46)	(47)
22. Performance evaluation of nursing staff	4	3	2	1	0	4	3	2	1	0	(48)	(49)
23. Performance evaluation of medical staff	4	3	2	1	0	4	3	2	1	0	(50)	(51)
24. Performance evaluation of hospital administrators	4	3	2	1	0	4	3	2	1	0	(52)	(53)
25. Promotion of nursing staff	4	3	2	1	0	4	3	2	1	0	(54)	(55)
26. Promotion of medical staff	4	3	2	1	0	4	3	2	1	0	(56)	(57)

Decision Area	Your Actual Participation					Your Preferred Participation					
Personnel (continued)	Always	Often	Sometimes	Seldom	Never	Always	Often	Sometimes	Seldom	Never	
27. Promotion of hospital administrators	4	3	2	1	0	4	3	2	1	0	(58) (59)
28. Discipline and discharge of nursing staff	4	3	2	1	0	4	3	2	1	0	(60) (61)
29. Discipline and discharge of medical staff	4	3	2	1	0	4	3	2	1	0	(62) (63)
30. Discipline and discharge of hospital administrators	4	3	2	1	0	4	3	2	1	0	(64) (65)
31. Shortage and turnover problems of nursing staff	4	3	2	1	0	4	3	2	1	0	(66) (67)
32. Presence of collective bargaining agent or union among nurses	4	3	2	1	0	4	3	2	1	0	(68) (69)
33. Work strikes, stoppages, and union demands	4	3	2	1	0	4	3	2	1	0	(70) (71)
Planning											ID (1-3) Record 03 (4-5)
34. Formulating long-term goals of hospital	4	3	2	1	0	4	3	2	1	0	(6) (7)
35. Formulating long-term goals of nursing department	4	3	2	1	0	4	3	2	1	0	(8) (9)
36. Planning activities to achieve hospital goals of nursing department	4	3	2	1	0	4	3	2	1	0	(10) (11)
37. Planning activities to achieve nursing department goals	4	3	2	1	0	4	3	2	1	0	(12) (13)

Decision Area	Your Actual Participation					Your Preferred Participation						
Planning (continued)	Always	Often	Sometimes	Seldom	Never	Always	Often	Sometimes	Seldom	Never		
38. Evaluating hospital goal achievement	4	3	2	1	0	4	3	2	1	0	(14)	(15)
39. Evaluating nursing department goal achievement	4	3	2	1	0	4	3	2	1	0	(16)	(17)
40. Expansion, renovation, opening or closing of hospital facilities	4	3	2	1	0	4	3	2	1	0	(18)	(19)
41. Allocation of beds, equipment and space	4	3	2	1	0	4	3	2	1	0	(20)	(21)
42. Determining need for new equipment, services, or supplies	4	3	2	1	0	4	3	2	1	0	(22)	(23)
43. Organizational structure of hospital	4	3	2	1	0	4	3	2	1	0	(24)	(25)
44. Organizational structure of nursing department	4	3	2	1	0	4	3	2	1	0	(26)	(27)
45. Meeting demands of governmental regulatory bodies	4	3	2	1	0	4	3	2	1	0	(28)	(29)
46. Affiliation with a nursing school	4	3	2	1	0	4	3	2	1	0	(30)	(31)
47. Affiliation with a medical school	4	3	2	1	0	4	3	2	1	0	(32)	(33)

Decision Area	Your Actual Participation					Your Preferred Participation						
Work-Context	Always	Often	Sometimes	Seldom	Never	Always	Often	Sometimes	Seldom	Never		
48. Education and development needs of nursing staff	4	3	2	1	0	4	3	2	1	0	(34)	(35)
49. Career ladders for nursing staff	4	3	2	1	0	4	3	2	1	0	(36)	(37)
50. Tasks and responsibilities of nursing staff	4	3	2	1	0	4	3	2	1	0	(38)	(39)
51. Tasks and responsibilities of medical staff	4	3	2	1	0	4	3	2	1	0	(40)	(41)
52. Tasks and responsibilities of hospital administrators	4	3	2	1	0	4	3	2	1	0	(42)	(43)
53. Work schedules of nursing staff	4	3	2	1	0	4	3	2	1	0	(44)	(45)
54. Patient care assignments of nursing staff	4	3	2	1	0	4	3	2	1	0	(46)	(47)
55. Type of nursing care organization (i.e., primary or team nursing)	4	3	2	1	0	4	3	2	1	0	(48)	(49)
56. Use of support services by nursing staff	4	3	2	1	0	4	3	2	1	0	(50)	(51)
57. Nurse-physician collaborative relationships and conflict resolution	4	3	2	1	0	4	3	2	1	0	(52)	(53)

In closing, please respond to these last questions:

a. In general, do you feel the amount of overall nursing participation in the important decisions of your hospital is:

_____Less than adequate

_____Adequate

_____More than adequate

____ (54)

b. As a nurse administrator, do you feel that you have an adequate opportunity to participate in the important decisions that are made in your hospital?

_____Very much so _____Often

_____Seldom _____Not at all

____ (55)

c. In what year were you born?

19 ____ ____

____ ____ (56) (57)

d. What is your gender?

_____Female _____Male

____ (58)

e. What was your initial educational degree when entering the nursing profession?

_____LPN Certificate _____Associate in Nursing

_____Diploma in Nursing _____Baccalaureate in Nursing

____ (59)

f. What is your highest level of educational degree at present?

_____Diploma in Nursing _____Masters in Nursing

_____Associate in Nursing _____Masters in related field
Please specify_____

_____Baccalaureate in Nursing _____

_____Baccalaureate in related field
Please specify_____ _____Other doctoral degree
Please specify_____
_____

_____Ph.D in Nursing

____ (60)

Thank you - your collegial support and assistance is appreciated!

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