

A Critical Perspective on Relations Between Staff Nurses and Their Nurse Manager: Advancing Nurse Empowerment Theory

Sonia Udod, Louise Racine

This study considers empowerment in nurse–manager relations by examining how conflict is handled on both sides and how the critical social perspective has influenced these relations. The authors use inductive analysis of empirical data to explain how (1) nursing work is organized, structured, and circumscribed by centrally determined policies and practices that downplay nurses’ professional judgement about patient care; (2) power is held over nurses in their relationship with their manager; and (3) nurses’ response to power is to engage in strategies of resistance. The authors illustrate how power influences relations between staff nurses and managers and provide a critical analysis of the strategies of resistance that result in personal, relational, and critical empowerment among staff nurses. Through resistance, staff nurses engage in alternative discourses to counteract the prevailing neoliberal organizational and managerial discourses of efficiency and cost-effectiveness.

Keywords: nurse, nurse manager, empowerment, power, critical social theory

Une perspective critique des relations entre le personnel infirmier et les infirmières gestionnaires : la théorie de l'avancement de l'autonomisation des infirmières

Sonia Udod, Louise Racine

Cette étude se penche sur la question de l'autonomisation dans les relations entre infirmières et gestionnaires. Elle examine notamment la façon dont les conflits sont gérés par les deux camps et l'influence qu'exerce la perspective sociale critique sur ces relations. Les auteures ont recours à l'analyse inductive de données empiriques afin d'expliquer (1) la façon dont le travail infirmier est organisé, structuré et encadré par des politiques et des pratiques déterminées par des instances centrales et qui minimisent le jugement professionnel des infirmières en matière de soins aux patients; (2) le pouvoir des gestionnaires dans le cadre de leurs relations avec les infirmières; et (3) la réaction des infirmières face au pouvoir et les stratégies de résistance. Les auteures mettent en lumière l'influence qu'exerce le pouvoir sur les relations entre le personnel infirmier et les gestionnaires et présentent une analyse critique des stratégies de résistance qui mène à une autonomisation personnelle, relationnelle et critique au sein des effectifs infirmiers. Par la voie de la résistance, le personnel infirmier amorce un discours alternatif qui neutralise les discours organisationnels et gestionnaires néolibéraux dominants axés sur l'efficacité et le rapport coût-efficacité.

Mots clés : infirmière, infirmière gestionnaire, autonomisation, perspective sociale critique, stratégie de résistance

Introduction

The concept of empowerment has been widely examined in the academic literature and is an important concept when applied to nursing practice. A multidimensional concept of empowerment refers to (1) enabling an individual to act by sharing power with others in order to achieve a common goal, and (2) enabling individuals to gain control over their lives as they become aware of aspects of the organizational system and their practice that constrain their work (Udod, 2011). According to Kanter (1977, 1993), power provides access to resources, support, and information and can help nurses to accomplish their work in meaningful ways.

Research by Greco, Laschinger, and Wong (2006) and Laschinger, Wong, McMahon, and Kaufman (1999) confirms that nurse managers play a key role by sharing access to resources, information, support, and opportunity in work settings that enable nurses to successfully deliver care within their organization. Laschinger and colleagues (1999, 2008) provide evidence of the pragmatic and empirical adequacy of Conger and Kanungo's (1988) view of empowering behaviours, in which the leader removes conditions from the work environment that decrease nurses' self-efficacy. By sharing power and enabling nurses to develop a sense of ownership in their work and within the organization, empowerment is thought to increase nurses' commitment and involvement, ability to cope with adversity, and willingness to act independently (Conger & Kanungo, 1988; Thomas & Velthouse, 1990). Studies show that when nurse managers empower staff nurses, they increase the nurses' commitment to the organization, reduce job stress, and reduce nurse turnover (Laschinger, Finegan, & Shamian, 2001a, 2001b; Priest, 2006).

In spite of this rich body of evidence, recent reports indicate that nurses' low levels of trust in management and lack of effective leadership affect nurses' working conditions and their ability to meet patient care requirements (Canadian Nursing Advisory Committee, 2002; Laschinger & Finegan, 2005; O'Brien-Pallas et al., 2005; Priest, 2006). Studies indicate that building trust between nurses and their managers is vital for creating conditions of nurse empowerment and that it occurs within relations of power that contribute to a positive work environment (Hardy & Leiba-O'Sullivan, 1998; Moye & Henkin, 2006). Overall, nurses' limited interactions with their managers, fuelled by low levels of trust, narrows the scope for creating conditions for nurse empowerment.

In this article we extend the concept of nurse empowerment from a critical social perspective by discussing how false consciousness may

prevent staff nurses from gaining control over the delivery of nursing care. We briefly describe critical inquiry and examine how nursing work is actively organized, structured, and circumscribed in line with hierarchically determined policies and practices that contribute to the disenfranchisement of nurses. Finally, we explain how power is held over nurses in their relationships with their manager, and how nurses' response to power is to engage in strategies of resistance.

Critical Theoretical Perspectives

Critical perspectives are a useful paradigm for conducting nursing research, as the aim of the critical tradition is to explore and explain how power is embedded in everyday nursing practice and care delivery (Aranda, 2006; Cheek, 2000, Racine, 2003). Our views of critical perspectives align with the Frankfurt School tradition. However, we concur with Kincheloe, McLaren, and Steinberg (2011) that critical perspectives share ontological assumptions with postmodern, poststructuralist, and postcolonial approaches. Critical approaches operate from shared world-views about the nature of reality, the goals of inquiry, and knowledge development (Lincoln, Lynham, & Guba, 2011). Our first premise is that power operates to shape the everyday reality of nursing practice (Aranda, 2006; Holmes & Gastaldo, 2002) and that the application of critical approaches provides an opportunity to explain that "all thought is fundamentally mediated by power relations that are socially and historically constituted" (Kincheloe et al., 2011, p. 164). Second, "facts cannot be isolated from the domain of values or removed from some ideological inscription [neoliberal efficiency and cost-effectiveness]" (Kincheloe et al., p. 164). Finally, critical approaches focus on privilege and how positions of privilege can subjugate other groups through "governmentality" (Holmes & Gastaldo, 2002; Kincheloe et al., 2011). In summary, critical theorists agree that power is a basic component of human life, shaping human and workplace interactions (Foucault, 1995; Kincheloe et al., 2011; Nicholson & Seidman, 1995).

Nurse researchers have used critical social theory as a lens through which to promote consciousness-raising in order to deconstruct power relations in nursing so that nurses can relate and act in more emancipated ways (Browne, 2000; Falk-Rafael, 2005; Fontana, 2004; Kagan, Smith, Cowling, & Chinn, 2009; Street, 1992). We reveal the ways in which power is exercised in organizations and how individuals develop the social and critical consciousness necessary to understand how power operates within the context of the nurse–nurse manager relationship.

Purpose

This study adds knowledge with respect to the concept of relational and critical empowerment theory by illustrating staff nurses' strategies of resistance to managerial practices so as to overcome ideological discourses of efficiency and cost-effectiveness. Empowerment cannot be fully understood and acted upon unless power itself is understood (Bradbury-Jones, Sambrook, & Irvine, 2008; Hardy & Leiba-O'Sullivan, 1998). The limitation resides in the fact that power in the nurse-manager relationship has been investigated mainly through postpositivist research (Laschinger et al., 2001a, 2001b; Laschinger, Finegan, & Wilk, 2009). The overarching research question guiding this study was as follows: *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?*

Methods

A previous study investigated how staff nurses and their managers exercise power in a hospital setting to better understand what fosters or constrains staff nurses' empowerment (Udod, 2014). The results of that study primarily advance the structural perspective (Udod, 2014). This study is intended to extend nurse empowerment theory to a critical social perspective.

Grounded theory (Corbin & Strauss, 2008; Strauss & Corbin, 1998) was used to theorize how power is exercised in the nurse-manager relationship. Participant observations, semi-structured interviews, and field notes were used to collect information from staff nurses about how the manager's role affected their ability to do their work. Fieldwork was conducted with 26 staff nurses on three units of a tertiary hospital in western Canada. Nurses ranged in age from 25 to over 50 years; 40% of the sample were 26 to 30. The majority of nurses were female (88%) and the majority had a nursing degree or a nursing degree in progress (64%). The length of time nurses had been working on their current unit ranged from 7 months to 24.5 years with a mean of 7.5 years. Nurse managers were not included in the data collection as the study focused on the relations of power from the perspective of staff nurses.

Data were analyzed using grounded theory methodology whereby sampling, data collection, and analysis are intertwined. As data were collected and generated, coding was begun at all three levels of analysis (open, axial, and selective) (Corbin & Strauss, 2008; Strauss & Corbin, 1998). A grounded theory perspective allowed for a meaningful explanation of how staff nurses exercise power in social relations with their manager.

Ethical approval was obtained from the university and hospital associated with the study.

Results

Because of the critical perspective used, the results demonstrate how staff nurses took action against institutional, organizational, and managerial oppressive forces to change their working conditions through resistance strategies. The findings are described around three areas: *organizational context*, *exercise of power in the nurse–manager relationship*, and *resistance strategies*.

Organizational Context

Nurses' constructions of organizational context are instructive in understanding the power dynamics between staff nurses and managers. From the perspectives of the participants, managerial priorities such as budgetary concerns and policies combined in various ways to restructure what counts as nursing work in redirecting and reprioritizing nursing care delivery. As Rudge (2011) points out, managerial priorities effected through the power of the institution serve to organize, control, and reorganize nurses' work by shaping the perceptions of their practice as acceptable and natural as it becomes a normalized part of nursing practice through the institution of policies for the cost-effectiveness and efficiency of the system.

“The Budget.” Nurses perceived that managers' preoccupation with the budget, and the associated fiscal and human resource cutbacks and shortages, frequently fell short of meeting patient care requirements on the units. Although nurses considered fiscal management a priority, they took exception to managers focusing primarily on the budget:

[The nurse manager's] goal was to . . . decrease the staff hours on the unit . . . even though you didn't notice a difference [in staffing], you were sort of stressed out . . . coming to work knowing that if you were short-staffed you weren't going to have that support brought in. Then there's a lot of questions. If you did ask for a sitter to come in, she [nurse manager] would really grill you about [it]. It was as if she didn't trust your judgement . . . she was looking at the dollar figure more than how stressed we were at work or what our work environment was.

Amidst physical and human resource constraints, nurses frequently found their nursing activities redirected because of multiple competing demands. How nurses came to view and carry out their work was shaped

by the repressive managerial practices of the nurse manager, which often took priority over direct patient care tasks.

Similar results regarding the regulation of nursing work through organizational processes and practices can be found in the literature (Wong, 2004). Nurses respond by completing their assigned patient care in less time, so that their work becomes treated as expendable. Nurses' work is often carried out within a culture of urgency in which "quality patient care" is supported without question while at the same time the ideology of the "caring" and "good" nurse is used to coerce nurses into doing more with less (Rudge, 2011). Close examination reveals that, in the midst of the sense of urgency to meet care needs, not only is nurses' work fragmented but nurses lose their ability to delineate how workplace conditions affect nursing — and thus resistance is averted (Rudge, 2011). In effect, nurses are absorbing the work and the pressures of the organization (Cooke, 2006) and limiting their own ability to provide patient care.

Being controlled by policies. Nurses described policies as a dominant and organizing aspect of their work that influenced care delivery. For instance, nurses' work was disrupted by policies that manifested as hospital alerts, rapid patient discharges and transfers to maximize bed capacity, and the numerous tasks they had to take on as a result of diminished administrative support:

We're told we absolutely have to take that patient, no ifs, ands, or buts, we are bringing up that patient now, they will be up in 5 minutes. . . . we always get told, "Oh, you'll manage, you'll manage, you'll manage," and you just say, "Why do we have to manage?"

In such situations, work and time pressures caused nurses to focus on "the basics of care" — tasks that are measurable and necessary for organizational efficiency. As a result, fears about patient safety and nurses' liability for potential mishaps frequently surfaced:

The crazy thing is, it [not replacing staff] continued to happen after . . . we would directly say, "Patient safety should be our primary focus and it is being compromised." . . . it makes you scared, because you're going home thinking, were there any med errors? I mean, you don't ever want to compromise your patients.

In adopting Smith's (1999) viewpoint, one can see that bed policies served as a ruling relation to control nurses' work (Wong, 2004). The responsibility for bed monitoring was integrated into nurses' practice and not problematized, because caring for patients wherever they are located in the hospital is part of nurses' work.

Policies represent a sophisticated and invisible form of power over nurses and their work (Rankin & Campbell, 2006). Patient safety¹ required nurses to engage in a substantial amount of charting to support management, even though the interests of administrators differ from those of nurses. In effect, the organization, through its proxies (nurse managers), enforced policies and regulations designed to safeguard the interests of patients and operational efficiency, seemingly without regard to how these might affect nurses' ability to provide good care. From a critical perspective, the discourse of patient safety reveals a disjuncture between the reality of nurses' everyday practice and the policies promoted by nurse managers. As a consequence, nurses experienced dissonance in their practice and began to draw up strategies of resistance in order to re-appropriate their practice.

Exercise of Power in the Nurse–Manager Relationship

Data analysis revealed that nurses were directed by bureaucratic policies and practices, even in the absence of the manager. This invisible hand of power represents a very effective ruling relation or means of “governmentality” (Holmes & Gastaldo, 2002), through which staff nurses became their own means of control and found themselves in an even more oppressive situation.

Working without an anchor. In the absence of dialogical and reciprocal relations, nurses and managers grew distant and nurses felt isolated from the manager's guidance, support, and access to resources, which in turn served as a deterrent to meaningful interaction. Without the active participation of the manager, nurses experienced the added pressure of having to meet organizational imperatives while also providing care. 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 nurses' work:

Well, how can I say this? I did bring up to her [manager] the fact that we did need support staff and all that, but when it's reflected back to you and nothing is done you don't feel like coming up to the person any more . . . [We] are listened to, but [our] opinions are not valued.

Such comments support the notion that “hearing is not listening” (Cicourel, 1983, p. 138). The manager's lack of visibility and accessibility

¹ Patient safety can be seen as an ideology promoting the “well-run” system described by Rudge (2011). It is used to govern nurses' work according to the values of the organization, reducing adverse events and complications to minimize patient stays and achieve cost-efficiency. We wonder if the real purpose of “patient safety” is to serve the ideology of the organization, subjugating patients as well as nurses in the process.

shaped nurses' practice. Rankin and Campbell (2006) report that nurse leaders learn to apply text-based methods of managing nurses, which include assessing workload and ensuring that documentation standards are met; such management techniques are expressed in policies and strategies designed to make efficient use of nurses' time and of other resources. The efficiency discourse as a form of power was taken up by nurses as a dominant discursive framework that was shaped and defined by the organization. Managers' monitoring and enforcing of policies achieved the desired level of involvement by nurses without the manager's presence on the unit, thus reinforcing the hierarchical and supervisory relationship at the expense of a collaborative nurse–manager relationship.

New governance models have also radically changed nursing leadership structures. The literature reveals that nurse managers have increasing spans of control (Laschinger et al., 2008; McCutcheon, Doran, Evans, McGillis Hall, & Pringle, 2009). In the present study, because the manager was less visible on the unit, nurses perceived themselves as scrutinized by the manager through policies in the form of incident reports and surveillance of documentation. Complex bureaucratic tasks are described in the following memo drawn from field notes written during an observation session:

Fidelity to the paperwork was highly prioritized by nurses in this study. In fact it appears to be more prized than educating the patient one on one. Nurses spend more time on paperwork saying that education has been provided . . . than in actually spending time with patients . . . Nurses can tick off tasks indicating they have responded to a specific activity, but it was not always clear that the specific activity was completed. Paperwork has become an acceptable and tangible substitute for patient education. I wonder what would happen if nurses actually spent time with patients instead of spending so much time on paperwork.

The fact that nurses could be observed, judged, and evaluated through their documentation reveals the discreet yet subjugating form of power that prevailed within the organization.

Silencing forms of communication. Communication or lack thereof represented a mechanism for circumscribing and altering dialogue between nurses and the manager. The effect of silencing was that nurses' voices were not heard and input into policy changes and decision-making at the unit level was minimized. On one unit, the implementation of a new care delivery model left staff feeling that they had little input into the decision-making process:

I know there [were] some meetings just prior to doing this [implementing the model] to discuss staff concerns. An e-mail was sent out, and I'm probably the only person on the ward that doesn't have a computer or an e-mail so I didn't know anything about it, but people told me it [the meeting] was, like, from 7:25 to 7:30, which I don't feel was much time to address any issues about the model. . . . Actually, I would have liked more staff input right from the beginning, and I'm not quite sure how they're going to be doing this because we're just trialling it and I'm hoping at some point there will be staff feedback. [The manager] has been somewhat receptive to that because she's letting us use it, whatever we feel is best in observation. We've raised the issue of having a senior assist or a special care aide as the second person, because they're not taking a patient load . . . I'm hoping that we'll be able to have input into modifying it to fit our needs.

Unresponsive institutional structures and practices and fragile nurse–manager relations made for a nurse–manager relationship devoid of shared power, potentially resulting in a sense of disempowerment among nurses. Nurses viewed the manager as a tangible and visible form of power and the primary architect of their job dissatisfaction. In this way, power was held over nurses, restricting their discussions with the manager and compelling them to execute managerial priorities without having any input.

The findings related to limited communication patterns are congruent with those reported in the empirical literature. Cheek and Gibson (1996) found that the privileging of physician and nursing management voices intruded into nursing issues and affected nurses' work. In a similar vein, Daiski (2004) found that nurses' perceptions of their disempowerment resulted from nurse leaders aligning with hospital administrators and that nurses navigated institutional policies as effective and obedient employees but with limited guidance from the manager. Finally, in the present study the manager's lack of visibility and limited communication caused nurses to have little trust in the manager and to sense the manager's power over them, prompting them to take resistive actions against the power of the organization as embodied in the nurse manager.

Resistance Strategies

In response to their experiences of disempowerment, nurses employed a variety of resistance strategies that were selective and were used at multiple points along a continuum, depending on the degree of oppression they felt within a particular context.

Setting limits flexibly. Nurses described setting limits flexibly, making disparaging and judgmental remarks to each other about the manager's

performance. 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 said that the time limit being afforded to a new manager was about 6 months. However, another commented as follows:

[The manager] is still new so we [nurses] are still giving her a year or 2 grace. [The clinical coordinator] has directly worked on the ward, so we know that she understands. We sometimes wish [the manager] would give the ward a whirl for a little bit to see what it's like, but we're giving her, certainly, a grace period.

Street (1992) suggests that nurses are most articulate about their relationship with nursing administration when their oppression is most explicit and when they are most active in terms of resistance. Similarly, nurses in the present study did not challenge the basis of the manager's pressure by critically examining the rules of the system that compel managers to make specific administrative decisions, but they did feel that the manager was largely to blame for their oppression. This may indicate that the participants were in a state of false consciousness, a state whereby staff nurses do not see their manager's oppression and are not conscious of their own oppression until their working conditions become untenable (Rudge, 2011; Smith, 1999).

Running interference. At the middle of the continuum of resistance strategies, nurses described running interference by not carrying out certain tasks or not engaging in certain activities as a more tangible but indirect form of resistance regarding their manager. On one unit, nurses refused to comply with a new care delivery model: "Everybody was kind of digging their heels in." Six months later the model was re-introduced. This change was not perceived as important to nurses, so they justified their non-compliance by indicating that they were not consulted on developing the policy for the model and the model might not work:

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.

Another study also found instances of passive resistance, with nurses ignoring charts or making minimal effort to record information (Street, 1992). In yet another study, nurses exhibited an indirect form of resistance, labelled "responsible subversion," aimed at bending the rules (Hutchinson, 1990), using different strategies such as pretending not to notice events in order to be seen as advocating for patient care, thus indirectly advocating for better working conditions; nurses made decisions

alone or in consultation with one another to advocate for patient care and reduce their stress, thus regaining control over their work.

Battling back. At the extreme end of the continuum, when nurses perceived themselves as having minimal control over their work they exercised collaborative power to engage the manager. “Collaborative power” refers to nurses joining together in a coalition to demand better working conditions under the guise of achieving better patient care. This strategy was productive because it was aimed at increasing meaningful interaction in decision-making to enhance nurses’ control over their work with the noble goal of safer and better care practices.

Nurses’ acts of positive resistance (Spreitzer & Doneson, 2005; Street, 1992) prompted them to meet with the manager’s superior for guidance in taking collective action against the manager. It was under such conditions that nurses took calculated risks to focus on the object of their care: the individual patient. The goal of the meeting was to advance the proposal for the new unit and respond to leadership challenges:

We wanted to do it in a way that would be a two-way conversation, like a dialogue: [the [manager] could express her concerns and we could also; we would let her have her say and explain to us what her plan was, why we were doing things and why things were not being done, rather than just attack . . . so that’s how it was set up.

Findings from the present study surrounding nurses’ resistance regarding their manager extend the work by Street (1992). Nurses were also able to resist oppressive situations and become effective advocates for patient care through a process of collective consciousness-raising, which came about during critical moments of oppressive leadership. According to Street, all oppositional behaviour needs to become a focal point for dialogue and critical analysis. In response to nurses’ actions, nursing administration held several meetings in which nurses were able to move beyond oppression by engaging with the manager to discuss work issues. It was not apparent that changes to policies or practices were instituted to alleviate organizational pressures, but the manager resigned as a consequence of these meetings.

Nurses’ most assertive acts of resistance rely on their professional knowledge of patient care, which includes documentation and going to a higher authority (Peter, Lunardi, & Macfarlane, 2004; Schroeter, 1999), which in turn is associated with “speaking truth to power” (Falk-Rafael, 2005). These acts of resistance call for nurses to exercise their power and advocate for patients through the expression and enactment of ethical and moral caring values (Falk-Rafael, 2005). Several authors challenge nurses to identify points of resistance and develop alternative discourses to improve patient outcomes by reducing adverse events (Baker et al.,

2004) and improve nurse outcomes with respect to job satisfaction, commitment, and burnout (Laschinger et al., 2001a, 2001b, 2009).

Discussion

The present study deepens our understanding of empowerment by including a third perspective, the critical social perspective. From this perspective, managers used their power, albeit subconsciously, to prevent nurses from challenging existing power positions by portraying the way nurses worked as acceptable or inevitable in light of organizational constraints (Hardy & Leiba-O'Sullivan, 1998). The critical social empowerment demonstrated in this study was a process whereby disenfranchised nurses became aware of the oppressive forces in their work environments and adopted positive and negative strategies of resistance against their managers by changing their working conditions. Nurses assumed responsibility for their own empowerment, and nurtured it by engaging in individual and collective actions to promote change.

The silencing of nurses was characterized by patterns of restricted and altered communication between nurses and their manager. In a study by Casey, Saunders, and O'Hara (2010), respondents reported a moderate level of critical social empowerment when they felt involved in decisions affecting themselves and their organization. Other research has found that work environments that are characterized by a perceived lack of support and lack of respectful teamwork are strong indicators of nurse burnout (Demir, Ulusoy, & Ulusoy, 2003). Moreover, a poor work environment and burnout may directly impact the nurse-patient relationship and hence the quality of care (Van Bogaert, Kowalski, Weeks, Van Heusden, & Clarke, 2013). Nurse manager strategies that include being visible and accessible and adopting a participative management style contribute to a high-performing work environment that fosters quality care (Wolf & Greenhouse, 2006).

Nurses' resistance to the oppressive nature of the managerial imperative was characterized by positioning to resist, and this resistance ultimately brought about change to their practice. The results of the present study parallel those described by Street (1992) as nurses' acts of passive and active resistance, and were especially evident in areas where nurses objected to bureaucratic processes and policies. Although these results may appear somewhat pessimistic, the use of a critical perspective sheds light on a different and positive view of critical empowerment. They demonstrate that when staff nurses become critically aware of the political, social, cultural, and economic contexts of their work, individual and collective empowerment becomes a reality and change becomes possible. Lincoln et al. (2011) underline the duality of critical inquiry as a require-

ment for bringing social critique to a situation with the possibility of making positive and liberating changes.

Implications for Managerial Practice and Quality of Patient Care

Our results clearly identify the centrality of managers' support and engagement in shaping nurses' relationships with them to achieve work effectiveness. It might be beneficial for managers to adopt a more inclusive, participative decision-making style, as this could have a positive effect on the work environment. For example, engaging nurses as active participants in developing practices and policies that underpin patient-care activities could influence nurses' job satisfaction. In addition, senior nurse administrators need to ensure that staff nurses have more of a voice in organizational decision-making and more meaningful involvement in defining and supporting care practices. Studies have demonstrated the importance of high-performing work environments that support nurses' perceptions of professional practice and quality patient care (Laschinger, 2008; McGillis Hall & Doran, 2007).

Summary

We believe that critical empowerment is a dialogical and dialectical process between nurses and their manager. It calls for managers to share power with, consult with, and involve nurses in decision-making in order to find alternative and productive ways to improve working conditions and better focus on patient care. Our results provide direction for staff nurses in exploring resistance as a means of change by critically appraising and problematizing institutional and managerial policies and practices as a way to (re)appropriate their own practice. Disempowering working conditions for nurses will continue until nurses are willing to critically examine the rules and social practices within the hospital bureaucracy that have a bearing on whether, how, and why certain actions are taken by managers and to explore nurses' role in their own oppression (Daiski, 2004; Street, 1992). Our findings should encourage nurses to critically reflect on how discourses of efficiency and productivity influence nursing practice and to see that they have some agency to advocate for themselves with regard to working conditions (Rudge, 2013) instead of passively supporting what Rudge (2011) describes as the "well-run" system.

References

- Aranda, K. (2006). Postmodern feminist perspectives and nursing research: A passionately interested form of inquiry. *Nursing Inquiry*, 13(2), 135–143.
- Baker, G. R., Norton, P. G., Flintoft, V., Blais, R., Brown, A., Cox, J., . . . Tamblyn, R. (2004). The Canadian Adverse Events Study: The incidence of adverse

- events among hospital patients in Canada. *Canadian Medical Association Journal*, 170(11), 1678–1686.
- Bradbury-Jones, C., Sambrook, S., & Irvine, F. (2008). Power and empowerment in nursing: A fourth theoretical approach. *Journal of Advanced Nursing*, 62(2), 258–266.
- Browne, A. J. (2000). The potential contributions of critical social theory to nursing science. *Canadian Journal of Nursing Research*, 32(2), 35–55.
- Canadian Nursing Advisory Committee. (2002). *Our health, our future: Creating quality workplaces for Canadian nurses*. Ottawa: Health Canada.
- Casey, M., Saunders, J., & O'Hara, T. (2010). Impact of critical social empowerment on psychological empowerment and job satisfaction in nursing and midwifery settings. *Journal of Nursing Management*, 18(1), 24–34.
- Cheek, J. (2000). *Postmodern and poststructural approaches to nursing research*. Thousand Oaks, CA: Sage.
- Cheek, J., & Gibson, T. (1996). The discursive construction of the role of the nurse in medication administration: An exploration of the literature. *Nursing Inquiry*, 3(2), 83–90.
- Cicourel, A. (1983). Hearing is not believing: Language and the structure of belief in medical communication. In S. Fisher & A. Todd (Eds.), *The social organisation of doctor patient communication* (pp. 138–155). Washington: Centre for Applied Linguistics.
- Conger, J. A., & Kanungo, R. N. (1988). The empowerment process: Integrating theory and practice. *Academy of Management Review*, 13(3), 471–482.
- Cooke, H. (2006). Seagull management and the control of nursing work. *Work, Employment and Society*, 20(2), 223–243.
- Corbin, J., & Strauss, A. (2008). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (3rd ed.). Thousand Oaks, CA: Sage.
- Daiski, I. (2004). Changing nurses' dis-empowering relationship patterns. *Journal of Advanced Nursing*, 48(1), 43–50.
- Demir, A., Ulusoy, M., & Ulusoy, M. F. (2003). Investigation of factors influencing burnout levels in the professional and private lives of nurses. *International Journal of Nursing Studies*, 40(8), 807–827.
- Falk-Rafael, A. (2005). Speaking truth to power: Nursing's legacy and moral imperative. *Advances in Nursing Science*, 28(3), 212–223.
- Fontana, J. S. (2004). A methodology for critical science in nursing. *Advances in Nursing Science*, 27(2), 93–101.
- Foucault, M. (1995). *Discipline and punish: The birth of the prison*. London: Penguin.
- Greco, P., Laschinger, H. K. S., & Wong, C. A. (2006). Leader empowering behaviours, staff nurse empowerment and work engagement/burnout. *Nursing Leadership*, 19(4), 41–56.
- Hardy, C., & Leiba-O'Sullivan, S. (1998). The power behind empowerment: Implications for research and practice. *Human Relations*, 51(4), 451–483.
- Holmes, D., & Gastaldo, D. (2002). Nursing as means of governmentality. *Journal of Advanced Nursing*, 38(6), 557–565.
- Hutchinson, S. A. (1990). Responsible subversion: A study of rule-bending among nurses. *Scholarly Inquiry for Nursing Practice*, 4(1), 3–17.

- Kagan, P. N., Smith, M. C., Cowling, R. W., & Chinn, P. L. (2009). A nursing manifesto: An emancipatory call for knowledge development, conscience, and praxis. *Nursing Philosophy, 11*(1), 67–84.
- Kanter, R. (1977). *Men and women of the corporation*. New York: Basic Books.
- Kanter, R. (1993). *Men and women of the corporation* (2nd ed.). New York: Basic Books.
- Kincheloe, J. L., McLaren, P., & Steinberg, S. R. (2011). Critical pedagogy and qualitative research: Moving to the bricolage. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE handbook of qualitative research* (4th ed.) (pp. 163–177). Los Angeles, London, New Delhi, Singapore, and Washington: Sage.
- Laschinger, H. K. S. (2008). Effects of empowerment on professional practice environments, work satisfaction, and patient care quality: Further testing the Nursing Worklife Model. *Journal of Nursing Care Quality, 23*(4), 322–330.
- Laschinger, H. K. S., & Finegan, J. (2005). Using empowerment to build trust and respect in the workplace: A strategy for addressing the nursing shortage. *Nursing Economics, 23*(1), 6–13.
- Laschinger, H. K. S., Finegan, J., & Shamian, J. (2001a). The impact of workplace empowerment, organizational trust on staff nurses' work satisfaction and organizational commitment. *Health Care Management Review, 26*(3), 7–23.
- Laschinger, H. K. S., Finegan, J., & Shamian, J. (2001b). Promoting nurses' health: Effect of empowerment on job strain and work satisfaction. *Nursing Economics, 19*(2), 42–52.
- Laschinger, H. K. S., Finegan, J., & Wilk, P. (2009). Context matters: The impact of unit leadership and empowerment on nurses' organizational commitment. *Journal of Nursing Administration, 39*(5), 228–235.
- Laschinger, H. K. S., Wong, C. A., McMahon, L., & Kaufmann, C. (1999). Leader behavior impact on staff nurse empowerment, job tension, and work effectiveness. *Journal of Nursing Administration, 29*(5), 28–39.
- Laschinger, H. K. S., Wong, C. A., Ritchie, J., D'Amour, D., Vincent, L., Wilk, P., . . . Almost, J. (2008). A profile of the structure and impact of nursing management in Canadian hospitals. *Healthcare Quarterly, 11*(2), 85–94.
- Lincoln, Y. S., Lynham, S. A., & Guba, E. G. (2011). Paradigmatic controversies, contradictions, and emerging confluences, revisited. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE handbook of qualitative research* (4th ed.) (pp. 97–128). Los Angeles, London, New Delhi, Singapore, and Washington: Sage.
- McCutcheon, A. S., Doran, D., Evans, M., McGillis Hall, L., & Pringle, D. (2009). Effects of leadership and span of control on nurses' job satisfaction and patient satisfaction. *Nursing Leadership, 22*(3), 48–67.
- McGillis Hall, L., & Doran, D. (2007). Nurses' perceptions of hospital work environments. *Journal of Nursing Management, 15*(3), 264–273.
- Moye, M. J., & Henkin, A. B. (2006). Exploring associations between employee empowerment and interpersonal trust in managers. *Journal of Management Development, 25*(2), 101–117.
- Nicholson, L. J., & Seidman, S. (Eds.). (1995). *Social postmodernism: Beyond identity politics*. New York: Cambridge University Press.
- O'Brien-Pallas, L., Tomblin-Murphy, G., White, S., Hayes, L., Baumann, A., Higgin, A., . . . Wang, S. (2005). *Building the future: An integrated strategy*

- for nursing human resources in Canada. *Research synthesis report*. Ottawa: Nursing Sector Study Corporation. Retrieved June 3, 2005, from <http://www.buildingthefuture.ca/e/study/phase1/reports/Research-Synthesis-Report.pdf>.
- Peter, E., Lunardi, V. L., & Macfarlane, A. (2004). Nursing resistance as ethical action: Literature review. *Journal of Advanced Nursing*, 46(4), 403–416.
- Priest, A. (2006). *What's ailing our nurses? A discussion of the major issues affecting nursing human resources in Canada*. Ottawa: Canadian Health Services Research Foundation. Retrieved May 20, 2006, from http://www.chsrf.ca/research_themes/pdf/what_sailingourNurses-e.pdf.
- Racine, L. (2003). Implementing a postcolonial feminist perspective in nursing research related to non-Western populations. *Nursing Inquiry*, 10(2), 91–102.
- Rankin, J. M., & Campbell, M. L. (2006). *Managing to nurse: Inside Canada's health care reform*. Toronto: University of Toronto Press.
- Rudge, T. (2011). The “well-run” system and its antinomies. *Nursing Philosophy*, 12(2), 167–176.
- Rudge, T. (2013). Desiring productivity: Nary a wasted moment, never a missed step! *Nursing Philosophy*, 14(3), 210–211.
- Schroeter, K. (1999). Ethical perception and resulting action in peri-operative nurses. *AORN Journal*, 69(5), 997–1002.
- Smith, D. E. (1999). *Writing the social: Critique, theory, and investigations*. Toronto: University of Toronto Press.
- Spreitzer, G. M., & Doneson, D. (2005). Musings on the past and future of employee empowerment. In T. Cummings (Ed.), *Handbook of organization development* (pp. 311–324). Thousand Oaks, CA: Sage.
- Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2nd ed.). Thousand Oaks, CA: Sage.
- Street, A. (1992). *Inside nursing: A critical ethnography of clinical nursing practice*. Albany: State University of New York Press.
- Thomas, K. W., & Velthouse, B. A. (1990). Cognitive elements of empowerment: An “interpretive” model of intrinsic task motivation. *Academy of Management Review*, 15(4), 666–681.
- Udod, S. A. (2011). *Seeking connectivity: An analysis of relationships of power from staff nurses' perspectives*. Unpublished doctoral dissertation, University of Toronto.
- Udod, S. (2014). Seeking connectivity in nurses' work environments: Advancing nurse empowerment theory. *Canadian Journal of Nursing Research*, 46(3), 110–127.
- Van Bogaert, P., Kowalski, C., Weeks, S. M., Van Heusden, D., & Clarke, S. (2013). The relationship between nurse practice environment, nurse work characteristics, burnout and job outcome and quality nursing care: A cross sectional survey. *International Journal of Nursing Studies*, 50(12), 1667–1677.
- Wolf, G. A., & Greenhouse, P. K. (2006). A road map for creating a magnet work environment. *Journal of Nursing Administration*, 36(10), 458–462.
- Wong, W. H. (2004). Caring holistically within new managerialism. *Nursing Inquiry*, 11(1), 2–13.

Acknowledgements

The intellectual contributions of Drs. Diane Doran, Jan Angus, and Heather Laschinger to this research project are gratefully acknowledged, as are the assistance and support of the Saskatoon Health Region in facilitating the project.

Sonia Udod, RN, PhD, is Assistant Professor, College of Nursing, University of Saskatchewan, Saskatoon, Canada. Louise Racine, RN, PhD, is Associate Professor, College of Nursing, University of Saskatchewan.