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THE DIFFICULT EMPOWERMENT IN DANISH HOSPITALS: POWER TO THE NURSES!?

Flemming Witt & Jørn Flohr Nielsen

UNIVERSITY OF AARHUS • DENMARK

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Flemming Witt & Jørn Flohr Nielsen

School of Economics and Management
University of Aarhus, Building 322
DK-8000 Aarhus C, Denmark
Phone: +45 8942 1585
E-mail: jflohr@econ.au.dk

Abstract

The employee empowerment literature promises better organizational performance as well as more motivated and satisfied employees. However, this literature often neglects the specific context of public services in general, or the health care sector, hospitals, and nursing in particular. Nurses in Danish public hospitals work in a unique situation that makes the uncritical transfer of empowerment interventions intended to redesign their work difficult or even unfeasible. Analysis from an institutional perspective of the ongoing power struggle between agents of change at several levels in the Danish health care field indicates how norms originating from the public bureaucracy and medical communities constrain such micro-level change initiatives. According to an organizational change perspective, narrow interventions would likely be inadequate, since conflict is likely given the particular characteristics of public organizations, and the specific attitudes of physicians and politicians and their desire to control the hospital sector. At the same time, this paper also emphasizes that the empowerment concept is likely to appeal to hospital managers and nurses in the Danish public hospital sector, since it builds on the nursing profession's self-conceptualization and is associated with better organizational performance. Our analysis starts by clarifying the concept of "nursing empowerment," and then applies a field perspective on Danish hospitals in order to identify the forces that may limit the possibility of empowering nurses and nursing. Based on this analysis, we discuss how to bring about successful nursing empowerment interventions.

Keywords: Barriers; Empowerment; Organizational Change.

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Introduction

General managerial trends made the 1990s an era of decentralization and empowerment. At the job level, however, the implementation of employee empowerment varies between nations, sectors, and organizations. For example, programs intended to increase such empowerment have not spread very successfully in Danish hospitals, a phenomenon that calls for explanations at several levels.

Hospitals are complex organizations in a complex field. They involve highly skilled and educated groups of experts each having their own strong opinions, norms, and traditions as to how work should be organized. These actors participate in the development, interpretation, and implementation of management structures at both the field and hospital levels. At the same time, hospitals are embedded in the public sector in many countries, which poses unique challenges when organizational change interventions are considered. In Denmark, research shows that organizational change has always been part of the public hospital sector, because of changing medical technology and personnel. Now, however, hospitals are being increasingly challenged by external resource-allocating actors, such as politicians, administrators, and patients, who question hospitals' resource consumption, priorities, structure, and function (Bentsen, Borum, Erlingsdottir, & Sahlin-Andersson, 1999). This has led to a focus on management and organizational reform initiatives that may contest the autonomy of the professions working in hospitals.

These reforms tend to be top–down initiatives, formulated at the field level and expected to be implemented at the organizational level; moreover, these initiatives are inspired by management and organizational theory developed outside the hospital sector (Bentsen et al., 1999). This approach to organizational change, which is embedded in a new public

management ideology, regards professional autonomy and traditions as part of performance and efficiency problems in the public hospital sector; given this view, conflict with the professions is likely (Jespersen, 2005). This external focus has so far been directed to management structures, at the organizational level of analysis (Sognstrup, 2003). In the future, however, emphasis could well be on the redesign of the jobs of hospital employees—including of nurses—and such job design initiatives in nursing w ould affect care quality, nursing attitudes, and hospital performance (McKee & Healy, 2002).

However, research into job design has been criticized for applying too narrow an outlook on working conditions (Parker & Wall, 1998). Previous prescriptions for job redesign have provided few guidelines that were useful in a public hospital nursing context, because it was insufficiently understood that these prescriptions comprised multilevel interventions involving complex political processes. Danish public hospital context may possess unique characteristics that make the uncritical transfer of job design interventions developed outside this context difficult or even unfeasible. Indeed, Danish empirical evidence shows that externally generated new public management reforms have had little or no impact on hospital work infrastructure at the job level (Bentsen et al., 2003).

Organization theorists have focused on structural variables as the antecedents of better organizational performance and positive individual. To a certain extent, the existence of enabling structures seems to be a necessary precondition, though proper action may also depend on individual employee attributes. The organizational concept of "empowerment" is one way to conceptualize enabling job redesign. In the late 1980s and in the 1990s, empowerment was the object of rigorous conceptualization and measurement, and it was basically understood to be an intrinsic motivational construct, a state of mind, an experience of being enabled that greatly

depends on the individual personality (Conger & Kanungo, 1988; Thomas & Velthouse, 1990). However, empowerment is also a structural construct denoting the practical delegation of responsibility down the hierarchy, giving employees increased decision-making authority and autonomy in doing their jobs. Both perspectives are important in the analysis of empowerment among hospital nurses, since they are generally considered to be dedicated to their work, i.e. driven by intrinsic task motivation (Seymour & Buscherhof, 1991), though the degree of dedication may be closely connected to proper work design and organizational structure (Adams & Bond, 2000; Tummers, Landeweerd, & van Merode, 2002). In addition, insights from critical empowerment theory suggest that one must carefully consider how the empowerment concept is understood, defined, and applied.

What forces hinder – or push – empowerment to Danish hospital nurses? Who is pushing and who is resisting? These are the main questions this paper attempts to address. The question is sufficiently large and complex that any answer must be incomplete and preliminary. The analysis is mainly based on recent empirical investigations carried out by other researchers and especially the authors' interpretation of Danish observations. Nevertheless, the aim is to develop propositions that may guide future research and practitioners' change efforts.

From both the descriptive and normative perspectives, this paper argues that although empowerment is a positive concept which can offer solutions overall organizational problems, it is a concept that needs to be applied with caution. In addition to general implementation difficulties, the introduction of empowerment, in redesigning nursing work, is likely to create resistance in a public hospital setting. Conflict could well arise between the two dominant professions, doctors and nurses.

Organizational and Critical Perspectives on Empowerment

Empowerment cannot be considered as a simple tool in the hand of management or a clearly defined intervention but the organization theorists' distinction between structural and psychological perspectives on empowerment contains some clarifications (e.g. Conger & Kanungo, 1988).

The structural or relational approach focuses on empowering management practices at the group or individual level of analysis, i.e. what management does to its employees, including the decentralization or delegation of decision-making authority as well as increasing the access to information and resources of employees at lower levels in the organizational hierarchy. Also emphasized in the approach are low formalization, continuous training, and the development of a so-called "psychological climate" (Carless, 2004; Kanter, 1979; Randolph, 1995; Spreitzer, 1996). Although psychological climate refers to how organizational environments are perceived and interpreted by employees and reflects their judgment of the degree to which their work is beneficial to their sense of well-being within the organization, its development greatly depends on intentional *structural* design. Management can influence psychological climate in several key ways, including by the development of role clarity, supportive leadership, professional interaction, appraisal and recognition, and opportunities for professional growth (Carless, 2004). Structural empowerment is rooted in job design. The rationale of this view is to release human potential in the organization, by giving employees the autonomy and opportunities.

Job design will help employees feel more in control of how they perform their jobs, be more aware of the business and strategic contexts in which their jobs are performed, feel they can choose between alternative actions, and believe they have some influence on what happens in

their job environments (Spreitzer, 1995). This should ultimately lead to more motivated and satisfied employees as well as better organizational performance (e.g. Bowen & Lawler, 1992). The mentioned feelings have been labeled "psychological empowerment," referring to cognitions that reflect the motivational content of being empowered (Spreitzer, 1995). Thus, psychological empowerment is a motivational and cognitive construct that refers to a process of creating positive perceptions and feelings among individual employees; these positive perceptions and feelings concern their job roles, and in turn increase the employees' intrinsic task motivation (Conger & Kanungo, 1988; Thomas & Velthouse, 1990). The antecedents of psychological empowerment may also greatly depend on individual attributes or interpretive styles (e.g. Thomas & Velthouse, 1990).

Researchers have discussed whether psychological empowerment is indeed something management tries to "install" in employees via intentional job design initiatives, or is rather an independent mind-set that employees have concerning their roles in the organization (Quinn & Spreitzer, 1997; Randolph,1995; Randolph, 2000). Efforts based on the assumption that employees tare merely passive recipients of a seemingly brilliant empowerment program designed by management are likely to fail. Structural empowerment initiatives on the part of management may increase the likelihood of psychological empowerment, but this alone is not a sufficient condition. Structural empowerment becomes just one of many antecedents that must be perceived by employees in order to facilitate psychological empowerment. Therefore, psychological empowerment theorists do not define structural initiatives such as delegation as empowerment *per se*, but rather as empowering conditions.

Both perspectives might be important in empowering a given workforce; taken together they create a two-level perspective on job design (Robbins, Crino, & Fredendall, 2002), a

perspective that creates the basis for analyzing general empowerment interventions and implications for practitioners.

However, there is a growing body of research indicating that general empowerment interventions fail to deliver promised performance and employee satisfaction improvements (Barker, 1993; Cunningham & Hyman, 1996; Forrester, 2000; Foster-Fishman & Keys, 1997; Labianca, Gray, & Brass, 2000; Lashley & McGoldrick, 1994). Some authors often explain this by citing local implementation difficulties, such as middle-management's reluctance to delegate power, potential intrapersonal "dark sides" of empowerment (e.g. strain and stress), or the lack of a more holistic perspective on empowerment initiatives (i.e. omitting required levels of analysis or relevant variables) (Forrester, 2000; Robbins, Crino, & Fredendall, 2002; Xie & Johns, 1995). However, researchers who are critical of "empowerment" initiatives emphasize that they do not indicate a moral turn on the part of management with respect to employee democracy in the workplace, but rather embody cynical instrumentalism in the interests of achieving greater legitimacy (Abrahamson & Rosenkopf, 1993; Staw & Epstein, 2000), more invisible but more effective control mechanisms (Barker, 1993; Hardy & Leiba-O'Sullivan, 1998), and/or merely exploit employees to improve organizational performance or displace responsibility for failures (Alvesson & Willmott, 1992; Argyris, 1998; Eccles, 1993). Employees can see through management intentions and may try to work against the implementation of empowerment initiatives, which is why empowerment initiatives fail (Labianca, Gray, & Brass, 2000).

Looking over these three perspectives, it can be argued that although each one interprets the empowerment construct slightly different, they are mainly complementary in contributing to an

overall understanding of empowerment in the workplace. In order to capture this reality, we provide the following general working definition of empowerment:

Empowerment is a process by which management enables certain job-related and positive psychological experiences of its employees in order to achieve improved performance and increased employee job satisfaction. Key antecedents of these experiences are the delegation of decision-making authority, access to organizational resources and organizational information, training, and the development of a supportive psychological climate. In addition, employees must have confidence in management intentions and a desire to be empowered, and management must be sensitive to this confidence.

According to this definition, structural empowerment initiatives are antecedents of psychological empowerment, and though it is management's responsibility to empower the workforce, employees must also choose to empower themselves. At the same time, this definition includes the critical perspective, via the emphasis on trust between employees and management as well as on employee personality attributes, i.e. emphasizing that employees should be able and willing to empower themselves. This definition also implies that empowerment initiatives are meant to be about simultaneously improving both organizational performance and the working environment, although not all employees may want to be empowered under those conditions. Management must therefore be sensitive to differences in needs and to the distribution of employees in different work units; accordingly, it must be prepared to differentiate the amount of empowerment extended to employees. Applied to Danish hospital nursing, this paper's definition of empowerment translates to "nursing empowerment," in which the delegation of decision-making authority to individual nurses includes the authority to make decisions regarding *both* patient care (e.g. defining provision and resolving diagnosis and discharge-related issues) *and* how nurses organize their own work (e.g.

allotting patients and work shifts). In addition, by definition nurses are to have access to organizational resources, such as the right to assign unit resources. This is broader autonomy than is found in the "parallel hierarchy," in which the nursing profession only has the authority and responsibility to organize its own work (Jespersen, 2005); it also confers broader autonomy on individual lower-level nurses than does the existing concept of "primary nursing," for example, because nurses have the autonomy to assign and allot patients among themselves (Bydam et al., 2003). The responsibility for nursing empowerment lies at the departmental level, since in Denmark hospital departments are usually self-contained units with a high degree of financial autonomy and responsibility (e.g. Sognstrup, 2003).

The next two sections present an institutional perspective on the Danish hospital sector and demonstrate that nursing empowerment, as defined here, may be difficult to without considering the broader political context of the hospital field. We also note that the empowerment construct was developed in the private sector, meaning that uncritical transfer of it to the public sector could be difficult, since the public sector may have attributes that differ greatly from those of the private sector. In general, change efforts in health care can hardly be described by the rational model. As stressed by Scott (2003), changes are influenced by competing logics (professional, state, and managerial).

The Case of Danish Public Hospitals

Danish hospitals exist in a context that makes it difficult to compare them with either private organizations or other public organizations. Danish hospitals differ from private organizations in that they generally have a unique context and attributes, which makes the implementation of management techniques developed outside this context unfeasible (e.g. Meyer, 1982). Danish hospitals also differ from other public organizations in that they employ powerful professionals,

who must be more involved in and have a greater impact on organizational change initiatives than is the case with other public-sector employees (Jespersen, 2005). Healthcare services in Denmark are somewhat comparable with those in USA and other Western European countries, in the sense that the healthcare services field is an institutional arena undergoing changes at several levels and in several respects, including in the managing and organizing of service delivery (Scott, Ruef, Mendel, & Caronna, 2000; McKee & Healy, 2002).

Therefore, organizational change interventions cannot be understood without an analysis of the organizational field in which they are to be embedded, an analysis which this paper will seek to do. An organizational field, as a level of analysis, lies between the organizational and social levels. The concept refers to a collection of organizations that in the aggregate constitute a recognized area of institutional life. To be defined as a field, the organizational interactions must be regulated and systemized as follows: "an increase in the extent of interaction among organizations in the field; the emergence of sharply defined interorganizational structures of domination and patterns of coalitions; an increase in the information load with which the organizations in the field must contend; and the development of a mutual awareness among participants in a set of organizations that they are involved in a common enterprise" (DiMaggio & Powell, 1983:148).

As also recognized by institutional theorists, institutional constraints do not completely determine human action at the micro level (Barley & Tolbert, 1997). However, it is important to take into account how even apparently rational planned change—even empowerment initiatives implemented at a specific level—are restricted and modified by institutional and cultural influences.

Hospitals as public organizations

The hospital field in Den mark is to a major extent safely embedded in the public sector, as all major political parties agree upon the safeguarding of hospitals as a tax-financed public service providing equal and free access for all citizens (Borum, 2004). Two defining characteristics of public organizations are that they are constantly under public scrutiny and that political interests are integral to their existence. This means that public organizations are subject to a greater range and intensity of external influence regarding decisions and have a greater need for approval and support from external field-level constituencies, such as regulatory bodies, unions, citizens, and clients, than private organizations do (Rainey, 2003; Rainey et al., 1976). Thus the purposes, methods, and spheres of operation of public organizations tend to be defined and constrained by law and legally authorized institutions. This is not surprising in the case of hospitals, since they have a large impact on the health of citizens, absorb much of the public budget, and are large employers. Hospitals also play a political role, creating legitimacy, serving as indicators of national progress and political ideology, and ensuring the health and welfare of citizens (McKee & Healy, 2002). Consequently, hospitals may find it hard to construct and implement internal management structures on their own without external intervention, or, alternatively, hospitals may be subject to pressure from various external constituencies to implement certain internal management structures that may not be in the hospitals' best interest. This pressure is likely to be reinforced by the employment, by these external constituencies, of powerful professionals with varying degrees of expert authority. Delegation of decision-making authority is, under these conditions, often met with resistance.

Because of their political context, public organizations must generally pursue a greater number of goals that are often more complex, vague, and conflicting than those addressed by private organizations. Public hospitals must pursue various intangible health-related objectives, i.e.

treatment and care in response to changing illness patterns in the general public, which creates a need for both a broad range of competence and a high degree of specialization. This entails teaching and research, since hospitals cannot exist without a supply of trained staff or without knowledge generated by appropriate research. In sum, this means that public hospitals tend to become organizationally complex, and that it is hard to define overall objectives, and this creates a basis for diversity and conflict among hospital employees. Since these employees are themselves powerful professionals in control of core activities, hospitals become arenas for power struggles. Consequently, it is difficult for any decision-maker in the hospital to attain autonomy in deciding on organizational issues if no agreement is achieved between key actors.

These objectives may all be conflicting and complex to operationalize. Hospitals, as a source of employment, are in direct conflict with empowerment initiatives, since delegation of decision-making authority and access to organizational resources often leads to layoffs and to changes in the roles of middle managers. But the very multiplicity of hospitals' goals is indirectly connected to barriers to empowerment, since multiple, vague, and conflicting objectives make it difficult to design unambiguous incentives and secure employee willingness to accept more decision-making authority and responsibility. At the individual level of analysis, goal conflict can lead to role conflict, which in combination with a lack of clear incentives has been shown to be inversely related to psychological empowerment (Spreitzer, 1996).

There is also a structural disconnect between the field and organizational levels in the public sector, in the sense that both the spatial and psychological distances between these levels are usually large. Politicians may have little insight into public services; they are elected for only limited periods, and may therefore focus more on signaling their ability to act by suggesting and initiating management structures and goals that are boundary setting and are easily and visibly

achieved. Implementation of deeper management initiatives, such as job design at the departmental or individual level, is solely the responsibility of individual organizations. It may also be difficult for public-sector employees to engage in debate or even to deliver information to decision makers (Rainey, 2003; Rainey et al., 1976). If politicians also tend to forget to include hospitals and/or public sector employees in policy formulation, and to neglect the results of such participation, then there may be little connection between goals and the means of achieving them. This may result in resistance on the part of hospitals to management initiatives proceeding from the organizational field level, meaning that employees will continue to work as before. All these characteristics seem to exist in the Danish hospital context (Jespersen, 2005; Vrangbæk, 2003).

The consequences of this disconnect may be reinforced by the lack of perfect market mechanisms in the public sector, since public organizations are predisposed to maintaining certain management structures (Rainey, 2003; Rainey et al., 1976). Almost all Danish hospitals are non-profit organizations, which collectively have a monopoly over the delivery of a large part of health services; this results in less incentive for cost reduction and operational efficiency. This factor is also relevant with respect to organizational structures, because when organizations do not have to make a profit and deliver their output in voluntary *quid pro quo* transactions, they may develop certain bureaucratic characteristics, such as excessive formalization, highly elaborate hierarchies, and rigidity that would be inefficient in the market and are in direct conflict with the ideals of empowerment. These characteristics may be strongly supported by norms of "equal treatment under the law" in client relationships and norms of democratic control (Downs, 1967).

Hospitals as professional bureaucracies

In addition to the special characteristics of all public organizations, hospitals employ powerful health professionals, who have their own interpretations of acceptable management structures, which may complicate organizational interventions (Jespersen, 2005). The power of the health professions stems from the fact that only doctors and nurses have the knowledge, skills, and authorization to carry out core hospital activities, i.e. defining patients' health care needs and providing treatment and care. This puts health professions in a key position regarding the allocation of health care resources, which creates a need for their professional representation in the regulatory bodies that, among other matters, are responsible for developing and interpreting new management initiatives in the hospital sector. As a result, these professions have a significant amount of control over the definition and demarcation of work areas and conditions in the hospital field, i.e. the government grants professional autonomy in return for the health professions providing public services. However, inherent in this interdependent relationship between health professions and the government are various conflicts, such as that between medically defined need and limited financial resources. In addition, according to the theory of professions, the behavioral characteristics of professions include a constant striving for unchallenged monopoly over knowledge and control in a particular area of expertise, for status, trust, respect, and social recognition, and for active defense from regulation and competition from other professions. This monopoly is gained or maintained via positive relations with the environment, regulatory bodies, and other organizations, but also by seeking to influence public values and norms (Sognstrup, 2003). In sum, this makes professions' relationship with the public administration apparatus and each other a primary focus in understanding hospitals.

Although professions and the government should be viewed as opposing powers, and not as involved a superior–subordinate relationship, we have witnessed increasing government

regulation in the hospital sector in Denmark since the 1980s. This is primarily manifested in increasing budgetary control and attempts to dictate acceptable alternative organizational-level management and organization structures so as simultaneously to achieve higher health care quality, higher service quality, and cost containment (Jespersen, 2005). Significant government regulation of the public hospital sector is unavoidable and even necessary, because of the potential side effects if professionals exercise complete monopoly and control. These side effects, which are well known from economic theory, include the misuse of power to lower quality or obtain personal benefit, poor internal handling of patient complaints, and reduced incentive to reduce costs and achieve operating efficiency. Despite this increase in direct government intervention, hospitals have retained autonomy in determining their organizational-level structures and in organizing work within their departments; however, even these areas of autonomy are receiving greater government attention, because of a higher prioritizing of administrative policy. Indeed, the Danish Ministry of Finance has been a primary force in the development of new public management strategies for the public sector, and external administrative experts with a political or economic background are now playing larger roles in formulating health policies and in running hospitals (Jespersen, 2005).

New public management in the health care sector is less a coherent theory concerning the reform and renewal of the sector and associated management tools, than it is a strategy or tendency based on an ideology that favors strengthening market mechanisms in the public sector and focusing on new forms of organizing inspired by the private sector. The market mechanisms invoked include the privatization or outsourcing of hospital activities, management by contract, performance-based compensation, a broader range of service alternatives, and greater patient influence on health care. New organizational designs could include features such as a flat or flexible structure, an output orientation, continuous

registration of performance, benchmarking, and the introduction of concept-based management techniques. Such strategies are implemented in a belief that they will bring about increased productivity, greater effectiveness and quality, greater service focus, and better control over health professionals. In Denmark, new public management has been dominated by these new forms of organizing (Bentsen et al., 1999).

As mentioned, new public management initiatives in the hospital sector are also designed to limit the autonomy of and increase control over the professions. New public management has a tendency to view professions as part of the problem rather than as part of the solution in improving performance and modernizing the health care sector. This has meant that professions have been affected in several ways. First, the professions have traditionally wielded great influence in the hospital field via representation on diverse public councils and commissions, but since the 1980s in Denmark there has been a tendency to involve professionals less at the field level, by limiting their access to the policy formulation arena and reducing their influence to lobbyism. In addition, more members of these councils are now people with a general management background (Jespersen, 2005). Second, new public management puts an alternative discourse on the health care agenda, which challenges the institutionalized health–dominated discourse and ultimately threatens the professions' self-conceptualizations and traditions. It is now legitimate to talk about hospitals as organizations that achieve different levels of performance; it is also legitimate to talk about patients as customers or clients.

Despite this challenge to the established institutional constellation, the health professions still retain a relatively dominant position at all levels of the Danish hospital sector (Bentsen et al., 1999; Sognstrup 2003). At the field level, the professions still have great access to the formulation and development of the legislation that regulates the hospital sector—more so than

in other sectors and professions. This access also includes nurses via the Danish nurses' organization (Sygeplejerådet) (Jespersen, 2005). One consequence of this is that there has been great stability or continuity in the arguments and alternatives regarding the overall organization and management of the hospital sector. One example is the argument that specialization and larger hospitals equal higher health care quality, an argument apparently unsupported by sufficient empirical evidence, but which nevertheless has resulted in the introduction of the "function-bearing unit" structure (Borum, 2004).

Professions are also dominant in hospitals. Professionals are often characterized as powerful actors who are more compliant to the norms of their professions than to the administrative hierarchy, which is why hospitals are often labeled "professional bureaucracies." At the hospital and especially the department level, the professions are still represented in management via head nurses and head doctors, although there has been pressure to abandon this divided management approach (Sognstrup, 2003). Hospital management is responsible for implementing reform initiatives established by institutions outside hospitals, and such initiatives are of course subject to local interpretation. This has resulted in management practices dominated by health profession thinking and interests (Jespersen, 2005).

Thus, at the operational level there are clear manifestations of isomorphism and professional continuity, since job design and routines are similar from hospital to hospital and have not changed significantly over the years. Rosters, conferences, ward rounds, and division of work are similar from place to place, which may be partly due to the strong professional networks of which health professions are part. This standardized work infrastructure creates stability and predictability in an often chaotic work environment, and also makes it easier for professionals to alternate shifts between departments or even hospitals. This continuity also means that it is

relatively hard to change hospitals' organizational structure and job design (Vinge & Knudsen, 2003). However, there are also examples of relatively great organizational change initiatives that were easily implemented, such as structural reorganization when new treatment technologies are introduced. These organizational changes seem to have been more successful because they are in accordance with professional norms and self-conceptualizations, and are therefore accepted by professionals as natural and unavoidable. The really difficult organizational change efforts are those that clash with professional norms and values in the hospital sector (Jespersen, 2005). Thus, regarding the relationship between professions and the administrative apparatus, there is room for several organizational change initiatives (Vrangbæk, 2003).

However, professions do not form a coherent whole, working together towards common ends in relation to their environments. The theory of professions emphasizes that professions strive to protect, expand, and maintain a monopoly over a particular area of expertise and work—often at the expense of other professions (Sognstrup, 2003). So, to understand the nursing profession, and what is likely to happen if nurses are empowered, one must examine the relationship between nursing and other professions. This paper will mainly analyze the relationship between nurses and doctors.

Doctors' area of expertise is the diagnosis and treatment of illness and injury, and education and research associated with this. This area of expertise is protected via official authorization. Doctors have traditionally defined the surgical and medical profession as the leading profession in the health sector, thus implicitly defining other health professions as subordinate. This position is maintained by field-level participation in counsels and commissions, while patient and public trust is facilitated by doctors' vows of professional secrecy and internal codes of

ethics. Doctors actively seek to influence and control the routines and organization of their own work.

Nurses' area of expertise is the care of ill and injured people, and this care is specified in terms of health-related elements, as well as related pedagogical and psychological elements. This professional position is also protected via official authorization that excludes the less educated from certain jobs. Nurses are seeking status on the same footing as doctors, by trying to define "care" as a separate body of knowledge via efforts to establish it as an independent research area. Nurses have gained the right to organize their own work in hospitals, which has resulted in the spread of the division of management between nurses and doctors (Jespersen, 2005). Nurses also participate at the field level and maintain the trust of patients and the public by means of ethics guidelines and behavioral norms. Common to both professions, but especially characteristic of nursing, is a humanistic attitude towards patients and a great intrinsic desire to provide high quality service and make a difference to the well-being of the patient. The existence of this humanistic attitude have apparently been confirmed by international studies (Seymour & Buscherhof, 1991).

These descriptions of the characteristics of doctors and nurses as professions suggests that there is potential for conflict at the field level, especially due to doctors' view of nurses as subordinate and to nurses' wish to free themselves from this view. This conflict is likely to spill over to the hospital level and manifest itself when organizational change reforms, including nursing empowerment initiatives, are interpreted or implemented locally within hospitals, since the empowerment of nurses poses a direct threat to doctors' self-conferred right to define and organize health-related issues in the hospital. It is likely that this conflict only really concerns the hierarchical positions of the two professions and not the principle of their right to manage

their own personnel in hospitals (Sognstrup, 2003). However, the definition of nursing empowerment formulated in this paper expands nurses' decision-making autonomy to include decisions regarding patients and unit resources that go beyond merely organizing nurses' own work; this makes conflict between professions more likely, since nurses are expanding their influence into the doctors' traditional domain.

The role of hospital managers

Although management at the department level is done by professionals in Denmark, top managers in hospitals primarily have a generalist background in social science (Jespersen, 2005). This reflects and reinforces administrative–professional conflicts. As mentioned by Blau (1967), there is a built-in tension between the "democratic" professional hierarchy and the parallel "bureaucratic" administrative hierarchy existing in professional bureaucracies. This conflict stems from the differences between the characteristics of management and professional logic.

Hospital managers with general social science training emphasize employee loyalty and commitment to the organization and obedience to orders and rules established by superiors in the organizational hierarchy, with the goal of making a profit that can secure the survival of the organization. These values clash with professional traditions that emphasize professional autonomy, loyalty to the profession and to patients, and the development of technical expertise in order to secure the highest quality treatment and care for patients based on the supply of medical technology. These logics clash because management logic tries to introduce a range of control mechanisms based on utility prioritizing, thereby supplanting the professions' logic of caring for all patients who need care. It is not acceptable according to professional logic to prioritize treatments, if the result is that some ill people will receive no treatment (Vrangbæk,

1999). Thus, the potential for conflict exists at several levels. Hospital managers are responsible for the implementation and enforcement of new public management initiatives in hospitals, and these initiatives increasingly emphasize economic factors, such as cost containment and productivity. These initiatives clash with the professional value of securing the highest quality of health care for patients, since it is difficult simultaneously to improve quality and reduce costs. Professionals are also not used to interference from anyone other than their peers, and perceive control mechanisms other than self-regulation as degrading and as obstructing their autonomy.

However, complex tasks make supervision and standardization difficult as modes of control. Instead, a high degree of self-control is suggested and even goal setting is questionable (Mills et al., 1983). Since managers with a general social science background usually have little insight into the core activities of patient diagnosis, treatment, and care, hospitals have a decentralized structure in the sense that the professionals executing the core activities have considerable power to work with clients without interference from anyone but their colleagues. Since there are also differences between the nature of the tasks and the size of various hospital departments, Danish hospital departments still have significant autonomy to organize their own activities as well as the responsibility to adhere to budgets (Sognstrup, 2003). This autonomy and responsibility would also enable the empowerment of nurses. It is still hospital managers, however, who control resource allocation in hospitals. Consequently, management and professions are dependent on each other, and it is thus unlikely that organizational or management change will succeed without some form of local compromise between managers and professions, or alternatively, without a dominant local coalition.

Thus, there seems to be a latent conflict between the three main parties comprising the Danish hospital sector. In addition to the likely conflict between doctors and nurses, there is also a conflict between both these professions and politicians, inspired by the general managers responsible for implementing new public management reforms. If change is to be introduced into this institutionalized system, then the boundaries between individual professions and management must be renegotiated, and this is likely to produce overt conflict between all parties.

In sum, this review suggests that the Danish hospital field is a continually changing, complex political system. However, the hospital field is in some respects a relatively stable field, and its many embedded and resistant professional traditions, routines, and norms make it hard to implement organizational change and job redesign initiatives. Furthermore, public hospitals have unique characteristics that distinguish them from other organizations—especially from private organizations—and this could influence efforts to empower nurses in departments using conventional empowerment definitions and programs.

Power to the Nurses!?

The body of literature dealing with empowerment—structural as well as psychological—promises that empowerment will bring about better organizational performance and more motivated and satisfied employees. Both outcomes are primary components of higher health care quality at a time of increasing budgetary restrictions (McKee & Healy, 2002). Some international studies have investigated these relationships in the American and Canadian nursing contexts (Laschinger et al., 2004; Laschinger & Wong, 1999), but the literature dealing with organizational empowerment generally pays little attention to the specific characteristics of public services—especially of the health care sector in general, and of

hospitals and nursing in particular. As we have seen, in addition to the general problems and side-effects encountered when implementing empowerment in itself, there are also great risks associated with examining changes in the working conditions of Danish nurses in isolation from the political and public organizational context of which they are part. This is mainly due to field-level influence on hospitals, for example, from politicians who want more control over the professions, or from physicians who want to define nursing as a supporting profession subordinate to them. However, it is also because some of these political interests may spill over to the organizational and departmental levels, and cause conflict between different groups of employees, for example, between hospital management and nurses or between nurses and doctors. Such conflicts can affect the likely outcome of any organizational change effort designed to empower Danish nurses in public hospitals. In addition, hospitals are public organizations that may contain built-in organizational barriers to the empowerment of nurses. In sum, these characteristics suggest that the uncritical application of "empowerment" as a way to change the working conditions of nurses may lead to overgeneralizations based on inaccurate assumptions about cause-and-effect relationships. In other words, unless a more holistic perspective on empowerment in a Danish public hospital nursing context is adopted, it is unlikely that redesigning jobs so as to empower Danish nurses will succeed.

Although steps have been taken to clarify these assumptions and relationships, multilevel theories of empowerment often remain implicit in empirical research. One theoretical paper tried to advance universal propositions for a three-level (individual, group, and organizational level) perspective on empowerment (Robbins, Crino, & Fredendall, 2002), but empirical validation was lacking. Furthermore, a recent empirical analysis tested hypotheses regarding a two-level (group and individual level) perspective on empowerment in a manufacturing company (Seibert, Silver, & Randolph, 2004). In the Danish public hospital field, however,

these perspectives are inadequate, since they do not take account of empowerment antecedents at the field level, the unique characteristics of public organizations, or conflict between groups of employees in an organization. Such a multilevel structural perspective illustrating how empowerment intentions may interfere with organizational conditions is presented in Figure 1.

[Insert Figure 1]

This paper has argued that Danish hospitals—characterized as public professional bureaucracies—are strongly influenced by field-level conflicts between various constituencies, making it therefore practically impossible for individual hospitals to eliminate field-level influence on management practices and organizational structure. This in turn makes it difficult for hospitals to implement nursing empowerment without some form of approval or acceptance from a dominant coalition of field-level actors. For an example of field-level coalition formation that exerted pressure on hospital management, take the development of the so-called "trojka management" model. This model emphasizes collegiality between the health professions as well as "unequivocal management" (*entydig ledelse*) where there is only one superior at each level. Trojka management was regarded as recognizing nurses' authority and responsibility to organize their own work and as downplaying the physicians' professional project of defining nursing as subordinate. Unequivocal management, in contrast, can be regarded as strengthening the doctors' position in hospitals. Similarly, the introduction of the "function-bearing unit" as an argument for larger hospitals reinstalls medical expertise as the core competence in managing hospitals (Borum, 2004). This power struggle in itself makes delegation difficult, and to the extent that there is room for empowerment nurses will probably hardly be involved. This leads to the following general proposition:

Proposition 1: Efforts to initiate nursing empowerment in public Danish hospitals are subject to conflicting field-level interests between external constituencies (i.e. the nursing and medical professions, unions, regulatory bodies, and patients).

More specific propositions are developed below and connected to the model in Figure 2.

[Insert Figure 2]

Key to the initiation of any empowerment effort in a organization is top management commitment, since they are likely to project their values and commitment onto department managers, who in turn can influence, for example, the amount of training provided, the level of formalization, and the level and amount of information and resources shared (e.g. Quinn & Spreitzer, 1997; Robbins, Crino, & Fredendall, 2002). However, there is a risk that management will not commit to nursing empowerment, since support from field-level constituencies has only emphasized boundary setting and has historically focused on recommending alternative acceptable organization-level structures, and has generally not given hospital management the authority or resources to enforce deeper organizational change (Jespersen, 2005). This lack of commitment is reinforced by the likely spillover of conflict from the field level to employee groups in the hospital, which has made nursing empowerment a long and conflict-ridden process, so far lacking in promising productive results. However, field-level actors have recently begun to intervene in department-level structures, by formally directing hospitals to implement particular departmental structures, i.e. it is likely that there are some department-specific formal restrictions on acceptable or unacceptable management structures or formalized restrictions on nurse behavior. This leads us to suggest the following two propositions:

Proposition 2: Lack of commitment on the part of hospital (top) management can negatively influence the initiation of nursing empowerment.

Proposition 3: Formal and budgetary restrictions are negatively linked to the initiation of nursing empowerment.

Key antecedents to nursing empowerment include the delegation of decision-making authority from department heads to individual nurses, access to organizational resources and information, and the development of a supportive psychological climate. However, department heads may in general be reluctant to delegate decision-making authority and access to department resources and information because of a fear of becoming superfluous (Kanter, 1979). Because of this, department heads might also find it difficult to provide supportive leadership, train nurses, accept professional growth, or provide appraisal and recognition. In addition, professional conflicts from the field level may spill over to department employees, and this may make it difficult to foster professional interaction and recognition between doctors and nurses. This tendency is reinforced by the high degrees of specialization in departments, which create a basis for diversity, power struggles, and role conflict. In sum, it may be difficult for department management to develop a supportive psychological climate. These arguments suggest the following two propositions:

Proposition 4: Department heads are reluctant to delegate decision-making authority, resources, or information to nurses when the departments are subject to tight budgetary control.

Proposition 5: Department heads find it difficult to create a supportive psychological climate when consensus is lacking.

The *critical* empowerment perspective suggests that department heads may be confronted by unwillingness on the part of many nurses when initiating nursing empowerment efforts. In addition to the difficulty of designing incentive systems that persuade nurses to accept more decision-making authority, this unwillingness may also stem from nurse distrust of management motives for changing job design, or particular nurses may even have low personal need for further decision-making autonomy. Increasing patient expectations, and their increasing authority to define their own care needs, may result in a low sense of competence and choice on the part of nurses, which might reinforce their reluctance to accept more decision-making authority. Indeed, a large Danish patient survey shows that although 84% of patients are satisfied with the care and treatment received at hospitals, patients now appear to be less passive and less inclined to accept the authority of doctors and other hospital employees. More patients now seek information from sources other than hospitals and general practitioners (Aarhus Amt, 2005).

Proposition 6: Nurses will demonstrate a low willingness to accept increased decision-making authority when the initiation of nursing empowerment is proposed by management.

Proposition 7: Explicit patient rights and expectations have an inverse effect on nurses' willingness to accept increased decision-making authority.

In sum, the characteristics of the Danish nursing context suggest that empowerment, when defined as a means of redesigning work, is likely to run into several adoption and

implementation barriers. Testing more specific propositions, such as those mentioned above, calls for deeper comparative, empirical research. Furthermore, international comparisons from an institutional perspective, like that of Coles' (1989) comparative analysis of small-group activities in the USA, Japan, and Sweden, may be a fruitful supplementary approach.

Implications for Organizational Change Interventions

The propositions set forth in this paper suggest that several factors limit the plausibility of using nursing empowerment as a job-level organizational change intervention in order to improve performance as well as nursing motivation and satisfaction. But do factors that facilitate nursing empowerment also exist? If so, is it possible to negate or minimize the mentioned barriers to nursing empowerment?

Externally initiated organizational change initiatives seem to have been unsuccessful in changing job design in the Danish hospital sector (e.g. Jespersen, 1999; Vinge & Knudsen, 2003). In addition to professional resistance, this may also have resulted from a rational organizational decoupling defense mechanism that has evolved to secure a reasonably stable working environment. According to Brunsson and Olsen (1993), organizations embedded in an environment containing conflicting institutional demands will tend to incorporate these demands into their organization. The management level will initiate suggestions, programs, and reforms, thereby signaling its willingness to act and its ability to change. However, the operational level of the organization may continue to work as it always has, or existing reforms may be coupled to other reforms or postponed in a way that neutralizes the effect of the existing reforms (Brunsson & Olsen, 1993).

Although this decoupling defense mechanism will not facilitate nursing empowerment, since no change actually takes place at the job level, the idea of hospitals' not being completely constrained by external forces, i.e. being actually capable of choosing to disconnect their technical core from the external environment, may prove promising for nursing empowerment. In practice, this could be facilitated by temporarily buffering central activities (rather patient care than departments) from their institutional surroundings, and be ready to use participation and conflict-handling interventions to increase local cohesion. For example, the observation of (although few) successful adoptions of lean thinking in hospitals indicates that they are not only institutions constrained by external forces, as seen from a deterministic perspective, but they should also be seen from a more voluntaristic perspective. Astley and Van de Ven (1983) argue that at the organizational level, each perspective alone only gives a partial view of reality; only when both perspectives are applied together can we achieve a comprehensive understanding of organizations. We do not claim that hospitals may completely ignore or even shape these contingencies, but that there is *some* room for planned change to make nursing empowerment more acceptable—especially by local actors. It is an empirical matter to specify what constitutes sufficient acceptance and formalized agreement, and how this is to be achieved. From an organizational change perspective, we should expect that narrow intervention will not suffice.

If a supportive situation can be created, a local-level project may lead to job-level organizational change for nurses, by producing some form of hybrid between organizational forms dominated by professional regulation and new public management. At present, strategic choice in initiating nursing empowerment and buffering should be possible, because hospital departments already possess considerable autonomy (Sognstrup, 2003) and because there is a tradition of field-level encouragement of experimenting with organizational forms and

structures (Jespersen, 2005). Protecting a project by granting it "experimental status" or by defining it as part of new public management within well-defined spatial and temporal boundaries may be ways to protect it from critical external control.

It should be noted that to negate the barriers to nursing empowerment described in this paper, and, we believe, to successfully implement nursing empowerment, the initiative for changing nurses' job design has to come from individual departments in hospitals and should not consist of externally initiated organizational change reforms. Locally initiated projects are more likely to increase understanding—both between professions and of management demands for economic consciousness. The manifestation of organizational-level conflict between management and professions or between nurses and doctors depends on how hospital management, on one hand, and individual professionals, on the other, in a particular hospital prioritize their commitment to the environment or to the local context and how much local trust exists between these parties. In their hospitals and departments, nurses and doctors can suggest and construct the division of work and interpret organizational change in ways that contradict existing field-level professional intentions. Hospital managers can seek to implement structural changes that, although inspired by new public management ideas, are sensitive to and build on professional norms and self-conceptualizations. Indeed, in the case of Denmark, there is recent empirical evidence concerning how interference tensions are perceived by hospital managers. Compared to the managers of other public organizations, they have to pay more attention to *all* the actors in their environment—county administration, politicians, professions, unions, media, and users—most of whom, including the professionals, are considered as "constructive partners" rather than opponents (Vrangbæk 2003).

In departments, the willingness of nurses to become empowered is the important condition and only through dialogue is it possible to diagnose the desire of individual nurses for autonomy, so management can respond by differentiating the degree of decision-making autonomy extended to individual nurses. In addition, the composition of nurses in different work shifts can over time provide vicarious experience and modeling for nurses with a low willingness to accept autonomy, as such vicarious experience has been shown to be correlated with psychological empowerment (Conger & Kanungo, 1988). A department management's reluctance to delegate decision-making autonomy, resources, and information may be overcome by focusing on tactics for enhancing collaboration and reassigning leadership roles. Locally, hospital and department management may commit to nursing empowerment if it is initiated with local consensus between department managements and professionals; if thus initiated, it is more likely to be associated with better performance and more motivated and satisfied nurses. Locally, doctors may also support nursing empowerment, since this level is less concerned with politics than the field level is and because nursing empowerment is in line with physicians' professional logic of autonomy and thus can be seen as part of a general redistribution of power from general managers to professions.

If localized consensus for nursing empowerment can be achieved, there is also a chance that nursing empowerment may be accepted as a job-level change intervention for nurses at the field level. This concept fits the nursing profession's agenda of getting field-level participants to focus more on the working conditions of nursing, and its desire to place nurses at the same organizational level as physicians. However, this project may raise up resistance from the medical profession, since nursing empowerment may be regarded as a threat to their desire to control the hospital sector. Conversely, doctors could well support the nursing empowerment concept, since they may regard it as tending to erode the control exerted by non-professionals in

the hospital sector. Furthermore, nursing empowerment fits with the ideas of new public management, since the concept is associated with organizational change and performance improvements. Finally, nursing empowerment is in line with patient expectations of responsiveness and higher quality interactions with nurses.

Conclusions

This paper focused on the empowerment of nurses as a way to redesign their jobs so as simultaneously to improve hospital performance and produce more motivated and satisfied nurses in the Danish hospital sector. The definition of "nursing empowerment" we presented integrated three theoretical perspectives on employee empowerment and expanded the current definition of nurses' autonomy to encompass decisions regarding both the organization of their own work and patient care.

Based on a broad analysis of the Danish hospital sector, this paper suggests that uncritical transfer of the empowerment construct to the present context may be difficult. In addition to the general difficulties of implementing empowerment initiatives, too many special interests may be embedded in the current job design, so that nursing empowerment initiatives may be more than likely to create conflict. Furthermore, public organizations have particular contexts and attributes that complicate the application of the nursing empowerment construct, since empowerment prescriptions have been developed outside the public sector. Indeed, this paper suggests six concrete theoretical barriers to nursing empowerment, namely: a need for field-level acceptance; reluctance on the part of hospital management to commit to nursing empowerment; formal and budgetary restrictions; the reluctance of department management to delegate decision-making authority, resources, and information; difficulties in creating a

supportive psychological climate; and low nurse willingness to be more empowered. Future research should seek to verify the existence of these barriers to nursing empowerment.

Prescriptive theories of organizational change argue that job design should be aligned with the larger organizational and group designs within which the job is embedded (Cummings and Worley, 2001). This quest for alignment is based on empirical findings indicating that job design is interrelated to both growth need strength and social system structure. This indicates that to understand the full effect of job design initiatives, both worker characteristics and organizational features must be taken into account (Pierce, Dunham, & Blackburn, 1979).

Given these contingencies, a more voluntaristic perspective emphasizes that these suggested barriers to nursing empowerment could perhaps be negated or minimized to facilitate the successful implementation of nursing empowerment initiatives in the Danish hospital sector. However, such change initiatives may have to originate from individual employees in hospital departments and not from external pressure: when nursing empowerment efforts are initiated by employees, they are much more likely to be accepted by nurses, doctors, and management. This is in line with Cole's (1989) international study that indicates the necessity of some degree of local invention to introduce improvements in small-group activities. At the field level, nursing empowerment is likely to clash with the desire of politicians to exert more control over the hospital sector, and with the desire of the medical profession to define nursing as a support profession subordinate to it. However, doctors could well support nursing empowerment, since it could be regarded as reducing the bureaucratic control in the hospital sector. Although it is difficult to exclude external influence on management structures, hospital departments currently largely comprise self-contained units and experimentation with organizational forms

is encouraged in some of them; this means that attempts to buffer patient care from the influence of external constituencies may not be out of the question.

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Figure 1: Barriers to Empowerment at Different Levels

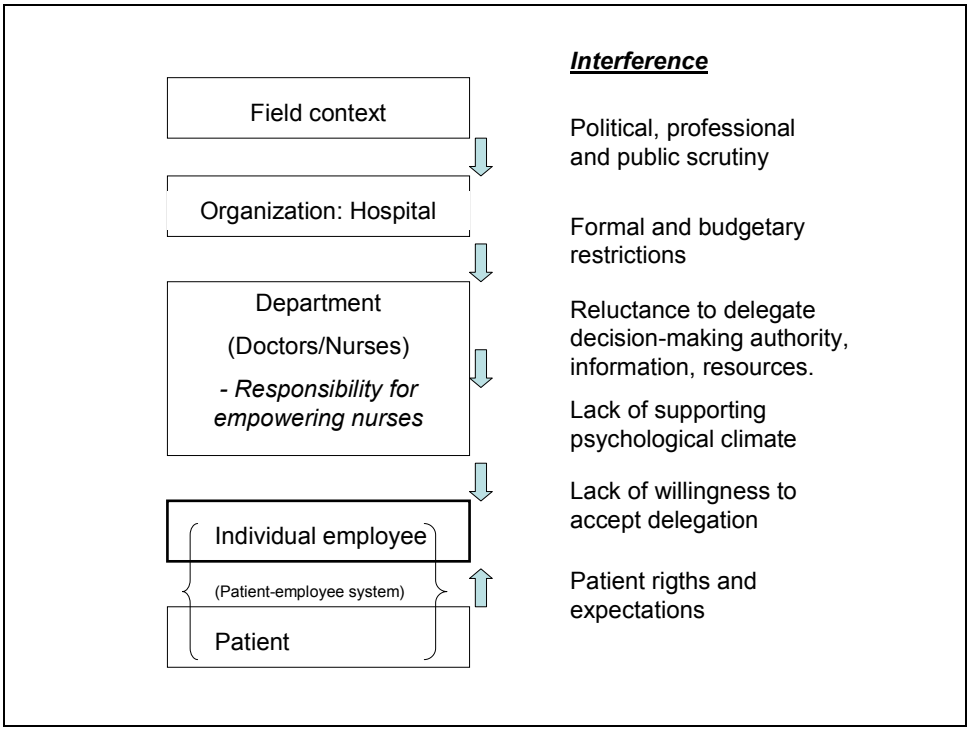
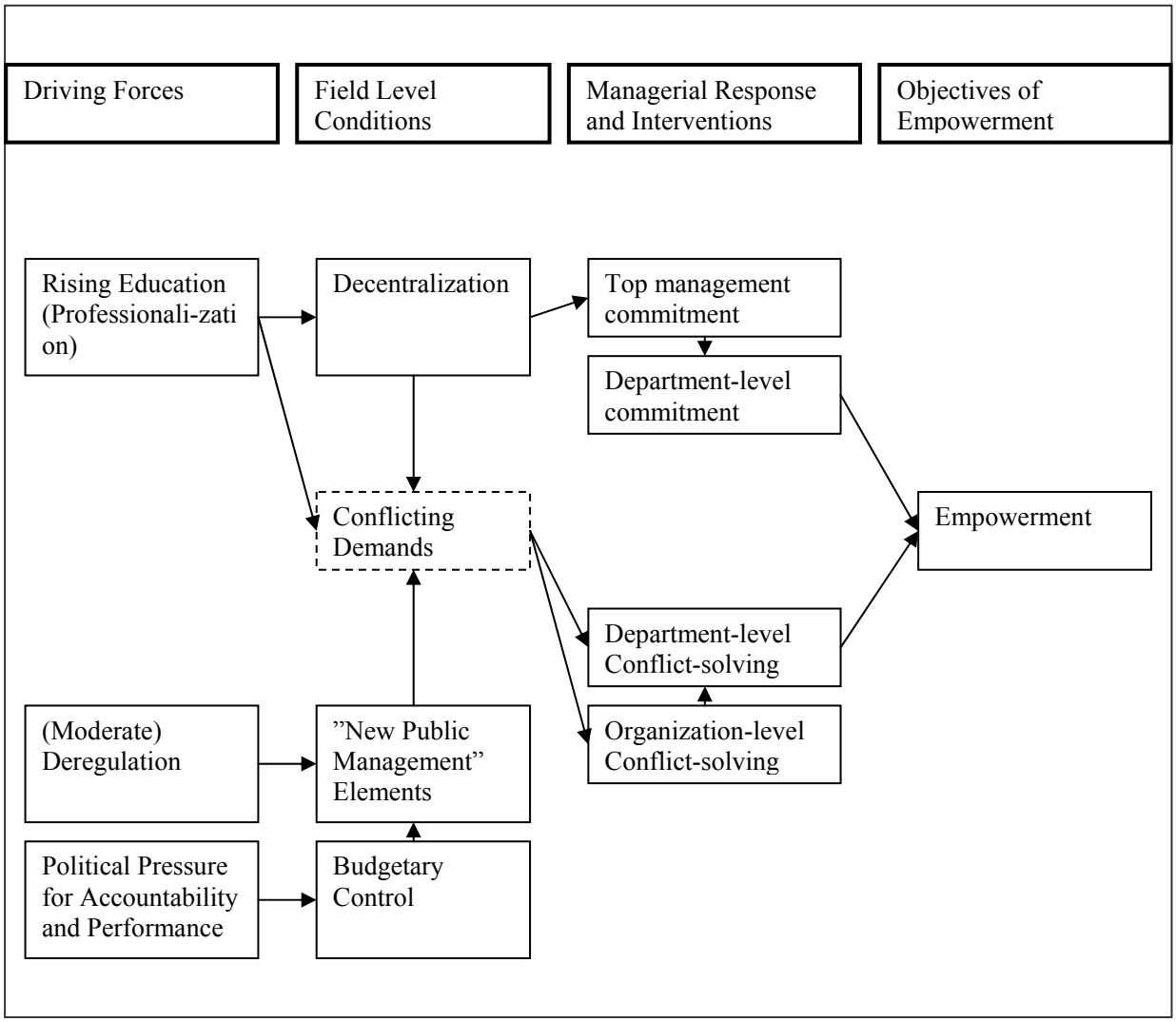


Figure 2: The Path to Empowerment in Danish Hospitals



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