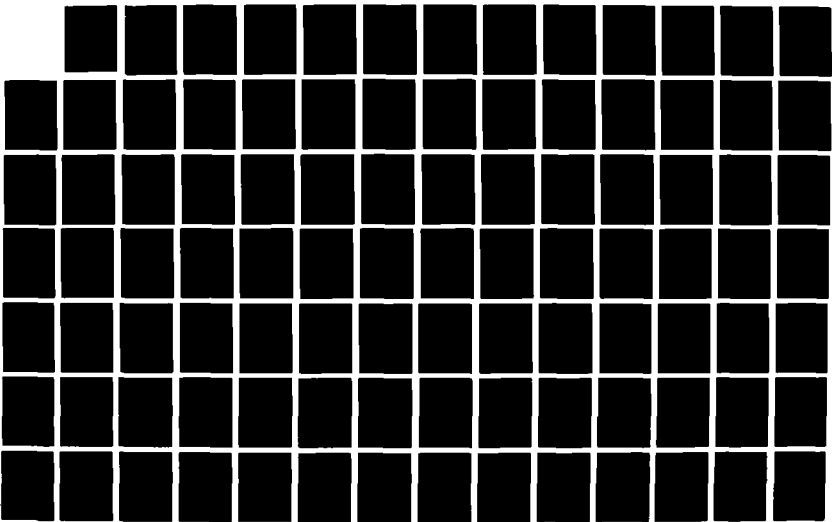


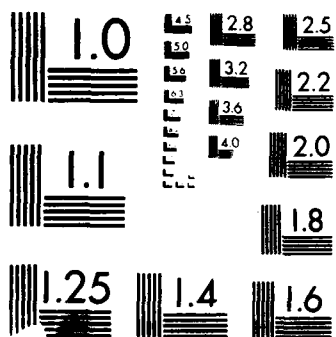
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The conclusions of this study were that nurse administrators perceive themselves as powerful and that these perceptions are related to certain personal and job-related variables. Recommendations for further study are to explore power perceptions of other nurses and hospital administrators and investigate other variables that may be related to power perceptions.



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NURSE ADMINISTRATORS' PERCEPTIONS OF POWER

By
Thomas Alvin Vann

Submitted in partial fulfillment of the requirements
for the Master of Nursing Degree
in the Nell Hodgson Woodruff
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The proposal for this study was approved by the Institutional Review Board, Nell Hodgson Woodruff School of Nursing, of Emory University, on December 31, 1987.

Accepted by the faculty of the Nell Hodgson Woodruff
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NURSE ADMINISTRATORS' PERCEPTIONS OF POWER

Abstract

The purpose of this nonexperimental descriptive study was to ascertain how hospital-based nurse administrators perceive their degree of power. Nurse administrators (N = 103) in a southeastern state were invited to participate by the return of an anonymous, self-administered questionnaire. The data producing sample was 59, with subjects ranging in age from 30 to less than 69.

Fifty-three of the subjects were female and 6 were male. Perceptions of power were obtained by use of the "Health Care Work Powerlessness Scale (revised)" (Guilbert, 1979) which is based on Seeman's (1959) powerlessness construct. Possible scores on the power scale ranged from 0 to 14. Respondents' scores ranged from 0 to 10 with a mean of 1.47 indicating a skew toward the high power end.

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CHAPTER I

INTRODUCTION

Background

The nurse administrator has the responsibility and accountability for the nursing care rendered to patients within an organization. To provide nursing care, the nursing department must involve itself with a variety of people--health care professionals, paraprofessionals, and the health care consumer. Normally, this tremendously complex interactional process is led by the nurse administrator whose use of power in the position affects the outcomes produced by the nursing department (Donaho, 1978). Thus, the position and authority embodied in the nurse administrator role empowers the nurse administrator (Claus & Bailey, 1977). Therefore, the nurse administrator possesses legitimate power and has potential for influencing individual groups interacting with the nursing department.

Recognition of nurses' rights to power is abundant in the literature (Ashley, 1973, 1975; Leininger, 1974, 1977; McFarland & Shiflett, 1979; Stevens, 1978; Ver Steeg, 1979). However, these authors and others (Bowman & Culpepper, 1974; Courtemanche, 1986; del Bueno, 1986; Hall 1973; Larsen, 1982; Stevens, 1983) have indicated that many nurses view themselves as powerless. One possible explanation for this

view is that nursing is predominantly a female profession. Women have historically viewed themselves as powerless. Thus, Ashley (1973) urged nurses to start examining power--potential or actual. To date, little published nursing research exists dealing directly with the power issue.

According to Parsek (1978), the acute shortage of nurse administrators who are conversant with the use of power is a contributing factor to the lack of nursing research on power. Ashley (1973) was concerned with the finding that nurses had failed to recognize their power or to use power to the profession's best advantage. Munn (1976) elaborated on obtaining and using power in nursing; and Langford (1977) was convinced that nursing did not have to continue its power impotence. The preceding examples of nurses' perceived or real lack of power led this investigator to question how nurse administrators perceive their degree of power.

Problem Statement

How do nurse administrators perceive their degree of power within their respective employing hospitals?

Justification of Study

The purpose of studying this question was to ascertain where on the power continuum nurse administrators perceived themselves to be functioning. Such information would be useful in understanding why some nurses perceive themselves

as being more powerful than others. This insight into power may aid the understanding and utilization of power by future administrators in both clinical and educational areas. If nurses are to progress in their profession, power is considered a vital component of this development and must be recognized by nurses as an area to be expanded.

Theoretical Framework

A concept recognizing situational aspects was used in this study due to the dynamics of power and powerlessness. Seeman (1959) provided such a framework with his construct of powerlessness. Powerlessness is the expectancy of probability held by individuals that one's behavior cannot determine or control the outcomes or reinforcements sought. Seeman further assumed that the low or high expectancies for the outcomes will differ in regard to the specific situation and will vary with the behavior involved.

Expectancy theory suggests that the strength of a tendency to act in a certain way is dependent on the strength of an expectation that the act will be followed by a certain outcome that the individual perceives to be attractive (Robbins, 1980). Vroom (1964) defined expectancy as an action-outcomes-association, or a belief on the part of the worker that a certain action will result in a particular outcome.

The expectancy construct of powerlessness was chosen for

this study because the concern of many nurses who feel powerless is reflected in this construct (Young, 1980). A person's sense of powerlessness is considered to be a factor which can affect a response to critical circumstances in one's career (Seeman & Evans, 1962). Neal and Seeman (1964) noted that powerlessness is not a synonym for feelings of generalized negativism, maladjustment, or despair.

Seeman's construct of powerlessness closely parallels Rotter's internal versus external control of reinforcement (Minton, 1972; Rotter, 1966; Seeman, 1963), which is known as social learning theory. Social learning theory postulates that human behaviors in specific situations are contingent upon one's expectancy that a particular behavior will be reinforced or rewarded (Polit & Hungler, 1983). Seeman's tool for testing the generalized powerlessness construct entailed a forced-choice between an internal belief statement paired with an external belief statement (Rotter, 1966; Seeman, 1963).

Guilbert (1970) used Seeman's construct of powerlessness (1959) in relationship to the study of decision making and work alienation. Guilbert viewed powerlessness as related to work alienation and developed a tool for measuring powerlessness perceptions on a unidimensional continuum.

The powerlessness and locus of control concepts may be linked together by systems theory. Systems theory has

been expounded by Bertalanffy (1968) to involve elements composing subsystems which combine to form systems that can be combined to form suprasystems. Gillies (1982) defined a system as a set of objects or elements interacting to achieve a specific goal. Further, a system is also an ongoing process that consists of diverse elements and their relationships to each other. Each system consists of interconnected and interrelated subsystems, each of which has its own objective contributing toward the goals of the larger system.

The function of any system is to process information, energy, or materials into planned outcomes for use within the system, outside the system, or both. As knowledge of biological science, medicine, psychology, sociology, and economics increases, the complex job of the nurse administrator becomes more difficult in the organizations in which and through which the nurse administrator must carry out job responsibilities.

The nurse administrator must work within, among, and upon a variety of systems of all types in the health care arena. The health organization in which the nurse administrator works is a structural system. The nursing department is a functional system. The management process that is the job responsibility of the nurse administrator is a power system. Each of these systems is goal directed, with

inputs and throughputs for each system intended to achieve specific objectives. Malfunctioning of any single subsystem can impede goal achievement for the total institution.

Therefore, the nurse administrator should aim to decrease the negative effects and increase the positive effects of the organizational, social, and individual systems, provided the systems are open to modification.

Complex systems are comprised of numerous subsystems. For example, a hospital nursing department consists of a number of subsystems, one being a power-authority subsystem. Each subsystem has a goal that serves the overall department goal. Each subsystem has a boundary and input, throughput, output, and feedback elements. The subsystems can operate simultaneously, in tandem, parallel to each other, or in series with each other.

Within the systems framework, the nurse administrator may be viewed as an individual system within the social system of the health organization or nursing department. The nurse administrator acts within the nursing department's power-authority subsystem. The nurse administrator's perceptions of power, according to a systems approach, would be influenced by several intervening variables, as opposed to a traditional cause-and-effect approach. As concluded by Young (1980), the nurse administrator may perceive power differently according to different systems elements, such as

the size of the organization (environment), or educational background and years of experience (inputs).

Research Questions

1. What are nurse administrators' perceptions of their degree of power?

2. Are there associations between demographic profile data and nurse administrators' perceptions of degree of power?

Definition of Terms

Association

A measure to assess whether or not a relationship exists between two nominal-level variables.

Demographic Profile Data

Data derived from the demographic portion of the questionnaire consisting of hospital and respondent characteristics (see Appendix B, Section I).

Nurse Administrator

Registered nurse employed as the top nurse executive in a hospital department of nursing. Examples of job titles include, but are not limited to: director of nursing or nursing service; nursing service administrator; and chief nurse. Excluded from this study were positions entitled assistant or associate director, supervisor, head nurse, charge nurse, or anyone occupying an acting director of nursing position. As noted as limitations of this study,

only non-military, non-psychiatric, and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredited hospitals were included in the study.

Perceptions of Degree of Power

Self-reported view of the respondent's degree of influence as measured by Guilbert's "Health Care Work Powerlessness Scale (revised)" (1979). Perceptions of power were represented by a numerical score on a zero (0) to fourteen (14) scale. The higher numbers reflected the lesser perceptions of power; the lower numbers, the greater perceptions of power (see Appendix B).

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

Stevens (1983) wrote that in the past the terms nurses and power have been likened to oil and water, not mixing well. Little power has been available to nurses playing the traditional woman's role, and nurses have viewed themselves as powerless (Claus & Bailey, 1977). These views and others will be explored in the literature review related to power. Findings from the literature will be organized as follows. First, an overview of power as historically perceived by society will be examined, followed by literature dealing with the concepts of power and powerlessness. These concepts will then be explored as seen by nursing in general and within the administrative role. Finally, general and nursing research will be discussed in relation to perceptions of power or powerlessness.

Historical Review

An exploration of the concept of power as it has been perceived for the past 2,500 years has been provided by Votaw (1966). A brief summary of his work will be presented.

Perhaps the first concept or oldest view of power developed by society was the "Naked Power Concept," viewing power as "evil." Power consisted of violence and force

whereby the strong controlled the weak. This concept was followed by the idea that society breaks into two groups, rulers and ruled. This view was known as the view of the "Rulers and the Ruled." Thus, an individual's power depended on fate. Votaw (1966) identified a third concept, the "Limited Supply Concept," that power existed in a quantitative amount. Thus, the acquisition of power for one individual or group subtracted power from another individual or group. The fourth identified, somewhat negative, view of power was the "Moralistic Concept." In this concept, power was rationalized as being acceptable if used in the pursuit of moral, ethical, and religious concerns.

Votaw (1966) credited Hobbes with the development of the bridge to link traditional and contemporary views of power. Hobbes viewed man as being suspicious and mean with a sole objective to maintain one's own life. However, Hobbes began to look at power more objectively as he felt power was necessary to maintain an orderly society.

The negative connotations and the narrow focus of power have been minimized in current power concepts. Contemporary concepts deal typically with three primary assumptions about power. First, power is a source of order, and can be either a negative or positive force; secondly, power is a relationship; and, thirdly, power is not static in quantity (Votaw, 1966).

Power Concepts

Total agreement among the definers of power is nonexistent. However, a wide spectrum of contemporary definitions of power will now be explored to develop a further understanding of the concept. Power is a word originally derived from the French verb *poer*, *poeir* meaning "to be able." And thus meanings such as "the ability to compel obedience, control, or dominion," and "capability of acting on or producing an effect" have been ascribed to power (Guralink, 1970). Dennis (1983) defined power as the ability to exert influence in ways that may further one's own interest. Minton (1972) viewed power as one's ability to affect the outcome of others, usually involving degrees of resistance. Salancik and Pfeffer (1977) saw power as simply the ability to get things done the way one wants them done. Clark (1974) stated that power implies the ability to make and implement decisions and successfully control resistance or any attempts to impose counterdecisions. The hidden face of power rests on the assumption that power is not totally reflected in concrete decisions. Beck (1982) contended that a person or group can exercise power by preventing policy issues from coming into the forefront and being publicly debated. Power is exercised by restricting the scope of acceptable decision-making issues.

Clark (1974) further stated that power permeates every

aspect of human life and is considered to be amoral since power can be used rationally or irrationally and constructively or destructively. Tawney (1952) and McMurray (1973) defined power as an individual's or group's capacity to modify the conduct of others in the manner desired, or to prevent one's own conduct from being modified in an undesired manner.

McClelland (1971) acknowledged that power can be viewed either negatively or positively. Negative connotations suggest submission and dominance, implying that power seeking individuals do so only to exploit others. For some, power has a negative connotation and is immediately linked to unionization or collective bargaining. Heineken (1985) contended that nurses who view power negatively tend to shy away from acknowledging and capitalizing on their sources of personal and professional power.

In contrast, the positive view of power recognizes that people cannot help influencing others. The individual concerned with the proper channels of influence will contribute to overall group effectiveness. In fact, to deny power by neglecting or repressing it is believed to create problems. Beck (1983) contended that power is not inherently corruptive, rather what one does with power is what determines the worth of power.

Lawless (1972) described the relationship quality of

power and identified the function of power as the intent of one person to influence the behavior, or the events controlled by another person. Beck (1982) said that power as a relationship versus an attribute of an actor is a controversial issue surrounding power. Lawless (1972) suggested that power is not seen as belonging to a particular individual, but as growing out of interactions between concerned individuals. Power is not considered to be static but rather an element of the group dynamics. Lawless concluded that power also incorporated the idea of dependence and that the power one individual has is relative to that of another individual.

Zaleznik and Kets de Vries (1975) viewed power along with normal and pathological behaviors as having a place in total personality development. Korda (1975) described power differently, as a basically physical force and a matter of territorial control and dominance. These three authors have recognized power and encouraged power utilization in a positive sense. In contrast, Lasswell (1960) stated that those interested in power are sick, a view reflective of the earlier negative views of power which do not encourage utilization or acceptance of power.

Based upon the previous findings, power would likely be recognized by management theorists as playing an important role in management. Kotter (1979), however, surveyed ten

popular management textbooks and found only three texts that dealt with the impact or role of power as related to management. Kotter stated that power is a neglected area of management theory despite its impact on organizational effectiveness, career progress, and job performance. Kotter further developed the aspect of dependence in power dynamics previously identified by Lawless (1972).

Sociologists and social psychologists who have studied organizations have engaged in the analysis of power sources and have also addressed power as a broad concept. Perhaps the most commonly cited reference on power is the French and Raven (1959) work that identified six bases of social power: reward, coercive, informational, legitimate, referent, and expert. According to these authors, the power holder is accorded power because of the power bases one establishes. Reward power is described as the ability of an individual to provide to another something one values in exchange for conformity or compliance. Coercive power is the ability of an individual to use threat to obtain another individual's compliance or conformity. Informational power is judicious sharing of valued information. Legitimate power is based on an individual's values which give sanction to a leader's right to influence and the individual's obligation to follow. Referent power arises from an individual's desire to identify with individuals or groups. Lastly, expert power is based on

the knowlege and skills of the individual.

Others have expanded on French and Raven's bases of social power. Kanter (1979) added position, supply, and support as power bases. Position power refers to the individual's location in the informal and formal organizational systems. Position power utilizes connections to other key personnel within the organizational structure as well as job definition. Obedience is owed to the person because of the legitimate power of command vested in the position. The higher ranking the position, the more power its holder wiolds (Dennis, 1983). Lines of supply as a power source allude to the individual's capacity to utilize resources. In the informal structure, lines of support ensure individuals that specific actions will have the approval from key individuals. In the formal structure, lines of support increase individual's power by allowing them to pursue innovative, risk taking activities without obtaining multiple time-consuming organizational approvals. Other writers (Hersey, Blanchard, & Natemeyer, 1979; McFarland & Shiflett, 1979) have viewed associative, or connection, power as a power base. This type of power occurs when the influencing person enjoys power over others because the others believe this individual has special "connections" with higher, influential people.

Minton (1972) described four distinct aspects of power:

manifest, subjective, motivational, and potential. Manifest power is described as the actual implementation of intentions. Subjective power is one's own evaluation of how one effectively implements one's intentions. Motivational power is the desire to obtain social compliance. Potential power refers to the predictions one can make about one's power for future situations.

Powerlessness Concepts

A paucity of literature dealing specifically with the concept of powerlessness exists. Seeman (Neal & Seeman, 1964; Seeman, 1959; Seeman & Evans, 1962) developed the expectancy construct of powerlessness as one aspect of his construct of alienation. Five alternative meanings of alienation can be seen as contributing factors toward one's inability to master one's life. The construct of powerlessness has been discussed within the theoretical framework. Meaninglessness is the second aspect of alienation and refers to an individual's confusion about what one should believe. Normlessness, the third aspect, is the high expectancy that socially unapproved behaviors are required to achieve given goals. The fourth aspect of alienation is isolation, which occurs when individuals assign low values to beliefs or goals that are typically of high societal value. Self-estrangement is the fifth and final aspect of alienation. Self-estrangement is essentially the

inability of the individual to find self-reward.

The problems created within an organization due to powerlessness were also explored by Kanter (1979). Kanter viewed powerlessness as leading to ineffectiveness within the organization, and further delineated organizational factors which contribute to power or powerlessness. Kanter cited the many rules, numerous predecessors, considerable established routines, abundant rewards for reliability or predictability, and countless approvals needed for making routine decisions as some of the job factors contributing to feelings of powerlessness. Other job factors seen as contributing to one's powerlessness were meager subordinate opportunities, insufficient problem solving-task force participation, infrequent group participation, sparse contact with senior officials, scanty interpersonal contacts in the job, decreased publicity, rigidity regarding personnel utilization, and limited task variety. These same powerlessness factors were supported by a survey of nurses. A survey of approximately 17,000 nurses found that 66 percent of the nurses sampled felt the administration unresponsive to their suggestions and 70 percent felt completely eliminated from the decision making process (Mottaz, 1988).

The inverse of the powerlessness factors is cited as also contributing to power generation. As previously stated, Kanter (1979) felt the position and not the individual may

determine an individual's power or powerlessness. Such powerless positions are more likely to be the low profile, routine jobs. Additionally, the support staff positions with no line responsibilities are seen as potentially powerless slots. Kanter (1979) cited staff jobs as keeping individuals out of the mainstream of the organization and increasing the difficulty of utilization of the information and support power networks.

A few studies focusing on individuals defined as powerless (Goodstadt & Hjelle, 1973; Goodstadt & Kipnis, 1970; Kipnis & Lane, 1962) primarily dealt with the types of influence used by these individuals. Goodstadt and Hjelle (1973) supported the view that those who are powerless may be more inclined toward the use of coercive power and may feel that the use of coercive power is the only way to influence others.

Another concept, previously mentioned in the theoretical framework, that addressed power and powerlessness was Rotter's Internal-External Locus of Control (1966). Rotter developed the idea of internally versus externally controlled individuals. The externally controlled person is considered one who perceives the events of life as totally unpredictable or the result of fate, chance, or luck. The internally controlled person is considered to be one who perceives events as contingent upon one's behavior or relatively

permanent characteristics. De Charms' Origin-Pawn Concept (1968) closely parallels Rotter's Locus of Control (1966). The Origin aspect resembles the perceived power or internal locus of control; the Pawn aspect, the perceived powerlessness or external locus of control. Thus, De Charms and Rotter have shown the linkage between power and powerlessness.

Power and Powerlessness in Nursing

One may infer that power is a vital component of daily encounters because of the nursing profession's interdependent functions within the hospital system. Ashley (1973) stated that nursing has, and always has had, power. Ashley contended that the power of nursing is derived from society's recognition that nursing provides an essential service, but nurses have created problems in power utilization because of an inability to capitalize on such influence. Nurses have attempted strategies, with limited success to date, to gain more autonomy and power. Strategies include shifting nursing education to the university setting, "seizing the technology" strategy, and unionization (Garant, 1981). Ashley (1973) also stated that few nurses have recognized the power they do have. Because of this lack of power recognition, nursing has been exploited in the past and will probably continue to be exploited unless something is done. Ashley (1976) stated that nurses need to recognize and cultivate the power they do

have and exercise that power in an intelligent and organized fashion.

Many nurses have internalized a subordinate attitude and see themselves as power subjects of other people, as described by Bowman and Culpepper (1974). Bowman and Culpepper also stated that for too long nurses have underestimated the power they have in being the largest group of health professionals in the nation. Grissum (1976), however, expressed concern that nursing's power base is supported by defective foundations. According to Ashley (1973), nursing's power is derived from the fact that nursing provides an essential service. This essential service is not clearly understood by the health care consumer who does not recognize nursing care as separate from medical treatment (Ashley, 1973; Grissum, 1976).

McFarland and Shiflett (1979) contended that power relations among individuals are highly situational and contingent on specific factors that may not be present elsewhere. They further stated that nursing operates within an implied social charter which sanctions power, legitimacy, and visibility. McFarland and Shiflett also contended that nursing as a profession lacks the autonomy necessary for self-determination and governance despite the fact that the power of the individual nurse is increasing. Miller (1980) suggested that nursing has not achieved a power base because

power has not traditionally been accorded to nurses, nurse leaders have not generated a sufficient power base through personal influence, and nurses have been unable to gain passage of legislation to enable nurses to have increased control over their professional activities.

Lambertson (1958) noted that the role of the nurse is influenced by women's roles in society and that in the male dominant culture, leadership is a function of men. Considerable evidence exists of a general cultural attitude that men make better leaders, and a large number of studies have demonstrated that neither men nor women want to work for a woman (Kanter, 1977). Lambertson stated that professional leadership is a synthesis of status leadership, which is primarily involved with education, and functional leadership, which is concerned with demonstrated competence. Lambertson (1958) defined one of the major problems which hampers leadership development as a general lack of social skills in leadership. Boyle (1984) contended that most nurses, as women, have not learned the skills of competition and cooperation that men learn from team sports.

Ashley (1976) also stated that nursing more than any other profession has been greatly influenced by social conceptions about the nature of women. Ashley further described nursing as an oppressed, predominantly female professional group with problems reflective of women's

problems in general. When nursing began in the early 1900s, norms dictated that woman's role was to serve man's need and convenience.

Garant (1981) described nurses as being ambivalent about wanting, getting, and retaining power. Garant contended that nurses are, perhaps, a mirrored reflection of a generation of women who are also grappling with the same basic growth and development issue of dependency versus autonomy.

Historically, the physician has been perceived as having unlimited power. Perhaps part of this explanation about power arose from the strength derived from numbers. Until the late 1960s the ratio of physicians to other health care workers was 1 out of 3, whereas it is now 1 out of 12 (Booth, 1983). Nursing has continued in a powerless tradition thus creating medicine's (men's) struggle to dominate nursing (women) (Ashley, 1976).

Cleland (1971) asserted that nursing autonomy is a false premise, whereby administrative positions are only available through male sanctions within the educational, medical, and hospital administrations. Nursing as a profession began with a power struggle when Florence Nightingale fought the whole health care system of male supremacy to start an educational system for nurses (Garant, 1981). Cleland (1971) stated that the lack of leadership in nursing has its base also in women's social position within the culture, that the

socialization process of the female child within the culture contributes greatly to the typical "submissive woman."

Wakefield-Fisher (1986) contended that power orientation is generally recognized as a trait in men far more frequently than in women. Cleland (1971) further described the leadership deficit in nursing as being most apparent in the areas of decision making, communicating needs and resources, functioning within the economic system, and establishing and maintaining professional standards. Nurses often still rely on past practices, routines, and the judgments of other professionals, rather than nursing colleagues, to determine current nursing practice (Boyle, 1984).

Ashley's and Cleland's beliefs of the role of female conditioning which has decreased power utilization by nurses was supported by Grissum and Spengler (1976). Grissum (1976) found that even mentioning the word "power" may produce anxiety and a sense of conflict in women; consequently, nurses may not use the power essential to growth or maintenance positions. Simpson and Simpson (1969) found that women in the semi-professions (nursing, teaching, and social work) place a higher priority on friendly, personal relationships with their co-workers than on conflict that leads to acquiring power within organizations. Despite the fact that 75% of the workers in the health care field are women and 97% of the nurses are female, the economic and

political power of the industry still rests in the hands of men (Grissum, 1976).

Lemkau (1980) stated that traditional female employment, of which nursing is an example, finds itself compromised by lack of autonomy, absence of meaningful decision-making responsibilities, underutilization of one's ability, and low income and status. Nursing is not fully established as a profession in the narrowest sociological definition of the term. A profession holds that there should be specialized knowledge, formal training, and organized association, ethical codes, and autonomy. McFarland and Shiflett (1979) cited the missing ingredient for nursing as autonomy, defined as the right of self-determination and governance without outside control. Lemkau (1980) contended that female nurse administrators are usually auxiliary to male administrators, and that top administrative posts in nursing are disproportionally held by men. Although the occupational role entails legitimate power, the female nurse is often inadequately prepared for its utilization, and she may feel extremely uncomfortable in a power position if she has accepted the prevalent ideas of passive female behavior.

Power and the Nurse Administrator

As cited by many authors (Beck, 1982; Lambertson, 1972; Manez, 1978; Novella, 1976; Traska, 1978), power is repeatedly recognized as having extreme importance within the

nurse administrator's role. However, a concurrent recognition of the need for research as a basis for the practice of nursing administration has been neglected (Dimond & Slothower, 1978). McFarland and Shiflett (1979) have contended that little is in the nurse's education today which teaches the art of politics or strategies for using power to gain such autonomy. Power may be viewed by nurses as undesirable because of its relationship with dominance and submission, as cited by McFarland and Shiflett.

Stevens (1978) contended that nursing has not recognized its power, or, has been asked to apologize for any position of leadership or power obtained. As cited by Stevens (1978), many nurse administrators may have been selected for inability and impotence. Leininger (1974) asserted that the modern nurse administrator must consider power because power is necessary to effective management. Leininger further contended that professional nursing must be involved in power to achieve a growth-producing, constructive influence upon individuals, groups, and/or society.

Kooker (1986) viewed the role of the nurse administrator as undergoing tremendous change and demanding a new management orientation: active participation in the power system of the hospital corporation. Peterson (1979) also contended that power is critical to the nurse administrator, and that power is a positive force. Peterson delineated the

tools of power as being an informal communications network, committee membership, persuasion, interpersonal relationships, and credibility. Similarly, Naisbitt (1982) predicted that future organizations would develop broader power bases where decisions would be made by networks of individuals. Nurse administrators are a part of that network and have a legitimate right to share organizational power (Aurilio, 1985). Peterson (1979) viewed power as relating more to the organization than to the single position of the nurse administrator, but that power involves the ability and willingness to influence the behavior of others. Dennis (1983) contended that the lack of studies concerning nurses (other than nurse executives) as holders of positional power may be due to the fact that the position held is not the greatest power source, knowledge is.

Claus and Bailey (1977) conceptualized the areas of power, authority, and influence for nurses. They defined power in a positive approach as willingness based on energy, ability based on strength, and action that yields results. They also contended that nurses have too long viewed themselves as powerless. Claus and Bailey provided a framework for power and influence, addressed the area of power development for nurses, and described the power bases as being personal, organizational, and social.

Personal power is increased through a heightened

self-esteem and self-awareness and may exist with or without positional (formal) power (Stevens, 1985). Related to personal power is the development of interpersonal power through reinforcement, disclosure, and feedback.

Organizational power is increased by effective management, and social power is developed by effective communications with peers, colleagues, and subordinates. Claus and Bailey (1977) described the entire leadership process as an interactive relationship in which power is considered to be a critical factor to effect work and task goals vital to a nurse administrator's ability for productive leadership.

General Research Related to Power and Powerlessness

Limited research exists in either general or nursing literature dealing with the leader's perception of power and powerlessness. A discussion of general studies which deals with the power issue follows.

Seeman and Evans (1962) studied perceptions of powerlessness among tuberculosis hospital in-patients. The hypothesis was that high alienation (powerlessness) among patients would be associated with limited knowledge about their physical condition and with the view that knowledge acquisition was irrelevant. A total of 150 randomly selected patients participated, and data were collected by means of two instruments. The first generalized powerlessness scale consisted of 12 forced-choice paired statements. Validity

and reliability were not addressed prior to the study, but the powerlessness scale's split-half reliability coefficient was 0.70. The second tool, prepared by the National Tuberculosis Association, was a 20-item measurement of patient knowledge. The Kuder-Richardson reliability figure was 0.80. The results confirmed that high alienation and poor learning were associated. Seeman and Evans (1962) reported that the "highs" in alienation had a mean knowledge score of 15.72; the "lows" in alienation had a mean knowledge score of 17.21. Using the two-tailed test ($t=2.216$), the difference was significant at the 0.05 level.

Neal and Seeman further tested the powerlessness construct in 1964. The hypothesis was that members of a work-based formal organization would exhibit less powerlessness than individuals without an organization to speak for them in the crucial area of occupation. The sample size was 609 randomly selected male participants. The same 12 forced-choice paired statements on powerlessness were used as in the earlier 1962 study co-authored by Seeman. Membership in work organizations was determined by the participants' membership in social fraternity or lodge clubs, business or professional associations, or trade or labor unions. Using a two-tailed test ($t=2.94$), the gross difference between the mean scores of the organized and the unorganized workers was significant at the 0.01 level. These

results confirmed the hypothesis. Neal and Seeman (1964) concluded that membership in a work-based organization is associated with a relatively strong sense of control over events. An incidental finding revealed that a high degree of powerlessness was not simply a function of socioeconomic status.

Perceptions of organizational climate and the feelings of powerlessness among teachers and school administrators were explored by Bazemore (1976). Since only an abstract of this project was available, an adequate critique is not possible. However, Bazemore reported a moderately high positive association between teachers' and school administrators perceptions of organizational climate and their sense of power. Administrators, holders of a master's degree, and those over thirty years of age reported the highest feelings of power in the study. Perceptions of power were also related to level of preparation, age, and position. The nature of the relationships were not specified in the abstract.

Nursing Research Related to Power and Powerlessness

A review of the nursing literature did not reveal any empirical studies of power in nursing administration. To this investigator's knowledge, no studies have been published within the nursing literature that deal specifically with nurse administrators' perceptions of power. However, a few

studies are related.

Salmin (1977) published a research report on "The concept of authority and power." The report only dealt with the identification of problem areas within a selected health care institution. Questionnaires and interviews were administered to randomly selected patients and nursing personnel. No details were given relating to sample size, instrument or instrument administration, interview techniques, or ethical considerations. The responses obtained were summarized into five classifications: (1) problems met by patients and families; (2) problems met by those giving direct care to patients; (3) problems met by head or charge nurses; (4) problems met by area supervisors or directors; and (5) problems met by administrators for nursing activities. The instrument and the sample size were not adequately addressed. Results obtained were a categorization of the problems with suggested approaches to solving such difficulties (Young, 1980).

Guilbert (1970) studied the construct of alienation, specifically powerlessness, in the exploration of the relationship between decision making and alienation. The study focused on how psychiatric nursing assistants viewed the decision-making ability of patients in comparison to the nursing assistants' perceptions of their powerlessness. Only an abstract of the study was available thus the study cannot

be adequately critiqued. The instruments utilized were a demographic data sheet, Seeman's (generalized) Powerlessness Scale, and a situational-decision tool. Sample size or selection was not addressed within the abstract. The author reported that the subjects who scored higher on the powerlessness scale assigned significantly more decisions to the nurse than did those who scored lower in powerlessness (Guilbert, 1970). The length of employment of the subjects was found to be an intervening variable that influenced the decision-making and powerless relationship (Guilbert, 1970).

Guilbert (1972) tested the powerlessness construct further in a pilot study primarily concerned with whether or not the degree of alienation experienced by nurses and nursing assistants was related to their views regarding who should make decisions directly involving psychiatric patients. Areas explored consisted of work alienation, powerlessness, and decision making. The research design was a descriptive survey. The sample consisted of 59 university graduate students and 140 nursing assistants employed at a large government-owned hospital which primarily served psychiatric clients. Ethical rights of both groups appeared to be adequately protected. The instruments consisted of seven paper and pen tools: (1) demographic data, (2) Miller Work Alienation Scale, (3) Health Care Work Powerlessness Scale by Guilbert, (4) Seeman's Powerlessness Scale, (5)

Crowne-Marlow Social Desirability Scale, (6) California F Scale, and (7) a decision scale developed by Guilbert.

This review will focus only on the demographic data and the area of powerlessness related to the subjects as these areas have greater significance to the current study than other aspects of the research. Perceptions of powerlessness were measured by Seeman's Powerlessness Scale. The tool's content validity was inferred from the construct of powerlessness (Guilbert, 1972; Rotter, 1966; Seeman, 1963). Reliability of the Powerlessness Scale as utilized with the nursing assistants' sample was 0.60 as calculated by the Spearman-Brown Correlation formula (Guilbert, 1972). The number of nursing assistants who perceived themselves as powerless was greater than the number of nurses who perceived themselves as powerless. The nursing assistants who had been employed by the agency less than two years saw themselves as more powerless in contrast to those employed seven or more years (Guilbert, 1972).

Since powerlessness was viewed as being a situation-bound characteristic (Seeman, 1967), Guilbert (1972) contended that the nursing staff's expectancies for control regarding the work situation might differ from control in more general matters and thus developed the Health Care Work Powerlessness Scale. The scale consisted of 12 paired forced-choice statements with content validity

developed by consultation with Seeman (Guilbert, 1972). The scale was utilized only with the graduate student nurses. The test-retest coefficient of stability with the 52 respondents was reported as $r = 0.81$ (Guilbert, 1972). The distribution of the scores was highly skewed, ranging from zero to seven, with 69% of the respondents obtaining a zero score. Guilbert considered the scale an ineffective measure, but a starting point for tool development. Five of the paired statements were reported to have unidimensionality and held most of the discriminatory power found in the scale (Guilbert, 1972). A possible reason suggested for the scores was that perhaps graduate students have few feelings of powerlessness, and that the academic environment instead of an actual work-related setting was seen as a contributing factor to decreased accuracy (Young, 1980).

Guilbert revised the Health Care Work Powerlessness Scale in 1979. Content validity was reported as being established by an expert panel review. Guilbert (1979) hypothesized that those who experience a greater feeling of powerlessness on Seeman's Scale would score higher on Guilbert's revised scale than those who experienced lesser feelings of powerlessness. The data supported the hypothesis, $r = 0.45$, $\text{sig.} = 0.000$ (Guilbert, 1979). Data to support concurrent validity was provided by use of the Health Care Work Powerlessness Scale (revised) with Seeman's

(generalized) Powerlessness Scale. The Miller Work Alienation Scale was administered within the same study, with a positive relationship reported between the Miller tool and the revised Health Care Work Powerlessness Scale. The nurses who experienced a greater feeling of work powerlessness did feel more alienated. Correlation between the two test scores was reported to be $r = 0.31$, $\text{sig.} = 0.000$ (Young, 1980).

Guilbert's instrument (Young, 1980) was sensitive enough to allow for categorization of respondents in "low," "medium," and "high" classifications. A split-half (odd-even) reliability test using the Pearson's Product Moment Correlation Coefficient was found to be $r = 0.769$ ($R_{spBn} = 0.869$). No test-retest data were available. All items positively correlated with each of the other items as demonstrated by an item-by-item analysis; in all but a few cases, the correlations were significant beyond the 0.05 level. Only one item demonstrated nonsignificant correlations to the other paired statements; the one item, however, was significantly related to five other items (Young, 1980).

Robb (Young, 1980) conducted a study of employees' attitudes toward work utilizing Guilbert's revised instrument. Robb's study included a sample of 208 health workers of varying occupations at a large medical center. Robb found that a better attitude toward the work environment

is associated with decreased perceptions of powerlessness. No significant differences or visible trends in relation to variables of area of work, length of service within the institution, age, or sex, were reported. Guilbert (Young, 1980) reported the reliability of the scale for Robb's study with Chronbach's Alpha as 0.86.

In summary, the areas of power and powerlessness have been discussed regarding historical development, general concepts, and related research. Within the nursing literature, power and powerlessness concepts on a broad spectrum as well as specifically in nursing administration have been explored. Nursing research dealing with power and powerlessness has been conducted by Guilbert in the area of psychiatric nursing with the utilization of the powerlessness construct as related to work alienation. Published research in the area of nurse administrators' perceptions of power is lacking and serves to support the need for an exploration in the area of nurse administrators' perceptions of power.

CHAPTER III

METHODOLOGY

Research Design

This study was a nonexperimental descriptive design. One of the purposes of a nonexperimental descriptive design is to systematically examine the characteristics of individuals or groups (Polit & Hungler, 1983). This approach was used because empirical knowledge is limited regarding the nurse administrator's perceptions of power and powerlessness.

In keeping with the research design, research questions were answered and because there were no hypotheses, the researcher did not manipulate any of the variables.

Setting

This study was conducted during Spring of 1988, in a southeastern state.

Population and Sample

The study population included all nurse administrators employed in hospitals in a southeastern state. The hospitals that could have potentially provided nurse administrators as participants were listed in the American Hospital Association's Guide to the Health Care Field (American Hospital Association, 1986). This guide included members as well as nonmembers of the American Hospital Association.

The study sample was limited to those nurse

administrators practicing in non-military, non-psychiatric, Joint Commission on Accreditation of Healthcare Organizations approved, and American Hospital Association member hospitals. The sample was chosen from hospitals in a southeastern state, resulting in a sample size of 59.

Protection of Human Subjects

1. An intermediary was not used as per the exception stated in the Nell Hodgson Woodruff School of Nursing Guidelines for the Procedure for Initiating Research (IX.A.1.b., p. 8). By means of a cover letter (see Appendix A), nurse administrators in a southeastern state were asked to fill out an anonymous questionnaire (see Appendix B) and return same in a non-coded self-addressed stamped envelope. Subsequently, the researcher was not able to tell who did or did not participate in answering the questionnaire and who did or did not provide data.

2. Subjects were selected from a listing of hospitals in the American Hospital Association Guide to the Health Care Field, 1986 edition.

3. Informed consent was provided by return of the questionnaire which included the statement "completion of the attached questionnaire constitutes informed consent."

Agency Consent Forms

Agency consent forms were not required due to the use of an anonymous questionnaire.

Data Collection

A self-administered questionnaire and cover letter (see Appendices A & B) was mailed to the entire selection sample. An addressed, stamped envelope was included to facilitate respondents' returns. Participants were assured that the questionnaires would be anonymous and any shared reports to Emory University, other institutions or individuals, and publishers would not contain specific identifiable data for either an individual or institution. Returned questionnaires constituted informed consent.

Data was collected for approximately two weeks and no additional questionnaires were considered after the established deadline. In the event the returned envelope and/or questionnaire contained any identifiable remarks (i.e., respondent's name, hospital name, return address) the notation(s) were removed from the questionnaire by the investigator. The questionnaires were separated from the envelopes and the envelopes were destroyed so no record would exist of a respondent's geographical location. The questionnaires were given identification numbers upon receipt to assist in editing and computerization of statistical data. The questionnaires were examined for clarity and completeness of data by the investigator. The data were compiled by the investigator.

Instrument/Data Collection Forms

The instrument selected for the data collection was comprised of two sections (see Appendix B). Section I of the instrument dealt with demographic data related to the participants and the respective employing hospitals. The basis for these questions was related to the review of the literature and the questions were prepared by the investigator. Data on the employing health care organizations covered such areas as types of service provided, ownership of hospital, professional organizational membership, and the number of employees in the department of nursing. Respondent data covered such areas as basic and current nursing education preparation, age, sex, nursing experience, professional organizational membership, and salary range.

Section II of the instrument was the "Health Care Work Powerlessness Scale (revised)" (Guilbert, 1979). This forced-choice instrument had a total of 14 paired statements. Content validity has been reported as being established by an expert panel review. The reliability was originally reported by Guilbert in Young (1980) as $r = 0.769$ (Pearson Product Moment Correlation Coefficient, split-half, odd-even, $R_{sp} B_n = 0.869$). Additionally, the reliability of the scale has been calculated as 0.86 (Chronbach's Alpha) (Young, 1980). No test-retest reliability has been calculated.

Each paired statement in Section II contained one internally controlled and one externally controlled item. Scoring of the instrument was accomplished by assigning a zero (0) to the respondent's selection of the internally controlled items and a one (1) to the externally controlled items. The internally controlled items reflected a perception that the situation and/or event was contingent upon the respondent's own behavior. The externally controlled items reflected a perception that the event was contingent upon a situation and/or event outside the respondent's control (Young, 1980).

The sum of the assigned scores provided a possible numerical range from 0 to 14. The lower score was indicative of greater feelings of power, or lesser feelings of powerlessness (Young, 1980). Section II of the instrument is copyrighted by Guilbert. Guilbert granted permission to reproduce and use the instrument in the study (see Appendix D).

Assumptions

1. Nurse administrators are able to identify their perceptions of power or powerlessness in responding to the instrument items.

2. The concept of power and powerlessness are at opposite ends of the same continuum with varying degrees between the concepts.

3. Perceptions of power and powerlessness are related to situational contingencies and not fixed personality characteristics (Young, 1980).

Limitations

1. The study was limited to the subject's perception of his/her own power rather than subordinates', peers', or supervisors' perceptions.

2. The study was limited to nurse administrators employed in a southeastern state listed in the 1986 edition of the American Hospital Association's Guide to the Health Care Field (American Hospital Association, 1986).

3. The perceptions of power may have only been reflective of a single point in time regarding possible situational contingencies (Young, 1980).

CHAPTER IV

PRESENTATION AND ANALYSIS OF DATA

Demographic and descriptive statistics were used to display the data in a meaningful manner and create a picture of the information obtained. The data will be presented according to the sections of the self-administered questionnaire.

First, the characteristics of respondents' employing hospitals will be described including data specific to the nursing department. Secondly, respondents' characteristics will be presented. Next, cross-tabulation tables will display the characteristics of respondents, employing hospitals, and perceptions of degree of power. Chi-square analysis was used to determine if the variables were associated. Chi-square is a test of statistical significance used to assess whether or not a relationship existed between two nominal-level variables (Polit & Hungler, 1983). This section will conclude with a discussion of the findings.

The Sample

Demographic data.

Fifty-nine subjects comprised the sample for this project, a response rate of 57%. The majority of the hospitals in which the respondents were employed provided general medical services (89,8%, N = 53). However, some

specialty hospitals were represented in the sample, such as pediatric (3.3%, N = 2), and other hospitals (6.7%, N = 4). Examples of other responses provided by the nurse administrators regarding services were, surgical, referral, alcohol and drugs, and Veteran's Administration.

When asked about hospital ownership, a majority of nurse administrators indicated that they worked in nongovernment, not-for-profit hospitals (50.8%, N = 30). The other hospitals were: nongovernment, investor owned, for-profit (23.7%, N = 14); government, nonfederal (22%, N = 13); and, government, federal (3.3%, N = 2).

The original categories of average daily patient census (ADPC) were condensed as some of the categories contained few responses. The ADPC was chosen as the measurement of hospital size rather than reported bed capacity as utilized by the American Hospital Association as the investigator felt this measurement was more reflective of the facilities' actual workloads. The most frequently reported category of hospital size was an ADPC of 50 and less (28.8%, N = 17). Sixteen of the hospitals (27.1%) were in the category of 201 ADPC and over. Twenty-two percent reported an ADPC of 51 to 100 (N = 13), and 20.3% (N = 12) reported 101 to 200 ADPC.

When asked about the number of assistant or associate directors in the department of nursing, most (35.5%, N = 21) of the respondents reported they had between one and three

assistants in their organizations. Thirteen (22%) of the nurse administrators reported 4 to 6 associate directors while only 6 (10.1%) had 7 or more. Nineteen (32.2%) of the respondents reported no assistants.

The data related to the number of supervisors within the nursing service department were not considered reliable as the responses did not logically correlate with hospital size (ADPC). The investigator, as Young (1980), inferred that respondents may have included first-line supervisory personnel (i.e., head or charge nurses) in their responses rather than second-line supervisory personnel (i.e., clinical supervisors). As the question was intended to reflect the latter, the responses to that question were felt to be indicative of question ambiguity, as also identified by Young (1980).

The number of department of nursing employees were reported by the nurse administrators as follows: less than 50, 10.1% (N = 6); 51 to 100, 16.9% (N = 10); 101 to 150, 8.4% (N = 5); 151 to 200, 16.9% (N = 10); 201 to 500, 27.1% (N = 16); and, 501 and over, 20.3% (N = 12).

When the nurse administrators were asked about age, no respondents answered in the extreme age groups (29 years and younger, 70 years and older). The largest represented age group was the 40 to 49 year group (37.2%, N = 22). They were followed by the 30 to 39 year group (32.2%, N = 19) and then

the 50 to 59 year group (28.8%, N = 17). The smallest age group representation was in the 60 to 69 year group (1.6%, N = 1).

The largest number of respondents were female (89.8%, N = 53) with 10.1% (N = 6) of the sample being male. The large percentage of males in the sample is similar to the percentage found in a survey of nurse executives (Andrica, 1988) which reported males as comprising 7% of the hospital-based nurse executives.

A majority of the respondents (49.1%, N = 29) reported receiving their basic nursing education in a diploma program, with 25.4% (N = 15) indicating a baccalaureate degree in nursing. In addition, 23.7% (N = 14) of the respondents indicated an associate degree as their basic preparation in nursing while 1.6% (N = 1) of the respondents reported a master's in nursing.

An inspection of the categories regarding the year in which the nurse administrators completed their basic nursing preparation revealed the following frequency distribution: prior to 1950, 3.3% (N = 2); 1951 to 1960, 27.1% (N = 16); 1961 to 1970, 30.5% (N = 18); 1971 to 1980, 33.8% (N = 20); and 1981 to 1987, 5% (N = 3).

As shown in Table 1, the data indicate that about 75% (N = 44) of the nurse administrators have gone beyond their basic nursing preparation. Although the number of nurse

Table 1
DISTRIBUTION OF SUBJECTS' REPORTED BASIC NURSING
PREPARATION AND CURRENT EDUCATIONAL LEVEL

Educational Program	Basic		Current	
	N	%	N	%
Diploma	29	49.1	6	10.1
Associate Degree	14	23.7	3	5.0
Baccalaureate*	15	25.4	20	33.8
Graduate*	1	1.6	30	50.8
Total	59	100.0	59	100.0

*In the basic nursing preparation column the numbers and percentages include only nursing degrees. In the current educational level column, the numbers and percentages include nursing and nonnursing degrees.

administrators reporting the highest current preparation as a diploma in nursing has decreased by 20.5% (N = 6) when compared to the earlier reported basic diploma preparation level, the associate degree distribution has also decreased by 21% (N = 3). An increase in the baccalaureate education was reported (33.8%, N = 20), and a dramatic increase in graduate education was reported, with over 50% (N = 30) of the respondents being prepared at the graduate level. The current baccalaureate and graduate degree categories reflect both nursing and nonnursing degrees with the respondents reporting nonnursing degrees in areas such as business, education, and psychology. Over 60% (N = 36) of the respondents' current educational levels were completed within the past 10 years.

When asked about the number of active years of nursing experience, 10.1% (N = 6) of the respondents reported less than 10 years of experience; 38.9% (N = 23) reported 11 to 20 years of experience; 30.5% (N = 18) reported 21 to 30 years of experience; and 20.3% (N = 12) reported 31 years of experience and over. The nurse administrators were also asked to indicate the number of years that they had been in nursing administration. Over 18% (N = 11) of the sample had less than 5 years of administrative experience. However, 28.8% (N = 17) had 6 to 10 years of administrative experience and 25.4% (N = 15) reported 11 to 15 years of administrative

experience. Eight (13.5%) respondents indicated having 16 to 20 years experience and 13.5% (N = 8) reported experience of 21 years and over.

In response to the question of the professional organizations in which the nurse administrators held memberships, over half (66.1%, N = 78) of the sample reported that they were members of the American Nurses' Association or a state nurses' association. These two groups were combined for analysis since the state nurses' associations belong to the American Nurses' Association. Over 72% (N = 43) indicated that they belonged to the American Organization of Nurse Executives. Only 13.5% (N = 8) respondents reported membership in the National League for Nursing. In addition, the nurse administrators reported other organizational affiliations (45.7%, N = 27) such as local nurse administrators' groups, American Association of Operating Room Nurses, American Association of Critical Care Nurses, American College of Health Care Executives, and honor societies such as Sigma Theta Tau.

The nurse administrators reported salaries ranging from \$15,999 and less to over \$50,000. Only 1.6% (N = 1) of the respondents reported earning \$15,999 and less. The remaining salary distributions of the nurse administrators in the sample were as follows: \$16,000 to 24,999, 0% (N = 0); \$25,000 to \$29,999, 8.4% (N = 5); \$30,000 to \$39,999, 22% (N

= 13); \$40,000 to \$49,999, 28.8% (N = 17); and the majority of the nurse administrators reported salaries of \$50,000 and over, 38.9% (N = 23). The original categories of salaries were condensed as some of the categories contained few responses.

The Data

Correlations among demographic variables.

Only the demographic relationships which were found to be significant will be discussed in this section. Tables describing other variables are reported in Appendix C. Various demographic variables were cross-tabulated with each other by chi square analysis. The acceptable level of significance for this study was 0.05.

There was a significant relationship between age and yearly salary at the 0.02 level. As shown in Table 2, the age group most often paid \$50,000 and over and accounting for 47% of subjects in the \$50,000 bracket was the 50 to 69 year category (18.6%, N = 11). There were very few respondents (6.8%, N = 4) in the 30 to 39 year age group that were earning \$50,000 and more, only 17% of the \$50,000 bracket. The 50 to 69 year group also only had 1 respondent in the \$29,999 and less category.

Salary was found to be related to the current level of education ($p < 0.01$) as shown in Table 3. The diploma, associate, and baccalureate degree respondents accounted for

Table 2
DISTRIBUTION OF SUBJECTS' AGE BY SALARY RANGE

Age	Salary Range							
	Less than		\$30,000 to		Over		Total	
	\$29,999		\$49,999		\$50,000			
	N	%	N	%	N	%	N	%
30-39	3	5.1	12	20.3	4	6.8	19	32.2
40-49	2	3.4	12	20.3	8	13.6	22	37.3
50-69	1	1.7	6	10.2	11	18.6	18	30.5
Total	6	10.2	30	50.8	23	39.0	59	100.0

Chi-square = 11.80 4 Df

Significance = 0.02

Contingency coefficient = 0.1056261

Table 3
DISTRIBUTION OF SUBJECTS' CURRENT EDUCATIONAL
LEVEL BY SALARY RANGE

	\$29,999 & less		\$30,000 to \$49,999		\$50,000 & over		Total	
Education	N	%	N	%	N	%	N	%
Diploma & A.D.	2	3.4	6	10.2	1	1.7	9	15.3
Baccalaureate	3	5.1	12	20.3	5	8.5	20	33.9
Graduate	1	1.7	12	20.3	17	28.8	30	50.8
Total	6	10.2	30	50.8	23	39.0	59	100.0

Chi-square = 16.585 4 Df Significance = 0.01

Contingency coefficient = 0.142267

84% of those reported yearly earnings of \$29,999 and less; in addition, the diploma and associate degree nurse administrators only represented 4.3% of the respondents earning yearly salaries of \$50,000 and over. The graduate prepared respondents accounted for 73.9% of the highest income category (\$50,000 and over). Only 1 respondent reported in the lowest income category (\$29,999 and less) was graduate prepared.

Salary was also significantly related to the reported employing hospitals' ownership ($p < 0.05$) as illustrated in Table 4. A majority (52.1%) of the respondents in the \$50,000 and over category were employed in nongovernment, not-for-profit hospitals. Nurse administrators employed in not-for-profit hospitals also reported the largest number of salaries (83.3%) in the \$29,999 and less salary category. The federal and for-profit hospitals had no respondents in the \$29,999 and less salary category.

The hospitals' average daily census was significantly related to the nurse administrators' current level of education ($p < 0.01$). As shown in Table 5, 66% of the diploma, associate, and baccalaureate degree prepared nurses were employed in the smaller hospitals (100 and less, ADPC). The nurse administrators with graduate education were more likely to be employed in the larger hospitals (201 and over, ADPC), and accounted for 81% of the respondents in the (201

Table 5
DISTRIBUTION OF HOSPITALS' AVERAGE DAILY PATIENT CENSUS
BY SUBJECTS' CURRENT EDUCATIONAL LEVEL

	Education Level							
	Diploma & Associate Degree		Bacca- lureate*		Graduate*		Total	
	N	%	N	%	N	%	N	%
Average Daily Patient Census								
Less than 100	7	11.9	13	22.0	10	16.9	30	50.8
101 to 200	2	3.4	4	6.8	7	11.9	13	22.1
201 and over	0	0	3	5.1	13	22.0	16	27.1
Total	9	15.3	20	33.9	30	50.8	59	100.0

Chi-square = 17.56 4 Df Significance = 0.01

Contingency coefficient = 0.1493705

*The numbers and percentages include nursing and nonnursing degrees.

and over, ADPC) category.

The last significant relationship in the demographic variables was found between the employing hospitals' size (ADPC) and the nurse administrators' age as illustrated in Table 6. The youngest age group's (30 to 39) respondents were more likely to be employed in the smaller hospitals (100 and less, ADPC), accounting for 58% of their employment; and they were least likely to be employed by the larger hospitals (201 and over, ADPC), accounting for 15.7% of their age group's employment. The 50 to 69 year age group respondents were less likely to be employed by the smaller hospitals (100 and less, ADPC), as only 22% of their age group's respondents were employed by the smaller hospitals. However, 50% of the 50 to 69 year group was employed by the larger hospitals (201 and over, ADPC), accounting for 56% of the nurse administrators who reported as being employed by the larger hospitals. This finding was significant at the 0.01 level.

Nursing administrators' power perceptions.

Research Question 1. What are nurse administrators' perceptions of their degree of power? The nurse administrators' range of power scores was 0 to 10 on a 0 to 14 scale. The lower numbers on the scale are reflective of increased perceptions of power and the higher numbers on the scale are reflective of decreased perceptions of power. The actual distribution of the nurse administrators' scores per

Table 6
DISTRIBUTION OF HOSPITALS' AVERAGE DAILY PATIENT CENSUS BY
SUBJECTS' AGE

Average Daily Patient Census	A g e							
	30-39		40-49		50-69		Total	
	N	%	N	%	N	%	N	%
Less than 100	11	18.6	15	25.4	4	6.8	30	50.8
101 to 200	5	8.5	3	5.1	5	8.5	13	22.1
201 and Over	3	5.1	4	6.8	9	15.2	16	27.1
Total	19	32.2	22	37.3	18	30.5	59	100.0

Chi-square = 17.68 4 Df

Significance = 0.01

Contingency coefficient = 0.1502379

item are displayed in Table 7. For ease in data analysis the power scores were condensed into the following categories: 0 to 4, "high"; 5 to 9, "medium"; and 10 to 14, "low." The nurse administrators' scores were skewed to the left with 93.2% (N = 55) scoring high, 5.08% (N = 3) scoring medium, and 1.7% (N = 1) scoring low.

Correlations among power perceptions & demographic variables.

Research Question 2. Are there associations between demographic profile data and nurse administrators' perceptions of power? Nurse administrators having a greater length of service in the administrative role did not perceive a statistically significant greater degree of power when compared to nurse administrators with lesser years of administrative service. Distribution of the respondents' nursing administrative experience by their perceptions of power is illustrated in Table 8. Though not significantly different, the one low power score was reported by a nurse administrator with less than 10 years of experience, and two of the three medium scores were reported by respondents with less than ten years of nursing administrative experience.

Nurse administrators with graduate educational preparation did not perceive a statistically significant higher degree of power than nurse administrators with undergraduate educational preparation. Neither the basic level of nursing preparation nor the current level of

Table 7
SUBJECTS' POWER SCORES DISTRIBUTION

		External		Internal	
Questionnaire					
Item Number	N	%	N	% %	
1	1	1.7	58	98.3	
2	11	18.7	48	81.3	
3	6	10.1	53	89.9	
4	3	5.0	56	95.0	
5	0	0	59	100.0	
6	4	6.8	55	93.2	
7	18	30.5	41	69.5	
8	1	1.7	58	98.3	
9	2	3.4	57	96.6	
10	6	10.1	53	89.9	
11	5	8.5	54	91.5	
12	7	11.9	52	88.1	
13	6	10.1	53	89.9	
14	16	27.1	43	72.9	

Table 8
DISTRIBUTION OF SUBJECTS' NURSING ADMINISTRATION
EXPERIENCE BY POWER PERCEPTIONS

Year Group	Power Perceptions							
	Low		Medium		High		Total	
	N	%	N	%	N	%	N	%
Less than 10	1	1.7	2	3.4	25	42.4	28	47.5
11 to 25	0	0	1	1.7	27	45.8	28	47.5
26 and Over	0	0	0	0	3	5.0	3	5.0
Total	1	1.7	3	5.1	55	93.2	59	100.0

Chi-square = 2.93 4 Df Significance = 0.60 (NS)

Contingency coefficient = 0.0284659

education was significant as shown in Tables 9 and 10. However, the one low power perception score was held by the nurse with diploma preparation as the basic nursing preparation.

Nurse administrators employed in hospitals having less than an average daily census of 100 occupied beds had 47% of the high power perceptions, however, 50.9% of the respondents were nurse administrators employed in hospitals with less than 100 average daily census. The distribution of the variables is illustrated in Table 11. The relationship between average daily census and perceptions of power was not significant at the 0.15 level.

The relationship between the nurse administrators' power perceptions and number of years employed in nursing was found to be significant at the 0.01 level, as illustrated in Table 12. All nurse administrators employed in nursing over 31 years (20.3%, $N = 12$) scored high in power perceptions. One nurse administrator scored low in power perceptions and had less than 10 years active nursing experience.

An unexpected finding was the significant relationship ($p < 0.05$) between the nurse administrators' power perceptions and membership in the American Nurses' Association or state nurses' association, as illustrated in Table 13. Over 66% ($N = 118$) of the respondents reported membership in the American Nurses' Association or a state

Table 9
DISTRIBUTION OF SUBJECTS' BASIC NURSING PREPARATION
BY POWER PERCEPTIONS

Preparation	Power Perceptions							
	Low		Medium		High		Total	
	N	%	N	%	N	%	N	%
Diploma	1	1.7	1	1.7	27	45.8	29	49.2
Assoc. Degree	0	0	1	1.7	13	22.0	14	23.7
Baccalaureate								
in Nursing	0	0	1	1.7	14	23.7	15	25.4
Masters								
in Nursing	0	0	0	0	1	1.7	1	1.7
Total	1	1.7	3	5.1	55	93.2	59	100.0

Chi-square = 2.42 6 Df Significance = 0.90 (NS)

Contingency coefficient = 0.0236281

Table 10

DISTRIBUTION OF SUBJECTS' CURRENT EDUCATIONAL
LEVEL BY POWER PERCEPTIONS

	Power Perceptions							
	Low		Medium		High		Total	
	N	%	N	%	N	%	N	%
Education								
Diploma & Assoc.								
Degree	0	0	0	0	9	15.2	9	15.2
Baccalaureate*	0	0	2	3.4	18	30.5	20	33.9
Graduate*	1	1.7	1	1.7	28	47.5	30	50.9
Total	1	1.7	3	1.7	55	93.2	59	100.0
Chi-square = 4.45 4 Df Significance = 0.40 (NS)								
Contingency coefficient = 0.0426041								

Table 11
DISTRIBUTION OF HOSPITALS' AVERAGE DAILY PATIENT CENSUS
BY SUBJECTS' POWER PERCEPTIONS

Average Daily Patient Census	Power Perceptions							
	Low		Medium		High		Total	
	N	%	N	%	N	%	N	%
Less than 100	1	1.7	3	5.1	26	44.1	30	50.9
101 to 200	0	0	0	0	13	22.0	13	22.0
201 and Over	0	0	0	0	16	27.1	16	27.1
Total	1	1.7	3	5.1	55	93.2	59	100.0

Chi-square = 7.04 4 Df Significance = 0.15(NS)

Contingency coefficient = 0.0657698

Table 12

DISTRIBUTION OF SUBJECTS' ACTIVE NURSING EXPERIENCE
BY POWER PERCEPTIONS

		Power Perceptions							
		Low		Medium		High		Total	
Active	Nursing								
Experience	Years	N	%	N	%	N	%	N	%
Less than 10		1	1.7	1	1.7	4	6.8	6	10.2
11 to 20		0	0	1	1.7	22	37.3	23	39.0
21 to 30		0	0	1	1.7	17	28.8	18	30.5
Over 31		0	0	0	0	12	20.3	12	20.3
Total		1	1.7	3	5.1	55	93.2	59	100.0

Chi-square = 19.90 6 Df Significance = 0.01

Contingency coefficient = 0.16597

Table 13
 DISTRIBUTION OF SUBJECTS' AMERICAN NURSES'
 ASSOICATION AND STATE NURSES' ASSOCIATION
 MEMBERSHIP BY POWER PERCEPTIONS

		Power Perceptions							
		Low		Medium		High		Total	
Member-	ship	N	%	N	%	N	%	N	%
Yes		0	0	2	1.7	76	64.4	78	66.1
No		2	1.7	4	3.4	34	28.8	40	33.9
Total		2	1.7	6	5.1	110	93.2	118	100.0

Chi-square = 6.18 2 Df Significance = 0.05

Contingency coefficient = 0.058203

nurses' association and scored high on perceptions of power.

Another surprising relationship, significant at the 0.000 level, was between the nurse administrators' power perceptions and National League for Nursing memberships. As the data in Table 14 indicate, the surprising feature of this finding was that 86.4% (N = 51) of the respondents were not members of the National League for Nursing and they all scored high on power perceptions. The respondents with low and medium scores (6.8%, N = 4) were members of the National League for Nursing.

The nurse administrators' perceptions of power were not found to be significantly related to age, hospital ownership, sex, salary, or membership in the American Organization of Nurse Executives. The contingency tables of these variables can be seen in Appendix C.

Discussion

In view of the 57% return rate of the questionnaires and the geographical limits of this project, the findings of this study must be discussed with caution. Nonrespondents' views of their power within their respective organizations may have differed significantly from the power views of the respondents. Also, the skewed results were expected due to the homogeneity of the nurse administrator group. Additionally, recognition must be given to the fact that limited published research exists concerning nurse

administrators as a subgroup of the nursing profession. Therefore, the unique characteristics of this subgroup of nurse administrators may vary from the nursing profession as a whole with respect to perceptions of power.

Contrary to what has been previously suggested in the literature (Bowman & Culpepper, 1974; Leininger, 1974, 1977; Stevens, 1978), nurse administrators in this study did not see themselves as powerless. The results of this study indicated that 93% of the respondents obtained scores which were rated as high perceptions of power. The nurse administrators' perceptions of power, according to the systems approach (Gillies, 1982), would be influenced by several intervening variables. The nurse administrator may perceive power differently according to different systems elements, such as years of experience and membership in professional organizations (inputs).

Years of experience, a significant element in the nurse administrator subsystem (Gillies, 1982), was identified as a statistically significant variable related to perceptions of power. Nurse administrators who were actively employed in nursing over 10 years (86.4%) reported the highest perceptions of power, with significance at the 0.01 level. According to the results of this study, the number of years actively employed in nursing in relation to power perceptions accounted for a more significant correlation than power

perceptions responses to hospital ownership, average daily census, age, sex, or salary. This finding is supported by the theory base. As addressed in the theoretical framework, nurse administrators may perceive power differently according to different system elements. In this particular finding, years of experience in nursing is considered an input into the power subsystem of the nurse administrator.

Interestingly, a correlation at a significant level of acceptance was not found with regard to power perceptions and experience in nursing administration.

Many of the nurse administrators with fewer years of experience in nursing administration scored high in their power perceptions, contrary to the expectation that increased familiarity with the nurse administrator role could lead to more confidence and perceptions of greater power. Role expectations vary from organization to organization, and individuals moving from one organization to another may feel more or less powerful because of history with previous organizations (Young, 1980). Social learning theory postulates that human behaviors in specific situations are contingent upon one's expectancy that a particular behavior will be rewarded (Polit & Hungler, 1983). Expectancies, therefore, may be based upon past experiences. Evidently, the actual administrative experience encountered by the nurse administrators would vary with different organizational

structures and philosophies. In all probability, the role experiences of the respondents varied enough to account for the finding being at the 0.6 level of significance.

This study's sample revealed that 75% of the nurse administrators had gone beyond their basic educational level and about 51% had achieved graduate level education. Educational background is another systems element that may impact nurse administrators' perceptions of power. However, educational level was not found to be significantly correlated to power perceptions. As a note of interest, nursing as a profession is still struggling with interprofessional conflicts regarding the basic educational level for entry into practice (Lynaugh, 1980). In contrast to the results of this study, McCarthy (1980) reported that over 60% of the registered nurses employed in the United States have diploma preparation in nursing with less than 8% having graduate preparation. However, the educational levels of nurse administrators are not representative of the nursing population as a whole. Andrica (1988) reported a profile of hospital-based nurse executives and listed 73% of the nurse executives as graduate prepared, a finding more closely correlated to the 51% of graduate prepared nurses administrators in this study.

As described in the theoretical framework discussion, a system is an ongoing process consisting of diverse elements

and their relationship to each other. Each system consists of interconnected and interrelated subsystems, each of which has its own objective contributing to the goals of the larger system (Gillies, 1982). Education is one of the diverse elements in the nurse administrators' system. Lynaugh (1980) contended that the role played by universities in the development of the nursing profession has been crucial to achievement of competence, discipline, and power in the profession.

Recognition must be given to two factors which may account for education not being significantly correlated with power perceptions. First, higher education for women has historically been patterned under the paternalistic model. Within this model, women have been educated to negotiate the tasks they would fill in society. The tasks which men would allow women to do have traditionally been in the nurturing professions (Lynaugh, 1980). A second factor which may explain why education may not be correlated to power perceptions is that considerations must be recognized that may impact on an individual's decision to undertake further education. Considerations such as limited opportunities for advanced education, situational contingencies, economic reasons, and personal commitments, may be external to the power system of the nurse administrator.

An incidental finding revealed that the nurse

administrators who were members of the American Nurses' Association and state nurses' associations were more likely to report higher perceptions of power. Over 66% of the respondents scoring high on power perceptions were members of the American Nurses' Association and state nurses' associations. According to the research, women living outside the mainstream social pattern of wife and homemaker have sought security, status, and power through professional affiliation (Lynaugh, 1980). The American Nurses' Association became the national professional organization which has attempted to achieve solidarity among nurses. Stevens (1983) contended that the American Nurses' Association has strengthened the power base of nursing in our society.

In contrast, significant relationships were not found between high perceptions of power and membership in the American Organization of Nurse Executives. Recognition must be given to the fact that the American Nurses' Association and the American Organization of Nurse Executives have different purposes and objectives, a fact which may explain why power perceptions in relation to these two organizations differed.

Another incidental finding of the study revealed that the nurse administrators who were not members of the National League for Nursing reported higher perceptions of power.

This finding is not unexpected, since two of the functions of the National League for Nursing are to foster programs related to the nursing needs of society, and to develop and support services for the improvement of nursing education (Stevens, 1983). These functions are marginally correlated to the practice of nursing administration. The preceding two incidental findings need to be regarded with caution in view of the small sample size and empty cells for statistical analysis which may have resulted in questionably significant correlations.

CHAPTER V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

In order to ascertain how nurse administrators perceive their degree of power, a descriptive survey was conducted. Subjects were 59 hospital-based nurse administrators in a southeastern state. The study sample was limited to nurse administrators practicing in non-military, non-psychiatric, Joint Commission on Accreditation of Healthcare Organizations approved, and American Hospital Association member hospitals, as listed in the American Hospital Association's Guide to the Health Care Field (American Hospital Association, 1986).

Nurse administrators were invited to participate in the study by the return of an anonymous, self-administered questionnaire. Perceptions of power were obtained by the use of the "Health Care Work Powerlessness Scale (revised)" (Guilbert, 1979) which is based on Seeman's (1959) powerlessness construct. Possible scores on the power scale ranged from 0 to 14.

Conclusions

Based on the data and findings, the following conclusions seem warranted:

1. Nurse administrators perceive themselves to be powerful.

Although the subjectivity of the respondents is a confounding factor that is involved in the measurement of perceived power, other speculations can be made to explain the findings. Nurse administrators, by virtue of their key positions in their organizations, may perceive themselves as powerful. Nursing is the key to hospital's cost control, productivity, marketing, image, and reputation.

Other factors may have contributed to the nurse administrators' high perceptions of power. The demographic profile of the nurse administrators reflected a majority (39%) with annual incomes of over \$50,000, and over 50% had a master's degree. One could speculate that high power perceptions are related to knowledge and income. The position titles of the respondents were not obtained but may have been perceived as powerful titles, such as Vice President of Nursing.

Other variables that may have shown significant relationships to power perceptions might have been the respondents': attendance at board of directors' meetings; responsibilities for patient-related departments such as social service, dietary, and respiratory therapy; management style; length of time employed in the hospital; or, reporting directly to the Chief Executive Officers.

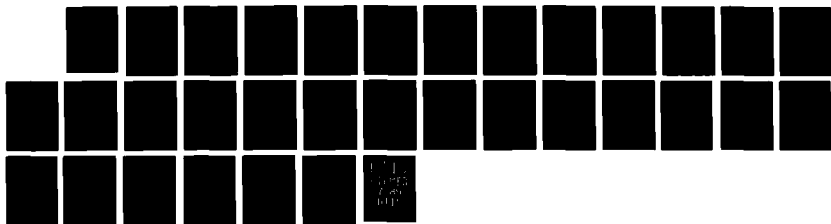
The investigator speculates that the respondents' sex, hospital size, and membership in the American Organization of

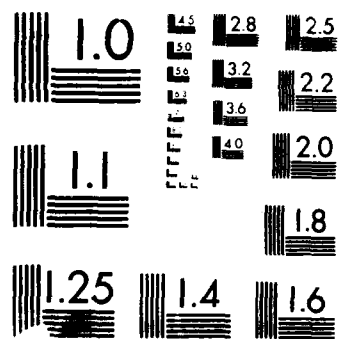
AD-A208 442 NURSE ADMINISTRATORS' PERCEPTIONS OF POWER(U) AIR FORCE 2/2
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Nurse Executives (AONE) were not significantly related to power perceptions due to the skewed percentages in these categories (90% female; 51% average daily patient census; 73% AONE membership). Hospital size should be less relevant to the ambitious nurse administrators than sophistication and systems. Larger hospitals with more resources tend to be more advanced in some areas such as computerization, but smaller hospitals can be attractive as well.

2. Nurse administrators with over 10 years of experience in nursing have high perceptions of power.

According to Booth (1983), no other source of power is as enduring and strong as one that is built on knowledge and expertise. The position held is not the professional's greatest power source; knowledge is (Dennis, 1983). Knowledge and decision making abilities increase with experience, and the experienced nurse administrators who have been in nursing over 10 years reported higher perceptions of power. The clinical backgrounds of the respondents were not obtained, but clinical expertise information may have provided additional insight into their experience and knowledge bases.

3. Nurse administrators who belong to the American Nurse' Association and state nurses' associations have high perceptions of power.

According to the research (Dimond & Slothower, 1978),

the professional is a part of three social systems that are operative in service organizations: the task system, the identity system, and the governance system. The task system is the work of the organization: research, education, patient care. The identity system refers to the career or professional development track. The governance system is made up of committees, boards, and agencies that set standards for the profession, such as the American Nurses' Association and state nurses' associations. Within these three social systems the nurse administrator can find professional identity, creativity, and power. Standards set by the American Nurses' Association may be used by nurse administrators as a form of power to maintain professional influence with employers for hiring appropriately prepared nurses, and define the scope of practice to the various public, private, and governmental agencies using the services of nurses. According to Stevens (1983), the American Nurses' Association's real source of power for the nursing profession may lie in its lobbying efforts.

4. Nurses who do not belong to the National League for Nursing (NLN) have high perceptions of power.

The investigator speculates that this conclusion lacks relevance to the study because of the nature of the purposes and objectives of the National League for Nursing. One of the major functions of the NLN is the accrediting process of

all types of nursing education programs. The NLN's efforts to promote power in the profession are best reflected in the position statements on issues affecting research, education, practice, and consumerism. The fact that the NLN maintains nonnurse memberships in its organization may weaken its power for nurses. Nurse administrators may recognize this weak link in the organization and avoid membership in the NLN.

Based on the findings of the study, the following hypotheses were formulated:

1. Nurse administrators with over 10 years of nursing experience will perceive a higher degree of power when compared to nurse administrators with less than 10 years of nursing experience.

2. Nurse administrators who belong to the American Nurses' Association and state nurses' associations will perceive a higher perception of power than nurse administrators who are not members of the American Nurses' Association and state nurses' associations.

Recommendations

Based on the data and conclusions, the investigator offers the following recommendations for further research:

- a. that further investigations of this type be conducted with head nurses, staff nurses, nurse supervisors, and hospital administrators, for comparison with nurse administrators.

- b. that investigation of the power concept with a larger sample size be explored to decrease the probability that sample size would contribute to questionable findings.
- c. that investigation of other variables that may be related to power perceptions be explored, such as nurse administrators' titles, management styles, longevity in the organization, clinical expertise, reporting chains, interactions with the board of directors, and responsibilities for patient-related departments (social service, dietary, respiratory therapy).

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Appendix A

Cover Letter for Questionnaire

704 North Smiley Street
O'Fallon, Illinois 62269
(618) 624-2838

Dear Nurse Administrator:

I am a graduate student in nursing administration at Emory University and am conducting a study on nurse administrators' perceptions of power. The purpose of this letter is to invite you to participate in the study. You were selected because of your key position as a nurse administrator in a Joint Commission accredited hospital in a southeastern state.

The accompanying questionnaire should take you about 15-20 minutes to complete. The first section consists of general information about your employing hospital, your job, and yourself. The second section deals with your perceptions of influence and control within your employing hospital. For your convenience, a self-addressed, stamped envelope is enclosed. Please return the questionnaire within 2 weeks of receipt.

To ensure anonymity, please do not include your name on the returned questionnaire. Findings from this study will be reported as group data, and no individuals or institutions will be identified. Completion and return of the questionnaire will serve as evidence of your willingness to participate and your consent to have the information used for purposes of this study.

Completion of this questionnaire allows you to contribute to needed nursing research. Thank you in advance for your contribution to this investigation. Upon completion of this study, a copy of the findings will be shared with you upon your request by writing to me at the above address and enclosing a stamped, self-addressed, business-size envelope. Should you have any questions, feel free to contact me.

Sincerely,

Thomas A. Vann, R.N.

Appendix B

Instrument

SECTION I

Please answer the following questions concerning general information about your employing hospital, your job, and yourself. Place the number of the response that pertains to you in the space provided at the left of each question.

1. ____ Please indicate the nature of services your employing hospital provides.

1 = General hospital services
 2 = Specialized services, pediatric
 3 = Specialized services, rehabilitation
 4 = Other specialty, please specify: _____

2. ____ Please indicate the type of ownership of your hospital.

1 = Government, federal
 2 = Government, nonfederal
 3 = Nongovernment, not for profit
 4 = Nongovernment, investor owned, for profit
 5 = Other, please specify: _____

3. ____ Using the following categories please indicate the approximate average daily census of in-patients in your hospital.

1 = Less than 25	7 = 201-250	13 = 501-600
2 = 26-50	8 = 251-300	14 = 601-700
3 = 51-75	9 = 301-350	15 = 701-800
4 = 76-100	10 = 351-400	16 = 801-900
5 = 101-150	11 = 401-450	17 = 901-1000
6 = 151-200	12 = 451-500	18 = Over 1000

4. ____ Please indicate the number of assistant or associate directors of nursing service who are responsible to you as director of nursing using the following categories.

1 = None
 2 = 1-3
 3 = 4-6
 4 = 7-9
 5 = 10 and over

5. ___ Please indicate the number of supervisors within the nursing service department who are responsible to you as director of nursing using the following categories.

1 = None	5 = 10-12
2 = 1-3	6 = 13-15
3 = 4-6	7 = 16 and over
4 = 7-9	

6. ___ Please indicate the approximate number of full-time and part-time employees in the department of nursing using the following categories.

1 = Less than 50	5 = 201-500
2 = 51-100	6 = 501-750
3 = 101-150	7 = 751-1000
4 = 151-200	8 = Over 1000

7. ___ Please indicate your basic nursing preparation.

1 = Diploma
2 = Associate Degree
3 = Baccalaureate in nursing
4 = Masters in nursing

8. ___ Please indicate the approximate year you completed your basic nursing preparation using the following categories.

1 = Prior to 1930	5 = 1961-1970
2 = 1931-1940	6 = 1971-1975
3 = 1941-1950	7 = 1976-1980
4 = 1951-1960	8 = 1981-1987

9. ___ Please indicate your highest current level of education.

1 = Diploma
2 = Associate Degree
3 = Baccalaureate in nursing
4 = Baccalaureate in another field, specify: _____
5 = Masters in nursing
6 = Masters in another field, specify: _____
7 = Doctorate

10. ___ Please indicate the approximate year you completed your highest current level of education using the following categories.

1 = Prior to 1930	5 = 1966-1970
2 = 1931-1940	6 = 1971-1975
3 = 1941-1950	7 = 1976-1980
4 = 1951-1960	8 = 1981-1987
5 = 1961-1965	

11. ___ Please indicate your nearest age group using the following categories.

1 = 20 and younger	5 = 50-59
2 = 21-29	6 = 60-69
3 = 30-39	7 = 70 and older
4 = 40-49	

12. ___ Please indicate your sex.

1 = Male
2 = Female

13. ___ Please indicate the number of years you have actively been employed in nursing using the following categories.

1 = Less than a year	5 = 16-20	9 = 36-40
2 = 1-5	6 = 21-25	10 = 41-45
3 = 6-10	7 = 26-30	11 = 46-50
4 = 11-15	8 = 31-35	12 = Over 50

14. ___ Please indicate the number of years you have been actively employed in nursing administration. This includes only such positions as clinical supervisor, assistant director of nursing, and director of nursing. Use the following categories.

1 = Less than a year	5 = 16-20
2 = 1-5	6 = 21-25
3 = 6-10	7 = 26-30
4 = 11-15	8 = Over 30

Please indicate your membership in the following professional organizations by placing a "1" in the space by those which you are a member, and a "2" by those you do not belong.

15. ___ American Nurses' Association

16. ___ A state nurses' association

- 17.____ National League for Nursing
- 18.____ American Organization of Nurse Executives
- 19.____ Other, specify:_____
- _____
- 20.____ Please indicate if you are currently holding the director of nursing position on a temporary basis while a permanent director of nursing is being sought.
- 1 = Yes
2 = No
- 21.____ Please indicate your approximate current annual salary using the following categories.
- | | |
|-------------------------|-------------------------|
| 1 = Less than \$15,999 | 5 = \$30,000 - \$34,999 |
| 2 = \$16,000 - \$19,999 | 6 = \$35,000 - \$39,999 |
| 3 = \$20,000 - \$24,999 | 7 = \$40,000 - \$44,999 |
| 4 = \$25,000 - \$29,999 | 8 = \$45,000 - \$49,999 |
| | 9 = Over \$50,000 |

SECTION II

For this section of the study you are asked to select the ONE statement out of each pair of statements which you more strongly believe to be true. It is quite possible in some cases that you may not really agree with either statement in a pair. In these cases please check the one statement which comes close to expressing the way you feel.

Please check ONLY ONE statement out of each pair. Be sure to check the one which you actually believe to be more nearly true, rather than the one you think you "should" check or the one you would like to be true.

It is important to this study that you choose one statement out of each pair. PLEASE DO NOT OMIT MAKING A CHOICE OUT OF ANY PAIR.

Remember, there are no "right" or "wrong" choices. It is your individual opinion that is important to this study.

1. ☐ A. When a person works for a large organization such as this facility, that person has little chance of exerting any real influence on working conditions.
☐ B. Even in a large organization such as this facility, the individual can have a real influence on working conditions, if that individual makes his (her) ideas known.
2. ☐ A. The type of treatment program a patient receives is decided by the doctor; there's really little anyone else can do except go along with it.
☐ B. Everyone who works with patients here can have a real influence on what treatment approach will be used.
3. ☐ A. Some people are just lucky and seem to advance in their jobs by simply being in the right place at the right time.
☐ B. Many people don't realize how much the cause of their failure to get ahead on their jobs is the result of their own work performance.
4. ☐ A. It doesn't do much good to try to think of ways to improve conditions at work; you usually can't try new ideas anyway.
☐ B. If you have a good idea about some way to improve conditions at work, you can usually get the backing you need to try it.
5. ☐ A. It does little good to plan one's career too far ahead; some people get the breaks and some don't.
☐ B. People are better if they plan their careers and set goals for themselves rather than trusting to fate.
6. ☐ A. Individuals can influence the established rules at this facility, if they make their own needs known.
☐ B. Established rules at this facility can't be changed for an individual's needs or problems.

7. ___ A. As a member of the treatment team I can have a real influence on the treatment program prescribed for patients.
- ___ B. Even though I am considered a member of the treatment team, it's really the doctors who decide what treatment the patient will receive.
8. ___ A. Whether or not a person gets a raise or promotion in their job depends mostly on luck and knowing the right people; there's not really much the individual can do about it.
- ___ B. Whether or not a person gets a raise or promotion on their job depends mostly on whether that individual is well prepared and does a good job.
9. ___ A. I think people like myself can have an influence on how things run here.
- ___ B. It's rather silly to ask someone like myself to make suggestions about how things should be run here; people seldom pay any attention to them.
10. ___ A. When decisions are being made at this facility, the opinions of the people affected by that decision do have an affect on what's decided.
- ___ B. When decisions are being made at this facility, the opinions of the people affected by them have little influence on what's decided.
11. ___ A. Offering valid complaints about one's work situation here doesn't seem to do much good.
- ___ B. Offering valid complaints about one's work situation here is usually helpful in bringing about needed change.

12. ___ A. Persons like myself have little chance of protecting our professional interests in this job when they conflict with those in positions of power.
- ___ B. I feel we have adequate ways of coping with those in the positions of power in this facility and can protect our own professional interests.
13. ___ A. Employees at this facility can usually participate in making important decisions related to their own work.
- ___ B. Individual employees have little opportunity to participate in making important decisions related to their own work.
14. ___ A. Facility-wide policies are made by those few people in power, and there is not much the individual employee can do about it.
- ___ B. The individual employee can usually have an influence on facility-wide policies.

Note: Section II is copyrighted by Evelyn K. Guilbert

Please make sure you have answered all the questions.

Thank you for your time and cooperation!

Appendix C
Statistical Data

Table A
DISTRIBUTION OF HOSPITAL OWNERSHIP BY
SUBJECTS'S CURRENT EDUCATIONAL LEVEL

Hospital Ownership	E d u c a t i o n L e v e l							
	Diploma & Associate Degree		Bacca- laureate*		Graduate*		Total	
	N	%	N	%	N	%	N	%
Federal Government	0	0	0	0	2	3.4	2	3.4
Nonfederal Government	1	1.7	3	5.1	9	15.2	13	22.0
Not-for-Profit	5	8.5	11	18.6	14	23.7	30	50.8
For-Profit	3	5.1	6	10.2	5	8.5	14	23.8
Total	9	15.3	20	33.9	30	50.8	59	100.0

Chi-square = 9.46 6 Df Significance = 0.15(NS)

Contingency coefficient = 0.0864242

*Note: Baccalaureate and graduate levels of current education include nursing and nonnursing degrees.

Table B
DISTRIBUTION OF HOSPITAL OWNERSHIP BY
SUBJECTS' POWER PERCEPTIONS

Ownership	Power Perceptions							
	Low		Medium		High		Total	
	N	%	N	%	N	%	N	%
Federal Government	0	0	0	0	2	3.4	2	3.4
Nonfederal Government	0	0	1	1.7	12	20.3	13	22.0
Not-for-Profit	1	1.7	1	1.7	28	47.5	30	50.9
For-Profit	0	0	1	1.7	13	22.0	14	23.7
Total	1	1.7	3	5.1	55	93.2	59	100.0

Chi-square = 2.62 6 Df Significance = 0.85 (NS)

Contingency coefficient = 0.025531

Table C
DISTRIBUTION OF SUBJECTS' AGE BY POWER PERCEPTIONS

Age	Power Perceptions							
	Low		Medium		High		Total	
	N	%	N	%	N	%	N	%
30-39	0	0	1	1.7	18	30.5	19	32.2
40-49	1	1.7	2	3.4	19	32.2	22	37.3
50-69	0	0	0	0	18	30.5	18	30.5
Total	1	1.7	3	5.1	55	93.2	59	100.0

Chi-square = 5.92 4 Df Significance = 0.20 (NS)

Contingency coefficient = 0.0558912

Table D
DISTRIBUTION OF SUBJECTS' SEX BY POWER PERCEPTIONS

Sex	Power Perceptions							
	Low		Medium		High		Total	
	N	%	N	%	N	%	N	%
Male	0	0	0	0	6	10.2	6	10.2
Female	1	1.7	3	5.1	49	83.0	53	89.8
Total	1	1.7	3	5.1	55	93.2	59	100.0

Chi-square = 0.82 2 Df Significance = 0.70 (NS)

Contingency coefficient = 0.0081333

Table E

DISTRIBUTION OF SUBJECTS' AMERICAN ORGANIZATION OF NURSE
EXECUTIVES MEMBERSHIP BY POWER PERCEPTIONS

	Power Perceptions							
	Low		Medium		High		Total	
	N	%	N	%	N	%	N	%
Member-ship								
Yes	0	0	2	3.4	41	69.5	43	72.9
No	1	1.7	1	1.7	14	23.7	16	27.1
Total	1	1.7	3	5.1	55	93.2	59	100.0

Chi-square = 4.77 2 Df Significance = 0.10 (NS)

Contingency coefficient = 0.0455283

Table F
DISTRIBUTION OF SUBJECTS' SALARY RANGE
BY POWER PERCEPTIONS

Salary Range	Power Perceptions							
	Low		Medium		High		Total	
	N	%	N	%	N	%	N	%
Less than \$29,999	0	0	1	1.7	5	8.5	6	10.2
\$30,000 to \$49,999	1	1.7	2	3.4	27	46.0	30	51.1
Over \$50,000	0	0	0	0	23	38.7	23	38.7
Total	1	1.7	3	5.1	55	93.2	59	100.0

Chi-square = 6.86 4 Df Significance = 0.15 (NS)

Contingency coefficient = 0.0641961

Appendix D

Permission to Use Instrument

END

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