



Workplace Empowerment as a Predictor of Nurse Burnout in Restructured Healthcare Settings

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ABSTRACT

A longitudinal design was used to test an expanded model of Kanter's (1977) work empowerment theory in a random sample of 192 staff nurses. Kanter argues that work environments that provide access to information, support, resources and opportunity to learn and develop are empowering and influence employee work attitudes and organizational effectiveness. A model linking the effects of structural and psychological empowerment at one point in time to nurses' reports of burnout three years later was tested. The Conditions of Work Effectiveness Questionnaire-II, Spreitzer's Psychological Empowerment Scale and the Emotional Exhaustion subscale of the Maslach Burnout Inventory-General Survey were used. Structural equation modelling analyses revealed a good fit of the data to the hypothesized model ($\chi^2=198.68$, $df=85$, $IFI=.90$, $CFI=.90$, $RMSEA=.08$). Perceptions of structural empowerment had a direct effect on psychological empowerment (.435), which in turn, had a direct effect on perceptions of emotional exhaustion (-.283). That is, nurses' perceived access to workplace empowerment structures resulted in increased psychological empowerment at Time 1 and these feelings of empowerment were

predictive of reported burnout levels at Time 2. These results strengthen those of previous cross-sectional research that linked empowerment to burnout among nurses and suggest that fostering environments that enhance perceptions of empowerment is an effective way of preventing burnout among nurses.

INTRODUCTION

A decade of hospital restructuring initiatives in Canada resulted in the layoff of thousands of nurses. Ironically, the nursing profession is currently experiencing a serious nursing shortage (O'Brien-Pallas et al. 1998; Ryten 1997; Sochalski 2001). According to the Canadian Nurses' Association, Canada could suffer a shortage of 113,000 nurses by the year 2011 (Canadian Nurses Association 1997). Given that fewer people are choosing nursing as a career and that the current nursing workforce is aging (Canadian Institute for Health Information 2000), it is becoming increasingly difficult to retain and recruit nurses. Buerhaus et al. (2000) argue that the nature of the work environment in nursing contributes significantly to this shortage.

There is considerable evidence to suggest that the current nursing work environment is harmful. Survivors of restructuring face increased responsibilities and fewer support staff to assist them. To add to this stress, the patients they look after are sicker. To cope with increased patient care demands, many hospitals have instituted mandatory overtime. Such arduous work schedules lead to exhaustion and the demoralization of nurses. In addition, nurses feel that their skills and abilities are not respected in the workplace. Thus, it is not surprising that nurses have become burned out (Baumann et al. 2002), with many leaving the profession all together (Aiken et al. 2001).

Many researchers (Aiken et al. 1997; Laschinger et al. 2002) argue that the working environment of hospitals must change if the current nursing shortage is to be solved. The results of Aiken's research on magnet hospitals suggest ways in which to change the hospital environment (Aiken et al. 1999; McClure et al. 1982). Magnet hospitals are hospitals that attract and retain nurses through participative governance systems wherein nurses are involved in decisions that affect their work. Nurses

in magnet hospitals have lower levels of burnout and higher levels of job satisfaction than those who work in non-magnet hospitals. Moreover, patient outcomes are better in magnet hospitals (Aiken et al. 1994; Aiken and Patrician 2000; Aiken et al. 1997). Laschinger (1996) also has demonstrated the importance of the work environment on work attitudes and behaviours. Nurses who consider their work environment to be empowering report higher levels of satisfaction and commitment, and lower levels of job strain and burnout than those who do not consider their work environment empowering (Laschinger et al. 2001). Recently, Laschinger and Almost (in press) linked workplace empowerment to the conditions that define magnet hospitals in three independent studies of nurses in different roles and settings.

Originally developed to explain organizational behaviour in the business sector, Kanter's (1977, 1993) Theory of Structural Power in Organizations provides a useful explanatory framework for studying work environments in other settings. Kanter argues that structural conditions in the workplace influence the ability of employees to accomplish work. Being able to perform one's job effectively influences job satisfaction, work effectiveness and levels of burnout (Hatcher and Laschinger 1996; Laschinger and Havens 1997). While there is considerable support, particularly in nursing populations, for Kanter's theory, most of this research is cross-sectional in design, and, of course, it is difficult to make definitive cause-and-effect statements with this type of design. The purpose of this study was to determine whether perceptions of structural empowerment could predict subsequent burnout three years later. If structural

empowerment is an effective tool at preventing burnout, then Kanter's theory could offer considerable practical advice for improving the working conditions in nursing that is both theoretically and empirically based.

THEORETICAL FRAMEWORK

Kanter's Theory of Organizational Empowerment

Kanter (1977, 1993) argues that people react rationally to the situation in which they find themselves. When situations are structured in such a way that employees feel empowered, they are more likely to be satisfied with their work and to feel that high-quality patient outcomes are achievable. Empowerment occurs when the work environment is structured in a way that enables employees to do their work. These are the organizational structures that Kanter believes are particularly important to the growth of empowerment: having access to information, receiving support, having access to resources necessary to do the job and having the opportunity to learn and grow. Access to these empowering structures is facilitated by formal job characteristics. That is, jobs which are visible and central to the organization's goals and which allow the employee flexibility enhance empowerment. In addition, informal job characteristics such as alliances with superiors, peers and subordinates within the organization further influence empowerment. Employees who believe their work environment provides access to these factors are empowered in Kanter's thinking. This results in increased levels of organizational commitment and feelings of autonomy and self-efficacy. Consequently, employees are more productive and effective in meeting organizational goals. In short, Kanter would argue that an empowered

environment provides an antidote to the deleterious conditions of the nursing environment that lead to burnout.

There is considerable support for Kanter's theory of empowerment in the nursing population. Empirical studies have linked empowerment to organizational attitudes and behaviours, such as organizational commitment (McDermott et al. 1996; Wilson and Laschinger 1994), job satisfaction (Laschinger et al. 2001) and trust in management (Laschinger et al. 2001). Recently, Laschinger et al. (2002) found that changes in staff nurses' workplace empowerment predicted changes in their job satisfaction over time. At least two studies have examined the relationship between structural empowerment and burnout. The studies found, as expected, that empowerment was associated with lower levels of burnout and job strain (Hatcher and Laschinger 1996; Laschinger et al. 2001). However, since this research is cross-sectional, it is unclear whether lack of empowerment lead to burnout, or whether perceptions of burnout coloured the perceptions of empowerment.

Spreitzer (1995) took a somewhat different approach to empowerment. Instead of focusing on the actual characteristics of the work environment, she focused on the psychological interpretation employees make of this environment. She defined psychological empowerment as a psychological state that employees must experience for managerial interventions to be successful. Psychological empowerment has four components: meaning, competence, self-determination and impact. Meaning entails the congruence between the beliefs, values and behaviours of employees and the requirements of the job. Competence refers to

the confidence employees have in their ability to perform their job. Self-determination refers to feelings of control over work. Impact is a sense of being able to influence important outcomes within the organization.

Spreitzer and Mishra (2002) argue that psychological empowerment enables employees to cope better with stressful working conditions, thereby increasing their loyalty to organizations, even under difficult circumstances. In their study of 350 aerospace employees, they found that more empowered employees had greater attachment to their organization during a period of downsizing. However, empowerment did not predict voluntary turnover, directly or indirectly through commitment. Other researchers have linked psychological empowerment to organizational commitment (Kraimer et al. 1999; Spreitzer 1995; Wu and Short 1996) and turnover intentions (Koberg et al. 1999).

In sum, there is evidence from both Spreitzer's and Kanter's work to suggest that employee outcomes are related to empowerment (be it psychological or structural). What then is the relationship between the two approaches? We argue that psychological empowerment is a logical response to structural empowerment. That is, providing access to structural conditions of empowerment described by Kanter may lead to feelings of psychological empowerment, which in turn affects job attitudes and behaviour. Laschinger et al. (2001) did indeed find support that psychological empowerment was an intervening variable between structural empowerment and job satisfaction.

Burnout in Nursing

Burnout is a common phenomenon in nursing and other health professions. According to Maslach and Leiter

(1997), burnout is "the index of the dislocation between what people are and what they have to do. It represents an erosion in values, dignity, spirit and will – an erosion of the human soul. It is a malady that spreads gradually and continuously over time, putting people into a downward spiral from which it is hard to recover" (17). Burnout results in chronic emotional exhaustion, cynicism and detachment from work and feelings of ineffectiveness on the job. Burnout is a serious problem that is costly for both people and organizations. Maslach and Leiter (1997) describe several sources of burnout. A major source of burnout is an overloaded work schedule, that is, having too little time and too few resources to accomplish the job. Lack of control (e.g., a situation in which reducing costs becomes more important than meeting client or employee needs prevails), performing tasks that conflict with employee values and beliefs and a breakdown in social work factors are also factors that lead to burnout. Performance suffers when work is so fast-paced that workers lose a sense of community. Finally, unfair management practices may lead to distrust and disillusionment among employees and result in symptoms of burnout.

Burnout has been studied extensively in nursing. Several studies by Aiken and her colleagues linked lower levels of burnout to work environments that provided job autonomy, control over the practice environment and good nurse/physician relationships (Aiken et al. 2002; Clarke et al. 2001). Emotional exhaustion has been related to work pressure (Robinson et al. 1991) and a lack of workplace support (Sims 1997). Bakker et al. (2000) found that nurses who feel that the demands of their job exceed the accompanying rewards reported

higher levels of emotional exhaustion than those who did not experience such an imbalance. This relationship was particularly strong for nurses with strong needs for personal control. Simoni and Paterson (1997) found that nurses with greater hardness who used direct-active coping behaviours (changing the stressor, confronting the stressor, finding positive aspects in the situation) reported lower burnout than did those who were less hardy and used inactive coping responses.

While none of these studies directly looked at empowerment and burnout, the presumed causal variables are consistent with variables comprising empowerment. For example, job autonomy, control over practices, lack of support map quite easily onto Kanter's concepts of having access to information, receiving support and having access to resources necessary to do the job. Thus, the research discussed above suggests that an empowered environment is less likely to lead to burnout. More direct evidence of the relationship between structural empowerment and burnout was found in the work of Hatcher and Laschinger (1996) and Laschinger et al. (2001). These cross-sectional studies found that perceptions of structural empowerment were related to burnout.

Very few studies have been conducted using longitudinal research. Thus, in this study, we hope to show that structural and psychological empowerment will predict subsequent burnout three years later. This time lag enhances our ability to interpret the results by reducing potential concerns over temporal causality confronted with cross-sectional research (Pearce and Sims 2002). Given the high costs associated with burnout, the results of this research will have important implica-

tions for creating environmental conditions that reduce the likelihood of this phenomenon.

Model to Be Tested in the Study

This study was designed to test a model of empowerment derived from Kanter's and Spreitzer's theories. We hypothesized that structural and psychological empowerment at Time 1 would predict burnout at Time 2. More specifically, we predicted that structural empowerment would enhance feelings of psychological empowerment, which in turn would decrease perceptions of burnout three years later. In other words, employee perceptions of structural empowerment should have direct effect on psychological empowerment, which in turn should have a direct effect on burnout. The effects of structural empowerment on burnout are indirect with the relationship between structural empowerment and burnout being mediated by psychological empowerment. Presumably, nurses who have the necessary support and resources to perform their jobs effectively should feel more psychologically empowered. This in turn should translate into a healthier approach to work, resulting in less burnout down the road. In other words, when nurses feel that they have the resources and skills necessary to provide high-quality care, they will be less inclined to manifest symptoms of burnout, such as emotional exhaustion.

METHOD

Setting and Sample

The sample for this study was drawn from staff nurses at two points in time during the period of hospital restructuring in the province of Ontario (1998 and 2001). Six hundred nurses who worked in urban tertiary care hospitals were randomly selected from

the College of Nurses of Ontario registry list. In the second wave of the study, nurses who responded at Time 1 were re-surveyed to examine perceptions of working conditions three years later.

Strategies suggested by Dillman (1978) were used on both occasions to maximize the return rate. Thus, for both time periods, three mailings were conducted. The first mailing was followed by a reminder letter at three weeks, and a second questionnaire was mailed three weeks later. As a token of appreciation for the time to complete the lengthy questionnaire, nurses received a gift certificate from a popular coffee shop. In the first wave of data collection, 20 questionnaires were returned due to change of address and another 15 were returned uncompleted. The final sample for Time 1 consisted of 412 useable questionnaires (73% overall return rate); 195 males (70.1% return rate) and 217 females (75.6% return rate).

To determine the effect of prolonged exposure to an increasingly stressful work environment brought on by the uncertainty of downsizing, burnout was measured at Time 2. Thus, respondents were re-surveyed in early 2001. Two hundred thirty-nine people completed the questionnaire, yielding a response rate of 58%. Although the sample is smaller than the original, it is still powerful enough to test the proposed model. While there is no commonly agreed upon method for calculating sample size for testing structural equation models, Hoyle (1995) maintains that sample sizes of 200 yield stable results for various fit indices used to determine the degree of fit between observed and expected patterns of results. Thus, the sample is well within accepted parameters.

Although the overall return rate (58%) for this wave was satisfactory,

there were considerably fewer eligible cases for analysis as many nurses who participated in the first phase of the study were not accessible for the second phase. Eight respondents had retired, 10 left the profession, eight were on long-term disability, three died, eight were now working in administrative roles and 31 were no longer at the same address. Only four chose not participate. It was impossible to determine the reason for non-participation of the remaining 47. We compared respondents who responded to both surveys with those who did not complete the second questionnaire and did not find any significant differences on demographic variables.

Of the 239 questionnaires returned, 54 respondents did not complete the entire questionnaire. Thus, the final matched sample for the two points in time was 192 (104 females, 88 males). This sample consisted of nurses who worked both full time (58%) and part time (42%). They worked in a variety of different specialities: 34% were in medical-surgical, 36% were in critical care, 11.5% were in maternal child and 18.5% were in psychiatry. Twenty-two percent of the respondents had baccalaureate educational preparation; most were diploma-prepared (78%). Respondents averaged 40 years of age, with 16 years of nursing experience and 8 years experience in their current workplace.

Data Collection Instruments

The major variables in this study were measured by questionnaires that have been used routinely in the literature. Structural empowerment was measured by the Conditions for Work Effectiveness—II (CWEQ-II) (Laschinger et al. 2001), psychological empowerment was measured by

Spreitzer's (1995) Psychological Empowerment Scale (PES) and burnout was assessed by the Emotional Exhaustion subscale of the Maslach Burnout Inventory—General Survey (MBI) (Schaufeli et al. 1996). Items on the CWEQII and the PES were rated on 5-point Likert scales. The five items of the MBI-GS were rated on 7-point scales ranging from 0 to 6. These three measures have been used in previous studies of staff nurses. All scales had acceptable internal consistency with reliabilities ranging from .77 to .91 (see Table 1). More detailed information about the characteristics of these scales can be found in the result section under measurement model. Data were collected on respondents' gender, age, years of nursing experience, years on current unit, specialty area, educational level and work status.

Data Analysis

Structural equation modelling techniques (Arbuckle 1997) were used to analyze the hypothesized model. Structural equation modelling (SEM)

is a comprehensive approach to modelling relations among variables and is particularly useful for testing theory. The primary aim of SEM is to model covariances, which entails proposing a set of relations and evaluating their consistency with the relations actually observed in an existing data set (Bollen 1989). SEM procedures were used in this study because this approach permits modeling a set of relations among constructs, simultaneous estimation of all hypothesized paths and estimation of indirect or mediating effects. Unlike multiple regression or ANOVA, the SEM approach explicitly acknowledges the presence of measurement error and provides a means of controlling for it in the analysis (Baron and Kenny 1986; Hoyle and Smith 1994).

There is little consensus in the SEM literature concerning the best index of overall fit for evaluating structural equation models (Hoyle and Panter 1995). Based on Hoyle and Panter's (1995) recommendations, several criteria were used to evaluate fit of the model. These included omnibus fit

indices, such as the Chi-square (χ^2) (Jöreskog and Sörbom 1989), and incremental fit indices, such as the Comparative Fit Index (CFI) (Bentler 1988), the Incremental Fit Index (IFI) (Bollen 1989) and the Root Mean Square Error of approximation (RMSEA) (Browne and Cudeck 1989).

The χ^2 is interpreted as the test of the difference between the hypothesized model and the just-identified version of the model. It is actually a "badness-of-fit index"; therefore, smaller values indicate better fit (Hoyle and Panter 1995). Low nonsignificant values are desired (Kline 1998). However, the χ^2 is very sensitive to sample size. Thus, in a model with a relatively large sample size, the null hypothesis is expected to be rejected almost all of the time. Because of this limitation, the χ^2 was used only to evaluate the relative differences in fit among competing models. Incremental fit indices indicate the proportion of improvement of the hypothesized model relative to a null model in which it is assumed that there is no correlation

Table 1. Measurement model

Constructs/Indicators	Mean	SD	Alpha Reliability	Unstd. Loadings	SE	Std	R ²
Structural Empowerment	—	—	.77	—	—	—	—
Opportunity-1	11.09	2.45	.79	.788	.148	.546	.298
Information-1	7.34	2.47	.81	.528	.131	.365	.133
Support-1	7.67	2.40	.77	1.00	—	.709	.502
Resources-1	8.77	2.27	.78	.475	.113	.349	.122
Formal power-1	7.16	2.09	.66	.741	.123	.602	.363
Informal power-1	11.46	2.12	.60	.483	.119	.387	.150
Psychological Empowerment	—	—	.87	—	—	—	—
Meaning-1	12.34	2.30	.94	1.55	.378	.721	.520
Confidence-1	13.13	1.76	.85	1.18	.301	.733	.537
Autonomy-1	10.63	2.53	.86	1.33	.307	.572	.327
Impact-1	6.90	2.81	.92	1.00	—	.387	.150
Burnout (emotional exhaustion)	—	—	.91	—	—	—	—
Emotionally drained by work-2	3.52	1.50	—	.729	.064	.709	.502
Used up at end of day-2	3.78	1.51	—	.736	.064	.713	.509
Wake up tired-2	3.15	1.67	—	.974	.064	.854	.729
Work a strain for me-2	2.78	1.65	—	1.00	—	.887	.787
Burned out by work-2	2.87	1.77	—	.980	.070	.810	.657

among observed variables. The generally agreed upon critical value for the CFI and IFI is .90 or higher (Kline 1998). The RMSEA is the standardized summary of the average covariance residuals and is thus a measure of the lack of fit between the data and the model (Kline 1998). Low values (between 0 and .06) indicate a good-fitting model (Browne and Cudeck 1989). Modification indices are computed for each parameter that is constrained to zero within the model. This index "approximates the amount by which the model's overall c^2 would decrease if a particular parameter were freely estimated" (Kline 1998: 134). However, consideration of whether or not to add a path suggested by these indices should be made on theoretical, not empirical grounds.

RESULTS

Testing the Model

The model proposed in this study tests the ability of our model to predict the effect of employee perceptions of structural empowerment and psychological empowerment at one point in time on their perceptions of burnout following a three-year period of working in stressful conditions. The model was tested using structural equation modelling (SEM) procedures for longitudinal analysis with maximum likelihood estimation. Prior to testing the hypothesized model, the potential confounding effects of contextual variables, such as age, sex, years of experience, unit tenure, specialty, hospital size and work status were examined. No statistically significant relationships were found and these variables were not included in the test of the hypothesized model.

Measurement Model

The CWEQ-II consists of 18 items designed to measure six components

of Kanter's concept of structural empowerment: formal power, informal power and perceived access to the work empowerment structures of opportunity, information, support and resources. Each component is measured by three items. Laschinger et al. (2001) established construct validity for this measure in a confirmatory factor analysis that revealed a good fit of the hypothesized factor structure ($c^2 = 279$, df = 129, CFI = .992, IFI = .992, RMSEA = .054). In this study, acceptable fit indices were obtained for this measure ($c^2 = 12.5$, df = 8, CFI = .97, IFI = .97, RMSEA = .054).

The Psychological Empowerment Scale measured the four components of Spreitzer's (1995) concept of psychological empowerment: meaningful work, competence, autonomy, and impact. Each subscale contains three items. Spreitzer (1995) established evidence of convergent and divergent validity in a study of managers and non-management personnel. Laschinger et al. (2000) further validated the proposed factor structure in a confirmatory factor analysis (CFA). In this study, the measurement model had acceptable fit indices ($c^2 = 4.63$, df = 1, CFI = .97, IFI = .97, RMSEA = .14).

The five-item Emotional Exhaustion MBI-GS subscale was used to measure burnout (Schaufeli et al. 1996). A CFA resulted in a good fit for the hypothesized factor structure with all items loading on a single factor ($c^2 = 2.81$, df = 4, CFI = .99, IFI = .987, RMSEA = .001). Factor scores were created for the sub-components of structural and psychological empowerment. The latent variable, Structural Empowerment, had six indicators (opportunity, information, support, resources, informal power, formal power), and the latent variable, Psychological Empowerment, had four indicators

(meaning, confidence, autonomy, impact). Emotional exhaustion had five indicators corresponding to the items in this instrument. Results for the measurement model are presented in Table 1. This table also includes the means and standard deviations of the individual scales.

Effect of Empowerment at Time 1 on Burnout at Time 2

A structural equation model was constructed to assess the influence of structural and psychological empowerment at Time 1 on emotional exhaustion or burnout at Time 2.

This analysis revealed a relatively good fit of the hypothesized model for the data according to standards recommended by Bentler and Bonett (1980) and Browne and Cudeck (1989). (The fit indices are: Chi-square=198.68, df=85, IFI=.90, CFI=.90, RMSEA=.08). The model accounted adequately for the observed covariances among the manifest variables. The standardized regression coefficients for the structural component of the model are shown in Figure 1.

The results revealed that perceptions of structural empowerment had a statistically significant direct effect on psychological empowerment at Time 1 ($\beta=.44$) and an indirect effect on burnout through psychological empowerment ($-.105$). Psychological empowerment at Time 1 had a significant effect on perceived emotional exhaustion at Time 2 ($\beta=-.28$). This suggests that creating environments that provide access to information, support, resources and opportunities to learn and grow resulted in increased feelings of psychological empowerment. Nurses' feelings of empowerment in their work environment at Time 1 predicted a significant proportion of reported levels of burnout at Time 2 ($R^2=.107$).

Figure 1. The impact of structural and psychological empowerment on burnout

DISCUSSION AND MANAGERIAL IMPLICATIONS

Our data suggest that perceived access to structural empowerment in staff-nurses work environment had an impact on psychological empowerment, and ultimately, emotional exhaustion after a three-year period of exposure to stressful working conditions. This study strengthens the results of previous cross-sectional research by Hatcher and Laschinger (1996). While their study showed that structural empowerment was related to burnout, the longitudinal design used in the present study enabled us to show that perceptions of structural empowerment preceded the burnout predicted by Kanter's theory. That is, antecedent variables were collected prior to the outcome variables enhancing the causal nature of the research. The results of the present study have both theoretical and practical implications. Theoretically, our results provide a way of integrating Spreitzer's work on psychological empowerment with that of Kanter's. More specifically, structural empowerment is an antecedent variable to psychological empowerment. Practically, the findings highlight the importance of creating environments that provide access to structures that empower nurses to accomplish their work. Such environments result in nurses feeling pride and accomplishment in their work and being less likely to experi-

ence burnout. Suggestions for creating such environments are discussed shortly.

Although the results are quite robust, the study nevertheless has limitations common to most longitudinal studies. It is possible that some other historical event occurred during this time period that may have accounted for our results. However, the downsizing and restructuring that occurred during this time period was a very salient event and it is hard to imagine a comparable historical event that would have been experienced by all subjects. (That said, the amount of restructuring experienced by different nurses would have varied across units and hospitals and thus may have affected the results.) Still, given that many events could have occurred between the two time periods, the fact that empowered individuals were able to emerge three years later experiencing less burnout is impressive. On a related issue, it is possible that other unmeasured factors may have affected their results. For example, the work of Simoni and Paterson (1997) suggests that personality characteristics, such as hardiness, may have also mitigated the impact of environment events on subsequent burnout. Thus, future researchers may want to address the role that personality plays in moderating the relationship between burnout and empowerment, and, in particular, explore the relationship between hardiness and psychological empowerment.

Another difficulty with longitudinal research is that the final sample is considerably smaller than the original. This raises the possibility that respondents who replied to both surveys were somehow different than those who only responded to the first survey or to those who did not respond at all. Fortunately, nurses in the final sample did not differ significantly from those in the original sample on any demographic or substantive variables. Unfortunately, we could not compare our sample to those who chose not to participate. Finally, as is the case with all studies in which the same subject completes all measures, method variance is a concern (although less than is the case with cross-sectional research).

Not only do these results have theoretical implications for the work of Kanter and Spreitzer, they also provide theory-driven suggestions to improve the working environment. Many of the sources of burnout described by Maslach and Leiter (1997) could be eliminated or reduced by creating structural conditions of empowerment advocated by Kanter. For instance, providing access to resources, such as time and personnel, would lighten nurses' overloaded work schedules, the most frequently identified source of burnout by nurses. Reasonable workloads would also avoid the possibility of nurses being forced to do things that conflict with their professional values and beliefs, such as not providing adequate patient teaching or leaving tasks undone at the end of a shift. Aiken et al. (2001) found that 26% of nurses in a study in the United States and Canada admitted that these important aspects of patient care often were left undone because of heavy workloads.

Providing access to information about organizational events and future

plans can provide nurses with a sense of control over their work environment, thereby reducing the likelihood of frustration and lack of trust in management. Managers who share information build a strong foundation for trust and cooperation. Brown and Kanter (1982) argue that when managers ensure that open and honest access to information occurs in a timely manner, they enhance their own credibility and integrity. Creating and maintaining both formal and informal lines of communication is an important way of keeping employees informed and communicating respect for their need to know about things that affect their work. Visible leadership, combined with coaching, counselling, facilitating and listening skills enables managers and staff nurses to interact effectively.

Providing support for nurses' work by demonstrating concern and understanding about the problems encountered by nursing staff is an important part of the managers' role. Nurse managers can enhance quality of work life by supporting the balance between family and work life through employment opportunities, such as job sharing and part-time work, or self-scheduling. Managers who work in a collegial manner with nursing staff will create a sense of community in the work unit in which all feel that they are important contributors to the process of achieving organizational goals. Participative management practices enable nurses to be involved in unit decisions that have an influence on their work. These practices communicate respect for nurses' abilities to contribute meaningfully to organizational issues beyond direct patient care concerns. Finally, regular, specific and timely positive feedback is a simple and effective way of supporting and recognizing nurses' contributions to

organizational goals.

Building alliances with other members of the healthcare team increases this sense of community and facilitates a more comprehensive, integrated approach to patient care. These alliances increase informal power and promote increased trust and respect among team members. Quality of work life is enhanced through a work environment that is characterized by healthy relationships with peers and the ability to function as a cohesive team.

Support for flexible approaches to patient care that reflect nurses' expertise and judgment fosters a sense of professional pride in nurses. Rigid adherence to rules and regulations without regard for individual situations is ineffective and communicates a lack of respect for nurses' knowledge as a basis for practice. This may contribute to nurses' feeling of burnout. According to Kanter, employees in this kind of environment tend to disengage from organizational activities, doing only what is necessary. Consequently, employees become disillusioned and organizational productivity suffers.

With today's flattened organizational structures and decreased resources, there is little room for vertical promotion. However, according to Kanter (1993), knowledge and skills acquisition are more important. Therefore, management must find other ways for providing nurses with opportunities that challenge their professional growth and development, build their knowledge and enhance their skills and expertise. Opportunities for staff nurse growth and development could include job enrichment activities, such as participation on cross-functional teams or job exchange programs, both internal and external to the organization. Other

activities for developing new skills include managing short-term projects, trying out new roles on an interim basis in internship programs and taking secondments to high-profile committees, projects or task forces within the organization that are critical, central and relevant to work accomplishments.

CONCLUSIONS

The results of this study support earlier cross-sectional research testing Kanter's theory and add to the body of empirical knowledge supporting the application of this theory in nursing work environments. Further evidence was established for the suggestion that psychological empowerment is a logical outcome of structural empowerment and that empowerment plays a role in preventing burnout. These results provide encouraging direction for healthcare managers charged with creating healthy workplaces for nurses. Healthy work environments benefit both nurses and ultimately the clients in their care. Nurses who are emotionally exhausted and burned out often experience apathy about their work and a lack of confidence in their abilities (Maslach and Leiter 1997). This is potentially dangerous for patient care. Thus, management must make every effort to create working conditions that prevent this syndrome from occurring. Managers must find ways to ensure that structures are in place to enable nurses to accomplish their work in a meaningful way and feel psychologically empowered. This will require abandoning the "command and control" style of management and adopting a more facilitative integrative approach. Such innovative approaches will help to ease the growing shortage of nurses both by attracting new members to the profession and encouraging experienced nurses to

stay. Our work suggests that application of Kanter's theory could be an effective recruitment and retention strategy in current healthcare work settings experiencing shortages of these essential personnel.

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Provider's Perspective

The System Must Respond

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Why is it necessary to add more excellent literature to a problem that is already well documented and understood but not acted upon? This is the fundamental question I am left with after reviewing the article by Laschinger, Finegan, Shamian and Wilk.

The question is not a criticism of the paper or the authors but, rather, a lament at the lack of systematic response to what we all know is a ticking time bomb for our healthcare system. The growing shortage and disaffection of nurses, arguably our most critical healthcare providers, must be addressed.

The authors add to the analysis in

an important way with their study design and attention to statistical thoroughness. Their longitudinal approach is an important step forward, as is their validation for nursing of findings in other work settings.

However, stripped of these important features, the article again points to the need to change how we structure our work settings and support our caregivers or we risk accelerating very dangerous trends. Still, there is a huge chasm between knowing and doing.

In this regard, the section "Discussion and Managerial Implications" is most enlightening, because the authors point out a number of logical and clear

methods to positively address both structural and psychological empowerment. However, as this section is read, one can easily see many barriers to these actions. Too small budgets, too little time and lack of long-term attention are but a few of the very real pressures preventing the system from generating effective responses. Still, for the attentive and long-term leaders who understand that the health of our system and its capability to meet the needs of our citizens is directly tied to the care of our caregivers, this article will reassure you that you are on the right track, or will hopefully stimulate you to begin the journey.