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**NURSES' VOICE: THE MEANING OF VOICE TO EXPERIENCED
REGISTERED NURSES EMPLOYED IN A MAGNET HOSPITAL WORKPLACE**

A Thesis in

Adult Education

by

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ABSTRACT

Magnet Hospitals are healthcare environments that have recognized excellence in nursing care. These accredited Magnet Hospitals, a term coined in the early 1980's, were seen to have the ability to attract nurses. These hospitals have quantitatively documented greater patient satisfaction, greater nurse autonomy, lower incidence of nursing burnout and greater nursing retention. As healthcare faces one of its most significant nursing shortages, Magnet Hospitals illustrate an organizational and corporate strategy that aims to recognize nursing and hopefully retain and recruit nurses during this challenging time.

While there are numerous quantitative studies that examine aspects of Magnet Hospitals such as nursing autonomy in practice, organizational hospital structure, lower nurse burnout and greater nurse retention, there remain few studies that have examined this workplace environment from a qualitative perspective.

The use of nursing's voice in this study was meant to qualitatively examine what it means for the participants to be working at an accredited Magnet Hospital. Voice implies autonomy, self-awareness, and power. The concept of voice dovetails into the Magnet Hospital literature as it provides a different lens to see what it means for the nurses who work within this setting. Voice is imperative to examine in the context of a Magnet Hospital as it helped give insight to what the nurses' perceptions were at one particular Magnet Hospital and what they viewed as important to their work at that hospital.

The findings revealed that the nurses did not feel that their voice was heard within this Magnet Hospital. There were several consistencies that arose from the conversations with the participants which include: importance of the nurse manager, physician-nurse

relations, staffing concerns, committee structure, and working within the Magnet Hospital itself. Based upon these themes, several implications for nursing, human research and development, and adult education are discussed.

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CHAPTER ONE: INTRODUCTION

This chapter provides an overview of a qualitative study that seeks to understand the meaning of voice to experienced registered nurses within a Magnet Hospital workplace setting. This chapter includes a background to the study, a purpose statement, a conceptual framework that guides the study, an overview of the research methodology, an identification of the significance of the study, and a list of assumptions and limitations associated with the study.

Background to the Problem

There is much discussion within the field of adult education in recent years about women's learning styles within multiple adult education contexts (Flannery, 1995; Freire, 1970; hooks, 1984 & 1994; Howell, Carter, & Schied, 2002; Hugo, 1990; Lather, 1991; Tisdell & Taylor, 2000; Weiler, 1991). This discussion arises from the fact, that for years, men were the central focus of learning and research within the disciplines of psychology, adult education, and the workplace. This, of course, is related to the fact that men are viewed within western culture as the dominant workforce participant as well as the primary authors of higher education literature and research. Western culture has been traditionally based upon this patriarchic social structure, where men had more power and privilege manifested in their higher wages at work, and a gender stratified workplace where the men have had higher and more powerful positions than women. Men were typically lawyers, clergymen, heads of corporations, and doctors. The women, on the other hand, were found in the more supportive roles such as caretakers of children, secretaries, teachers, and nurses. While this gender stratification in the labor market has changed somewhat as a result of the women's movement, there is still much change that

needs to occur. Women are still being affected by a male dominated society related to their learning, to their socialization, and place in the workplace.

Much of the literature about women's learning styles in both the classroom and in the workplace has focused on how women come to voice, how they can claim power and control over their own lives and learn to stand up for themselves. This is in light of the fact that women have been raised in a patriarchal culture that has traditionally paid more attention to the voices of men than women (Collins, 1991; Gilligan, 1982; Sheared & Sissel, 2001). One of the most striking professions where the empowerment and autonomy of women has struggled to exert itself against patriarchy has been within the hospital organization; this refers specifically to the nursing profession (David, 2000).

Traditionally, hospitals are heavily structured into tiers of management and rely on a strongly patriarchal system of interactions. This bureaucratic model was first introduced by the work of Max Weber, a sociologist from the early 1900's. Weber developed a mechanistic design that incorporated the following characteristics: tight control of the employees' behaviors; strict rules for conduct and procedures; each employee has a very defined and specific job to do within the organization; the structure of the business is very hierarchical; new employees are selected for their technical skills and are appointed; and the organization has a career ladder (Hellriegel, Slocum, & Woodman, 2001). Within these hierarchical organizations, decision-making processes are very formal and prescribed. Power comes from the higher tiers of administration and trickle down through the administration ladder; this is sometimes referred to as centralization (Hellriegel, Slocum, & Woodman, 2001). Hospitals are renowned to have a bureaucratic, centralized structure that segregates its operations so that each pocket of

expertise (e.g., surgical services, emergency medicine) works to its maximum potential. This organizational work structure has often made it difficult for women employees, specifically nurses, as evidenced by low job satisfaction and high burnout rates (Sovie, 1993).

As nursing continues to grow and establish itself as its own profession from under the umbrella of the medical model, there will be much resistance and fear of change from both medicine and nursing. However, in order for healthcare to retain its nursing staff and more effectively meet the needs of the patients, nurses must be better recognized within their own professional model. One way for nurses to become better “heard” within this patriarchic society of healthcare is to commit to an organizational management style that will pay more attention to the voices of nurses.

The concept of coming to voice has been talked about much in the postmodern feminist literature. Postmodern feminism frequently uses the concept of voice as a means to speak up against the oppression of women within the contexts of society, education, and in the *workplace* (Code, 1995; Goldberg, 2000; Hayes & Flannery, 2000; hooks, 1984, 1994; Howell, Carter, & Schied, 2002; Lee, 1994; Mahoney, 1996; Sheared, 1999; Sheared & Sissel, 2001; Tisdell & Perry, 1997; Weiler, 1991). This postmodern view has particular implications for nursing. Nursing’s voice within the context of a patriarchal society of medicine is of great interest because of its domination over nursing practice and the fact that nurses have been overlooked in the healthcare environment for decades. This oppression refers not just to the fact that women within healthcare have traditionally had the lower paying jobs and are overlooked as far as administrative promotion, but also that they are also neglected in the recognition that nurses provide the primary care to the

patients within the hospital setting (David, 2000). Ironically, it is noted that it is nursing care that directly affects patient mortality and morbidity (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002).

Nurses typically feel that their voices have not been heard within the traditional medical model of healthcare (David, 2000). Rather, healthcare has exhibited a gendered stratification in the labor market for years. Currently, women make up at least 90% of the nursing profession (U. S. Department of Labor, 1999). Doctors (typically male) have had the higher paid wages and have held the power within healthcare organizations. Conversely, nurses have been taken advantage of for years with long hours, low pay, and no power within the healthcare institution (David, 2000; Spence, 1991). Ironically, it is the nurse who performs most of the patient care tasks of the bedside and provides support for patients as well as families (Upenieks, 2003). As evidenced here, nursing is an example of a profession that still struggles to overcome male domination within the workplace (David, 2000).

The workplace oppression of nurses becomes a paramount issue for the healthcare industry, as they must strive to make the nursing profession more attractive to women in order to overcome an existing nursing shortage. Healthcare organizations must reexamine their workplace environment and culture to see how it can be more female-oriented and where female power is felt and seen in order to attract and retain more nursing staff. Such workplaces do exist. “Magnet Hospitals” are work environments where nurses have a shared power and collaborative practice between various disciplines within the healthcare institution.

Magnet Hospitals are healthcare organizations that have set an example for nursing care and are able to attract nurses despite the nursing shortage. The term “Magnet Hospital” is a term that signifies an accredited institution that has proven itself as a model place of employment for nurses. According to the American Nurses Credentialing Center (ANCC), the Magnet Nursing Services Recognition Program for Excellence in Nursing Service is the “highest level of recognition that the ANCC can accord to organized nursing services in health care organizations” (ANCC, 2000, p. 13).

Magnet Hospitals were introduced in the early 1980’s as institutions faced an increasing challenge to recruit and retain nurses in the face of a serious nursing shortage. Several hospitals were studied that did not appear to be affected by the nursing shortage, identifying similarities that seemed to be characteristic of these institutions: autonomy within clinical practice, status within the organization, collaboration, and nursing leadership (Scott, Sochalski, & Aiken, 1999). In short, a common characteristic to each of these hospitals is recognition of nursing’s value to the organization. Other characteristics that have been found to be in common among Magnet Hospitals include: the nurse has a visible power among the hospital executive committee as manifested by being a voting member on the hospital’s Board of Directors; nursing departments are flat and decentralized; nursing decisions are supported by administration, and there is good communication between nurses and physicians (Aiken, Havens, & Sloane, 2000; Coile, 1999; Havens & Aiken, 1999; Kramer, 1990; Lashinger, Shamian, & Thomson, 2001; Mason, 2000; Scott, Sochalski, & Aiken, 1999; Sovie, 1984).

The concept of autonomy within the clinical practiced is discussed in the majority of the Magnet Hospital research and should be introduced here. Autonomy is primarily

enabling the nurse to make changes regarding their patient's care and act upon those changes within the clinical setting. In the various Magnet studies there was not one universal definition of autonomy used, however a scale of autonomy was devised to help standardize what autonomy meant – this is known as the Nursing Work Index and is discussed further in Chapter Two. This idea of autonomy becomes closely related to the concept of voice that was examined further in this study.

There are numerous benefits for attaining Magnet Hospital status. First of all, it signals to other nurses that this particular institution really values nursing and would be an ideal place for employment. There are lower rates of nurse burnout and higher levels of job satisfaction. Second, the community is made aware of the excellence in nursing services within the Magnet Hospital. This helps the marketability of the hospital while improving relations within the community it serves. Third, there are clinical benefits related to Magnet Institutions, such as improved quality patient care (Aiken & Havens, 2000).

As described above, the research on Magnet Hospitals has been primarily descriptive of its organization style. This research also includes outcome specific details about nurse benefits of working within a Magnet Hospital such as lower burnout and greater retention. There are, however, currently no qualitative studies that investigate the nurse's perceptions of what it means to work within a healthcare organization which nursing is recognized and touted as being exemplar. What about the actual perceptions of the nurses who work within a Magnet Hospital? What is their experience of working within a Magnet Hospital and having a voice?

Magnet Hospitals appear to be a solution to healthcare's traditional repression of nurses. By promoting nurse autonomy and including nurses within the power structure of a hospital, Magnet Hospitals appear to place a greater value on the nursing profession. As a benefit of this nursing value, Magnet Hospitals enjoy greater nurse satisfaction, lower nurse burnout rates, and better outcomes for not only patient care but also for the healthcare organization as a whole. Thus, it became critical to further examine Magnet Hospitals as a potential solution not only to the nursing shortage and nursing satisfaction, but also to the workplace environment where women's voice and experiences have been traditionally repressed and overlooked. The problem critical to this study then became examining the actual experience of the registered nurse of having a voice within a Magnet Hospital setting.

Purpose

From this background information it becomes evident that further investigation of female nurses within a Magnet Hospital was necessary. As stated earlier, nurses have long felt the oppression of the medical profession and have sought a work environment where they can feel valued and respected for the care and decisions they make regarding patient care and their own professional development. The actual perceptions of the nurses who work within a Magnet Hospital have yet to be examined.

Trying to better listen and gain an understanding of the meaning that nurses place on having a voice within these healthcare organizations will contribute to the literature about what attracts and retains nurses to work within this hospital setting. Several of the questions proposed in this study were: What was the essence of voice from experienced medical surgical bedside nurses within a Magnet Hospital? Did the nurses feel that the

organizational culture of a Magnet Hospital supported their voice? If so, how did it relate to the hospital's organizational structure?

By exploring the aforementioned questions it was hoped to gain a better perception of the nurse's experience of having a voice within this nursing exemplar workplace setting. Restated, the purpose of this study was to try to understand the nurses' meaning of voice as they work within a Magnet Hospital setting. This purpose was achieved by interviewing experienced registered nurses.

Conceptual Frameworks

There are two different conceptual frameworks that influenced this study: feminist humanist and critical-emancipatory. Both frameworks will be discussed in the literature further, but the feminist humanist is the springboard for this study as it discusses the role of the individual female and her autonomy and voice. Critical-emancipatory will also be discussed in further detail, but this framework helps guide the study as it pertains to social change and the intersection of gender, inequality, and critical reflection.

The humanist philosophy stems from humanistic psychology. To summarize, humanistic psychology includes that the individual has control over their own destiny, that people are inherently good and will strive to make the universe a better place, individuals are free to act upon what they feel is best, behavior is the outcome of personal choices, and that each person has a potential for growth and development (Maslow, 1970; Rogers, 1983). The humanist philosophy primarily deals with the individual and their attempt to grow, learn, and act upon information.

Currently, much of the literature regarding women's voice has stemmed from this humanistic paradigm, meaning that it discusses the concept of voice primarily from an

individual sense and not a societal sense. Since this study focused on the meaning of voice for female nurses, the study utilized a feminist humanist conceptual framework. The feminist humanist conceptual framework helped lay the groundwork for this study because it was this lens that focused on the individual development of women's voice via the connections and relationships of others (Belenky, Clinchy, Goldberger, & Tarule, 1986).

It would be remiss to think that the feminist humanist lens was the only one that guided this study. As discussed earlier, there was an emphasis on the workplace and attention to power and gender within the context of this study, thus a critical-
emancipatory framework has also influenced this work and was utilized to better situate the reader within a societal context, where voice is viewed as a necessary tool to express and activate change against oppression.

Hospitals are organizations that wield power not only in the community, but also within the workplace structure. Within their walls, traditional hospitals have often eclipsed nurses from the medical (male) power structure and bureaucracy. The resultant nursing shortage, low job satisfaction, and greater burnout rates are all indicators that this particular model of healthcare is not conducive to the nurses that work there. Magnet Hospitals offer a different perspective where the organization is designed to place nurses with greater autonomy and power within the healthcare structure. It is this intersection of power and gender that allowed this study to be also influenced by a critical emancipatory feminist lens.

It was within this conceptual framework where there is interconnectedness between power and gender. This conceptual framework definitely impacted this study in

that it was expected that issues about gender, power, and change may be evoked from this specific workplace setting where the traditionally oppressed nurses are valued and perhaps given a voice. It should be noted that the critical emancipatory framework was not the guiding conceptual framework for this particular study, but it would be remiss not to mention its impact on the questions asked and the researcher's assumptions for the study. Certainly, concepts of silence which relate to the critical emancipatory framework became identified by the participants of this study and will be investigated further in a later study.

Statement of the Problem

Magnet Hospitals provide one avenue of research that examines a workplace environment that seems to embrace nursing's voice and values the work of the nurse at the bedside. Most of the Magnet Hospital literature provides the reader with descriptive studies examining positive patient and quality outcomes secondary to the hospital's quality nursing staff. There is an emphasis on education and support for nurses' ability to make clinical decisions noted in several of these quantitative studies, providing descriptive statistics (Aiken, Havens, & Sloane, 2000; Havens & Aiken, 1999; Havens, 2001; Sovie, 1984). The flattened organizational structure style, the autonomy and empowerment that nurses have to perform their jobs, as well as the value placed on communication between levels of management help define a Magnet Hospital (Sovie, 1984; Havens & Aiken, 1999; Havens, 2001). Despite all of this current research, only a very few studies (Kramer & Schmalenberg, 2002; McClure, Poulin, Sovie, & Wandelt, 1983) have provided a qualitative examination of Magnet Hospitals.

In the original study (McClure, Poulin, Sovie, & Wandelt, 1983), there were three broad themes that evolved from their qualitative research: administration, professional practice, and professional development. Within the theme of administration, further commonalities were noted such as management style that was participative, the quality of leadership was crucial to recruitment and retaining registered nurses, the organizational structure was decentralized, and personnel policies that illustrated that salaries and benefits of Magnet Hospitals were competitive to other hospitals within their communities. Professional practice was defined further to include autonomy, primary nursing, mentoring, professional recognition, and respect. Professional development was also clearly emphasized within these Magnet Hospitals. They recognized the benefits of a baccalaureate and higher degree education and valued tuition reimbursement benefits. It is from these three themes that the quantitative basis for Magnet Hospital research has evolved.

Currently, more qualitative research needs to be done in this area to better ascertain the views and experiences of the nurses within this healthcare setting. Nurses' experience and their perceptions of their voice within the workplace setting need to be further explored. These insights gathered from interviews, not simply from a Likert Scale tools as in quantitative research, became imperative to better understand the workplace for nurses and women within a Magnet Hospital setting where nursing is sought out and considered exemplar.

Clearly the organizational culture of these Magnet Hospitals demonstrates a value that promotes the autonomy and empowerment of the nursing staff and there-by promotes

women. Magnet Hospitals appear to promote the nursing staff and support their clinical decision-making skills (Upenieks, 2003).

The concept of voice, in particular women's voice, became a central theme to this phenomenological study. There has been much research done in feminist literature that defines what it means to have voice (Belenky et al., 1986; Code, 1998; Gilligan, 1982; Goldberger, Tarule, Clinchy, Belenky, 1996; Hayes & Flannery, 2000; hooks, 1984; Hugo, 1990; Lather, 1991, 1995, 1998; Scott, 1994; Sheared & Sissel, 2001). These authors provided a varied look at the use of voice and what it means to have voice. The voice literature discussed how voice is shaped, what voice is, and the various uses of voice. Although this literature base is large, there is not a large base of knowledge specific to nursing's voice.

Within the nursing literature, there is a considerable amount of information that focused on the term autonomy. This term implies the concept of voice. Studying nurses' voice within a Magnet Hospital, a setting that is expected to be a more powerful environment for nurses, became an imperative.

Research Questions

This study explored the following questions: What was the essence of voice from experienced medical surgical bedside nurses within a Magnet Hospital? Did the nurse feel that the organizational culture of a Magnet Hospital support nurse's voice? If so, how did it relate to the hospital's organizational structure?

The first question explored the nurse's perception of voice within the context of their Magnet Hospital workplace. How did the participants feel that their voice is heard? To what end? Who heard them? In what way are these nurses' voices heard? Also, there

were some structural pieces that were examined and explored through these interviews to ascertain information regarding the nurse's voice. These questions included the following, depending on what organizational aspects the nurse raised: How did these Magnet Hospital nurses serve on hospital-wide committees? How did they affect change at these meetings? How did these nurses feel supported within the Magnet Hospital setting? What were the supportive structures that helped or deterred the voice of nursing within this Magnet Hospital context?

Secondly, the organizational culture was examined. This cultural piece was studied starting from the above-mentioned questions. Also, there was a brief review of documents that will help explore this issue further, such as the Magnet Hospital application document from the healthcare institution. Items such as the hospital mission statement and the nursing operating code of conduct and standards were also reviewed.

Methodology

This study was qualitative in nature using a phenomenological study design. Qualitative research is a type of research that speaks to human subjectivity and intersubjectivity (Morse, 1989) and how humans make meaning in the world. Qualitative studies exhibit several characteristics which include: non-generalizable research, meaning-making value, importance of the natural setting, the researcher as the interpreter, induction methods, reciprocity, a small sample size, and the goal of uncovering a previous unknown. This study took a phenomenological approach in relation to exploring the experience of nurse's use of voice and organizational structure within a Magnet Hospital. It employed interviews with female nurses and discussions about the way they perceived their use of voice within a Magnet Hospital. There was also an examination

and review of Magnet Hospital documents regarding their organizational culture so as to ascertain the hospital structure that is believed to support nurses.

A purposeful sample of twelve identified registered nurses from one particular Magnet Hospital was utilized for this study. Based on Benner's (1984) definition of novice to expert, the sample utilized registered nurses with at least five years clinical experience with direct patient care and they have worked within the chosen Magnet Hospital for at least the past three years. The sample participated in two interviews held at times and places convenient to them at the hospital. Documents from the Magnet Hospital application to the ANCC were reviewed to determine the organizational culture components for the chosen Magnet Hospital.

Significance of the Study

This study was important for numerous fields of study. First, nursing faces one of its biggest nursing shortages ever, it was important to get the nurses perspective about what it is that helps recruit and retain them to hospitals. This investigation regarding nurse's voice was an attempt to uncover what makes Magnet Hospitals so desirable to the bedside nurse. The bedside nurse – nurses with direct patient care, was at the crux of this study. It was imperative to understand their perceptions of working within this particular workplace environment. The nursing literature has no qualitative studies that examine the use of voice within the workplace. There is a dearth of qualitative research study done on the topic of Magnet Hospitals. By completing this qualitative study that examined the voices of bedside nurses, the research revealed more about workers perceptions within a Magnet Hospital workplace setting and tried to uncover the meanings that the participants equate with their use of voice. Utilizing qualitative research for this study depth added to

the quantitative research studies that have been conducted regarding Magnet Hospitals, which to this date, have all examined specific outcome criteria such as nurse burnout and patient satisfaction. Qualitative research became imperative to deeply understand nurses' perceptions of their voice working within a Magnet Hospital setting.

For human resource development and management, this study provided business an opportunity to observe what workers felt was important for job fulfillment and a sense of value that both contributed to the workforce as well as the workforce giving back to the employees. Listening to the voice of organizational members helped better promote communication and collaboration within the institution. Also, paying particular attention to the commonly oppressed or overlooked employees can help better guide organizational practice so that systems can interact more fluidly and better promote worker's needs.

For adult education, this study helped inform the research base of women's learning. This study built upon the concept of women's identity in educational practice as the participants were asked about their use of voice within a workplace setting. By being attentive to how women conceive their meaning of voice within a workplace allowed adult educators a unique perspective of how to better target adult educational programs for adult learners, in particular, women. Adult education could also benefit from this study as it revealed what women workers perceived as meaningful when using their voice, thereby helping to guide educational programs that extend outside the classroom and into the workplace. It was the hope of this study to gain a more holistic understanding of women's learning within the workplace.

Definition of Terms

To better understand some of the terms presented in this chapter, I have presented a glossary of terms for the reader to utilize.

Voice: Voice is a capacity to articulate oneself. It reflects a person's self-awareness or situated awareness. However, voice is more than self-identity – for voice may be used as a collective. Voice is more than self-esteem for that refers to merely a self-worth. Voice is more than empowerment for that is an enabling of power. Voice is different from autonomy because it is not always centered on power and/or individual practice. Voice then is a potpourri of all of these terms, yet is a separate identity in itself. Voice is an emancipatory action that allows for others to gain an understanding about someone else and their perspectives, opinions, and/or judgments. Voice may be powerful or incidental, but having a setting that allows voice to be spoken and heard is of utmost importance for nurses (Belenky, Clinchy, Goldberger, & Tarule, 1986; Brown & Gilligan, 1992; Code, 1998; Flannery, 1995; Gilligan, 1982; Gilligan & Lyons, 1990; Gilligan, Rogers, & Tolman, 1997; Goldberger, Tarule, Clinchy, & Belenky, 1996; Hayes & Flannery, 2000; Herrmann & Stewart, 1994; hooks, 1984 & 1994; Tisdell & Perry, 1997).

Magnet Hospital: Those healthcare institutions recognized by the ANCC as attaining and currently certified with the Magnet Hospital credentialing.

Experienced Nurses: Women who work as a nurse within this particular hospital setting for at least the past five years and who provide direct patient care.

Power: This refers to the autonomy in practice and a value to nurse's decision-making (McClure, Poulin, Sovie, & Wandelt, 1983).

Autonomy: When the nurse is enabled to act upon what they feel is in the best interest of the patient (Kramer & Schmalenberg, 2002).

Organizational Culture: “a complex pattern of beliefs, expectations, ideas, values, attitudes, and behaviors shared by members of an organization” (Hellriegel, Slocum, & Woodman, 2001, p.512).

Patriarchy: A male dominated culture.

Assumptions of the Study

The assumptions of this study are:

1. Nurses who work in a Magnet Hospital will feel that they have a voice within the healthcare setting.
2. Magnet Hospitals are structured so that nurses are emancipated and have greater autonomy in practice.
3. Nurses within a Magnet Hospital will feel that they are valued and that changes that they suggest are acted upon.

Limitations of the Study

The following limitations may have existed in the research:

1. Qualitative research does not produce generalizable results. These women’s stories are bound by the context in which they were chosen and certainly cannot be generalized to include all nurses.
2. The subjects may have been uncomfortable discussing experiences that have occurred at the workplace.
3. The sample consisted of nurses from one Magnet Hospital setting.

4. The researcher was currently employed at this hospital at the time of the study.

Summary

In conclusion, this chapter provided a brief overview to the premises of this study. This chapter included a background to the study, a purpose statement, a conceptual framework which helped guide the study, an overview of the research methodology, an identification of the significance of the study, and a list of assumptions and limitations associated with the study. In Chapter 2, a summary and analysis of the literature related to Traditional Hospitals and Magnet Hospitals is provided. Chapter 3 provides an explanation and rationale utilized for the methodology that conducted the study. The information discussed in Chapter 4 includes a biographical sketch of the participants and commonalities that occurred within the interviews. Chapter 5 of this study discusses the relevant findings of the study and conclusions from the participant responses. Chapter 5 also discusses the implications for practice and makes recommendations for further study.

CHAPTER TWO: LITERATURE REVIEW

Introduction

This literature review focuses upon the six areas of research relevant to this study: conceptual framework literature, nursing shortage, Magnet Hospitals, autonomy, voice, and female leadership. The first section concerning the nursing shortage provides the reader with an overview of the current crisis in healthcare related to nursing. The second section discusses the research pertinent to Magnet Hospitals. The third section of this literature review discusses the concept of autonomy and its importance to nursing. The fourth section examines the concept of voice and outlines the literature that has informed this study. Lastly, female leadership is discussed as it relates to both autonomy and voice in practice.

Conceptual Framework Literature

It will first be important to further support the conceptual framework literature as referred to in Chapter One. The guiding framework that structures this study is a feminist humanist perspective. Also shading this study and its questions is the critical emancipatory framework. Each of these frameworks will be discussed below.

Feminist Humanist

As noted earlier, the humanist perspective stems from humanist psychology grounded in the works of Maslow (1970) and Rogers (1983). This philosophy believes that the individuals are in control of their own destiny and learning. It is believed that outcomes from this type of philosophy are a result of personal choices. It is these personal choices that help the individual to grow intellectually to their maximum potential.

Stemming from this philosophy where the emphasis is on the individual and their perceptions is the work of Belenky, et al. (1986). In the work of *Women's Ways of Knowing*, the authors examine several women and study their different knowing styles – from silence to constructed knowledge. Within the text, there is an “emphasis on the significance of relationship and affectivity as learners construct new knowledge” (Tisdell & Taylor, 2000, p. 9). Belenky, et al. discuss that education is still up to the individual, but the study also points to the relational and affective components of women learners. The women that are discussed in this study reiterate their own learning experience. This foundational study blends both the humanist philosophy and the feminist perspectives.

For this particular Magnet Hospital study, the conceptual framework of feminist humanist becomes paramount as the sample was only female nurses and it was their own experience of having a voice within a Magnet Hospital that was at the center of the research. This framework will help guide the general questions that tried to get at the nurses' meaning of having a voice within this particular workplace setting. However, due to the context and traditional roles that nurses have typically been socialized to, it is important to also consider another conceptual framework that examines the intersection of not just gender, but also of power and class; this framework is known as critical emancipatory.

Critical Emancipatory

This critical perspective is grounded in education with the works of Paulo Freire. Freire began his works in the 1970's as he examined the political nature of language in education. Freire called for a societal change and action that will liberate people from the oppression of a male centered education. Freire (1970) stated

The important thing, from the point of view of libertarian education, is for men to come to feel like masters of their thinking by discussing the thinking and views of the world explicitly or implicitly manifest in their own suggestions and those of their comrades. Because this view of education starts with the conviction that it cannot present its own program but must search for this program dialogically with the people, it serves to introduce the pedagogy of the oppressed, in the elaboration of which the oppressed must participate. (p. 118)

Freire discussed concepts such as power and social emancipation stemming from education. Freire did not, however specifically address the issue of gender in his critical theory. This evolves later, when bell hooks, in her text *Teaching to transgress* (1994), pointed out specifically how gender can be included within this intersection of power, culture, race, and class. Building upon this critical perspective, bell hooks elaborated upon this further and added a feminist lens. hooks (1994) related

If we examine critically the traditional role of the university in the pursuit of truth and the sharing of knowledge and information, it is painfully clear that biases that uphold and maintain white supremacy, imperialism, sexism, and racism have distorted education so that it is no longer about the practice of freedom. (p. 29)

Building upon this critical philosophy where-by social change is proposed, feminist authors stress awareness of the oppressive nature of language in education, and also the intersection of gender, inequity of class and race, and critical reflection. Tisdell & Taylor (2000) reiterated the importance of how these concepts impact education and student awareness in the society to promote change.

As stated earlier, this conceptual framework was not the primary guiding force to this study, but it did definitely impact it. The questions that were examined in this study, asking medical-surgical nurses about their meaning of voice within a workplace setting, elicited answers that did discuss power, autonomy, and change. It was important to hear these responses and utilize this information for future research as suggested in Chapter Five.

Nursing Shortage

Historically, nurses have been the primary healthcare providers for this country, accounting for over half of hospital staff (59.1%) in 2000 (Heinrich, 2001). Currently, healthcare is facing a crisis as the supply of nurses becomes scarce. The nursing shortage has become an imperative issue facing all facets of healthcare, especially in the hospital setting.

Issues that have impacted the current nursing shortage are numerous. One of the most cited reasons for the nursing shortage is the increasing number of retiring baby-boomer nurses (Buerhaus, Staiger, & Auerbach, 2000; Burling, 2000; LaDuke, 2001; Heinrich, 2001). According to a report released by the Government Accounting Office (Heinrich), 40% of all registered nurses (RNs) will be older than age 50 by the year 2010. Another study reveals that the percentage of working nurses younger than age 30 has decreased by 41 percent, compared to less than one percent decrease in the labor market for the age group as a whole (The Lewin Group, 2001). This aging workforce accounts for a large projected gap in nursing supply and demand. This gap is but one serious implication facing the health care industry.

Due to the aging population of laborers, aged nursing professionals are less able to perform some of the physically demanding patient activities, and they have a greater susceptibility to work-related injuries (The Lewin Group, 2001). A number of these nurses must face early retirement because of the physical demands of the job.

Government studies show that nurses sustain more back injuries than heavy construction workers (Foley, 2001). These increasing physical demands associated with nursing are causing many nurses to leave the hospital setting and settle for lower paying, less stressful workplaces (The Lewin Group, 2001).

The increased physical demands of nurses are usually directly related to the increased patient loads that nurses are required to carry, otherwise known as patient-nurse ratios. Currently in many hospitals, there are alarming rates of elevated patient to nurse ratios. In the past, hospitals downsized their nursing staff in order to accommodate a shift in payment systems. In the early 1990's, patient stays became shorter and hospitals rationalized a lower number of nursing staff required for the care for patients (Cadrain, 2002). As reported in one article, 75 percent of nurses believe that they are caring for too many patients and that this is compromising their nursing care (Duchene, 2002). This increased workload has led to poor job satisfaction among nurses and as a consequence, has led to nurse attrition.

Common attrition issues seen within hospital settings are: staffing levels; heavy workloads; increased overtime; lack of ancillary staff; and low wages (Heinrich, 2001). Lower staffing levels are reflected in high patient-nurse ratios. In addition to caring for a high number of patients, there is an accompanying component of high acuity patient care; this means that patients who are being admitted to hospitals are sicker and require more

care. Patient acuity (degree of illness) has intensified despite the decreased number of staffed positions and beds available within the acute care setting (Heinrich, 2001). The environment itself is changing as well, as there is a shift in cost control from acute care settings to more ambulatory settings. This change in environment has led to a decrease in hospital beds staffed as well as a decrease in the length of patient stays. The nurse faces this high stress work environment where staffing is short, the patients are sicker, and increasing the potential for burnout.

Burnout refers to workers leaving their jobs due to high levels of stress and job discontent. Fackelmann (2001) reported that in 4 out of 5 countries, including the United States, 40% of all nurses said that they were unhappy with their current job. Malach-Pines (2000) studied the concept of burnout in nursing and stated that “nurses are considered to be particularly susceptible to the danger of burnout because of the very stressful nature of their work” (p. 23). Staff nurses, those nurses who provide care for the patient at the bedside, are especially susceptible to burnout.

The concept of burnout is examined further in a much-publicized study by Aiken, Clarke, Sloane, Sochalski, & Silber (2002). Their research data was collected from more than 150 nonfederal adult general hospitals in Pennsylvania and found that high patient to nurse ratios caused high levels of nurse burnout and increased job dissatisfaction. These researchers indicated that nurses within hospitals with the highest patient to nurse ratios were “more than twice as likely to experience job-related burnout and almost twice as likely to be dissatisfied with their jobs compared to nurse in the hospitals with the lowest ratios” (p.7). Recent American Nurses Association (ANA) surveys reported that over 40 percent of nurses in American hospitals are reporting dissatisfaction at work, compared to

15 percent in all workers. This report also reveals that 43 percent of American nurses score higher than expected on indicators of job burnout (Foley, 2001). As evidenced here, nursing burnout within the hospital setting becomes a significant factor affecting the current attrition of nursing staff.

Other contributing attrition factors such as an increased use of overtime and a lack of supportive staff add to this concept of nurse burnout. Nurses are increasingly being required to stay overtime in order to provide adequate patient care. The term, “mandatory overtime,” refers to a situation where an employer insists that a nurse work extra time or face dismissal for insubordination (Foley, 2001). Mandatory overtime is done to justify a nurse to stay at the patient’s bedside in order to provide safe and effective patient care. If a nurse should decide to leave at the end of her shift, thus refusing being mandated, she may be legally charged with patient abandonment and lose her license (Foley). Although this scare tactic is sometimes implemented, it is more commonly the nurse’s guilt of leaving the patient rather than the loss of license that keeps the nurse at a patient’s bedside for extended hours.

In a recent ANA survey, it was discovered that at least two-thirds of nurses are being required to work some mandatory or unplanned overtime every month (Foley, 2001). These long hours compiled with increased patient-nurse ratios and increased work demands all contribute to the increasing nurse burnout rates and attrition.

The nursing shortage literature also refers to a lack of wages for nurses. Sochalski (2002) reported that nursing wages have remained flat throughout the 1990’s despite increased demand. Also, nursing wages are not reflective of the years of service many of these employees have provided. In Sochalski’s article, she stated that “wages paid to

hospital staff nurses who graduated twenty years earlier were only 10 percent higher than wages paid to those who came into nursing ten years later” (p. 5). One survey completed in 1997, found that the mean average nursing salary for hospital nurses was \$39,900 (The Lewin Group, 2001). Current statistics from the U.S. Department of Labor reveals that nursing wages for the year 2001 averaged \$48,240 (BLS, 2003). This increase of twenty one percent over a four-year period, points to the fact that only now are hospitals recognizing that this may be a contributing factor of the nursing shortage. Hospitals are reacting to this shortage by attempting to compensate a previously lagging wage increase for staff nurses.

Nurse attrition is only one part of the nursing shortage dilemma; another cause for the nursing shortage crisis involves the continual decline in nursing school enrollments (AACN, 2000; LaDuke, 2001; Nevidjon & Erickson, 2001). For the past twenty years, opportunities for women in the workforce outside of nursing have grown tremendously. As a result, the number of women entering into the field of nursing has steadily declined (Buerhaus, Staiger, & Auerbach, 2000). This lack of students going into the field of nursing combined with the aging workforce has serious implications for nursing’s future. With fewer women choosing nursing as a profession, the current shortage will only worsen. All of the aforementioned factors have been found to contribute to the current nurse shortage. These shortage factors have been found to impact the care of patients and affect RN satisfaction and attrition of nurses within Traditional Hospital organizations.

Traditional Hospital organizations refer to those healthcare institutions that are heavily structured into tiers of management and rely on a strongly patriarchal system of interactions (Balle, 1999). This bureaucratic model was first introduced by Max Weber, a

sociologist from the early 1900's. Weber developed a mechanistic design that incorporated the following characteristics: tight control of the employees' behaviors; strict rules for conduct and procedures; each employee has a very defined and specific job to do within the organization; the structure of the business is very hierarchical; new employees are selected for their technical skills and are appointed; and the organization has a career ladder (Hellriegel, Slocum, & Woodman, 2001). Within these hierarchical organizations, decision-making processes are very formal and prescribed. Power comes from the higher tiers of administration and trickle down the administration ladder. This is sometimes referred to as centralization (Hellriegel, Slocum, & Woodman, 2001). Traditional Hospitals have a bureaucratic, centralized structure that segregates its operations so that each pocket of expertise (e.g., surgical services, emergency medicine) works to its maximum potential (Balle, 1999).

Nursing has functioned within these Traditional Hospital work environments for decades. The lack of autonomy and power that nurses have typically lacked has manifested itself in healthcare organizations since the time of Florence Nightingale in the 19th century. Nightingale's influence produced an image of a nurse as "subordinate, nurturing, domestic, humble, and self-sacrificing" (Meadus, 2000, p. 7). This image of the oppressed nurse continues to the present day and is reinforced in the traditional hospital setting. This subordinate nursing image will be noted in the section to follow that delineates why some hospitals do not retain nursing staff.

Magnet Hospitals

In contrast to the Traditional Hospital, a "Magnet Hospital" is a term that signifies an accredited institution that has proven itself as a model place of employment for nurses.

According to the American Nurses Association (ANA), the Magnet Nursing Services Recognition Program for Excellence in Nursing Service is the “highest level of recognition that the American Nurses Credentialing Center (ANCC) can accord to organized nursing services in health care organizations” (ANCC, 2000, p. 13). The term Magnet Hospital accreditation is awarded to the hospital as a whole, but gains its recognition from the excellence in nursing care that is delivered there.

Magnet Hospitals were introduced in the early 1980’s as institutions faced an increasing challenge to recruit and retain nurses in the midst of a serious nursing shortage. Hospitals that were not affected by this nursing shortage were studied in depth and several characteristics were noted: autonomy within clinical practice, collaboration, and nursing leadership, and an improved nursing status within the organization whereby nursing was seen to produce a “body of knowledge that illuminated the professional nursing practice of nurse administrators and staff members” (Scott et al., 1999, p. 9). In short, the common characteristic of each of the Magnet Hospitals is to value nursing’s contribution to the organization. Since these hospitals did not appear to be affected by the looming shortage, they were deemed Magnet Hospitals for their ability to attract and retain nursing staff.

Magnet Hospitals have been studied in depth over the past twenty years to examine their commonalities and patient outcomes. The studies look at several of the same issues that seem to plague the nursing shortage. In fact, by design, Magnet Hospitals appear to target the issues affecting the nursing shortage within Traditional Hospital settings and do something about them.

A study performed by McClure, Poulin, Sovie, & Wandelt (1983) put together a task force that investigated hospitals not apparently affected by the nursing shortage in the early 1980's. One of the purposes of this study was to "identify and describe the organizational variables that had helped to create nursing practice and hospital environments that promote the nursing staff's job satisfaction, with accompanying fulfillment of both professional and personal needs" (p. 1). The study concluded that there were indeed similarities between institutions that had low vacancy rates for nurses' verses other hospitals with high attrition. The similarities between these Magnet Hospitals were participatory management, able and qualified nurse leaders at each level of the organization, nursing placed at the executive level of the hospital, decentralized department structures which reflected a sense of control for the nurses within their immediate work environment, quality of nursing staff equated with quantity of nursing staff, autonomy of an empowered nursing staff, importance of education and teaching performed by nurses, positive nurse images, and an emphasis on personnel growth and development. From the information gained from this study, other researchers have tried to quantify and further define what it means to be a Magnet Hospital.

Several of these studies have examined the common characteristics among Magnet Hospitals regarding the workplace environment. Similarities between workplace environment within Magnet Hospitals include flat and decentralized nursing departments, supported nursing decisions through administration, good communication between nurses and physicians, and nursing's visible power among the hospital executive committee as manifested by a voting member on the hospital's Board of Directors (Aiken & Havens, 2000; Aiken, Havens, & Sloane, 2000; Coile, 1999; Havens & Aiken, 1999; Kramer,

1990; Laschinger & Havens, 1996; Laschinger et al., 2001; Mason, 2000; Scott et al., 1999; Sovie, 1984).

As seen here, it becomes evident that nurses within a Magnet Hospital setting are not fostered to remain oppressed (as often exhibited within Traditional Hospital settings), but are rather celebrated for their excellence in care and services. Magnet Hospitals recognize and support nurses' decision-making abilities and encourage them to think for themselves.

Autonomy

In the Traditional Hospital setting, burned-out nurses frequently feel less empowered (Laschinger & Finegan, 2001) and that their clinical decisions are less supported or acted upon (Aikens, Havens, & Sloane, 2000). Magnet Hospitals offer a very different approach. Magnet Hospitals appear to foster empowering nurses to create change and make clinical decisions based upon their knowledge and experience. Studies have examined and attempted to quantify what it means to the nurse to have autonomy in practice. The findings from numerous studies reveal that nurses within Magnet Hospitals using the Nursing Work Index (Kramer & Hafner, 1989) and modified Nursing Work Index – Revised demonstrate more autonomy in practice and thereby exhibit greater job satisfaction and less burnout (Aiken, Havens, & Sloane, 2000; Havens & Aiken, 1999; Kramer, 1990; Laschinger, Shamian, & Thomson, 2001; Scott, Sochalski, & Aiken, 1999).

Kramer & Schmalenberg (2002) reported that there are several studies that target this issue of autonomy of nurses within Magnet Hospitals. The problem arises that there are many different definitions of autonomy. In the various Magnet studies there was not

one universal definition of autonomy used. Kramer and Schmalenberg pointed out that there may be organizational (professional) autonomy and clinical autonomy. In order to better define the term of clinical autonomy, the authors have created a Clinical Autonomy Scale which included: Autonomous Patient Care Action, Autonomous Nursing Care Action, Limited Autonomy, Unsupported Autonomy, and No Autonomy Practice. This scale goes into depth at trying to define and refine the definition of clinical autonomy for Magnet Hospital measurement. However, up to this point, the tool has not been utilized.

This clinical autonomy tool stated that nurses who exhibit “Autonomous Patient Care Actions” are “free to act on what (they) know is in the best interests of the patient” (p. 37). This action occurs often in Magnet Hospitals and is essentially the highest goal of autonomy. Not only are the autonomous actions of the nurse supported by his/her peers, but also they are sanctioned by the organization as a whole. It is this definition of autonomy that gives evidence to the fact that the nurse’s voice is heard and acted upon through good collaboration with other coworkers.

The main autonomy tool that has been utilized from the Magnet studies has been based on a Nursing Work Index. This NWI tool was originally devised by Kramer and Hafner (1989). The Nursing Work Index examined, using a Likert Scale survey, 65 items that targeted professional nurse practice environments. As the studies of nursing autonomy and environment progressed, other researchers such as Aiken & Patrician (2000), modified this survey (NWI-R) to include 55 items that addressed organizational attributes which were viewed as being supportive of professional nurse practice: autonomy over the work environment, work relationships with physicians, and a final

summary of organizational support (Aiken, Lake, Sochalski, & Sloane, 1997). The NWI-R blends clinical nurse authority with professional nurse authority in the practice setting.

The NWI-R has become the cornerstone of the quantitative research that surrounds the nurse and her job satisfaction, autonomy, and practice within the Magnet Hospital work setting. This Likert Scale survey has cast a light onto many of the organizational and work environmental attributes that have made the Magnet Hospitals so different from the Traditional Hospital. The studies that utilized the NWI and the NWI-R brought to the forefront that Magnet Hospitals were very different than Traditional Hospitals in the way that they are organized and structured (Aiken, Havens, & Sloane, 2000; Havens, 2001; Kramer, Schmalenberg, & Hafner, 1987; Laschinger, Shamian, & Thomson, 2001). These studies also were able to better discern the differences in staff nurse's perceptions of working at the patient's bedside in a Magnet Hospital. These studies state that staff nurses had more autonomy in their clinical practice, they enjoyed better relationships with the physicians at the Magnet Hospitals, and that they demonstrated higher job satisfaction with improved retention and recruitment (Aiken, Havens, & Sloane, 2000; Havens & Aikens, 1999; Havens, 2001; Laschinger, Shamian, & Thomson, 2001).

While these studies have successfully laid the groundwork in establishing a difference between Magnet Hospitals and Traditional Hospitals, a weakness must be noted. These studies have *quantitatively* not *qualitatively* reported what nurses have been experiencing within the Magnet Hospital workplace setting. There is currently no research that examines the nurses' perceptions about working within a Magnet Hospital setting other than what is reported through a Likert scale of choices. Through this

research, hearing the stories and perceptions of the actual nurses who work within these institutions will help add to the current Magnet Hospital research and has implications to not only nursing, but also to organizational studies and adult education.

Voice

As defined in the previous section, clinical nursing autonomy includes freedom, support, and sanction to act on what they know is best. Extending from this definition, an autonomous nurse can be said to have voice. In the following section, various uses and definitions of voice will be examined such as the literal definition of voice, voice as it pertains to women and women's studies, voice and race, voice in the classroom, and voice in the workplace. Other areas that also relate to voice for this study such as silence and female leadership are also discussed in this section.

Literal Definition

The concept of voice takes on numerous meanings and definitions. In examining the literal definition of voice, the Oxford English Dictionary (1989) has five pages devoted to its explanation. The dictionary opens the discussion concerning voice to include several definitions: "Sound, or the whole body of sounds, made or produced by the vocal organs of man or animals in their natural action; especially sound formed in or emitted from the human larynx in speaking, singing, or other utterance or expression" (p. 727); "The supremacy or upper hand in a struggle" (p.728); "The expressed opinion, judgement, will, or wish *of* the people, a number of persons, a corporate body, etc., occasionally as indicated or shown by the exercise of the suffrage" (p. 728); "An expression of opinion, choice, or preference uttered or given by a person; a single vote,

especially one given in the election of a person to some office or position or on a matter coming for decision before a deliberative assembly” (p. 729).

Voice and Women

To find where the concepts of voice have been significantly developed, one must turn to the voice and women literature. One particular text that is very helpful in synthesizing information concerning the various uses of voice is *Women as learners* (Hayes & Flannery, 2000). Within this text, Hayes summarized several meanings of the term voice and how it relates to their learning. The three uses of voice are as follows: literal; metaphorical and political. This first use of voice is just as it is called, the literal usage of voice. This refers to women’s speech or dialect and how the spoken word is used in learning situations. Hayes described the second use of voice as metaphorical, voice referring to women’s identity. It is this metaphorical use of voice describes how women are represented by the manner in which they speak, the confidence they use to express themselves and their opinions, and what is revealed about their own identity by the words and expressions that they utilizes. Third, voice is defined in a political sense. In the political sense, voice is used to reflect the power of women’s identity in order to develop their own sense of “collective identity and oppression as women, and of the means to challenge this oppression” (p. 80). As evidenced here, there are several different perspectives surrounding the term voice and what it means to have voice. All three of these definitions will be touched upon within this study, the literal voice of nurses, the metaphorical sense of voice, and the political. “Voice” has been in the English language for a long time, but the various connotations associated with voice and *women* stem primarily from the works of Carol Gilligan.

Carol Gilligan. Gilligan's work and her discussion of women's voice originate within the area of psychology. Gilligan (1982) was specifically interested in the difference between men and women's judgments and moral actions. She noted that women had a much higher disposition for being sensitive to others and putting others first. Hence, women's use of voice was radically different. Goldberg (2000) summarized Gilligan's research and stresses that before Gilligan's groundbreaking research, women had been "unable or unwilling to express what they felt" (p. 702). Men were previously thought to be morally superior to women in that their voice resounded the predominate culture values of logic and justice over care and relationships. Women's voice would commonly reflect not their own true feelings, but rather conveyed information within the patriarchy rules of the society in which they were held. Brown & Gilligan (1992) reported that their interest in women's voices came from listening to these differences between men and women as they talked. While men tended to speak more about their autonomous selves within their own culture, women discussed more about how they lived in connection to others. Men were viewed as self-directed and self-governing. Women on the other hand, lived with an ongoing identity paradox of whether to give up their voice and self-identity or live life as a "good woman" and being able to be involved in relationships.

Brown & Gilligan (1992) also pointed out the importance of this relational knowing and learning and how that seems to differ from men. Within their study, they noted as adolescent girls age, they become more aware of themselves and the complexity of the various voices and perspectives within relationships. The young women in this study became more self-reliant in their decisions and responsibility for themselves, and

they were better able to differentiate their feelings and thoughts from others. This pivotal work helped to move the concept of voice from a merely a moral judgment difference between men and women into a concept of self-identity for women.

In later studies (Brown & Gilligan, 1992; Gilligan, Rogers, & Tolman, 1991) Gilligan further investigated teenage girls and the issue of resistance or disconnect between women and society, relational to voice versus silence. This issue of silence versus voice was more of an emancipatory view meaning that no longer was the author simply investigating difference in her study. Gilligan's later works pointed towards the ways voice and silence affect women in relationships not simply the individual person. These later works made the point that there is not just voice and silence, but there are nuances to the use of voice and the situation in which it is used called resistance. In their study, Gilligan, Rogers, & Tolman (1991) discussed how they noticed a series of disconnects of voice within psychological resistance, political resistance, and healthy resistance.

Within the concept of psychological resistance, male and female youths are encouraged and struggle to stay in relationships. Boys are pressured to take on the roles of superheroes in order to obtain their manhood. Girls on the other hand are pressed to take on perfection be the woman whom "everyone will promote and value and want to be with" (Gilligan, Rogers, & Tolman, 1991, p. 24). It is here that girls differ from boys in that the girls are judged by the value of their relationships with others and boys are not. Within the superhero ideal for the adolescent males, the ideal boy is one who can be fiercely independent and think logically under stress.

Psychological resistance is therefore resistance to the disconnections that evolves from this struggle where the ideal world of societal expectations collides with reality for the individual. The individual self remains at the heart of psychological resistance.

Political resistance is defined as “the willingness to act on one’s own knowledge” (Gilligan, Rogers, & Tolman, 1991, p. 2). Political resistance refers to is a situation where a girl speaks out about her own life experiences. This type of ownership to a girl’s story typically goes against the grain of what is expected within society of being the “nice” girl. By speaking out, girls who exhibit this political resistance potentially lose relationships that are a typically defining issue for women. This type of resistance deals more with the individual within a culture/society.

Healthy resistance is when these adolescents come into conflict with what is the expected norm of society and what they have experienced. It is this intersection of reality and expectation that creates resistance. Healthy resistance is the acknowledgement of this intersection and the urge to overcome simply what society expects.

As noted above, when the authors dealt with this issue of resistance, they framed it using the terms psychological, political, and healthy. They shifted female voice into a more of a societal context. They bring into focus the concept or notion that society begins to take on a gendered perspective; society has genderized women into being and acting a certain way. Voice in the context of this book refers to girls’ speaking out and upending the engendered societal psyche.

While Gilligan’s works may be considered feminist, as she holds gender to the center of what she writes, she never addresses other issues that intersect with this. What

are missing from her work are issues of power, privilege, and race. These issues were dealt with later on in her work.

Gilligan's works are bounded within a psychological framework. She does not speak about women's oppression or power. In fact, Gilligan does not address *any* intersection between gender, race, class, or sexual orientation. Gilligan deals strictly with the psychological development of women and their use of voice in building or deconstructing relationships. About the time when Gilligan started to examine the issue of voice and adolescent girls, another set of authors took hold of the concept of voice and built upon Gilligan's concept of voice, and centered it upon knowing. This knowing refers to the knowledge of a woman's self within the context of the society.

Women Ways of Knowing. In the book, *Women's Ways of Knowing (WWK)* (1986), the authors Belenky, Clinchy, Goldberger, & Tarule started using the metaphor of voice. The term "voice" in WWK builds upon the Gilligan notion of verbalization, and suggests that the metaphor of voice includes ways of knowing and learning, processing information, and the *self* within the society. This metaphor of voice influences what women know and what they say or choose not to say. The authors note that there is an intersection of voice development, with the mind and self-development.

The major contribution that WWK offered was a discussion of five different ways of knowing, each of which can be connected to voice. These five different ways of knowing included: silence, received knowledge, subject knowledge, procedural knowledge, and constructed knowledge. Silent women felt subordinate to the powerful people who dominate them; they were unable to articulate themselves to their own self or the people around them and lived in great isolation. Received knowers listened

attentively to others. Within this way of knowing, women relied on the thoughts and opinions of others in order to function to do the right thing and get along with others. Subject knowers were distrustful of logic and words. This is the type of knowing that stressed the legitimization of intuition and listening to the self for answers. Procedural knowers did not rely on the self for answers, rather, they relied on procedures, techniques, and structure to know and process their information. Procedural knowers recognized that people perceived their world from a myriad of lenses, and in order to improve their knowledge they sought out not simply what people think, but rather, how they formed their opinions. There was a synthesis of subjective knowing and objective knowing with procedural knowers. Lastly, there were the constructed knowers.

Constructed knowledge referred to how gain information by empathizing information and the situation. Constructed knowers were conscious and self-aware of what they bring to the table in order to make sense of a problem. They were able to gain knowledge from themselves, from others, and from a given situation. It is how the constructed knowers obtained knowledge that made them unique.

As evidenced by these definitions of ways of knowing becomes a thread throughout these knowledge formation levels. First, for the silent, there was no voice. Silent women did not know how to construct the words to convey what they feel; they viewed themselves as being without knowledge. Second, received knowers used the voice of others in order to establish the rules of their world. The truth that they sought came from the actual rhetoric that was spoken from people in authority. Third, the subjective knowers, the truth of how or what they know came from their inner voice. These women relied on their inner voice, or intuition to lead them in ways of knowing.

Fourth, the procedural knowers regarded voice not only subjectively but also objectively. These women recognized their intuition, but would not rely on it to come to a decision. Procedural knowers relied more on how others came to voice or know in order to create their information. Fifth, constructed knowers' recognized the importance of self and the use of their voice and their connectedness to the world. Constructed knowers came to recognize that "all knowledge is constructed, and the knower is an intimate part of the known" (p. 137).

As noted above, WWK contended that there were five different ways of knowing for women and these ways of knowing can be connected to voice. However, Belenky, et al., (1986) did not address issues about the place of context and ways of knowing, thus ignoring the context of knowledge production. This leaves a gap in the literature. WWK did not address issues that surround power, race, and politics. Also, WWK provided a framework of women's knowing that was very structured and linear in scope.

Similar to the psychology-based authors before, Belenky, et al. suggested that there is a desired outcome of constructed knowledge and that the other types of knowing were merely steps along the way to reach this ultimate goal. The questions that arose are: Can or should the construction of voice and knowledge occur in a linear fashion? Is constructed knowing more valuable than other ways of knowing? In the text *Women as Learners* (2000), Hayes addressed this very concept when she reviewed the WWK literature. She pointed out the importance of context in relevance to women's personal development; without considering this issue, the construct of voice would be deficient.

Knowledge, Difference, and Power. As a follow-up to the WWK original work, Goldberger, Tarule, Clinchy, & Belenky (1996) deconstructed ways of knowing and how

it relates to self, knowing, and voice, but also took into consideration context, power, and silence. In this book, they tried to attend to the shortcomings that were criticized in the WWK text. One of the main differences in this text is a diversion away from knowledge constructed solely from the self (as seen in WWK) towards a knowledge that is co-constructed from individuals living in community. Knowing occurred from being situated within a context where power and status can influence what is known and who knows it. This was a fundamental shift in knowledge and self from the WWK book.

Also different in the Goldberger et al. (1996) work was the definition of voice. The metaphor of voice used in the WWK book as a self-identity. From this definition, it was assumed that lack of voice, or silence, meant a lack of identity. The silent women in WWK were a powerless group that referred to themselves as “deaf and dumb.” In this later book, the authors related that silence refers to a lack of power and not being able to be heard by those in control of a situation.

Other conceptual differences found in this later text include: culture; power; and collective knowing. These concepts reiterated that women’s voices and knowledge are shaped from their context. Goldberger posited that there are different ways of knowing. Power and knowledge existed within a culturally bound context of various cultures, there was not merely one set of lenses to view the world and obtain knowledge. Goldberger, et al. proposed this concept of knowledge, and power within context, as positionality.

Although this later Goldberger et al. (1996) work brought about and discussed positionality, the lens from which it is written is still middle class academia. The authors provided various chapters that addressed certain issues but some areas were still lacking. In particular, the concept of race and how that impacts knowing, being known, and voice

was still deficient. In order to better understand area better, there is a body of literature from the Black women's perspective that helps to fill the gaps not addressed in the voice literature to this point.

Voice and Race

Several authors that address voice from this particular lens include hooks (1984), Collins (1991), and Sheard (1999). These three authors in particular, helped provide a better perception of voice and race.

hooks (1984) is one of the first Black feminist authors that addressed this concept of voice. She made the claim that previous feminist works that were written about voice are discussed from a "privileged" feminist view. hooks proposed that earlier feminist authors could not possibly understand fully what it meant to intersect race, class, and gender oppression. In her book, *Teaching to transgress* (1994), hooks stressed the importance to "upend" the traditional patriarchy that education so closely adheres to. At the heart of her persuasion was a different way to look at and pay attention to the voices of others. Her argument against the earlier feminist authors who claimed that gender is the sole driving force for a feminist view merely perpetuates this Western patriarchal mindset. hooks reiterated the need to reconstruct feminism to include not only the privileged feminists who are able to talk about their experiences, but also included women's voices who were previously not written about.

Within her definition of voice, not only did hooks use the term voice as a metaphor for the self, she also addressed voice within its literal definition. She stated, "Critical feminist writings focused on issues of difference and voice have made important theoretical interventions, calling for a recognition of the primary voices that are often

silenced, censored, or marginalized” (hooks, 1994, p. 173). hooks spoke about voice as a liberation tool for the oppressed within a classroom or culture.

Patricia Hill Collins provided another facet of voice. Although hooks (1984) discusses and analyzes feminism as a whole, Collins (1991) took on the Black feminist concept and retooled it to challenge mainstream Western academia.

Collins (1991) discussed voice as a call for Black activism and empowerment. Collins pointed out that Black women’s voices in the literal sense are different from that of other social science literature. Black women tended to talk from more of a group perspective, utilizing the pronoun “our” instead of a distancing “their.” Collins also discussed voice in the metaphorical sense. She cited that in her classrooms, she provided Black women’s life experience to support analysis and validate the use of Black women’s voice as identity. Collins challenged the Eurocentric male dominated structure of academia. She discussed the importance of the African-American lived-experience and called upon these women to share their voice within the academic community to emancipate the culture of Western education so it is more inclusive and sensitive to the Africentric feminist epistemology.

In summary, Collins’ suggested a different way of knowing focusing on more of a community approach. Additionally, knowing was different depending on positionality. The concept of positionality referred to learners coming to know and experience the world through their own set of lenses. Collins addressed judging as she stated that it is first important to know about your own life, wealth, and life experience in order to judge or understand someone else’s. She also pointed out more questions concerning Black voice, such as why it has been oppressed and the power it could illicit. Lastly, Collins

stated there is a call and response where the calling is not simply the use of voice, but what the response was equally important.

Collins (1991) and hooks (1984) agreed that Africentric scholars and feminist scholars ignore that class, gender, and race can be a unifying whole. Sheared (1994) pointed out that by doing this marginalized voices have been silenced. In order to act upon this silence, Sheared created the womanist perspective. Defined, “the womanist perspective seeks to expose the differences and similarities that human beings experience in the classroom as a result of skin color, language, economic status, and personal experiences” (Sheared, 1994, p. 29). Within this perspective, the womanist helped give voice to the traditionally marginalized voices within the classroom by creating polyrhythmic realities that help engage students to think critically.

Sheared (1999) discussed at length the importance of giving voice to students “in the margins.” By giving voice to those who are marginalized, she related that it is the responsibility of the teachers to realize their own power, position, and privilege within the classroom setting. Sheared suggested that the teacher move more into the margin themselves in order to better understand and give voice to students who may have been previously overlooked. She further discussed the importance of the teacher to give up some of their own perceived power and perform some self-reflection in order to better grasp their own positionality and authority within the classroom setting.

These three authors provided a more critical examination of voice. The authors stressed the importance of including an African American perspective to the definition of voice. This helped point out that African American women’s voices have been missing in the literature up to this point. These authors helped set the stage for a more critical

understanding of the metaphor of voice and politics. Not only has voice represented the identity of the women, but it also needed to include the culture of the women and the context from the margins that they came from. They also noted the power of voice as a result of self-reflection as it allows a person to be more sensitive to the voices of others. By bringing together this body of literature, it helped to add better depth and understanding to the notion of voice.

Voice and the Classroom

As seen above, there are numerous contexts that can influence voice. Belenky et al. (1986) began the discussion regarding voice and most of its influence as external. As the concept of voice is better understood and utilized, there are numerous implications for its practice. One area where the concept of voice is evolving and being discussed and further studied is that of the classroom.

Tisdell (1996) and Lee (1994) examined this use of a more inclusive classroom that promoted students' voices within this context. Certainly the issues of race, class, and gender need to be addressed in order to create a more inclusive student curriculum. Paying attention to these different voices becomes a focus and a charge for educators to best teach to a broad spectrum of students. Tisdell (1996) pointed out that academia seldom values the personal experience of its students; rather, the university promotes learning from a more rational perspective. Lee posited that teachers need to be more cognizant about their use of language and power within the classroom so as not to silence students. These students who are usually silenced from a lack of power are referred to in the literature as "marginalized" (hooks, 1984; Tisdell & Perry, 1997) or "oppressed" (Collins, 1991; Friere, 1970). These authors pointed to the fact that not all students have a

voice within the classroom setting, and it is the responsibility of the educator to better enhance and be aware of the voices of *all* their students to best provide an inclusive curriculum.

How can the educator be more sensitive to student's voice? One practice-related piece utilized the examination of "border" pedagogies into the classroom (Tisdell & Perry, 1997). In this study, the faculty examined how different teaching methods sensitive to critical discourse could be better utilized. The authors provided the rationale as, "voices of those who have been historically and culturally marginalized in education through traditional curricula and pedagogical processes" (Tisdell & Perry, 1997, p. 2). This study illuminated the fact that critical feminist theory and its focus on voice can begin as a pedagogical model.

These students from the outside, or "others" as described by Fine (1998) relay that when these terms are used, it further promoted their oppression. Fine proposed that researchers need to include the marginalized students or "work the hyphen" in order to better comprehend the stories of those typically marginalized. Her view is more from a social science perspective and does include working class women. In order to better hear the stories of the *Other*, a researcher must first self-reflect and be aware of their own positionality.

Authors such as bell hooks (1984), focused much of their voice literature on the use of pedagogical models, meaning teaching models for children, in order to create the necessary changes in education. She asserted that by examining and changing the educational process in pedagogy rather than andragogy (the education of adults), it will become more effective for social change.

To conclude this analysis of voice, there were several areas of inconsistencies regarding the concept of voice. These inconsistencies primarily stemmed from the different lenses that authors used to write and study voice. There seems to have been a humanistic or psychological slant to the early literature regarding this concept. Gilligan (1982) noted that the voice of women is different from men. Belenky et al. (1986) pointed to a linear understanding of different ways of knowing and using voice. In both of these cases, voice focused on the individual and it was implied that everyone has a voice/identity if they so choose to use it. This use of voice will help better the society and advance the individual using voice within their lives.

Later literature (Code, 1995 & 1998; Collins, 1991; Flannery, 1995; Gorman, 2001; Herrmann & Stewart, 1994; hooks, 1984 & 1994; Lee, 1994; McDonald, 1999; Pierce, 1998; Sheared, 1999; Tisdell, 1996; Tisdell & Perry, 1997) regarding the concept of voice focused more upon the emancipatory potential of recognizing different voices. There was a distinct call to action in these emancipatory writings to improve and be aware of one's own voice and positionality in order to better hear the voices of others. This is not to imply that the writings concerning voice were all evolutionary, that all voice started out with the individual at the center and evolved to a call to action to embrace of all voices of all cultures and backgrounds. This text recognized the concept of voice is merely shaded by the writer's lens, and these lenses may be inconsistent.

Similar to the inconsistencies of lenses that writer's use, the concept of power as it relates to voice was inconsistent as well. Power was not really discussed in the earlier writings regarding voice. This could be have been related to the fact that the psychological perspective did not necessarily recognize the issue of power. The

postmodern, and certainly the post-structural feminist lenses do acknowledge power and oppression so these authors reflected this in their definition of voice. Despite these differences among the literature, there were also a number of similarities with the conceptualization of voice.

Some of the consistencies are the foundational work of Carol Gilligan (1982). Building upon Gilligan's work has stressed the importance of voice has for education, feminist studies, and the workplace. Gilligan's work provided the framework for the further examination of the concept of voice. Her early studies illustrated that there was indeed a difference between the use of voice for both men and women in the way they communicated. Another consistency within the literature was a call to recognize voice, within academia, within the workplace, within every area of our lives. These diverse voices can and should be heard.

Most of the early authors that address voice through this psychological frame (Belenky, Clinchy, Goldberger, & Tarule, 1986; Brown & Gilligan, 1992; Gilligan, 1982; Gilligan, Lyons, & Hammer, 1990; Gilligan, Rogers, & Tolman, 1991) have stressed that through knowledge development, there is a development of voice (or silence). Voice became closely linked to education and how things became better known. Later works (Belenky, et al., 1996; Code, 1998; EAPA, 2000; Goldberger, et al., 1996; Flannery, 1995; Hayes & Flannery, 2000; hooks, 1984 & 1994; Lee, 1994; Mahoney, 1996; Pierce, 1998; Tisdell, 1996; Tisdell & Perry, 1997; Young, 1997), discussed how the issues of voice were linked to power and positionality.

The importance of voice within educational and feminist works has been reiterated throughout this text. There have been numerous studies that have utilized the

concept of voice and how it can be utilized in the work setting. These will be discussed further.

Voice and the Workplace

There is a growing body of research pertaining to voice in the workplace, particularly for nursing. Much of the nursing literature has the term voice as an implied meaning within the terms of autonomy and empowerment (Aprile, 1998; DuPlat-Jopnes (1999); Forbes, Bott, & Taunton, 1997; Gorman, 2001; Kenner, 2001; Kerfoot, 2000; Kuokkanen & Leino-Kilpi, 2001; McDonald, 1999; MacDonald, 2002; Rafael, 1998). The terms autonomy and empowerment both imply that the voice of the workers will be heard and acted upon. Aprile (1998) related that women's voices and life experiences are a legitimate source of knowledge and impact practice despite the patriarchal society in which we live. This echoed strongly the different types of knowing as proposed in the WWK text. Providing this type of legitimating for nursing's voice is a necessary component for nurses working within a male dominated work environment.

A doctoral dissertation by Gorman (2001), presented a brief overview of how voice is important for nurses. Gorman pointed out the irony of the nursing profession was that nurses will use their voice to be patient advocates yet were silent on their own behalf. She stated that nursing administration became a crucial facilitator in order to hear the voices of nurses regarding their workplace. It was this internal communication within the workplace that held importance for nursing and for business in general. Not only do nurses need to fill an advocacy role on behalf of patients, but they also need to use their voice to be advocates unto themselves. This voice of advocacy for patients and self is of great relevance to the workplace.

In a book authored by Buresh & Gordon (2000) it was discussed that, despite an erosion of patriarchy in Western society, “it is alive and well within health care” (p. 43). This learned selflessness, or loss of voice has not benefited the nurse at all, but merely propagated the oppression. Instructing nurses in how to use their voice to attain an equal voice within the healthcare setting was the crux of Buresh & Gordon’s text. Nurses’ having a voice within a workplace setting was believed to be one of the reasons nurses feel that they have autonomy over their practice, especially within a Magnet Hospital setting.

The preceding section of this literature review discussed and defined voice within the context of gender, classroom, and workplace. It would be remiss, however, not to mention the antithesis of voice and that is silence.

Silence

Although most of what is written about in this text addressed the idea of voice, there was also a body of literature that addressed the concept of silence. It was important to briefly examine some of the authors that discussed this topic in order to better critically understand the concept of voice.

Mahoney (1996) stated that women’s voice has been a central theme in the literature, she posited that silence was equally important to understand power. She argued with the postmodern perspective that there is only one unified feminist voice. Mahoney stressed that women’s individual voice was diverse and numerous, just as their rationale for silence was. Munhall (1995) on the other hand described silence as “unspeaking” which will eventually lead to “anger and depression” (p. 207). In contrast, Munhall stated that silence gives others power. These two ends of the spectrum were interesting in

light of the voice literature. Mahoney relayed that keeping silence had its own multidimensional rationale that leads to power. She suggested that were times when silence was more powerful than voice. Munhall negated this concept and stated that when voice was not used, the power of the silence was given up to someone else. Munhall's writing appeared to come from a more humanist perspective, where everyone has the right and the opportunity to use their voice, it was rather a personal choice whether or not to use it.

This lens drove at some of the inconsistencies of being without voice. Silence was viewed not necessarily as the antithesis of voice, but rather a concept in its own right. One author suggested that silence was powerful; on the other hand, another suggested that silence meant giving up one's own voice to empower someone else. These definitions were polar due to the fact the author's lenses were diverse. The key summary here was that silence was more than the un-use of voice; rather, it was a powerful tool in and of itself. In this respect, voice and silence can be both seen as a use of power.

Power and how it related to voice was a theme that was seen within interwoven within the female leadership literature, as discussed below. This literature became important to look at in regards to voice and Magnet Hospitals as it demonstrated a different, integrated look at how some workplaces have had the concept of voice interwoven through its leadership style.

As stated in the above literature, the concept of voice has been used in many ways. Building upon the theoretical uses of voice will be a section regarding the practical application of voice in the workplace. Voice in the workplace has been discussed in the literature, especially in the area of female leadership.

Female Leadership

Female leadership literature proposed that there is much more connectedness to the way women lead compared to that of men, meaning that women tend to lead with a more personal approach than men. Authors who wrote concerning female leadership have paid attention to the voices of the employees and involved a connectedness that has not been seen with typical male hierarchical management (Biklen & Brannigan, 1980; Borman, 1993; Clark, Cafarella, & Ingram, 1998; Grossman & Valiga, 2000; Helgesen, 1990; Morrison, White, & Velsor, 1987; Rosenbach & Taylor, 1998; Rosener, 1990; Smith & Smits, 1994; Stivers, 1991). In the following literature review, the concept of voice was implied as a way of sensing and being sensitive to the needs and opinions of employees.

Helgesen (1990) described female leadership in the metaphor of a web rather than the typical hierarchical pyramid. This web-like leadership model is recognized in current literature as “connected” and is more commonly utilized in the management style of today’s organizations. It was implied that this connectedness is achieved when leadership and management are able to listen to the voices of employees and share goals within a flatter, web-like management model. Women leaders tend to share these goals in a different manner than their male counter-parts.

A research study by Rosener (1990), found that women in leadership positions described themselves differently than men in similar positions. The women used characteristics that described a “transformational” leadership; that is to say they got their subordinates to transform their own individual goals toward a goal that was more interested in the betterment of the worker group. Women in leadership positions

commonly used more personal characteristics in order to achieve these shared goals, such as personal contacts, interpersonal skills, and charisma rather than relying on the traditional hierarchical business structure. These female leadership characteristics were discussed in other studies as well.

Grossman & Valiga (2000) described male qualities such as dominance, independence, objectivity, rationality, competitiveness, aggressiveness, boldness, decisiveness, toughness, and logical thinking. Female characteristics were most notable as being compliant, dependent, emotional, weak, passive, and nurturing. The authors pointed out that none of these female traits were commonly associated with the concept of leadership. They further pointed out that there were not many women in leadership positions because society does not expect it. There were few role models for women and they were sometimes discriminated against if they do exhibit strong leadership skills. These authors made a call for action for women to continue to strive and achieve leadership positions despite a common expectation that society is not typically expecting this different leadership style.

The strength of female leadership was that it inherently pays attention to the voice of employees within the workplace. By having their voices heard, workers can be more effective and productive for organizations in today's changing work environment.

Kerfoot (1993) related the following:

The best organizations believe that a model for mutual growth in which the employees and the organization can both grow together is the strongest model. In this kind of model, the employees and the organization develop a mutually satisfying relationship in which both add value to each other. (p. 323)

This shared destiny as proposed by Kerfoot, reflected a sensitivity or listening to the voices of the workers. A relational or connected workplace becomes attractive to the employees because of the fundamental importance that worker's voice plays.

From the above stated articles and examples, it was clear that listening to the employee's voice and leadership's sensitivity to this voice were missing links that could help business better succeed and connect to the workers in a way that it has not in the past. It was interesting to note however, that the concept of positionality among leadership was not discussed in relation to the concept of voice within the workplace setting. This seems to only be seen within the academia literature. The marginalization and "otherness" of workers was never really stated either, rather it was implied. Cultural difference and how it impacts having a voice within the workplace was not discussed either. These were interesting gaps in the literature regarding voice in the workplace.

It was evident however, that paying attention to the voice of employees had beneficial ramifications that allowed for a greater sensitivity among management and leadership. The voice of the employees needed to be heard in order to create a more connected, better functioning work environment. It is within this connected workplace setting that employees appeared to have a voice and greater work satisfaction along with improved patient care; Magnet Hospitals are such workplace environments.

Given the fact that the nursing profession is facing a severe nursing shortage, and it is predicted to become worse by 2020, it becomes imperative to research *qualitatively* the nurse within the Magnet Hospital to gain a deeper understanding of what it means for them to have a voice within this unique workplace setting. By having a voice within the hospital environment setting, it is believed that nurses will demonstrate greater job

satisfaction, have less incidence of burnout, thereby improving nursing recruitment and decrease nursing attrition.

CHAPTER THREE: METHODOLOGY

Introduction

This chapter reviews the purpose of the study. It will describe the fundamentals of qualitative research, the design of the study, the qualifications of the researcher, and the sampling procedures. Data collection techniques and analysis process will also be discussed. The purpose of this study was to understand the meaning of voice to experienced female registered nurses who work within a medical surgical area of a Magnet Hospital. What was the meaning of voice to an experienced registered nurse working within a Magnet Hospital workplace setting? The design of this qualitative study will use a phenomenological approach that focused on the use of interviews as the primary means of data collection. The use of this research design was to better understand the meaning of voice to the experienced bedside registered nurses within a Magnet Hospital. A feminist humanist conceptual framework, influenced by a critical emancipatory feminist framework, helped guide this study which was discussed in Chapter One.

Overview of the Qualitative Research Paradigm

Qualitative research is a research method that encompasses the realm of many various styles and studies. Qualitative research is a type of research methodology that examines the “gestalt” – it speaks to human subjectivity and intersubjectivity (Morse, 1989). Qualitative studies, exhibit several characteristics which include: non-generalizable research, meaning-making value, importance of the natural setting; the researcher as the interpreter; induction methods; reciprocity; a small sample size; and the goal of uncovering a previous unknown. This related to my particular study in that there

were no qualitative studies that pertain to the examination of Magnet Hospitals to this point. Most of what has been researched regarding Magnet Hospitals has used a quantitative approach that helped to justify the quality of nursing care and nursing/patient satisfaction outcomes within these particular healthcare organizations. I felt strongly about hearing the voices of the nurses within their environment of a Magnet Hospital. Nurse's voice cannot not be measured merely by a survey result; interviews were needed to hear the nurses' actual words, opinions, and feelings regarding their perceptions of working as a nurse within a Magnet Hospital. It was this qualitative research that helped fill in the gap for a better, more holistic understanding of the nurses' role in Magnet Hospitals.

Qualitative research attempts to assess a participant's meanings made within a certain context. Morse (1989) writes that, "Human beings create meaning in interaction with one another. Given the different views of man/woman in the world, it stands to reason that different questions will be asked, which will require the use of different methodological approaches" (p. 20). Trying to uncover these different meanings is at the heart of the qualitative design. It was this qualitative trait in particular that truly drove my study within the context of a Magnet Hospital. Asking questions such as: How do nurses perceive their voice within a Magnet Hospital? How is nursing's voice utilized within this particular work environment and how does this impact the Magnet Hospital as a whole? It was these questions that got at the participant's meaning making of their voice within the context of a Magnet Hospital.

Qualitative research is naturalistic. This term dovetails into the preceding characteristic in that life, as studied, occurs in the context in which it is lived. Qualitative

research examines participants as they interact and perceive their world. Munhall (1994) states, “Experience and perception are our original modes of consciousness. Perception, which takes place through the body, is an individual’s access to experience in the world” (p. 15). This study lends itself to the naturalistic in that I am trying to gain an understanding of nurses’ voice within the context in which they work.

Also with qualitative research it becomes important to discover the meanings of human experience in the natural world; the methods are structured inductively. As transcripts and field notes are compiled, the researcher must develop themes and categories from the data collected. Patton (2002) states, “Qualitative inquiry is particularly oriented toward exploration, discovery, and inductive logic. Inductive analysis begins with specific observations and builds toward general patterns” (p. 55-56). For my study, I will be utilizing both, field notes and transcription while interviewing the sample of nurses from the two different Magnet Hospitals. It was from these field notes and transcription that there was consistencies and themes that developed from the inductive process of qualitative research. For this particular study, the meaning making that nurses had concerning their work as a nurse within a Magnet Hospital became the heart of the study.

In order to ascertain this meaning making approach, a phenomenological qualitative design was necessary. The next section discusses an overview concerning the phenomenological research method.

Overview of Phenomenological Research Method

Phenomenology is one type of a qualitative research method (Morse, 1994; Patton, 2002). Phenomenology examines the question, “What is the meaning, structure,

and essence of the lived experience of this phenomenon for this person or group of people?” (Patton, 2002, p. 104). Streubert & Carpenter (1999) define phenomenology “as much a way of thinking or perceiving as it is a method. The goal of phenomenology is to describe the lived experience” (p. 45). Munhall (1994) pointed out that phenomenology focuses on *meaning* rather than on the behaviors observed. For this particular study, the meaning of nurses’ voice within a Magnet Hospital context was the intent of the study.

Phenomenology maintains that meaning is constructed contextually as an inter-subjective phenomenon. “Human beings create meaning in interaction with one another. Given the different views of man/woman in the world, it stands to reason that different questions will be asked, which will require the use of different methodological approaches” (Morse, 1989, p. 20). Eisner & Peshkin (1990) also stated that phenomenology examines the way in which individuals or groups make sense of their worlds. This qualitative method takes a look at the meaning-making of the participants, as Munhall concisely offers, “To study meaning this way is to become the question you are asking” (p. 48). In the case of my study, questions regarding nurses’ voice and what they perceive as having voice must first be constructed; how do the nurses make meaning of their voice?

In conclusion, phenomenology is a qualitative research method that stems from a philosophical history and helps the researcher uncover a participant’s meaning-making within a certain context. Munhall (1994) states, “To ask a question from this perspective is to be conscious of something and turn your attention to this something, and this turning is an intentional act” (p. 48). It was the purpose of this study to better understand the participant’s essence of voice within a Magnet Hospital workplace setting.

Background of the Researcher

My first introduction to Magnet Hospitals was when I began teaching a nursing leadership and management course. I read the studies with great interest because what the articles revealed was that certain hospitals recognized excellence in nursing. What a novel concept!

All during my professional career as a bedside nurse, I heard about the strife nurses have had to overcome in order to make changes happen within a hospital setting. It would often be pointed out that nurses have struggled under the medical model for eons. Nurses did not have even their own language to use when describing the interventions and care for their clients. Finally, the advent of the nursing care plan came into focus and the articulation of nursing care had begun. Nurses would have to stand when a physician came onto the floor to do rounds with their patients. Nurses were viewed not as professionals, but rather as the handmaidens to doctors. This type of socialization has pervaded and plagued hospital nursing for centuries. So when I read about hospitals that “up-ended” this way of thinking, you can be sure that it grabbed my attention.

I then introduced the concept of Magnet Hospitals into my leadership class. I asked the students to describe an ideal work setting in which they felt they could work most effectively. Not too shocking, the result looked very much like a Magnet Hospital. Nurses here had autonomy to practice, had visible power within the institution, and were better-satisfied and safer to practice within their work setting. The students were amazed not only that such hospitals existed, but also that nursing can show quantitative data that validates their patient care with positive outcomes.

I have been a nurse for over fifteen years and have seen many changes in nursing toward overcoming patriarchal oppression and validating nursing's work within the hospital setting, but there is still much progress to be made. Magnet Hospital research has done much to confirm nursing's impact on healthcare, however more research must be done. The Magnet Hospital literature points to nursing's excellence and impact within a hospital setting, there is still a huge gap in the literature. Further qualitative research must be done to better understand the role of nurses within these Magnet Hospitals.

Participant Selection Procedures

For my this study, I wanted to study bedside female nurses that work within a hospital setting that appears to be attractive to a female workforce. Unlike traditional hospitals, Magnet Hospitals have quantitatively been proven to attract and retain nurses. This workplace setting intrigued me (as a nurse myself) about what it means for these nurses working within this particular workplace setting. I wanted to hear the nurses' perceptions about their work environment as well as how they thought they were perceived within the Magnet Hospital.

First, a purposeful sample was chosen; this refers to selected individuals specific to this study that will provide specific insights to the phenomenon to be studied (Patton, 2002). The purposeful sample was all female to reflect the dominant working population of bedside nurses. The participants all had at least five years working experience as a registered nurse - the last three were at their current Magnet Hospital workplace setting. This five year experience criteria was chosen based on the works of Benner (1984) who examined nurses on a continuum of practice from novice to expert. It was felt that it would be prudent to include the perceptions of new nurses within this particular

workplace setting. I wanted to make sure that I was hearing the perceptions of seasoned or experienced registered nurses who were comfortable within their workplace setting and better understood the role as a nurse within the organization than the novice nurse.

I first contacted the nurse managers from one particular Magnet Hospital from the three specific medical-surgical nursing floors. I then passed along my criteria for a sample to the nurse managers. From the nurse managers, a list of twenty nurses who fit the sample criteria was generated. I then contacted each of the potential candidates via email and several in person, explaining my study and my wish to include them in this nursing investigation. I provided further contact information if they would be interested in participating – twelve of the women had contacted me; one flatly refused stating she was too overworked. This sample of twelve female nurses was then interviewed. The participants all worked at the patient bedside within different medical-surgical areas of the Magnet Hospital. The medical surgical areas were chosen, as explained earlier, because it reflected the majority of patient care within a hospital setting. There was less likely to be favoritism among doctors and upper management to these areas because they dealt with a more diverse patient population.

Criteria for participant selection were based on the following:

1. Female registered nurses because they reflected the current workforce of nursing (97%).
2. Nurses with at least five years experience, the last three were at their current Magnet Hospital setting. The rationale for this criterion was to better understand the perceptions of experienced registered nurses working within this particular

context and not to confuse their experience with learning a new role/workplace setting.

3. Nurses working within medical surgical areas of the Magnet Hospital because the type of nursing can influence the upper management and physicians to perceive the nurses. Specialty care nurses, such as intensive care nurses, potentially wielded more power within a hospital setting than those of medical surgical nurses because they tend to work more intimately with specific doctor groups.

I fully have complied with the Pennsylvania State University Office of Regulatory Compliance. Protection of the participant's rights was maintained in several ways. First, an informed consent was explained and signed by the participant prior to engaging in the research study. As part of the record keeping process of this study, a copy of this was kept with the researcher and the other was given to the participant. Secondly, the confidentiality of each participant was maintained during each aspect of the research process. As the research was summarized, each participant was identified by a pseudonym.

Also, since this particular research occurred within a specific Magnet Hospital setting, I obtained permission to do the study from the IRB of that hospital before submitting my information to Penn State University. I followed all of the application protocols set forth by the Magnet Hospital.

Data Collection Procedures & Methods

The participants' names were obtained from the nurse managers of the three medical – surgical areas of the Magnet Hospital. From that list, I contacted each of them to ascertain interest in my study, as stated above. Each woman that responded was further

contacted and read the qualifications of the study to make sure that they were eligible to participate. Each of the participants volunteered their time and met with me during non-working hours. The data collection occurred from August 2004 to January 2005. Initially a pilot study was performed to assess the interview protocol. This pilot study process helped me refine my questions and interviewing technique. The pilot study also helped me ascertain some of the general themes that I would center my questions around later, such as physician interactions, committee work, and organizational structure. I gathered the data from two face-to-face interviews held at the Magnet Hospital, usually in classrooms away from the clinical areas that the nurses worked in. The initial interviews lasted approximately one hour. The follow-up interview was used to verify the participant's answers and helped clarify, or further explore, any areas that were significant to the study, as well as any personal reflections that occurred since the initial interview. The second interview lasted generally thirty minutes. I also kept personal notes that reflected thoughts, experiences, or comments that were made throughout the interview process.

The interviews that were utilized for my study were semi-structured, or general interview guide as described by Patton (2002). This general interview guide involved the creation of several questions to be asked of the participant before the interviewing begins and then included open-ended questions that were more specific to the particular study. Each participant was asked the questions in basically the same order. The interviews were all held in a face-to-face format. The interview guide provided enough of a framework so that the participant was able to articulate what it meant for them to have a voice within the workplace setting of a Magnet Hospital. This type of interview practice allowed for

enough of a focus on the nurse's voice without steering the conversation. I allowed for the participants to elaborate on any detail they wish to expound upon. As Patton (2002) points out that this type of interview "keeps the interactions focused while allowing individual perspectives and experiences to emerge" (p. 344). A brief outline of the interview includes: Age of the participant, years in nursing, highest degree obtained, committee work, draw to nursing, biggest detriment to their nursing care, physician interactions, and providing an advertisement for their particular unit. These questions helped focus the interview around their perception of voice, organization, and assets/detriments to their current nursing practice.

Another part of the data collection included the use of field notes and documents. Patton (2002) stresses the need for note taking during the interview process. He cited these field notes serve at least four purposes: assist the interviewer to formulate new questions as the interview progresses, help the interviewer reflect on the direction of the interview – making sure areas are covered, help facilitate analysis, and are helpful in case the tape recorder malfunctions.

For my study I used these notes to primarily assist with my data analysis. These notes were utilized as soon as possible following each interview to help synthesize the information offered by the participant to help create the whole picture as I saw it unfold. These notes did not just include the mannerisms and behaviors of the participants, but they also included notes of the setting in which the interview took place. Important issues such as the atmosphere in which the interview takes place needed to be documented and included in this study, especially as it pertained to the organizational culture piece of my research. There were also brief demographic data that each participant was asked at the

beginning of each interview which included information such as: name of participant, age range, title of current position, how many years worked as a nurse, previous job experience, how many years worked as a nurse at a Magnet Hospital, years in current position, education level completed, and further professional or educational goals. Upon the completion of each interview, I found a quiet spot to review and record my notes as accurately as possible.

I also reviewed the application for Magnet status from the chosen hospital. I wanted to ascertain where they speak to specific core values (such as communication and collegiality), which are required in the Magnet Hospital Application Process.

Data Analysis Procedures

In the qualitative paradigm, particularly the phenomenological approach, most of the data collected and analyzed comes from interviews, observations, and documents. Within the phenomenological approach, it is the purpose to “get at” the interviewee’s lived meanings that have helped guide their actions and interactions (Marshall & Rossman, 1999). In-depth interviews then, provide a means to grasp a hold of this information and convey the information that has transpired between the interviewer and the person being interviewed. Also, as Patton (2002) pointed out, “the skilled interviewer is thus also a skilled observer, able to read nonverbal messages, sensitive to how the interview setting can affect what is said, and carefully attuned to the nuances of the interviewer-interviewee interaction and relationship” (p. 27). It is this sensitivity that became essential when conducting qualitative research. It was through the use of these interviews, observations, and documents that I conducted my data collection.

Verification

The quality of qualitative research is determined by its “trustworthiness.” Lincoln & Guba (1985) reveal four terms that speak to this issue of trustworthiness, the parallel of reliability and validity within a qualitative design. These four trustworthiness terms are: credibility, transferability, dependability, and confirmability.

Credibility

First, Lincoln & Guba (1985) define the idea of credibility as “truth value” (p. 296). This concept not only looks at how the researcher can carry out a credible study, but also it involves the reproducibility of a study using different lenses. Credibility includes the following areas to support the qualitative study: researcher sensitivity, prolonged engagement in the field, and triangulation.

Researcher sensitivity encompasses competence and skill of the researcher, acknowledgement of changes and biases with the researcher, and interactions with the participants of the study. Prolonged engagement in the field refers to the time it takes for the researcher to truly “learn” the culture, testing for misinformation, and triangulation. In order to achieve researcher sensitivity, I plan on spending five months fully engaged in this research process.

Triangulation represents the use of multiple sources to check the same data. There are several types of triangulation strategies: methodological triangulation, observation triangulation, source triangulation, investigator triangulation, peer debriefing, and negative case analysis. Methodological triangulation is the use of different methods to check the same data. Observational triangulation (member checks) is comparing observations with the interview data. It looks at what is said within the context of the

interview. This type of triangulation would require a researcher to have follow-up interviews to ascertain that the data recorded reflects the thoughts of the participant. Source triangulation looks at the data collected and then compares it to other accounts from the same interview, such as field notes and oral accounts. Investigator triangulation simply means that there is more than one analyst utilized. Peer debriefing uses an outside person to review the analytic processes of the study. Lastly, negative case analysis is defined as “continuously to refine a hypothesis until it accounts for all known cases without exception” (Lincoln & Guba, 1985, p. 309). Patton (2002) adds that “Where patterns and trends have been identified, our understanding of those patterns and trends is increased by considering the instances and cases that do not fit within the pattern” (p. 554). Any findings that do not fit the pattern will be clearly delineated.

For this particular study, I used several peer members to check for triangulation, since I did hold personal biases about this research project. I also conducted a second interview with each participant to ensure possible clarifications or reflections that occurred following the first interview. These methods helped strengthen my study via triangulation.

Transferability

Transferability refers to the strategy of providing thick, rich descriptions with the goal to “accumulate empirical evidence about contextual similarity; the responsibility of the original investigator ends in providing sufficient descriptive data to make such similarity judgments possible” (Lincoln & Guba, 1985, p. 298). To ensure transferability, I stated the guiding theoretical framework and showed how these concepts not only shaped my data collection process but also the analysis of the data.

Dependability

Dependability examines the design and findings of the study looking for consistency. This trustworthiness tool asks the question, “Does this study make sense to other researchers?” There is much overlap in triangulation methods here as well as the potential use of an auditor to make sure the study is represented fairly and unbiased.

As the researcher, I recorded each interview and created an audit trail that will allowed for another researcher to examine my procedures and processes to determine the appropriateness of this study and my findings. I utilized external persons, peer reviewers, to also examine all of my interviews for emerging themes. Having this piece also added to the dependability of my study so it is believed to be correct.

Confirmability

Confirmability is used synonymously neutrality and objectivity. This concept answers the questions, “Does the study provide confirmable data?” “Is there an audit trail provided?” Triangulation methods can also be utilized to assist the researcher in confirming the results of the study. To ensure confirmability, I kept accurate records of the each interview and used external peer reviewers to verify the emerging themes extracted from each interview.

These four trustworthiness criteria of credibility, transferability, dependability, and confirmability helped refine and define the qualitative research method. These four criteria were necessary in completing a trustworthy qualitative research design.

Summary

This chapter restated that the purpose of this study is to understand the meaning of voice to experienced registered nurses who work in a medical surgical area of a Magnet

Hospital. This chapter provided a description and rationale for utilizing a phenomenological qualitative research design method. The chapter also provided my qualifications as a researcher and clarified the volunteer sample criterion for this study. It outlined several ethical considerations related to confidentiality and protection of human subjects. Finally, this chapter described qualitative research data collection methods, data analysis, and verification procedures that will be utilized in this study.

CHAPTER FOUR: DATA PRESENTATION

This chapter will first present a brief biography of the participants in this study and offer an examination of the research findings. The purpose of this study was to understand the nurses' meaning of voice working within a Magnet Hospital setting. This purpose was achieved by interviewing experienced registered nurses. The major themes that were discussed by the participants were: staffing shortage, positive nurse – physician relations, supportive nurse managers, teams that click, varying levels of satisfaction with committees, and low impact as a result of accreditation.

Participants of the study

Twelve female nurses ranging in age from 26 to 53 with at least five years of clinical experience at one Magnet Hospital were utilized for my conversations. Ten out of the twelve participants graduated from the nursing school that is associated with the hospital. Three nurses have bachelor's degrees from other colleges in Pennsylvania. All of them have nursing experience within this particular hospital for at least five years and currently work at the bedside in a medical-surgical area of the hospital.

A table that includes biographical information along with a written brief biography of each of the twelve participants follows this introduction. The biographies will introduce the participant and also address their specific comments related to their perceived effects of Magnet Hospital and patient care. The participants will be introduced in the order that they were interviewed. Each woman has been given a different name to protect her identity. The hospital utilized in the study received official Magnet Status in 2002. The name of the Magnet Hospital in which the participants work will also not be specified.

| Participant's Name | Age/Years in Nursing | Highest Degree Earned | Committee Work | Greatest Asset to Current Nursing Practice | Impediment to Current Nursing Practice |
|---------------------------|-----------------------------|---|---------------------------|--|---|
| Marcia | 44/23 | Associate's Degree | None currently | Good leadership | Not enough nurses aides |
| Martha | 52/31 | Diploma | Education Council | Clinical ladder/Councils | Too much traffic on the floor |
| Mary | 26/5 | Bachelor's Degree | Steering Committee | Variety of patient care | Too many patients |
| Tristin | 32/11 | Bachelor's Degree | None currently | Being able to give patient care | Not enough staff |
| Candice | 41/20 | Diploma | Clinical Practice Council | Have the time to talk with patients & get to know them | Not enough staff |
| Trudy | 46/13 | Diploma | Education Council | Learning and humor | Staffing |
| Alice | 26/5 | Diploma | Education Council | Customer Service/Resources | Staffing |
| Bonnie | 39/18 | Associate's Degree | Steering Committee | Nursing Care/Salary | Staffing |
| Gretta | 39/18 | Diploma | Clinical Practice Council | Manager/Change | Motivation of Staff |
| Amy | 34/13 | Diploma | Staffing Coordination | Manager/Bridge Medication System | Physical Environment |
| Denise | 57/8 | Bachelor's Degree in Health Physical Education/Recreation | Education Council | Manager/Staff Support | Staffing/Physical Environment |
| Nancy | 55/6 | Diploma | None Currently | Manager/Patient Care | Staffing |

Marcia

Marcia graduated from a school of nursing associated with this particular hospital twenty-three years ago. She has an associate's degree in science from a nearby college. She has worked at this hospital her whole nursing career. She started out working in critical care and worked in that area for about three years. Following those three years she

has worked continually in medical-surgical nursing. In particular, she has worked on her current floor with this mix of patients for the last fifteen years.

Marcia feels that attaining Magnet status has not made a difference to her nursing care of patient; rather it is merely “good advertisement.” When posed with a question regarding Magnet Hospital and its effect on her daily practice as a nurse, Marcia stated:

I think it’s made the hospital more committee driven. And I think that if there’s more pressure on each individual to get involved in committees. And I guess I drag my feet to committee involvement. I didn’t really change my outlook on what I want to offer. I don’t know, but I think that the world as a whole is driven-I think the boundaries between work and family and home are getting more blurred. And I think there’s a lot more pressure in the world. I would hope that as a magnet hospital that we would continue to honor the people that want a job with boundary lines. When you sit on a committee, you give of yourself emotionally too. If you’re somebody that doesn’t want to give emotionally as much as maybe somebody that’s single and has their whole life career and their whole life is, is wound up in being an RN, I fear that with this magnet status that that person won’t be valued as much....because they want to draw that boundary. But on my floor I’m okay. I don’t feel that. The whole world just seems to just getting to be more of a pressure cooker. And women, a lot of times are in health care. And when you are the support person out there, of the husbands and the kids (it is a lot of stress).

Marcia spent a lot of time discussing her frustration of being pulled in different directions between her family responsibilities and the expectations of being a nurse

working with patients on the floor, especially with the Magnet expectation of increased nurse involvement on committees. She stated,

(There needs to be an) understanding that I'll want to draw boundaries between my home and my work. And I'm not going to sit on a committee right now because I don't desire to get that involved and give that much beyond what I already do.

Martha

Martha was the participant with the most amount of clinical experience, working at this particular hospital for thirty-one years. She is a single parent with two children who are both in college. She graduated from the school of nursing associated with the hospital and received her diploma. She worked as a nurse manager for a short time and then returned to bedside nursing. All of the years that she has spent at the hospital, she has remained a medical-surgical nurse. Martha currently has been on the hospital based education council committee for the past three years.

When Martha was asked about how being a Magnet Hospital has impacted her nursing care, she stated:

Did it really change my nursing at the bedside or anybody's nursing? What I do? I don't know. I can't really say yes or no. I mean, I think maybe more emphasis is put on it being open and pleasant and, but I don't know. I guess maybe. I guess I thought it was that way all the time. I can't really think of a specific thing that because now we're magnet makes a difference at the bedside. So just because we got the little paper that says yes, magnet hospital, I don't think that made the changes. I think the changes occurred before. And that's how we got the magnet

status. Because we had the magnet status, then that changed people's views of the hospital because it's an advertisement tool. Because I think it's a recognition thing.

Mary

Mary is a 27 year old nurse who has worked at the hospital for the past five years. She graduated from an area college with her bachelor's degree in science. She recently passed her certification in medical-surgical nursing and serves as the chairperson of the floor's steering committee.

Mary also relayed that she did not feel that having attained Magnet Hospital status had changed any of her bedside care. She had this to say about patient care and achieving Magnet Hospital status:

I don't think I noticed a change. I know I didn't notice a change. No, I don't think it did change the really good (patient) care. For the institution, yes, I think it has (made an impact). It's a great (advertisement). I wonder how the public feels about it? I know they had sent a little magnet (in the mail). It explains what the Magnet designation meant. But I don't know if people are conscious of that when they choose to come here. I don't know if they really take them into consideration. I know it's an advertisement to get more nurses to come here or that nurses can look here.

Tristin

Tristin has been a nurse at the hospital for the past eleven years working in medical surgical nursing and has work experience as a nurse's aid at a nursing home prior to that. She received her diploma from the nursing school at the hospital and then went on

to obtain her bachelor's degree from a local college. She is a single mother and works part-time. She has served on education council for her floor, but currently does not sit on any committees.

Tristin stated that she is angry at the administration of this Magnet Hospital. She does not feel that they are in tune to the patient care issues that are occurring at the bedside. When we spoke she was asked to state her opinion about being a Magnet Hospital; she stated:

It makes me resent our administration even more. Because they can waste the time trying to prove to everybody else that we're so wonderful. They can't make us wonderful. It would take our administration out of their offices and onto the floor actually giving patient care from time to time so they don't forget what it's like to give care to high volumes of patients in a short period of time. (They forget what it is like to) deal with angry doctors and frustrated families. It's easy to get behind a desk and forget the reality of patient care. And then they come out walking on the floor when they have some evaluating, you know, whether it be JCHO (an accreditation body for hospitals) or if it would be Magnet coming, or whoever else comes and evaluates us. They come walking up in their high-heeled shoes and their pretty suits and they act like they're big stuff but they don't have a clue what's going on that floor 364 days a year.

Candice

Candice is a nurse that has worked in this hospital for twenty-two years. She graduated from the nursing school associated with the hospital with her diploma in nursing. She started her career working in critical care for a short time but has spent the

last seventeen years on her current medical-surgical unit. She currently serves on hospital-based clinical practice council.

Candice shared many experiences concerning her years as a bedside nurse and discussed how she has seen changes implemented within the clinical setting. When asked about Magnet Hospital she responded:

It's supposed to be that if you work in a Magnet Hospital that just says that the nurses in that hospital are top notch. You'll get excellent nursing care if you go to a Magnet Hospital. As far as I'm concerned you've always gotten excellent nursing care at (this hospital) no matter whether it's been a Magnet Hospital or not. And having that designation, I don't know that that has changed anybody's practice. Because I think that we gave excellent care before. I have never had one patient say anything to me about this being a magnet hospital. Or they'd see a banner or something like that, they might say what's all that about? And then, you know, we would explain to them the process that we went through and what it means. You are getting excellent care. It's an award given to hospitals that has shown that they have excellent nurses....things like that. And they're usually like, oh, okay. But I don't know that anybody's really ever said well yeah, I did a search on the internet for magnet hospitals before I decided what hospital I was going to go to. And I don't know that I've ever really heard anybody say that that's come here looking for a job either. Which was also another thing that I understood, was to make it a lot easier for us to get nurses to work here.

Trudy

Trudy has been a nurse at the hospital for thirteen years. She has worked on her current floor for the past seven years. She states that she enjoys medical-surgical nursing because there is “a lot of really, really interesting things happening.” She currently sits on the education committee.

Trudy had this to say about being a Magnet Hospital:

I have no idea what it’s supposed to mean to me. “The Magnet Hospital”...it’s a recognition you get for the level of education for the nurses, the expansion of their practice. So it’s a recognition. (But it hasn’t made any changes at the bedside) because I think it was always there. I mean, I’m not saying that we don’t have all those qualities. We do. They’ve always been there. The hospital’s always been progressive (with) the new technology. Before Magnet (the hospital) was always excellent with education.

Alice

Alice was the youngest of the participants at 26. She has been working at the hospital for the past five years. She presently works in medical-surgical nursing and has been on this particular floor for three years. Alice graduated from the nursing school associated with the hospital and serves on the education council on the floor.

Alice spent a lot of her interview time talking about what it means to work at a Magnet Hospital:

So I think that with having that Magnet status and that, you know, this is saying that we do provide good care for our patients at every level, not just at the nursing level. We try to, try to provide the best care we possibly can. And with being a

Magnet Hospital, I don't know if I'm making sense, but it adds to the wow factor. If they're a Magnet Hospital they must have good nurses that work there. They (the nurses) must have some, you know, exceptional knowledge at some level. They want to work there.

Bonnie

Bonnie has worked at the hospital for eighteen years. She was the only participant that worked night-shift. She holds an associate's degree in science from a local college and has recently passed her medical-surgical nursing credentialing exam. She serves on the steering committee on her floor.

Bonnie relayed the following information regarding her thoughts about being a Magnet Hospital:

I think maybe we got (Magnet Hospital recognition) because of the care we give. That's why we've been nominated for that award. It's not an award for nursing care. It's an overall hospital-wide recognition. Like, (it takes into account) what is the death rate. What kind of excellence your hospital's giving. We don't have a lot of agency nurses working here. So you get a lot more hands-on care. You've got a lot more long-term nurses here than, I think, a lot of other places. (So it helps with retention.)

Gretta

Gretta is a registered nurse with eighteen and a half years at this hospital. She graduated with her diploma from the nursing school associated with the hospital. She functioned in the role of management for seven years and then returned to bedside nursing due to management changes. She states that being an assistant nurse manager was

her favorite job but loves where she is at currently primarily because of her nurse manager. She currently works full-time and serves on the hospital-wide clinical practice council.

Gretta stressed that she has never worked at another hospital, but that her experience of working at this particular Magnet Hospital has been good. She stated:

I've never worked anywhere else. This is all I know. I'm happy here. I like my job. Sometimes scary to me when I think there (are) things that I feel like we still need to work on. And days where I get real frustrated and I think wow, you know, we're not perfect. But when I see things, I think wow, we're magnet hospital. Boy, what do those other hospitals look like? I hear a lot of patients and they seem to know what that means. And it's really nice when patients come and they say they wouldn't go anywhere else or they were upset they had to go someplace else. I've had patients recently come from other states to come here. So then you really want to make sure they have a really good stay. That's neat to hear. When you see things in articles and magazines (that refer to this hospital being a Magnet Hospital) that go everywhere. And you see on TV, it's really neat to know that that's where I work. (It makes you feel proud.) because it's a wonderful place to work.

Amy

Amy is a registered nurse who has worked at this particular hospital for the past fourteen years. She received her diploma from the nursing school associated with the hospital. She marveled at the fact that when she graduated, the market for nursing was

very tight. Amy was one of twenty nurses that applied for the only position available on an orthopedic floor.

Amy mentioned about her years of service at this Magnet Hospital and how she would not go to work anywhere else. She stated that:

I can't necessarily say it's made a big difference to me. I only say that because I think this is a good hospital to start with; even if we wouldn't have magnet recognition I wouldn't leave. As far as drawing people here, I think it's definitely a plus. I don't know that until the hospital started to go for Magnet (designation) I can honestly say (that) I didn't know much about it before that. So it makes me then wonder how many other nurses that are out there that see that in our advertisement really understand what that means. Because I've been here this long and I've heard bits and pieces about it. But the true understanding of it hadn't come about until we actually went through that. I think now since more hospitals have gotten it, I think nursing overall is more aware of what it means. But I don't think, um, I don't think it's still gotten to where it could be. Because I just don't think that some people understand it. I don't think that they understand unless their hospital is in the process of going for it. (I think) that they maybe (the nurses will) totally understand if they see an advertisement that says magnet recognition, what that means. To me it means that the best nurses work here. And I think there are a lot of good nurses that work here. I think this hospital offers the nurses here, the employees here a lot of things that are very, very positive.

Denise

Denise has worked at the hospital on the same floor for the past nine years. She graduated from college with a bachelor's degree in physical education but could not get a job in this area. She worked various jobs but was not happy. She then turned to nursing and went to a local nursing school and graduated with her diploma. She served several years on the hospital-wide education council and has recently resigned that post to be a member of the steering committee on the floor.

Denise relayed that she was disappointed with Magnet Hospital designation as it relates to her nursing practice. Denise stated:

(Magnet Hospital has not made any difference to my nursing practice.) They (management) said that (it) will attract the best. What's the best? What's their definition of best versus my definition of best? I want the attitude. I want that attitude there that you're there because it's a calling that you have inside of you. I don't care what your grade is. You can have an A student doesn't give a crap about nursing. They just made a good grade. And I think that when they (management) look at Magnet status, I think they're looking at the good grades. Are we? You know, I haven't seen anybody come through Magnet that affects this floor. So maybe it's too soon to answer that question. But I haven't seen it yet.

Nancy

Nancy has been a nurse for the past six years; previous to that she worked as a nurse's aide for three years all within this hospital setting. She graduated from the nursing school associated with the hospital and graduated with a diploma in nursing. She does not sit on any committees at the present time since she has recently joined the medical surgical area from a cardiac floor.

Nancy stated that working in this particular hospital has made her more aware of her nursing practice and the changes that have occurred to nursing. She stated:

It probably means that (we have) changed. And you know, become(ing) aware of doing, things the right way each time and being really proud of being a Magnet Hospital. I guess that's mostly what I see. People are more aware of it. The other staff members would communicate things that we should do it like this; I should do it like that. Or maybe they feel more free to communicate to other staff members if they see somebody doing something wrong.

Overall, from the conversations with the participants, it was revealed that most nurses did not feel that attaining Magnet Hospital has made any difference to their direct patient care. There are however, pieces of what makes a hospital good enough to achieve Magnet status that nurses feel are present and have gotten progressively better in the past few years. These pieces give insight into important aspects of being a Magnet Hospital, particularly regarding the concept of voice.

Presentation of the Data

Themes concerning voice within a Magnet Hospital

This section discusses the information gleaned from the participant's conversation, touching upon their concept of voice within the following areas: staffing, interactions with physicians, nurse manager, teamwork, committee structure, and Magnet Hospitals. The table below summarizes the major themes and findings of the study.

| Themes | Findings |
|-------------------------------------|---|
| Staffing Shortage | <ul style="list-style-type: none"> • Patient care • Talking and listening to patients • Knowing the patient • Burnout • Voice • Suggestions |
| Interactions with Physicians | <ul style="list-style-type: none"> • Respect • Collaboration • Open Communication • Voice • Negative Examples and Loss of Voice |
| Nurse Manager | <ul style="list-style-type: none"> • Retention • Direction and Support • Positive Attitude • Teamwork • Flexibility • Approachable • Voice |
| Teamwork | <ul style="list-style-type: none"> • Support • Personalities • Knowledge • Perseverance • Humor |
| Committee Structure | <ul style="list-style-type: none"> • Validation • Dissemination of Information • Dissatisfaction • Voice |
| Magnet Hospital | <ul style="list-style-type: none"> • Good Hospital • Practices in Place • Anger |

Staffing Shortage. In the following section, the participants are clear that they have no voice in regards to staffing issues. Not only are they not heard when expressing

immediate and long-term staffing assistance, but they are not seen as they struggle with the results of staffing shortages.

First, the nursing shortage has affected the way the nurses provide their patient care. Nurses stated that even with the advanced technology that they have access to, the patients for which they are caring, are much more ill and require more staff to care for their physical needs. The nurses feel that this institution still staffs the floors with the same number of patient care providers as it did years ago, despite the acuity/severity of the patient's illness increasing exponentially. One participant discussed the fact that they do not even have more nursing assistants to help with basic physical care despite the greater patient care demands. Tristin relayed, she was frustrated at the fact that the nursing administration was not taking into account the acuity (severity of patient illness) when trying to staff the units. She stated, "it would make the day better if they considered patient acuity when they staffed the unit and not just the immediacy of (placing a patient in a bed)-because we don't have enough nurses to staff the beds. I mean, if you don't have the staff, then you need to find a way to get staff because the patients aren't getting the care."

This lack of staffing does not allow the nurses to provide their patient's with the basic physical nursing care that they were taught to give in their training. Tristin stated that her ideal of staffing meant that she could simply give her patient a bath, or shave a client's face, and walk a patient down the hall. This particular participant went so far as to say "my ideal, I'd quit being an RN and I'd be a nurse's aide." Mary noted:

...as frustrated as I get sometimes I'm not at the point that coming to work, I dread coming to work or I have second thoughts about coming in to work every

day. I'm not there yet. I still, (have) the good days that we have I try to focus on those I guess. Last weekend and on Monday I did patient baths, I made beds. I mean, I felt like a real nurse. I mean, not that I don't feel like a nurse any other day. But I just felt like I really had great, I did great patient care.

Second, not enough staffing has affected the way nurses are able to talk to their clients. They relayed that when there is not enough staffing, nurses do not get the opportunity to talk with their patients to learn about what is going on in their lives. This discussion becomes important as nurses are the caregivers that routinely set out to anticipate patient needs prior to their discharge. Candice stated that she experiences frustration when she is

consumed by things that need to be done. Then forgetting there is a person laying there in that bed. You do need to talk to them. You do need to stop and say hey, how are you really feeling? You know, not just go in and do your real quick assessment...if you are too task oriented you'll never find those things out. Then, you know, you're doing your patients a disservice.

Mary related that some days she really does not spend the time with her clients as she should, she becomes frustrated when she does no more "than run in, throw meds in their face, write in the chart, taking orders off. And because today I felt like that's all I did. I didn't really get to spend time with any of my patients."

Third, related to talking to patients, several nurses in this study stated that they do not get the opportunity to really "know" their patients as they would like to. Staffing shortages have not allowed the nurses with enough time to know and identify the subtle changes that may have occurred during the client's hospitalization. Mary reflected that a

good day for her meant that she could dialogue with the physician and she “could just tell them if anything had changed, if anything was new.” She also stated that “I really got to know my patient rather than run in, throw meds in their face, write in the chart, (and) taking orders off.”

Fourth, the lack of staffing has led to more physical demands of the nurse at the bedside. Several nurses in this study report being physically exhausted at the end of the day. When there are not enough nurses on the floor, the nurses are required to pick up extra patients so that their “patient load” becomes greater. Many of the participants came up with ideal working nurse/patient ratios that were significantly less than what they were currently dealing with. The nurses relayed that the physical demands of being “pulled in many different directions” leave them “burned out” at the end of their shift. Mary stated that at the age of 27 she comes home from work and is exhausted to the point where she questions her ability to “do this anymore.”

To make matters worse, some of the participants relayed their dissatisfaction of being mandated to staff their units when there are not enough nurses for the next shift.

Marcia relayed that:

if we are in a nursing shortage where they mandate nurses, I think they should pay us time and a half for when we're mandated. And I felt, do feel really unappreciated when there for a time, mandating was bad and there wasn't anything more than 3-11 pay.

When nurses on the floor recognize that there is an issue of staffing for the next shift, it is often the charge nurse's responsibility to get extra staffing to assist on her floor. This becomes a frustrating circumstance when the nursing supervisors are called and

extra staff is requested but there is no one to send. This suggests that the nurses within this study have no voice as it relates to staffing issues.

Trudy relayed that she only calls upon the supervisors when her floor is in dire need. She stated, "I never do that. I'm not one of those people. When I call, I need help." Her frustration lies in the fact that when she finally musters the call to the supervisors, there is more often than not, no help to send, thus increasing the patient load for the nurses on the floor and leading to burnout of the staff. Tristin stated her anger and frustration when she has approached management to try to remedy the staffing crisis on her floor:

because I feel like I have gone to supervisors and approached them about the staffing situation. And they tell me to go to my nurse manager. And I go to my nurse manager. She says, you know, all, all our FTEs are full. I said I understand that FTEs are full. But we have one nurse who's on pregnancy leave. We have another nurse who's on orientation. These two are on orientation. Here are the three people who are not being held accountable to perform at the level of their role.

Currently, the participants of this study feel that this staff is not available and leads to much frustration. In order to compensate for this issue, nurses are being made to stay on the floors and work extra hours. As Martha stated, "when your staffing's down it's, morale gets low, working longer hours. It affects everything across the board." Denise also echoed this frustration of not being staffed adequately.

a bad day consists of nothing really wrong, you're just so busy you can turn around the end of the day and it's 2:00 and you think what did I do today? Or

3:00, that's bad. Because you did the best you can, you could. To do everything you can do. That's when you have your eight patients and everybody's okay, but you, you're spread so thin you did not do the kind of job you know you're capable of doing. That's a bad day. (Lowering the nurse – patient ratio) would be good. That's one of the goals up there. (Having) enough time between heavy workloads. That's one of the goals of this hospital. How they're going to achieve that in med surg I don't know. I'd like to know that question. Because they say that they're going to cut down (on the) flex pool or, what do you call it? Agency...they want to cut down on that, they want to cut down on mandatory overtime. They want to make that no pull policy, which should be very interesting soon. You know, I don't worry too much about our pulling. But I think there's other floors that don't have the teamwork (and) they'll suffer something fierce.

As a result of this discussion, the participants were asked if they were given a voice concerning staffing on their floors, what would it look like? Based on their years of experience and expertise, most suggested a patient load of four to five patients per nurse would be ideal. The dayshift staff currently care for about six or seven patients. This number increases to seven or eight on night shift as the business of the floor decreases. Ideal staffing on the floor for these various units requires usually one more nurse. The staff related that this would make a big impact on their satisfaction providing patient care to a lesser number of patients and it would reduce their job burnout potential. Mary stated an ideal day would decrease

the quantity of the patients that we're taking care of. If I only had, like, four patients to focus on, or five patients to focus on, I think I wouldn't feel quite as overwhelmed as having, you know, six or seven like I did today.

Denise also stated her ideal staffing would have a nurse with "four or five patients instead of six or seven."

These nurses were genuinely concerned at their lack of having a voice regarding being able to adequately care for too many patients with an increased severity of illness. Mary stated simply that providing great patient care "means that I felt like they could identify me as their nurse."

As evidenced in this section, the nurses in this study relayed that they do not have a voice when it comes to issues of staffing. They feel that they are not being heard when they do voice concern regarding how many patients that they are taking care of and the severity of illness that they are dealing with every day. Based on their experience, they have clear ideas about what could be done to improve staffing by decreasing the patient load, but they are not being heard.

Positive Nurse-Physician Relations. The concept of voice comes through loudly and consistently when examining the relationship between nurses and physicians in this study. Many of the nurses that participated stated that they had a sense of voice when dealing with the physicians at this hospital.

The nurses felt nurse-physician relationships in regards to communication and working relationship were actually good and have significantly improved over the past several years. They felt that being at the bedside caring for their patients solidified the respect the doctors demonstrate toward the nurses. Other terms that were used to describe

nurse – physician interactions were collaborative, communicative, and supportive. These terms implicitly imply that the nurses perceive that they have a voice when dealing with the physicians at this particular hospital.

First, the idea of respect was mentioned numerous times from the participants. Respect means that there is a level of mutual trust and open communication in which the nurse can voice her opinions regarding patient care and feel that she is being valued.

Marcia related:

I think we are heard more by the doctors and respected by what we say. That we are, looked on more as their eyes. I think we're trusted more. I think, doctors are overworked so that the, other issue is I think they have to depend on us more.

Bonnie stated:

They always praise us for the work we do. I think that they think that we're very competent in how we take care of our patients. They tell you (and) they tell the patients. (One physician stated) how proud he is to work here and the kind of nurses are taking care of their patients.

Martha stated,

So you get to know the physicians and, and then things work better, I think, that they know you when you're calling with a particular problem, that they know, you know, that they can depend on the information that you've giving them. That kind of thing. You've got a better rapport...

Amy states, "he (the doctor) respects the care that we have given because he knows us."

This idea of respect also was related to the fact that these experienced nurses have earned the physician's trust. Trudy stated, "I think I've earned a level of trust with the docs." It was felt that having experience working with the different doctors and establishing a trust has led to their respect. Trudy stated, "that takes years to build. That takes time to get there. That takes the building a level of trust." Martha relayed:

years ago there used to be certain physicians that you'd round with and nothing was right. But I mean, I think as a whole the physicians really do give nurses credit, maybe because of the clinical ladder and magnet status. That's, that was really a nursing driven initiative. I think they have respect for the nurses here. I really think most of the physicians do. And they value your opinion when you come. When they round.

Second, the theme of collaboration resounded in several of the conversations with the participants. The nurses act as the information hub regarding their patients and facilitate collaboration between various departments such as medicine, physical therapy, and social work. The nurses must voice for the patient what is needed for their care and make sure that all departments are receiving all of the appropriate information for their care. Marcia stated, "Nursing is so many different things. But here, we're kind of like a facilitator between all the different departments. And I really like that." Alice stated, "I don't feel like I have to pull teeth to get something, get something ordered or get something, or something that I feel will benefit the patient."

Third, the theme of open communication between physician and nursing staff was evident. The participants revealed that doctor-nurse relations have improved greatly over the past few years. Denise stated

they (the doctors) used to be very standoffish. And not talk to the nurses as much as what they do now. I think they get more input of the patient, um, questions about the patient. You know, specific questions. They're just more open and honest and easy going compared to what they used-they'd just tell you off before and walk away. I've had-and, and sometimes that still happens. (It) depends on who it is. But, that's not the rule of thumb. Now it's the exception. That has improved, I have to say that.

Mary relayed:

they seem to really want to know what nursing has to think because we're, I mean, we're there 24 hours and they're only there for, you know, 10, 15 minutes

maybe, if that, with a patient. I don't really know of any doctor who has never wanted any communication with the nurse.

Martha echoed the sentiment about good communication between physicians and nurses, "they listen to you or your questions and try to answer them."

Participants felt that one of the greatest physician compliments to the nursing care is when a physician requests their patients to a specific unit. If a physician requests a specific floor for his patients, even though they would not typically be admitted there, it was seen as a great compliment to the nursing care provided. The idea of specifying patients to a particular floor reinforces the respect that the doctors have of the nursing staff. Amy stated:

I think physicians really appreciate our unit. Specific plastics physician will request our floor even after flap and skin grafts. Even knowing that we have infectious disease patients on our unit. (He requests the patients to our floor) because he knows (us). And he knows a lot of us from back when. He obviously knows all the new people that are on our floor too. But he respects us and he respects the care that we have given because he knows us. He can look beyond the fact that he's still putting his skin graft patient or his free flap patient on a unit where there's also somebody across the hall that is MRSA or VRE (infectious diseases). You know, he can get past that.

Candice echoed this sentiment when she stated:

I think for the most part we have a very good relationship with just about all the physicians here at the hospital. Um, I know that there are quite a few groups who really like to have their patients up here. They tell us. We've had a couple

different doctors come up and say I like when my patients are up here. I want my patients to be up here.

Another area, not addressed in the literature but was brought up by one of the nurses, addressed how much she appreciated the physicians supporting the nurses to improve the physical conditions of the floor. Amy stated

Physicians are supportive of us. We've had several physicians who have said to higher up, you know, this is ridiculous. That we come here and that they don't have the dressing supplies. Why don't you have dressing supplies? Can't you get us a cart? So now we have carts with dressing supplies specifically on our unit for our major bowels and what have you. Or even different things in the patient rooms. We had the old time lights. We didn't have the flipper down ones when we first went down to Four East. And we had several physicians that went to our nurse manager and said this is ridiculous. I come in to do a dressing change, I can't even see because you guys have the old time lights. And so we got new lights. They don't necessarily hold it against us. And they know it's not our nurse manager's fault either. But they know standing and complaining to me in the hallway isn't going to get new lights either. So they have taken upon themselves to go wherever they need to go to get something to improve our unit. So we have gotten some upgrades. Thanks to the physicians. I mean, even though it is for some of their benefit, it's also for the patients, also for us.

Also interesting and contrary to the Magnet Hospital literature, there were two instances when the nurses conveyed negative experiences with the doctors. The two

conversations highlighted the fact that listening to the nurses is of the utmost importance for the nursing staff. Bonnie stated that one particular doctor

has a lot of problems with you questioning him or, you know, you know, one time he, because they were calling him with a high blood sugar. And he goes well, what are they on steroids for anyway? And the nurse thought just because of one of the disease processes they had. And he goes, I know this patient like the back of my hand. And to make a long story short he goes, well, I'll be in. And hung up on her. And didn't give her any, like, do you want us to get an insulin coverage for this high blood sugar? So she wrote that. And then he got all upset and then proceeded to have an argument at the station. Then he went into the patient and said that nurse doesn't know what she's talking about. So he defamed the nurse to the patient and the nurse was outside the room. And the nurse came in the room.

Trudy relayed this example,

We had a patient today who had staples, who had an AV graph done who had staples in his arm which we removed per the doctor's orders. He still had two sutures in place. I don't think the surgeons realized that we still had the sutures in his arm. So when he made rounds today I said, by the way, he still has his two sutures, we don't even have an order to remove them. He said sure no problem and then wrote the order and that was fine. So I mean, I guess I have had problems. I did have-actually there was one doctor I had an issue with. We had a patient who was crashing. And she was still full, a full code. I guess there were issues as to her prognosis. She had been in the unit and had been transferred to our floor. I had heard from the nurses downstairs that there was a problem,

maybe, with her code status. Then the doctors need to address that with her family. When she came to our floor and was crashing, I had wanted to send her back to the unit. The doctor didn't want to do that and he didn't want to make her a no code blue either. You're up against a brick wall. So that, that was the hardest part. I know it's one particular physician. I kept pressing him. It was over the phone. I kept saying, look, her saturations were in the 70s and we already had her on a non-rebreather and she was unresponsive. Something was obviously going on. I don't remember all the details, this was probably about a year ago. But he just kept saying, I don't think that she needs to go (to the unit). I said look, I have nine other patients that I'm responsible for. I cannot be in this room every minute. She needs more care. She needs to go to the unit, and he still (did not listen to me). Eventually-my manager was actually on the floor at the time. We thought we might actually have to code her. She (the manager) got on the phone and asked him as well. Finally he (the doctor) did say we could transfer her to the unit. So that was hard. Then she went to the unit and came back later that night. Because when I came in the next day her name was on our census again. And I said "What happened here?" She went to the unit and was made a no code blue and was passed back to us. And then she passed away a day later. But what kind of needless was that? But that doesn't happen every day.

This idea of the doctor being perceived as the ultimate authority and speaking down to nurses was not well received by the participants of the study. They felt that doctors used to be able to talk to staff in an authoritarian manner – completely dismissing nurse's voice, but that is no longer the case. Nurses are no longer viewed as the doctor's

handmaid; rather they bring their own expertise of knowledge from having direct, hands-on care of the patient.

As seen here, nurses perceive that they have a voice when dealing with most physicians in this particular hospital. The participants view themselves as having respect, collaboration, and open communication with the medical staff as a result of having a voice.

Supportive Nurse Managers. Another theme where voice becomes evident is in the conversations related to nurse managers. The participants relayed that the voice they have when dealing with an effective nurse manager is the main reason why they stay on their units. The areas where voice becomes apparent is in the leadership qualities displayed with the staff, vocalizing a positive attitude, being flexible and creative with the staff, allowing autonomy for the nurses, listening and being approachable.

Discussion of the nurse manager and her effect upon nurse retention was voiced by several of the participants. Amy stated, "I love my nurse manager. She plays a big role in that (retention). I've had several nurse managers. And she by far is the best nurse manager that I've had." Gretta reiterates this by stating, "What keeps me here? Well, I think the one thing that keeps me here now is my boss. She's just great."

Leadership and voice was stated as being important to several of the participants of this study in that they felt that it important to have a nurse manager that provided direction and assisted the staff with change and communication that came from higher administration within the hospital. The participants felt that it was important having someone to "look out for the unit," to have a voice for the unit so to speak, so that the nurse at the bedside can focus on the patients and their families. Nancy related,

if we run into crisis situation our manager's there to help us. For instance, if a patient should go bad and code or whatever, because you need to transfer things for any reason at all to a critical care area our manager is always there to help us transfer that patient. So then they'll free up the nurse to get the other patients. And she (the manager) comes around every morning and asks if we need anything. (She asks if there is) anything she can do for us. How we're doing today so far. If there's something that we need; if we're frazzled she will help us

Another facet to this leadership idea was the importance of the nurse manager to verbalize a positive attitude for her staff and she is able to convey that value to the staff. Not only is she dedicated to the institution herself, but she wants the nurses on her floor to provide the best possible patient care. Gretta stated,

I think the one thing that keeps me here now is my boss. She's just great. She's probably been here two years more than me. So, you know, we're at the same place in life. You know, same things going out in personal life as here. She's just very fair. She doesn't have enough time in her day; I'd love to grant her that, but she's always been there if you needed her. She bends over backwards for people. I've had a lot of people come to me and give me positive enforcement and say why don't you go do this? You know, you'd be really great here (in another unit or role). And why don't you do this? Why don't you come work for us here? And sometimes, I think it'd be neat to change, to learn something different. But I think it's her that keeps me here. You know, if you don't have a boss that you can look up to, that can break (your passion for what you do). You can not want to come to work. I've been with other people before that things weren't just right. You

didn't, do things the same way. And I feel her standards are right where mine are. So I know if I have issues or problems that I'm having trouble getting staff to buy into she's right there to back me up. You don't always have that, because everyone has their own agenda and what's important. I'm very happy to say that she's my boss.

Also important in her role as leader was her job of hiring of new staff to "fit in" with the positive attitude expressed by rest of her floor. This helped to establish and promote the well-being of the rest of the nurses providing care at the bedside. Denise stated,

(The manager) treats everyone like they're the only employee. That's one of her, one of her strengths. She has many. She treats you like you're the individual, not just a group. And yet she pulls it together as a team. I don't know how she does that. I think leaders want a team but a manager looks at everybody individually. She does that very well. I don't know how she (does it). I think first of all, the formula of the people, right now click so well that her job is not real difficult except when you see someone who is different, with a different value perhaps. They will stick out like a sore thumb in that group. And that has (happened). I mean, every now and then you'll see someone like that. And I think you just check their charts a little better. You make sure the orders are done. You know what I'm saying? Because sometimes that's not their priority. Their priority is not the patient.

Personal attributes that were appreciated in the nurse manager included fairness, honesty, and being personable. These personal attributes were almost as if the nurses

working on the floor were describing their role model. They cited examples of how their nurse manager provided for the floor and spoke up for the floor within the hospital organization. The nurse manager exemplified examples of these personal characteristics and how she would support the staff on her floor. Denise noted that, “I think those values have to match. And if they don’t match, then you’re in the wrong place. One way or the other.”

Other attributes that were appreciated by the staff concerning the nurse manager were their openness to creativity and flexibility to the voice of their staff. Trudy stated how much she appreciated the fact that her nurse manager allows the staff to “think outside the box” and remains open-minded to staff suggestions. Numerous participants relayed that staffing flexibility is a big issue for them. Nurses in this study related how important it was to them to have a nurse manager that was willing to work with them in being creative with their work schedules. Typically, nurses who work full-time in this hospital are required to work four out of the six holidays and certain floors have requirements about the weekends they work. Managers who are willing to be flexible with this scheduling are held in high regard. Participants relayed that having their own autonomy with the schedule was important to them and having a manager that was flexible to work with them just making sure that all the staffing gaps were covered was much appreciated. Trudy stated:

we built our own schedule very creatively. (The nurse manager) said you show me three months of it working, a mock one for three months. Show me it works, and you guys can do whatever you want. So some work 10, some work 12, some work eight (hour shifts).

Related to this scheduling flexibility is the ability to work with other schedule conflicts that may occur outside of the hospital. Trudy stated that her nurse manager “is very pro-educated, education. Because she-we have that staggered schedule because so many of us are back in school.” This flexibility in scheduling the staff was very important and conveyed to the staff that furthering their education was an important value to the institution and to her personally. On Trudy’s floor, most of the support staff of nursing assistants and licensed practical nurses is currently back in school to further their education in healthcare. Another area of staff scheduling flexibility that was addressed included personal time off. Nancy relayed, “most managers that I worked with are very flexible and (if) there is some crisis in the family or something they would give you off. And juggle the schedule around.” Amy also stated:

We do a lot of different things with our schedule. She’s very open to listening to people’s ideas and sort of, you know, it doesn’t always have to be straight by the book. You know, like, this is how it’s going to be and that’s the way it is and that’s just too bad. You know, so she’s very open-minded as far as, like, you know, letting us give a voice about, you know, different things.

Another commonality among nurse manager descriptors was their willingness to listen to the staff’s voice and have open communication with the nurses of the floor. Keeping the nurses informed about the changes that are occurring in the institution via staff meetings and email are considered important jobs of an effective nurse manager. Marcia conveyed she trusts that her nurse manager “knows what’s happening and is not just looking out for their unit, but how we fit into the whole picture of things. And they’re taking care of that, as opposed to me having to worry about that.” The participants

appreciated their manager being “up front” with them about changes that may be occurring; for example Amy stated the importance of “being up front with us as to what’s going on. You know, with Four East right now, with all the construction and that type of thing, you know, she’s right up front with us and tells us what’s going on.”

Candice stated that it was important to her to have a nurse manager that was approachable to voicing new ideas and have effective communication skills so as to provide adequate feedback and a value to the changes proposed; “just being able to say hey, look, I need to talk to you about this. And then having an adult conversation about whatever the problem was. You know, not feeling as though you got your hand slapped.” Nancy stated, “It helps if the nurse manager is flexible and listens to the nurses.” It is a recurrent theme concerning the nurse managers – that listening to the voice of nurses is important. Martha also related that “She (the nurse manager) listens for feedback. She’s very good at that.”

Providing validation to what the nurses discuss with the manager is also important. It was revealed that feedback from the staff is often requested by the nurse manager in the form of surveys or verbal feedback from the nurse seeking opinions from the staff. Engaging in active listening skills and allowing the staff member to feel like they were being heard was a critical element to the nurse manager being perceived as effective. Candice relayed, “you can actually sit down and have an adult conversation about something and hopefully come up with a resolution to whatever, you know, the problem might have been or whatever.”

Lastly, the majority of participants in this study stated the vital role that the manager plays in disseminating information to the rest of her staff and the importance of

being involved in the various levels of committee work throughout the organization. This relays voice at various levels, not only on the unit but also on the organizational level. Nurses revealed that they relied on the support of the nurse manager to assist them with their committee work on the floor. Martha stated that “some of the projects that we do need the manager’s support to roll them out.” Most of the managers rely on email and floor staff meetings to disseminate the information gleaned from committees within the hospital. They also use staff surveys to further elicit feedback from the staff. With these things combined, the staff feels that the nurse managers listen to what they have to say.

Voice as it relates to the nurse manager is an important theme to all of the participants of this study. These nurse participants stress the importance of voice with their relationship to the nurse manager specific to leadership, positive attitude, flexibility, and good communication skills.

Teams that Click. The importance of voice and teamwork was echoed among each and every participant in this study. Most of the participants described their work environment on the floor as a team. Many of the nurses stated that the main reason that they stay within this hospital is the fact that they enjoy working with the team of nursing staff on their floor. The participants also stated that humor was an important thing that helped them cope with a bad day and it kept the mood light even on the most stressful of days.

There were many adjectives used to describe the voice of the team of nurses on the various floors: happy (Denise), stouthearted (Marcia), compatible (Mary), knowledgeable (Alice), and supportive (Amy). The overwhelming response from the participants was the fact that the personalities that “mesh together” helps to support and

lift up the floor. Denise stated, "I think it (the nursing staff) clicks because we have to. I really do. I think if you don't help each other you drown. And we all know that." Amy discussed at length the importance of teamwork on her floor.

We can pretty much tell (who will work out best on our floor). I think our nurse manager, since she's been around for so long now, she pretty much can (tell who will work out on this unit). The first day or two that they're there we'll joke and (be able to say), oh, they'll be here forever. You know what I mean? They just fit right into our unit. I think each unit sort of has their own personality too; as far as staff members. All of their (the staff) personalities' sort of mesh. We can sort of tell. And it's funny-I mean, it's not funny but it, it's funny in the sense of there's been people that have come and will be like, that doesn't work. They just don't fit in.

Gretta offered this insight about teamwork on her floor:

I think it's just too fast-paced for people to really pay attention to each other as a human being. But I think as a whole our unit gets along well. I can remember years ago, when people complained about people all the time. And that happens, but I don't think it's like (it was then). I think years ago we used to have problems between the shifts. Who's doing more work, who's not doing their job. And I don't hear that like I used to years ago.

Alice stated that one of the things she finds so comforting about her coworkers is the fact that she finds them to be a wealth of knowledge. Whenever there is a question related to a patient or a condition, there is always someone available to answer her query and there is a comfort in being able to ask her peers about information. Alice states,

“whatever she (her coworker) tells me I know is going to be right. You know, I think people, the people that are here, they’re very good nurses. Candice echoed this sentiment as well when she stated, “you have a question about something, you know, you can go to, you know, just about anybody on the floor and say I need to run this by you. I’m just, you know, I want to make sure that I have this right.”

Several of the nurses spoke about weathering through several difficult times together and that has helped to establish their teamwork. Marcia stated, “I work with a good, stouthearted bunch of people. And a lot of us have been here a long time, at least on day shift. And we’ve seen a lot of things change over the years. And we figured that this is going to change, it’s just a matter of holding out till when.” Candice also stated, “You’ve seen the staff come and you’ve seen the staffs go. And everything else that’s gone on, you’ve gone through it together.”

Other participants mentioned the fact that humor is what sees them through the worst of days. This concept of voice in regards to humor was a different facet of voice and teamwork. Trudy states it best when she said, “it’s a sense of teamwork, it’s a sense of friendship, laughter, tears. And yet we’re all working towards that common goal.” Denise also supported this idea when she stated, “it just clicks, the sense of humor, the happiness, the whole attitude is ‘I want to be here’.” She further states, “They’re supportive. They’re happy. They’re glad to be there every day just like I want to be.” It is almost as though the participants are describing a family or a significant relationship when they speak about the teamwork on their floor. Nancy states, “I had a bond with some of them that I felt comfortable...”

There were a few participants who were not pleased with their coworkers. Mary stated, "I don't focus on teamwork right now because I don't think that our floor necessarily is very strong right now in that. That's hard." She further goes on to say, "I think some of the employees that we have right now just don't perceive the way that their actions are affecting the way other people are behaving towards them." She did clarify the fact that teamwork definitely affects the morale of the staff. Mary states:

everyone seems to get along and things are going great, and then there's always a period where people complain about this and that. You know, and that always happens. But it seems like lately it's been really low. Just because we've been so busy.

Another participant stated that teamwork is not ideal on her floor. Tristin stated that management has tried to remedy the lack of teamwork but they have not been successful. "They've done little team building exercises here and there. But I don't know that it's really (helped), I mean, it's just sort of a hokey little game we'll play."

As evidenced here, voice and teamwork becomes essential for the retention of staff as well as help the morale of the floor. Voice as open communication and humor within the team are fundamental tools of an effective work environment for the participants.

Varying Levels of Satisfaction with Committees. Another consistent thing that was described by each and every participant was how voice and committee structure blend together on each floor. It appears as if the committee structure that is in place on each floor is applied hospital wide to each nursing department. This allows for communication to be disseminated to all levels of nursing within the organization.

There are three main hospital-wide committees that the nursing staff is to support and sit on; those include clinical practice (CPC), education, and quality. Each of these committees has a representative from each nursing floor that brings back information and disseminates it on their specific floor. The forum to disseminate this information is in the format of a steering committee which is held on each unit by the nurse manager for that floor. All of the staff is expected to attend the steering committees – nursing aides, licensed practical nurses, as well as all registered nurses. The representatives of the hospital-wide committees then voice and share their information with staff via these meetings as well as email and bulletin boards.

Generally, the participants feel that this committee structure works well at disseminating information to the rest of the staff and keeps the staff “plugged into” the changes within the organization as a whole as well as serve as a forum of support for nurses in various other areas. Candice stated that her nurse manager will seek out staff to serve on various hospital-based committees:

Will you please do CPC? You know, you’re one of the leaders on the floor. We need somebody strong to go to the CPC meetings hospital based and bring that information back to the floor then.

This relates to voice as it is suggested that strong leaders are asked to sit on these committees. Candice further goes on to state that not just any staff member should sit on the committees;

I think you have to have somebody that’s confident enough to be able to go to the meetings and speak their minds. You know, on Seven West we do it this way.

This is just a suggestion but this is how we do it on Seven West and we’ve found

that it works well. Or, you know, we're having a little bit of a problem doing something like this, you know, on Seven West. Does anybody have a suggestion of how, perhaps, we can, you know, work to make, do something a little different.

The meetings that the participants sit on are an expectation for the nursing staff.

The committee work, while being viewed as being generally beneficial because it improves communication and allows for voice of the staff, is also a requirement for their clinical ladder (a stepped progression for nurses to follow that validates their competence and excellence within the clinical areas). Trudy states that she enjoys being on committees, "Because it's an expectation of my job. And it helps me grow in my job. It gives me information. It helps me move further." Mary also states:

I was on the education council. I was our floor's representative. And then in May I handed it over to another nurse. But I just took up chairperson on the steering committee last month. So that's a new goal for me. It's basically nurses, unit clerks, nurses from all the shifts that come and it's collaboration between Ed council, PI, and CPC. And just issues on the unit. It's different than, like, a regular staff meeting. We look more, um, issues get resolved a little bit more. We look at more on the steering committee. I think then, we're able to bring things (up in conversation) more-it's not just the manager telling you updates of the floor. It's the floor working together to improve the floor. So it's really neat. I really enjoy it. It just seems like, um, we get a lot accomplished when, when we have input from all three shifts at one meeting. At staff meetings, it's just your own particular shift. So I do enjoy that. I think it's a more relaxed atmosphere too, than the staff meetings are. Because people seem to want to talk more about

things and I think bring up things that maybe they wouldn't bring up at a staff meeting or in talking with their manager just one on one. But it she of course is present on the steering committee, but it just seems like it's more of a team approach rather than, you know, one person dictating what's going on.

It should be noted however, that not every participant felt that being on a committee was a worthwhile endeavor. Marcia stated:

I was in clinical practice. I felt like I had some good ideas but that they weren't recognized by the stronger leaders that were there. (I wasn't) even recognized. I guess I just thought why waste my time? Let the people that have the big voice, the big guns, do the job. And if I'm not being heard anyway, why bother?

Because it is a day you can do your work, we don't have to work over and above to sit on a committee. We can come in, they usually give us a day time. But if I come away just feeling like I wasn't heard why bother? I mean, I thought about it in the future, if my kids get into college and I feel like I want to give, I can foresee myself giving more to the community than to my hospital at that time. But if I would foresee that I wanted to get more involved in the place that I work and I could be, I probably wouldn't go to clinical practice. I would probably go to something like the education community. Because I think my talents would probably lie more in that area. But I don't like sitting there listening to, like, listening to things and hashing it over and how could we do it. And especially know that if I have an opinion, and if it isn't heard, I think, uh, why bother? You know, I need to have purpose in what I'm doing. And so that's my own personal reason. But do I think clinical practice is good? Yeah, I think it is good and I'm

glad there's people that want to give their time to that and we appreciate what they're doing. But my skills don't, I don't think, lie in that area.

Marcia points out that she feels that she does not have a voice when she attends the committee meetings and she becomes frustrated by it. She relayed that the dissemination of information that comes as a result of the committees is beneficial, but the actual loss of voice during the meetings becomes more of a stress than a benefit.

Voice as it relates to committees becomes an important theme. The distribution of information that is gleaned from the meetings – both at the hospital level as well as the staff level are an expectation of professional development for the staff and allow for a voice among nurses throughout the hospital in various areas of practice.

Low Impact as a Result of Accreditation. As discussed earlier in the introduction of the participants, the nurses in this study relayed that being a Magnet Hospital was a nice recognition to achieve, but it has not impacted them as they anticipated in the workplace. Achieving Magnet status has not changed the way nurses' care for patients at this hospital. Participants revealed that they felt that they worked for a good institution before they achieved Magnet status.

Candice stated that, "As far as I'm concerned you've always gotten excellent nursing care at (this hospital) no matter whether it's been a magnet hospital or not. And having that designation, I don't know that that has changed anybody's practice." Amy reiterated this thought when she stated, "I think this is a good hospital to start with." The participants stated that while the hospital was a good work environment before it applied for magnet status, there were changes that evolved over time to enable it to apply for

magnet recognition. Mary stated, “(it) seems like the things we did to get magnet has been in place for a long time.”

Martha talked about the changes that the hospital had to undergo to become a Magnet Hospital and how the process has benefited nursing at this particular hospital.

Martha stated:

I think we had a lot of changes that enabled us to apply for magnet status. And I think now that we have magnet status it probably makes the hospital a little more aware of keeping those, like, our clinical practice councils and meetings going and support them maybe a little bit more. Because they know it's important. And also I think as far as replacing positions, we have a lot more, I want to say, choices in who we hire because most of the people that you talk to, when they go to the job fair or interview booth, wherever they find out about the hospital, they say I went there because it was a magnet hospital. I mean, we have a traveler.

That's why she came here. We basically, they know now to look. I only applied at magnet hospitals.

The participants relayed that the term Magnet Hospital was felt to be an honor to the excellent nursing care within the organization and that this excellence would help attract excellent nurses to work here. Alice stated, “it's to attract nurses that want to expand their, their career. Or that's a place to kind of blossom or to expand as far as the potential of your career as far as nursing.” Alice went on to further describe what it means to be a Magnet Hospital; “it's almost like the ‘wow’ factor. If they're a magnet hospital they must have good nurses that work there.”

Some of the participants discussed the marketing value of attaining Magnet status. They felt that by achieving Magnet status for this particular hospital, it increased the revenue and community perception of the hospital itself. When questioned about if achieving Magnet status has changed anything for the hospital, Mary stated “yes, I think it has.” Marcia also stated that “magnet is a good advertisement. Because they advertise that a magnet hospital attracts the best nurses.” Martha concurred with this when she stated:

because we had the magnet status, then that changes people’s views of the hospital because it’s a advertisement tool. Because I think it’s a recognition thing. And I don’t even know, I’ve asked such a question myself, but do you think the community really knows what magnet status means? I’m not sure they do. But they know it’s an award and it’s, must be a good recognition thing because not many people have it.

There were a few participants who did not express a positive attitude for achieving Magnet Hospital status. Denise stated:

They (administration) said (having this status) will attract the best. What’s the best? What’s their definition of best versus my definition of best? I want the attitude. I want that attitude there that you’re there because it’s a calling that you have inside of you. I don’t care what your grade is. You can have an A student doesn’t give a crap about nursing. They just made a good grade. And I think that when they look at magnet status, they’re looking at the good grades. Are we? You know, I haven’t seen anybody come through magnet that affects this floor. So maybe it’s too soon to answer that question. But I haven’t seen it yet.

Tristin also relayed that attaining Magnet Hospital status “makes me resent our administration even more. Because they can waste the time trying to prove to everybody else that we’re so wonderful, that they can’t make us wonderful.” When asked further what it would take to make the hospital better she replied:

it would take our administration out of their offices and onto the floor actually giving patient care from time to time so they don’t forget what it’s like to give care to high volumes of patients in a short period of time. Having to deal with angry doctors and frustrated families and they just-it’s easy to get behind a desk and forget the reality of patient care.

As seen here, Magnet status has not really changed the nurses’ perception of patient care for the participants in this study. In fact, a few of the participants ended up resenting the administration because becoming a Magnet Hospital was more of a marketing tool than it was paying attention to the voices of the nurses who work there. There are insights that were revealed from examining these themes that help to better understand what is important to the voice of nurses at this particular Magnet Hospital.

CHAPTER FIVE: CONCLUSIONS

Discussion and conclusions

The purpose of this study was to examine nurses' voice within a Magnet Hospital setting. The participants that discussed their experiences were all female, experienced registered nurses who worked directly with patients in a medical surgical area at one particular Magnet Hospital. These conversations uncovered themes that related to voice for the nurses in this study. This chapter will discuss the relevant findings of this study, draw conclusions from the participant stories, discuss the implications for practice and make recommendations for further research.

Relevant findings

The conversations with the nurses in this study were surprising. The Magnet Hospital accreditation appears in the literature to be a wonderful asset and acknowledgement to excellence in nursing care by valuing and listening to the voice of nursing; this study shows a definite disconnect to the Magnet Hospital that philosophical belief in practice. Overall, the participants relayed that working at a Magnet Hospital did not strongly impact their patient care. The nurses' conversations relayed that they felt that they worked for a good organization regardless of the Magnet Hospital designation. The nurses discussed the fact that they did not feel their voice was directly related to being a Magnet Hospital, but they did feel that their voice has impacted several areas within the hospital. These various areas were discussed as various themes that developed throughout the conversations. These themes give insight into what the nurses perceived as important to their sense of voice as they cared for patients. The themes that will be discussed are staffing shortage, positive nurse-physician relations, supportive nurse managers, teams

that click, and varying levels of satisfaction with committees. Another theme that was discussed was the theme of low impact as a result of Magnet Hospital designation.

Magnet Hospital

Staffing Shortage

The nurses in this study did not feel that their voice was being heard when it pertained to staffing issues. This feeling of helplessness flies up in contrast to what the literature presents concerning nursing practice within Magnet Hospitals. In the original Magnet study by McClure, et al. (1983), the authors discovered that the participants in the Magnet Hospitals felt that staffing was adequate and that the quality of the staff was just as important as the quantity of the staff. In the 2002 study by Kramer & Schmalenberg, they identified “Essentials of Magnetism” that included control over nursing practice and practice environment as well as adequate nurse staffing. Certainly, an important area of control for nursing practice would be the staffing ratios on each nursing unit. Other studies have echoed the sentiment that there is adequate staffing found in Magnet Hospitals and that nurses drive the changes that create their practice environment (Aiken, Havens, Sloane, & Buchan, 2000; Kramer, Schmalenberg, & Hafner, 1989; Laschinger, Shamian, & Thomson, 2001).

The participants in this study overwhelmingly stated that they felt there were not enough nurses taking care of patients at this particular Magnet Hospital. Out of the twelve participants, ten of them stated that the biggest thing that could improve their patient care was having another nurse on the floor. Not only did they relay that staffing is short, but several relayed their frustration at not being heard or not having a voice at all

when there was a call to help alleviate the staffing crisis on their floor. Trudy relayed her frustration when she stated:

I called the supervisor (for staff support) this morning. And I never do that. I'm not one of those people. When I call, I need help. No help was sent. So what do you do? You do what you have to do to get through.

Denise also echoed this frustration of not being staffed adequately. She talked about the initiatives of the hospital to lower the nurse-patient ratio, allow more time between heavy workloads, and implement a no-pull policy. She also stated that she has serious reservations about the success of those plans; "how they're going to achieve that in med-surg, I don't know."

Tristin stated that she has tried to address the staffing issues with administration, but this has left her bitter and resentful of the upper management. Tristin passionately vocalized that "you need to find a way to get staff because the patients aren't getting the care" and "I feel like they're not doing anything. It feels like things will never change." Tristin went on to further relay her frustration: "How do you make somebody understand the best we can is not good enough?"

All of these nurses state how the nursing shortage is negatively impacting them at the bedside at this Magnet Hospital. They discussed how they become easily frustrated because their voice is not being heard by management regarding solutions for the staffing crises that they are experiencing in the medical-surgical area of this hospital. This hospital's management displays a lack of sensitivity to nurses' voice regarding nurse staffing issues; this phenomenon is not documented in the Magnet Hospital literature. Contrary to this, Magnet Hospitals were described in the literature as focused on the

concerns and issues of the nursing staff and worked hard to empower the nurses to improve job satisfaction (Laschinger & Havens, 1996; Laschinger et al., 2001).

Aiken et al (2002) discussed the positive correlation between high patient to nurse ratios and high levels of nurse burnout and increased job dissatisfaction. This continues to be a significant area for further research. A report reveals that 43 percent of American nurses score higher than expected on indicators of job burnout (Foley, 2001). This is a real concern as the nursing shortage continues to progress.

The number of women going into the nursing profession is declining (Buerhaus, Staiger, & Auerbach, 2000). Trying to create more nursing programs to fill the gap is not an answer either, as there is declining numbers of qualified nursing educators to teach in such programs according to the National League for Nursing (2005).

Addressing the nursing shortage in the Magnet Hospital literature is found in the study done by Kramer and Schmalenberg (2002). One of the criteria for their “Essentials of Magnetism” compared and contrasted staffing adequacy indicators from three separate studies completed in 1987-87, 1989-91, and 2000-01. They noted that the vacancy rate (how many open nurse positions an institution offers) has increased from 4% in the original studies to a 9.6% vacancy rate in 2001. The turnover rate (seasoned nurses leaving a unit and new nurses being hired) has also increased from 1999 (median 9%) to 2001 (median 15.5%).

Trying to retain the nurses that are currently in the workforce becomes paramount. Examining what keeps the nurses at the bedside and satisfied is a big concern for employers. Magnet Hospital studies have helped open the door to such research. Investigating nursing retention techniques and what makes an institution excellent in

nursing care have been addressed in the Magnet Hospital literature (Aiken & Havens, 2000; Aiken, Havens, & Sloane, 2000; Coile, 1999; Havens & Aiken, 1999; Kramer, 1990; Laschinger & Havens, 1996; Laschinger et al., 2001; Mason, 2000; McClure et al., 1983; Scott et al., 1999).

Although the participants in this study were significantly frustrated with their inability to be heard regarding staffing issues, they did relay that there were positive aspects of their workplace as noted in the themes below. Again, these themes stress what the nurses felt were important to them regarding their work within this Magnet Hospital setting, but they appeared to be irrelevant to the Magnet Hospital designation.

Positive Nurse-Physician Relations

The theme of good nurse – physician interactions was quite evident from the conversations of the nurses in this study. The participants repeatedly stated that they felt that the doctors listened to what the nurses had to say concerning their patients. This feeling of collaboration between the nursing staff and medical staff is found to be a critical element in the Magnet Hospital literature (Havens & Aiken, 1999; Kramer, 1990; Kramer, et al., 1989; Kramer & Schmalenberg, 1993; McClure et al., 1983; Scott et al., 1999).

In the literature, the authors revealed that the term “good” nurse – physician relationships was rather vague, so Kramer and Schmalenberg (2002) stated that they wanted to quantify what that really meant. The authors developed a five category scale that emerged from the analysis of 262 descriptions of nurse – doctor relationships. The first category was the best or the most collegial. This category acknowledged equality of power between the nurse and the physician and relations were seen as excellent or

superb. The last category (Category 5) was the negative category, where nurses described their relationship with physicians as frustrating. In this category there is definite unequal power and power plays are quite evident.

For the participants of this study, they relayed that the nurse – physician relationships were good and that their voice was “listened to” regarding the care of the patients. As they described their relationship with doctors, the rating scale that Kramer & Schmalenberg (2002) would best assimilate the nurse – physician relationships at this Magnet Hospital would be a category two. Bonnie stated that the physicians vocalize to the staff and the patients that the nurses who work at the hospital are very competent in their patient care.

They always praise us for the work we do. I think that they think that we’re very competent in how we take care of our patients. They tell you (and) they tell the patients. (One physician stated) how proud he is to work here and the kind of nurses are taking care of their patients.

Martha stated that the doctors have respect for the nurses because they ask the nurses for their input regarding their patients. Martha reiterated the fact that this good relationship and collaborative style has been fostered over the years at this particular hospital and is possibly a result of the Magnet Hospital recognition.

Denise reinforced the idea that positive nurse – physician relationships have been evolving over the past several years. “I would say in the eight years that I’ve been here that’s improved a great deal. They (the physicians) used to be very standoffish. But that’s not the rule of thumb. Now it’s the exception.” This evolution of improved nurse-physician relationships has been a positive experience for the participants of this study.

An article that addressed this evolutionary phenomenon of growing nurse – physician relations in Magnet Hospitals is due to the rapid healthcare changes (such as cuts in resident physician work time) and increasing patient volumes. It was relayed that the physician needs to “recognize their need for the assessments and knowledge that only nurses can provide, then collegial relationships will flourish” (Kramer & Schmalenberg, 2004).

Several of the participants stated that physicians truly appreciate the nursing care that is given on their floor primarily because they refer their patients to that particular floor. Amy and Candice both relayed their perception that physicians appreciated the care that they provide to their patients because they have a bias sending their patients to specific floors where they feel the nursing care is the best.

Another nurse relayed the fact that she appreciated the physicians supporting the nurses by voicing frustrations over the physical condition of the floor. Amy stated that her floor has benefited from physical upgrades because the physicians talked to higher management regarding the poor condition of the supplies and lighting on her floor. This could be linked again to a lack of perceived voice from the nurses in that their own pleas for improved physical conditions for their floor were unheard and the nurses had to employ the assistance of the voice from physicians to get “something to improve our unit.”

Neither concept of physician bias toward specific nursing care, nor physician support for structural changes of the nursing unit were addressed in any of the Magnet Hospital literature. These nursing perceptions should be investigated further.

There were only two negative examples offered from the nurses concerning nurse-physician relations. The two participants that offered these examples used them to emphasize the frustration they feel when the doctors do not listen to the voices of the nursing staff. Bonnie and Trudy both provided scenarios where the nurse was silenced by a physician in the clinical area. A negative relationship between nurses and physicians was unheard of in the Magnet Hospital literature. The studies that were done exemplified the fact that in Magnet Hospitals, nurses and physicians had a very positive working relationship (Aiken & Havens, 2000; Aiken, Havens, & Sloane, 2000; Coile, 1999; Havens & Aiken, 1999; Kramer, 1990; Laschinger & Havens, 1996; Laschinger et al., 2001; Mason, 2000; Scott et al., 1999; Sovie, 1984).

Interesting to note was the fact that most of the nurses referred to the physicians as male. This gendered role stratification was not specifically addressed with the nurses in their interviews, but rather was implied by the use of the masculine pronoun and the male examples that were provided. When discussing interactions with the nurse practitioners, the pronouns went back to being female. No where in the Magnet Hospital literature is a gender addressed between doctors and nurses.

As evidenced here, the collaboration between nurse and physician goes beyond what was typically discussed in the Magnet Hospital literature of simply discussing a power relationship (Scott et al., 1999). In this study, the participants saw the physicians as advocates for the nursing staff and for the patients. The physician advocacy toward the nursing staff was evidenced by open communication which was evidenced by asking and answering questions regarding patients and being open to suggestions from the nursing staff. The physicians further support nursing care by requesting their patients to be cared

by the nurses on specific floors. Lastly, participants gave examples of times where the physicians spoke up and advocated for physical upgrades for the floor since their own voice was not responded to.

Varying Levels of Satisfaction with Committees

Another theme that recurred was recurrent from the conversation with participants in this study was the importance and similarity of committee structure and dissemination of information on the various floors. There are three major committees that the nurses serve on within this Magnet Hospital; they are the clinical practice council, quality council, and education council. The clinical practice council helps address direct patient care issues. The quality council examines areas in clinical practice that could be improved upon and require further monitoring. Lastly, the education council addresses educational issues of either patients or staff in order to make information more accessible. These hospital-wide councils direct and impact the nursing care given by all the nursing staff within the hospital.

There is also a steering committee that drives the unit specific changes for the specific nursing unit. This committee is made up of all the staff that serves on the particular floor. It is an expectation of the nurses' job that they will serve in some capacity on one or more of these committees. In this regard, the committee structure and how it is designed to function within this Magnet Hospital parallel that information which is found in the Magnet Hospital literature.

As stated earlier, Magnet Hospitals tout the fact that the nurses that work within them are generally more autonomous and more accountable for their nursing practice than at other non-Magnet Hospitals (Kramer, 1990; Kramer & Schmalenberg, 2002;

McClure et al., 1983; Scott et al., 1999). At this particular Magnet Hospital, the participants of this study generally felt that they were “kept up to date with changes” that were occurring within the hospital.

Mary stated that she enjoys the opportunity to serve on the various committees within the hospital in the past five years. Mary brought up the fact that “we’re able to bring things (up in conversation) more-it’s not just the manager telling you updates of the floor. It’s the floor working together to improve the floor. So it’s really neat.”

The importance of sharing information was brought up by several nurses. Martha stated that she appreciates the peer support that occurs at the hospital based committee meetings. She said

I think by becoming involved in the organizational meetings, not just on your unit that you learn a lot from other people and what goes on in other units that they may face a lot of the same issues you have and, and have a lot of good ideas, but instead of reinventing the process, somebody else may have had the same exact issue that you did.

Many of the nurses stated that it is on committees that they feel “plugged into” the information about the hospital and about nursing. It was evident that what was utilized more than anything within this particular Magnet Hospital was the use of email to broadcast information.

This is an example of what is stated in the Magnet Hospital literature that stresses a decentralized and flattened organizational structure (Aiken & Havens, 2000; Aiken, Havens, & Sloane, 2000; Coile, 1999; Havens & Aiken, 1999; Kramer, 1990; Laschinger & Havens, 1996; Laschinger et al., 2001; Mason, 2000; Scott et al., 1999; Sovie, 1984).

The idea of networking and peer support is one of the characteristics of a flattened organizational structure often reported in Magnet Hospitals; it is found to help improve nurse communication and decision making. Kramer and Schmalenberg (2004b) continue to research this concept in the Magnet Hospital literature. They state, “Control over practice is a participatory process enabled by a visible, organized, viable structure through which nurses have input and engage in decision making about practice policies and issues, as well as personnel issues affecting nurses” (p. 3).

It is important to note however, that not all of the nurses concurred with the fact that committee work made a positive impact on their work. As stated earlier, Marcia was very vocal about her dissatisfaction with her silence on the hospital based committees. Marcia stated, “I felt like I had some good ideas but that they weren’t recognized by the stronger leaders that were there. (I was not even) recognized.”

The idea of being silenced within a Magnet Hospital was not addressed in the literature. Rather, the literature overwhelmingly stressed the positive qualities of having nurses empowered by serving on the various committees. Upenieks (2003) concluded that greater access to work empowerment structures like committees where information is disseminated and having a flattened organizational structure allow for more nurse empowerment and improved job satisfaction.

Teams that Click

Another theme that was discussed related to the fact that nurses are very cognizant of the sense of teamwork that is displayed in their various areas. The support that is visible and heard from the voice of their coworkers is one of the main reasons why the nurses stay within this Magnet Hospital. Amy discussed that each unit has a

personality of its own. She went as far as to say how the staff can predict new staff's success by the way the new nurses interact on the floor.

Gretta talked about going through changes in staff and nursing units with the same group of people and how that helps cement the teamwork. Similar to Gretta in that the hectic pace of nursing fosters greater teamwork, Bonnie relayed this, "We all work together as a team. It's either do or die, especially on night shift." She went into further detail about how the scarcity of staff almost forces the issue of having to work together as a cohesive team.

Teamwork is certainly mentioned in the Magnet Hospital literature, but it is in the context of control over nursing practice. Kramer & Schmalenberg (2004a) reported that one of the Essentials to Magnetism has to do with working with other nurses who are clinically competent. Staff nurses within Magnet Hospitals viewed their co-workers as more clinically competent than those nurses who worked in non-Magnet Hospitals. Although most of what this study addressed examined the basic level of education needed for competent practice, it did not address the camaraderie of the staff in regards of a team. There was also no discussion about teamwork in light of enduring healthcare changes as seen on the nursing floors.

Another large component of voice evidenced in teamwork, as mentioned before, is humor. This was brought up by the participants in light of the teamwork discussions. Several of the nurses mentioned what an important component humor was to their teamwork. This is another area that was not addressed in any of the Magnet literature. In fact, there is a dearth of information regarding this concept within nursing literature.

Supportive Nurse Managers

This theme, along with the staffing issues, was probably the most discussed in the conversations with the participants. The nurses in this study were passionately aware of the sacrifices that the nurse managers make on behalf of their staff and the voice that she uses to support her unit. The participants stated in their conversations that one of the salient reasons why they stay where they are had to do with their dedication and loyalty to their nurse manager. Amy and Gretta were just two of the many nurses who were very vocal about the reason that they stay on their floor is the fact that they love working with their nurse manager.

The idea of retention and the role of the nurse manager were discussed in several of the Magnet Hospital literature, but there was not a lot of depth offered that examined this one single issue. Most of the articles reviewed stated that the retention was more of a broader administration issue rather than a single manager concern, as was commented by the participants in this study. Nurses within Magnet Hospitals typically perceive the support of management as a whole being better than nurses from non-Magnet Hospitals (Scott et al., 1999; Upenieks, 2003). Other nursing literature has found a direct relationship between nurse managers and nursing staff satisfaction and retention (Kleinman, 2004; McGuire, Houser, Jarrar, Moy & Wall, 2003).

There were other themes that surfaced related to the nurse manager. Themes that revolved around the manager were leadership, scheduling flexibility, being approachable, open communication, and the ability to disseminate information.

Scheduling flexibility was a big issue for many of the nurses in this study. They spoke about how much they appreciated the fact that the nurse manager could be flexible with their scheduling concerns. The nurses conveyed that they were pleased that they

could have a voice in the way they could self schedule and that the manager allowed them to work “outside of the box.” This could actually relate more to the nurse’s perception of control over practice rather than about their nurse manager as is documented in the Magnet Hospital literature (Aiken, Havens, & Sloane, 2000; Havens & Aiken, 1999; Kramer, 1990; Laschinger, Shamian, & Thomson, 2001; Scott, Sochalski, & Aiken, 1999). In this particular study however, the participants all stated that this scheduling autonomy was a result of having a flexible nurse manager who encouraged her staff to think for themselves and solve problems (Amy). Again, this study provided more of a specific example to the broader concept of staff nurse’s control over practice.

Candice spoke at great length providing examples of how her new nurse manager was so approachable and she was able to dialogue with her about any of her concerns. The concept of open communication in regards to effective nursing management is certainly not a new one. There are numerous studies in business that address the effectiveness of female communication and their dissemination of information from leadership (Biklen & Brannigan, 1980; Borman, 1993; Clark, Cafarella, & Ingram, 1998; Grossman & Valiga, 2000; Helgesen, 1990; Morrison, White, & Velsor, 1987; Rosenbach & Taylor, 1998; Rosener, 1990; Smith & Smits, 1994; Stivers, 1991). In the Magnet Hospital literature this concept of open communication is facilitated by a more decentralized hospital structure (Aiken & Havens, 2000; Aiken, Havens, & Sloane, 2000; Coile, 1999; Havens & Aiken, 1999; Kramer, 1990; Laschinger & Havens, 1996; Laschinger et al., 2001; Mason, 2000; Scott et al., 1999; Sovie, 1984).

In the 2002 report by Kramer & Schmalenberg, the authors compared Magnet and Nonmagnet Hospital staff nurses on “Attributes of Culture of Excellence.” This entailed four different findings on problem solving, nursing leadership and teamwork, quality of nursing staff, and creativity. The Magnet Hospitals overwhelmingly scored higher in all of these attributes than the Nonmagnet Hospitals. This report supports what the participants in this study relayed about their nurse manager – that in this Magnet Hospital, the nurse managers are change agents, visionary, have a positive attitude, value education, and allow for creativity from the staff they lead.

This study differed from the other Magnet Hospital research in the fact that the participants of this study stated overtly their loyalty and dedication to the nurse manager as a major means for retention. This major defining feature of the participants of this study could certainly provide a more specific lens to examine Magnet Hospitals and the success of their nursing staff.

Low Impact as a Result of Accreditation

It was interesting; the nurses in this study did not seem to have a common definition of a Magnet Hospital. The participants of this study agreed that this was an award that recognized good nursing care, but beyond that, they were not sure if they (or the public) knew what the benefits are. Several of the nurses voiced resentment in stating that the accreditation is merely a marketing tool. Mary stated, “I know they had sent my parents a little magnet about (the hospital) on the refrigerator. It explains the magnet designation meant. But I don’t know if people are conscious of that when they choose to come here.” Bonnie stated, “why we’ve been nominated for that award is for the nursing

care, that you're given here. It's not an award for nursing care. It's an overall hospital-wide recognition."

Some of the participants verbalized their anger about working in a hospital that touted itself in being a Magnet Hospital and having a nursing award, yet the reality of it was that it was that nurses were being silenced. Tristin and Marcia were the most vocal about their frustration levels. Tristin talked about her efforts to improve staffing on her unit and Marcia discussed her being silenced in the committee forums.

On the other hand, Martha stated that being a Magnet Hospital has its benefits. Martha stated,

I think we had a lot of changes that enabled us to apply for magnet status. Now that we have magnet status it probably makes the hospital a little more aware of keeping those practice councils and meetings going and support them maybe a little bit more. Because they know it's important.

Others like Amy and Gretta echoed that same reflection that the hospital was a good one to work in before they got Magnet status.

This study provided some deeper insights to that of the first Magnet Hospital (qualitative) study (McClure et al., 1983). There were many differences between this current research and the original Magnet Hospital study; a few will be addressed here. There were differences in the way the sample was collected; nurses from forty-one hospitals were utilized in the original study, my sample was from one specific Magnet Hospital. The questions that were asked in the first study reflected a much more generic stance on nursing; there was no personal experience that was asked in the interview guide. The researchers asked questions such as "What makes your hospital a good place

for nurses to work?” and “How is nursing viewed in your hospital and why?” Interviews were conducted with groups of nurses in the original study, not on an individual basis as in this case. The original study was looking for commonalities among numerous hospitals and grouped the findings under administration, professional practice, and professional development. My study was geared much more to the individual bedside nurse and her experience and meaning of voice working within a Magnet Hospital setting.

Voice and Nursing

Silence

As addressed earlier in this dissertation, voice and nursing have been researched as primarily an issue of autonomy in practice. It was amazing how many times the term silence came up in conjunction with frustration for the nurses in this study. Marcia stated her frustrations with being silenced at committee meetings. She wondered why she should bother volunteering information at the meetings if no one listens to her anyway. Tristin discussed her anger at being silenced when her concerns about staffing were not being addressed. These were examples of nurses not having a voice about their practice. The irony of this finding was the fact that they occurred within a climate where there was a greater expectation of autonomy, that of a Magnet Hospital.

This sense of silence was seen as similar to the silenced stage of women and voice found in the WWK literature. Silent women feel subordinate to the powerful people who dominate them; they are unable to articulate themselves to their own self or the people around them and live in great isolation. The participants in this study who voiced their concern about not being heard talked about being silenced by more powerful people,

either on committees or by management. The nurses did not feel that they could not articulate for themselves; but rather, felt that their opinions were not heard by the people who could affect change regarding certain topics. This feeling of isolation reported in the WWK research was not found in this study. If anything, the nurses who participated in this study revealed how much value they place on working within a strong team to carry them through the rough days. As noted above, the importance of team was imperative to many.

Teamwork

Similar to the studies heralded by Brown & Gilligan (1992), nurses in this study discussed their voice in the context of teamwork, especially in the area of humor. The participants verbally supported and encouraged each other, and humor was specific to their sense of team. Brown & Gilligan found that men tend to speak more about their autonomous selves within their own culture; women discuss more about how they live in connection to others. The participants in this study discussed how they encourage each other during the rough times and times of change. This voice of support was important to the team as was the concept of humor. Trudy stated,

That is the common thread for all of us on (our floor) - humor. If you don't laugh, you'll cry. We find things that are funny. Either we do it to each other or we just laugh about it. Sometimes it may not be appropriate humor. It's just a stress relief.

Alice agreed that in the concept of teamwork, humor was very important.

There was nothing in the Magnet Hospital literature that discussed humor within the concept of teamwork. In fact, when doing a literature search in the nursing data base, there was a surprising scant amount of data available. This may be a further area for

research as the participants in this study stated that an important reason why they remain on their units is because of good teamwork and humor is definitely a component of that.

Women

It was surprising during the conversations with the nurses the concept of gender and voice was not specified. Going back to the literature, the meanings of voice for women's learning as described by Hayes (2000) had three uses: literal, metaphorical, and political. The literal use of voice for these women was not specifically addressed. During the participant dialogues, I thought the concept of dominance and gender would have been more evident; perhaps rather than being literal, the concept was implied as political. One example of this is evidenced when the nurses discussed physician relations, they all referred to the doctor as "he." This use of political voice illustrates an implied dominance of doctors over nurses and could be one example of how the nurses in this study perceive their voice. As stated before, the Magnet Hospital literature discusses the doctor-nurse relations in the context of power (Kramer & Schmalenberg, 2004). Perhaps by the language that the nurses used, they perceived the doctors as having ultimate power over patient situations, but appreciated the evolution of improved respect and input from the nursing staff. More research could be done relating nurses, perceived power and voice in the workplace.

In the context of metaphorical voice, when women speak and reveal their identity Hayes (2000), a few of the participants in this study talked about their multifaceted roles as a woman. Some of the women discussed their roles outside of the hospital and talked about the added stress of working long hours and then going home and being expected to be a full-time mother as well. Marcia stated in her conversation that she withdrew from a

lot of the extra committees and obligations at the hospital in order to spend more time at home with her family. Tristin discussed her challenges of being a single mother and how working part-time has afforded her with a comfortable salary that allows her to be home more with her daughter. Gretta stated that one of the things she admired about her nurse manager was the fact that they are “at the same place in life. You know, same things going out in personal life as here.”

I thought there would be more discussions of the women’s voice in the various areas of their lives as they juggle jobs, motherhood, friendships, working relationships, among a host of other roles. I did not perceive any of this throughout our conversations. Also in this study, there was no discussion of race in relationship to voice. Granted, the participants of this study were all female and primarily white Caucasian. One participant was originally from Germany and another was Hispanic. Neither of these two women discussed anything remotely close to the concept of race and voice that was presented in Chapter Two.

It is important to note that the participants in the study viewed themselves as silent when it came to vocalizing within their practice. The nurses relayed that they appreciated the opportunity to network with other nurses who serve on committees within the hospital. They also stated that they felt that the physician - nurse relationships have improved greatly over the past few years. These two areas where nursing voice was heard paralleled the Magnet Hospital literature well; however, despite these two strengths, there was a large gap in the nurses’ perceived voice when it came to actual patient care and patient advocacy. The nurses felt like they were not being heard at all when it involved

staffing issues and direct patient care; they do not have enough time to care for the patients the way they would like to.

Female Leadership

Similar to the literature discussed by Helgesen (1990) concerning the organizational structure of female leadership, the organizational structure of the Magnet Hospital in this study revealed a decentralized and web-like configuration (see Appendix A). This leadership model is recognized in literature as “connected” and is commonly utilized in the management style of today’s organizations. It is implied that this connectedness is achieved when leadership and management are able to listen to the voices of employees and share goals within a flatter, networked management model. The strength of female leadership is that it inherently pays attention to the voice of employees within the workplace. By having their voices heard, workers can be more effective and productive for organizations in today’s changing work environment.

The Magnet Hospital literature has examined this decentralized organizational construction (female leadership model) and has noticed that it has improved perceived communication outcomes (Aiken & Havens, 2000; Aiken, Havens, & Sloane, 2000; Coile, 1999; Havens & Aiken, 1999; Kramer, 1990; Laschinger & Havens, 1996; Laschinger et al., 2001; Mason, 2000; Scott et al., 1999; Sovie, 1984). Dealing with an overwhelmingly female profession such as nursing, it becomes important to assess what type of communication and organizational structure best facilitates the dissemination of information as well as the feeling that the nurses’ voices are being heard by upper management.

Implications for research

This study opens up avenues for research for nursing practice, Magnet Hospitals, and adult education. The conversations that were obtained from the nurses in this study provided great insights to further implications.

The disparity of not being heard within an organization that touts the recognition of nurses becomes imperative to explore for further for nursing practice. Hospitals must demonstrate a greater appreciation of voice and value to the work that bedside nurses do. Research must investigate issues like identifying the components of what nurse's voice as a professional work environment. Is a Magnet Hospital the only answer or only the beginning for what best defines a professional nursing work setting? How can healthcare better refine and distinguish this environment where the voices of nurses are heard and acted upon?

Second, related to the concept of voice and not being heard, there is the issue of power. Although the nurses in this study did not specifically address the concept of power, it was understood – nurses were powerless to make changes in their practice in regards to staffing. The Magnet Hospital literature has just begun to address this issue, primarily in the form of physician – nurse relationships, but up until recently they utilized words such as collegial and respected. The concept of power has only recently come to light in lieu of the latest Kramer & Schmalenberg study (2002). This study specifically addressed power, but only in the context of physician – nurse relations. There is more research to be done to investigate how the nurses can increase their perception of power when it comes to direct patient care issues. Although most of the nurses within this study served on committees within the hospital that had outcomes that could affect patient care,

the overall sense was that this was not enough. Nurses still felt powerless when it came to making decisions to improve patient – staff ratios. Nurses also stated their powerlessness in regards to the major changes seen at the hospital, like the computerized medication delivery system. As seen here, more could be done to improve the sense of power to nurses, but what exactly does that entail? Are there any similarities between Magnet Hospitals and Traditional Hospitals in this regard?

Third, the nurses in this study did not relate that they were aware of what a Magnet Hospital truly was. The education that was performed by the institution when they applied for the accreditation did not succeed in conveying the very basic concepts of a Magnet Hospital. This lack of education relates not only to the workplace, but to the education of women within the workplace as well. Tying both the implications for research as stated above, perhaps an area of future investigation in adult education could examine where education, gender, power, and the workplace intersect. How do women best learn when they do not feel like they have a voice? Can voice be learned? Can it be taught? How does power influence the education of a typically oppressed population as seen in the workplace?

Lastly, this research has numerous implications for adult education. For adult learners, this study provides insights to what does/does not facilitate teaching for change. Ideally, a Magnet Hospital should be emancipatory, but in this study there was a distinct lack of voice and a covert gender issue. For adult education then, the question becomes – how can one better educate staff/learners for the impact of change? In respect to women as adult learners, this study provided examples of how these nurses perceived their voice as literal, metaphorical, and political. Gender was not so much specifically defined by the

participants, but rather, it was implied. Much can be utilized from these insights and apply it not only to the classroom, but also the workplace setting. What best facilitates women's learning, not only in the classroom, but also in the workplace? How can their voices be better heard? Can the different voices of women's learning be better incorporated into their education?

Also, this study gives further insight to the philosophical lenses that were utilized for the study. The women of this study discussed the term of silence as a means of their frustration in the workplace. The nurses from this study discussed the importance of being "plugged into" the information of the organization, and yet some felt like they were silenced after making this effort for self-improvement. The feminist humanist perspective does not provide much insight on this frustration that arose when the nurses' felt silenced. The concept of silence in regards to women's learning in the workplace needs to be further researched utilizing a critical emancipatory lens.

Summary and Reflection

I have presented just a few questions for practice that extend from nursing to adult education. There are certainly a whole host of ideas that have come to mind for further research. I would like to make a few statements and reflections about this study.

I was amazed at the fact that most of the participants did not know what a Magnet Hospital was! After reading all of the literature, it certainly appears in paper that a Magnet Hospital is a wonderful concept and an excellent workplace setting for nurses because they are recognized for the excellent care they provide. The participants in this study related that they felt they worked at an excellent hospital *before* they attained Magnet Hospital status; that attaining Magnet status has left them feeling like it is merely

a marketing tool. This felt a bit disappointing for me. My belief was, and still is, that anything that causes reflection for nurses is a good thing. I think that all too often, nurses become entrenched at the bedside focusing on the crisis of the moment and either forget or simply do not get the time to see all of the evolutionary changes that have been going on around them over the past few years. Watching this organization attain Magnet Hospital status was fascinating for me. When the concept of applying for this recognition was proposed by administration, the whole of nursing took a vote to decide whether or not to proceed. The presentation outlined nursing at our hospital over the past twenty years and highlighted the areas in which nursing has grown more autonomous. It was amazing. The nurses who came out of that meeting had tears in their eyes because they had never been shown before just how far they had come. Perhaps it was because I was a part of that groundbreaking that I feel so strongly that reflection is important to our profession; perhaps it is simply my optimism, but I do think that there is a greater need for nursing reflection and recognition of “just how far we’ve come.” I think that by illustrating this better to the nursing staff, much of the negativity that was so prominent throughout these interviews may be reduced.

The frustration that was stated by some of the nurses in this study was astounding. Upon my second interview with Mary, she even stated that she “did not realize how negative I sounded.” These participants were talented, experienced professional nurses who would like nothing better than to care for a patient so that by the end of the day, the patient knows who was taking care of them. The staffing concerns of these women were palpable. The nurses were not asking for anything grandiose in the matter of nurse/patient staff ratios, usually, it was asking for one more nurse on the floor,

or one more patient care assistant for that particular shift. It was amazing the acuties and the level of frustration that these women face just about every day when they come to work. And then not to feel like they are being heard!

One of the most powerful things that have occurred to me through this research is to think about how nursing's voice (and silence) has so many different avenues. Not only is there the literal voice where people speak, how they speak, and being listened to but also the metaphorical sense of voice which seems to be much more covert in this study. There is also the political use of voice that deals with power, which was clearly evidenced in this study. How much frustration there was with a lack of voice, or worse yet, with them being silenced. Being a patient advocate we are taught in school at a very early level that you need to be able to speak for your clients. What a disservice to the nursing profession not to be able to have the nurses able to speak on their own behalf!

One thing that should be mentioned is the context of voice that was not specifically addressed in this study. There appeared to be different sense of voice when dealing with administration and that to the direct patient care issues. Many times the nurses reflected that their voice was heard when discussing patient care issues; their insights to patient care with the physicians were generally heard and their work on committees involved a shared knowledge base. With a more administrative role, the nurses appeared to foster a serious disconnect to their voice. The nurses in this study demonstrated that having a nurse manager who listens and is flexible is astoundingly important to their sense of voice, but beyond that, these women felt silenced. No one in administration appeared to listen or be cognizant of the fact that the nurses were being

overworked and stressed because they could not provide the basic patient care they were taught to do.

Nursing is facing one of its biggest challenges with the nursing shortage. Magnet Hospitals are one avenue of research that has attempted to seek out what is important for nurses' recruitment and retention in the face of such adversary. I do not believe that it is the only answer. As evidenced here, nursing's voice becomes an important issue to further examine as it relates to their perceptions of power, autonomy, and job satisfaction.

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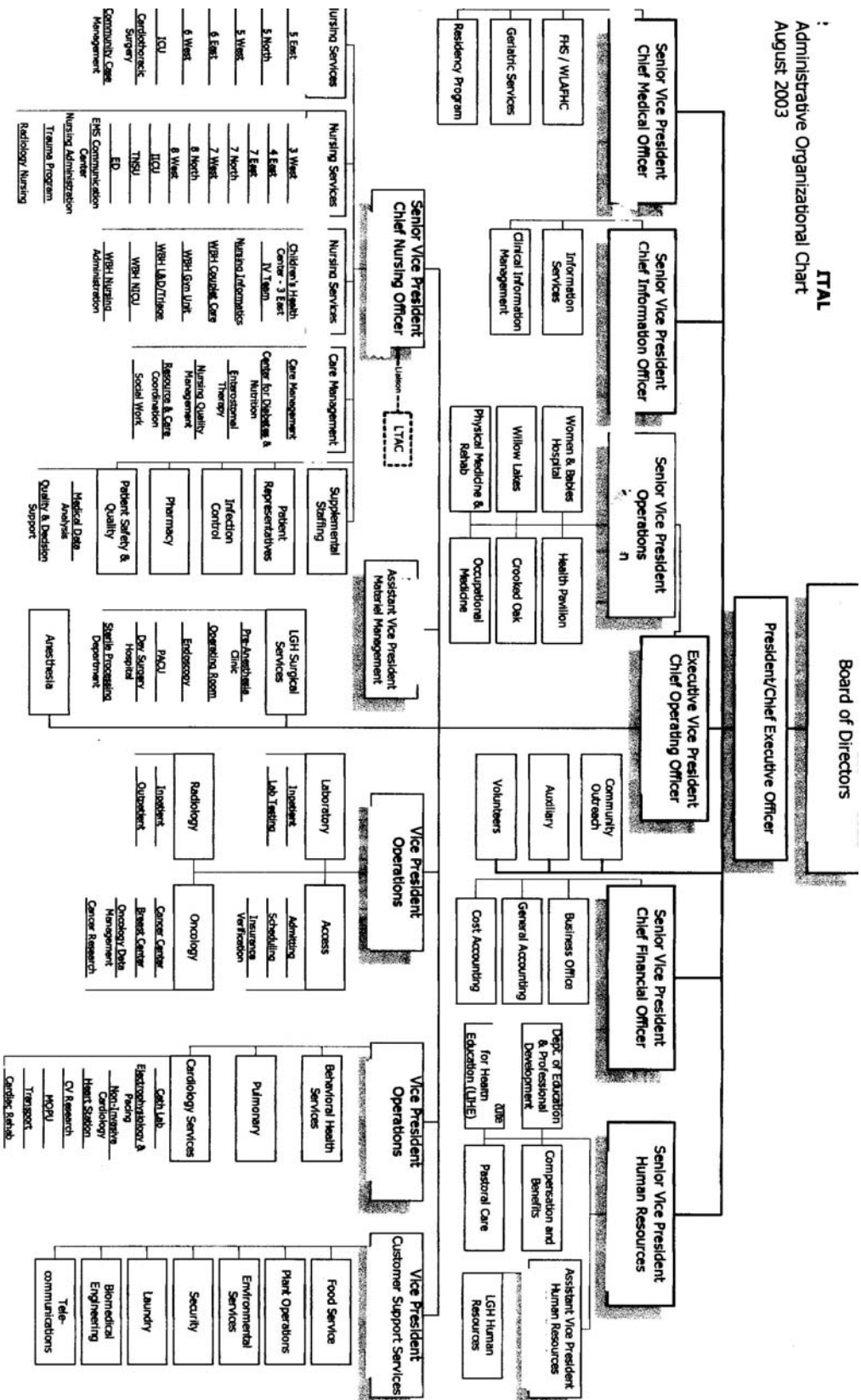
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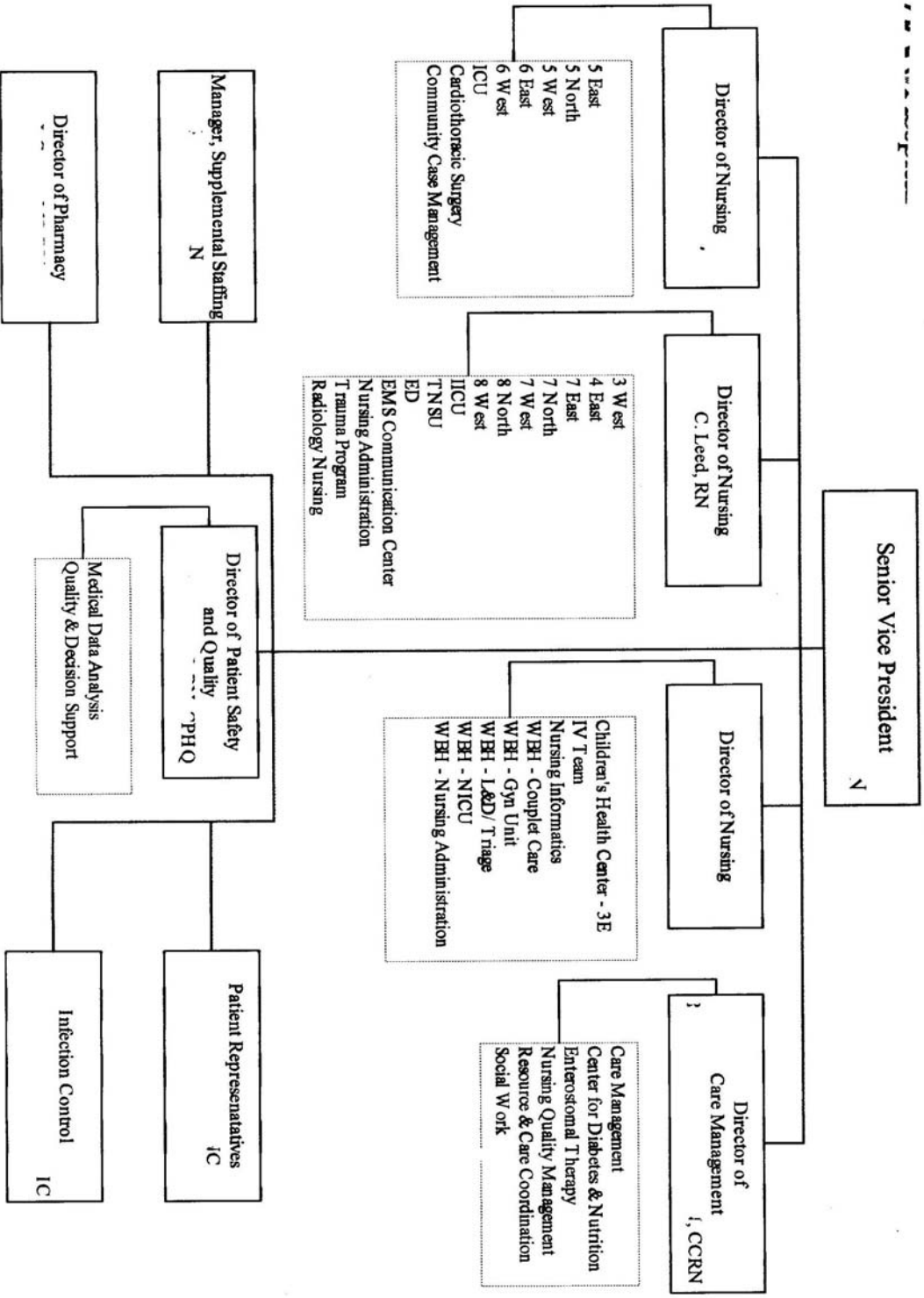
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Appendix A: ORGANIZATIONAL CHART



Patient Care Services Department



Appendix B: INFORMED CONSENT

Informed Consent for Recruiting Research Participants**Re: IRB# 18226****"The Meaning of Voice to Experienced Registered Nurses Employed in a Magnet Hospital Workplace"**

My name is Julie Beck and I am a Graduate Student at Penn State University. This research project is in partial fulfillment of my doctoral degree in Adult Education. I am interested in recruiting potential participants for my research that will investigate the meaning of voice for experienced registered nurses within a Magnet Hospital setting.

To be in this study you need to have at least five years bedside nursing experience with the last three being at the current Magnet Hospital setting. You need to be at least 18 years of age or older. Your participation is voluntary, so you do not have to participate if you do not want to. You can also end your participation in the study at any time by letting me know. You also do not have to answer any questions that you do not want to answer.

If you decide to be in the study you will be asked to complete two interviews. The first interview will last approximately one to one and a half hours. The second interview will be shorter and probably last about forty-five minutes. The interviews will be held at the site of employment, but not during working hours. The interviews will commence in 2004. The interviews will be tape-recorded. No one will know your identity except for me; and no one, but me, will listen to the tapes. The tapes will be kept in a locked filing cabinet and then destroyed after the study is finished. If the research is published, no information will be written that will identify you.

There are no known risks to participating in this study. Your current employer will not have access to any of the taped interviews or any specific views expressed during our interview.

If you participate in this study you might learn more about yourself as a nurse. You could also help workplace learning and Magnet Hospital research.

If you have any questions you can contact me, Julie Beck, at _____ or my advisor, Dr. Flannery at 717-948-6219. If you have any questions about your rights as a research participant, contact Penn State's Office for Research Protections at 814-865-1775.

Thank you!

I have read and received the previous consent form and have met the study requirements of being at least 18 years of age, having at least five years of clinical practice experience at this current institution, and currently work in a medical – surgical area providing patient care.

I agree to participate in the study of Nurses' Voice: Studying the Meaning of Voice to Experienced Registered Nurses Working within a Magnet Hospital Setting and have no further questions at this time.

I understand that I can withdraw from this study at any time and have been instructed to contact the researcher if I have any concerns or questions.

Signature of Participant

Date

I verify that the procedure for the informed consent has been followed:

Signature of Researcher

Date

VITA

Julie Anne Beck

Julie is a registered nurse who currently works in a local hospital as well as teaches nursing at York College of Pennsylvania. Julie received her Bachelor's Degree in Nursing from Bloomsburg University of Pennsylvania and her Masters Degree in Nursing with a focus on Adult Education from Villanova University.

Julie has worked as a nurse, primarily in critical care for the past seventeen years. She has served on various hospital committees; functioned in the role as a preceptor and cardiothoracic case manager; and currently serves as a facilitator for the nursing extern program. She has taught nursing part-time in local colleges and schools of nursing for eight years and has been full-time at York College for the last two years concentrating on health assessment and medical-surgical nursing in the chronically ill adult. She has mentored graduate students in the nursing program at York College and serves on numerous committees within the College and nursing department.

Julie is a member and has served on various committees of nursing organizations such as the AACN and Sigma Theta Tau International. She serves in the local community as a parish nurse and is a member of the St. Vincent DePaul Society. Along with her cohort, she has also received the outstanding graduate student in adult education award from *The Learned Society of the Whispering Pines*.