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A Correlational Analysis of Empowerment and Experience with Resistance to Change

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Abstract

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MS, Keller Graduate School of Management, 2007

BS, Excelsior College, 2002

Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Despite more than 60 years of research about the nature of change, resistance to change remains a problem across industries. Health care leaders have limited knowledge of how health care managers' perceptions of empowerment, years of experience, and resistance to change (RTC) relate. The purpose for this nonexperimental correlational study was to examine the relationship between empowerment, years of experience, and RTC among managers via an online survey. The theoretical framework incorporated Kanter's structural empowerment theory and Kotter's change theory. The sample included 245 out of 1,181 health care managers from Veterans Administration (VA) hospitals in the New York metropolitan region, recruited through a nonrandom purposive sampling method. There was a significant association measured between empowerment and RTC ($r = -.132$, $p = .05$), but no association between years of experience and RTC ($r = .060$, $p = .348$). The regression model showed that years of experience and perceptions of empowerment together in one model was not a significant predictor of RTC ($F(2,242) = 2.82$, $p = .062$, $R^2 = .023$). In the model, perceptions of empowerment was a statistically significant predictor of RTC ($\beta = -.136$, $p = .03$), but years of managerial experience was not ($\beta = .074$, $p = .249$). These findings, while not generalizable, offer a unique examination of organizational change among an underexamined population. According to study results, as empowerment increased, RTC diminished. In contrast, experience did not relate to the propensity to resist change. These findings have social implications for VA and general business leaders who may use these results to improve change management plans, empower staff, reduce RTC, and enhance organizational and patient outcomes.

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Dedication

I dedicate this work to my dad, James Edward Winters, and to my grandma, Ann F. McCarroll. I miss you both every day. Every child should have a hero, and I was lucky enough to have two. Thank you for always believing in me and for teaching me that hard work never killed anyone. Everything I have and everything I am, I owe to you.

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To coin a phrase, it takes a village to graduate a doctoral student. I would never have completed this dissertation without the people that surround me with love and support. There is a line in one of my favorite Neil Young songs that says it all, " . . . just find someone who's turning, and you will come around." The people who keep me turning include David, my amazing, loving, patient, supportive husband; my sunshine Rachael, Daniel, and Moe; my almost-mom-and-always-friend Mary; my extended family; those remarkable Brentwood Ladies; and my VA friends. Thank you all for keeping me going. You grace my life, and I thank you, thank you, thank you.

I also thank the brilliant professors and academics who supported and guided me along the way, including Dr. Anthony, Dr. Blando, Dr. Lentz, Dr. Dunfee, Dr. Granoff, Dr. Taylor, Hillary Wentworth, and Elizabeth Peterson. Your generosity, willingness to help, and expertise proved invaluable. I extend heartfelt gratitude to Dr. Lynn Szostek, for her constant encouragement and excellent advice along the way. I know I would not be completing my doctorate if it were not for her. For Dr. Szostek and the others who helped me along the way, I thank you for being the giants upon whose shoulders I humbly stand.

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Section 1: Foundation of the Study

Health care in the United States is costly, complex, and changing at an unprecedented pace (Birken, Lee, Weiner, Chin, & Schaefer, 2013). The need for organizational change in the 21st century appears to be unrelenting (Lewis, Romanaggi, & Chapple, 2010). Health care organizations need leadership that affects change rather than merely responding to or resisting change. Organizations that fail to change in response to stakeholder needs lose ground or may cease to exist (Hope, 2010).

Large-scale change happens with considerable frequency across most industries (Maurer, 2011), but despite its rate of recurrence, effective change management remains a significant challenge for many organizations (Birken et al., 2013). With failure rates for change initiatives holding firm at 70% (Maurer, 2011), identifying and implementing successful change practices continues to elude most business leaders and managers. Fundamental reasons for change failure include resistance to change and mismanagement of the change process by change agents (Kotter, 1996; Werkman, 2009). Managers are the primary change agents for most organizations (Hope, 2010), but often lack the power to manage change effectively (Kanter, 1993). Continued change failure breeds change resistance among employees (Ford & Ford, 2010), creating demoralizing and costly consequences for organizations.

Background of the Problem

The American health care environment is turbulent and marked by complexity (Chassin & Loeb, 2013). Organizations frequently merge and restructure, and the staff turnover associated with the reorganization contributes to an environment in which

leaders and managers have varied years of experience (Ng & Feldman, 2013). Leaders are struggling to keep pace with the constantly changing landscape amidst significant financial challenges (Chassin & Loeb, 2013). Change management is complex, and change failure is costly (Maurer, 2011). Health care is no exception to this rule. A number of variables contribute to change failure, but researchers routinely cite change resistance as the principal reason (Werkman, 2009). Without improved management of change, health care organizations face quality challenges and financial difficulty (Erwin, 2009).

Effective change depends on an engaging and visionary leader who can communicate the need for change (Kotter, 1996). Spicker (2012) identified a consistent tendency in the management literature to criticize managers as defenders of the status quo. This viewpoint reinforces the misconception that management is distinct from leadership (Spicker, 2012). Kotter's (1996) criticism of management as a source of resistance is evidence of this dichotomy. Kotter cited a shortage of leaders amongst many managers as the cause of change failure. According to Kotter, a lack of leadership and a focus on stability by managers limits change effectiveness.

Without diminishing the significance of executive leadership, the role of managers and frontline staff in change effectiveness is equally important (Hope, 2010). Kanter (1993) established that empowered subordinates drive effective change when managers act as conduits for free-flowing resources, communication, and support between the executive and frontline staff. Executive leaders create change strategy, but

the manager's relationship with stakeholders determines the success of the change

strategy (Buss & Kuyvenhofen, 2011; Melo, 2012).

According to the United States Bureau of Labor Statistics, more than 293,490

health care managers work throughout the United States, and the majority of managers

work within hospitals and skilled nursing facilities (United States Department of Labor,

2013). The health industry remains one of the fastest growing in the United States

(Wood, 2011), indicating an increasing need for managers and supervisors. The growing

demand for managerial staff creates an environment in which novice and expert managers

are equally responsible for implementing change (Kunze, Boehm, & Bruch, 2013). As the

industry grows, so do health care costs, to the consternation of politicians and taxpayers

(Salmela, Eriksson, & Fagerstrom, 2013). The rising cost of health care, the industry's

struggles to respond effectively to a changing environment, and the pivotal role of

managers to act as change agents (Salmela et al., 2013) support the decision to study the

response of health care managers to change initiatives.

The term *change agent* refers to individuals who act as catalysts to move

organizations along the change process (Khachian et al., 2012). As the change

implementers, managers represent the primary link between the executive and frontline

staff (Hope, 2010). The dilemma found in change management, leadership, and

organizational development, is the competing mandates a manager as a change agent

must face. Managers remain responsible for coordinating and facilitating the routine work

of an organization while simultaneously executing the change strategy envisioned by

executive leadership (Birken et al., 2013). Many managers passively or overtly resist change because they are held accountable but lack power (Buss & Kuyvenhofen, 2011).

A manager must assume the role of change agent in addition to mediating the effect of change on daily operations (Khachian, Manoochehri, Pazargadi, & Vardanjani, 2012; Leggat, Balding, & Anderson, 2011). Effective change agents enable others to adopt behaviors required for successful change implementation (Higgs & Rowland, 2011). This requires organizations to invest in developing managerial competence in communication, coaching, mentoring, and networking (Higgs & Rowland, 2011). If the success rate for organizational change is to improve, organizations must provide support to managers acting as change agents.

Leaders of successful organizations overcome resistance and drive the change needed to survive and even thrive in a chaotic business environment (Kotter, 1996). The role of the manager in this process is critical, but powerlessness is common within the ranks of middle managers (Raelin & Cataldo, 2011). Effective change management requires the manager to be an expert communicator in the face of competing priorities (Bryant & Stensaker, 2011), requiring both competency and empowerment (Leggat et al., 2011). Power disparity influences organizational performance, creating an environment of inadequate innovation and cohesion (Purdy, Laschinger, Finegan, Kerr, & Olivera, 2010), elements necessary for effective change.

Managers continue to struggle with change because they often lack the power needed for effective implementation (Kumarasinghe & Hoshino, 2010). Managerial disempowerment derails change initiatives, yet few researchers examined

disempowerment as a root of change failure (Kumarasinghe & Hoshino, 2010; Regan & Rodriguez, 2011). A decrease in average managerial job tenure across industries further complicates the problem of managers effectively implementing change (Ng & Feldman, 2013). Management experience can vary widely, and limited knowledge exists about how a manager's experience affects an organization's change effectiveness (Assaf & Cvelbar, 2011; Melo, 2012, Ng & Feldman, 2013). This quantitative study examined the health care manager's perception of empowerment, years of experience, and subsequent level of change resistant behaviors.

Problem Statement

Despite over 60 years of research on change management, successfully implementing organizational change remains an unrealized goal across industries (Decker et al., 2012). Change failure rates surpass 50%, and many organizational leaders attribute this failure to change resistance (Ford & Ford, 2010). Managerial engagement is essential for change success, yet many managers with varying years of experience resist change (Oreg & Berson, 2011). The role of the manager in change is critical, but successful managers require empowerment and development, elements often missing from health care organizations' change management plans (Nayahangan, Little, & Shevels, 2011). The general business problem is that continual organizational change is a reality throughout the health care industry, and health care managers do not implement change well. The specific business problem is that health care leaders have limited knowledge of the relationship between health care managers' perceptions of empowerment, years of managerial experience, and resistance to change.

Purpose Statement

The purpose of this quantitative study was to examine the relationship between the health care manager's perception of empowerment, years of managerial experience, and resistance to change using survey data. The predictor variables included empowerment and years of managerial experience; the criterion variable was resistance to change. The 1,181 managers employed in Veterans Affairs (VA) medical centers in the New York metropolitan region comprised the specific population for this study. These managers included professionals from many disciplines, with varied years of managerial experience, working in diverse health care settings.

Given the results of this study, I was able to provide healthcare leaders with an awareness of the relationship among managerial empowerment, years of managerial experience, and change resistance. Improving the change management plans in health care organizations may benefit society through the creation of innovative solutions to organizational problems, enhanced responsiveness to consumer needs, and lowered costs. Health care and general business leaders may use this information to improve change management plans, engage managers, and promote change effectiveness in various organizations.

Nature of the Study

This applied research study advanced understanding of how health care managers' power perceptions and years of experience influence their propensity to resist change. This enhanced comprehension provides insights into managing organizational change. This study required an objective analysis of the relationship between a manager's beliefs,

years of experience, and subsequent behaviors using survey and correlational methods. Under these conditions, a quantitative approach was the best approach for testing theories.

Kanter's (1993) theory of structural empowerment and Kotter's (1996) change management theory provided the framework for examining the relationship between a manager's perception of empowerment and resistance to change. Quantitative methods and a nonexperimental design provided the lens to examine this problem. Qualitative methods allow researchers to explore phenomena inductively when they know little about a problem or behavior (Bernard, 2013). Mixed methods research combines the analysis of numerical and narrative data and is most useful when either quantitative or qualitative methods provide inadequate explanations. Qualitative or mixed methods are suitable for exploring managerial empowerment and change resistance, but my purpose in this study was to examine the relationship between these two variables using numerical data. This focus called for quantitative methods.

An empirical investigation of how these elements relate to each other offered an opportunity to test theories generated by earlier qualitative work. Quantitative studies provide descriptive information and permit comparison between groups or variables; they allow exploration of correlational relationships (Castellan, 2010). Using quantitative methods in this study permitted me to establish if a relationship existed between a manager's perception of empowerment, years of experience, and degree of change resistance. Identifying if a relationship existed produced solutions to the problem of change resistance in managers.

I used a nonexperimental design for this quantitative correlational study; the experimental designs described by Campbell and Stanley (2010) were not suitable for this dataset as no randomization or establishment of a control group occurred. Descriptive research provides an opportunity to examine the current state of a phenomenon (Bernard, 2013). I presented a contemporaneous explanation of how perceptions of power and managerial experience affected a health care manager's response to organizational change. Using a correlational design permitted an assessment of how empowerment and years of experience relates to change resistance. No discussion of causation occurred; this study only established the degree of relationship between the variables.

Nonexperimental designs are useful for describing, explaining, and predicting behaviors, relationships, or outcomes (Pilcher & Bedford, 2011); however, these designs have constraints. Nonexperimental designs have the weakest ability to infer cause and effect between interventions and outcomes (Stone-Romero, 2010); however, I did not intend to prove causality, which thereby mitigated this threat to validity. Nonexperimental designs are less generalizable, but they facilitate examining events in which issues with access, ethics, or history prevent manipulation of variables (Pilcher & Bedford, 2011). In this study, I lacked the access, resources, and authority to alter the current state of structural empowerment within the population's organization and so did not create the conditions required for a true or quasi-experimental design. Despite the limitation, this study provided definitive evidence of a relationship between health care managers' empowerment, years of experience, and change resistant behaviors.

Research Question

The overarching research question for this study asked: what is the relationship between health care managers' perceptions of empowerment, years of managerial experience, and resistance to change?

Hypotheses

The hypotheses for this study were:

$H1_0$: There is no relationship between the health care managers' perception of empowerment and degree of resistance to change.

$H1a$: There is a relationship between the health care managers' perception of empowerment and degree of resistance to change.

$H2_0$: There is no relationship between the health care managers' years of managerial experience and degree of resistance to change.

$H2a$: There is a relationship between the health care managers' years of managerial experience and degree of resistance to change.

Survey Questions

The issues of workplace empowerment, experience (also known as tenure), and resistance to organizational change appear throughout the management literature. Valid and reliable instruments are available to examine each of these variables independently. I employed two measures to determine if a relationship existed between the variables of empowerment, years of experience, and resistance to change among health care

managers. These measures were the Conditions for Work Effectiveness Questionnaire II (CWEQ-II; Laschinger, Finegan, Shamian, & Wilk, 2001) and the Resistance to Change Scale (RTC; Oreg, 2003).

Laschinger et al. (2001) designed the CWEQ-II to measure the concept of structural empowerment. Using the CWEQ-II permitted the measurement of the predictor variable (perceptions of empowerment) in the selected population (health care managers). The only modification I made to the CWEQ-II was the conversion from a paper format to an electronic online version. Participants used a five-point rating scale ranging from "none" to "a large amount" to answer the following questions:

How much of each type of opportunity do you have in your present job?

1. Challenging work

2. The chance to gain new skills and knowledge at work

3. Tasks that use all your own skills and knowledge

How much access to information do you have in your present job?

1. The current state of the hospital

2. The values of top management

3. The goals of top management

How much access to support do you have in your present job?

1. Specific information about work you do well

2. Specific comments about work you could improve

3. Helpful hints or problem solving advice

How much access to resources do you have in your present job?

1. Time available to do necessary paperwork

2. Time available to accomplish job requirements

3. Acquiring temporary help when needed

In my work setting or job:

1. The rewards for innovation on the job are

2. The amount of flexibility in my job is

3. The amount of visibility of my work-related activities within the institution is

How much opportunity do you have for these activities in your present job?

1. Collaborating on patient care with physicians

2. Being sought out by peers for help with problems

3. Seeking out ideas from professionals other than physicians (e.g., nurses, social workers, physiotherapists, occupational therapists, and dieticians)

The CWEQ-II (Laschinger et al., 2001) included two questions that served as a validation index. Participants used a five-point rating scale ranging from "strongly disagree" to "strongly agree" to indicate their level of agreement to the following statements:

1. My current work environment empowers me to accomplish my work in an effective manner.

2. I consider my workplace to be an empowering environment.

The measurement of this study's criterion variable, resistance to change, occurred via Oreg's (2003) RTC scale. The only modification I made to the RTC scale was the conversion from a paper format to an electronic online version. Oreg used a six-point

rating scale to assess a respondent's resistance to change. Participants completing the RTC scale indicated their level of agreement (from "strongly disagree" to "strongly agree") to the following statements:

1. I generally consider change to be negative.

2. I will take a routine day over a day full of unexpected events any time.

3. I like to follow the same routines rather than try new and different ones.

4. Whenever my life forms a stable routine, I look for ways to change it.

5. I would rather be bored than surprised.

6. If there was going to be a significant change in the routines at work, I would probably feel stressed.

7. When I receive information about a change of plans, I tense up a bit.

8. When my schedule does not go according to plans, my stress level rises.

9. If my supervisor changed the performance evaluation criteria, I would probably feel uncomfortable even if I thought I would do just as well without having to do extra work.

10. Changing plans is irritating to me.

11. I am slightly uncomfortable even about changes that may improve my life.

12. When someone pressures me to change something, I tend to resist it even if I think the change may benefit me.

13. I sometimes find myself avoiding changes that I know will be good for me.

14. I often change my mind.

15. I do not change my mind easily.

16. Once I come to a conclusion, I am not likely to change my mind.

17. My views are very consistent over time.

Theoretical Framework

The theory of structural empowerment and change theory provided the theoretical basis for this study. Structural empowerment theory, developed by Kanter (1993), offered a context to examine organizational behaviors like change resistance. Kanter proposed that the social structures of the work environment determine employee behavior. According to Kanter, the elements of empowerment include opportunity (professional development), structure of power (organizational hierarchy), access to resources (material or human), information (data and knowledge), and support (direction and feedback from up and down the hierarchy). Kanter's (1993) theory figures prominently in research directed toward understanding health care staff performance (Bonias, Bartram, Leggat, & Stanton, 2010; Buss & Kuyvenhofen, 2011; Kumarasinghe & Hoshino, 2010; Laschinger, Gilbert, Smith, & Leslie, 2010; Nayahangan et al., 2011; Regan & Rodriguez, 2011). I used Kanter's theory to test if a relationship existed between managerial perceptions of empowerment, years of experience, and change resistant behaviors.

Kotter's (1996) change theory, based on an eight-step model for transforming organizations, provided an additional theoretical foundation for this study. Of particular interest in this study was Kotter's contention that successful change requires the empowerment of the change participants so barriers such as change resistance do not derail the initiative. Kotter's (1996) model appears in numerous organizational change studies, including those focused on health care organizations (Guzman, Gely, Crespo,

Matos, Sanchez, & Guerrero, 2011). I used Kotter's theory as the framework describing the essential managerial behaviors for successful change and identifying change resistant behaviors. A further discussion of both Kanter's and Kotter's theories occurs in the literature review section.

Definition of Terms

The major concepts in this study included change management, change resistance, empowerment, leadership, and management. As context influences meaning, the following definitions delineate how these terms apply to this study.

Change agent: A change agent is an individual who takes action to create change; additionally this person develops and supports the capacity to change in other people (Stefancyk, Hancock, & Meadows, 2013).

Change management: For the purposes of this study, change management is the processes followed during organizational change to achieve the desired outcome (Kotter, 1996).

Change resistance: Change resistance is the propensity to avoid making changes actively or passively, to underrate change routinely, and to resist change regardless of context or type (Oreg, 2003).

Empowerment: According to Laschinger, Leiter, Day, and Gilin (2009), the two forms of workplace empowerment are structural and psychological. As defined by Kanter (1993), structural empowerment elements include opportunity (professional development), structure of power (organizational hierarchy), access to resources (material or human), information (data and knowledge), and support (direction and feedback from

up and down the hierarchy). Laschinger et al. (2009) described the four elements of psychological empowerment to include meaning (work aligns with values), competence (the ability to perform the required work), self-determination (control over work), and influence (the ability to affect outcomes).

Leadership: According to Kotter (1996), leadership includes the practices and methods that establish direction, support development, and promote adaptability within the organization.

Lean: Based upon the Toyota Production System, lean manufacturing and thinking include customer-focused quality improvement processes designed to enhance value and reduce waste at each point of production or service activity (Pepper & Spedding, 2010). Lean change management techniques, developed originally for high-volume manufacturing, appear commonly in the service sector, including health care.

Manager: Without disputing that effective managers assume leadership roles routinely, this study focused on those members of an organization who report to senior leadership and are in charge of people or processes (Kotter, 1996). This group includes supervisors, first-line, and middle managers. These managers serve as the link between the executive and frontline staff (Hope, 2010), and enact change strategies specified by executive staff (Buss & Kuyvenhofen, 2011). These managers exercise supervisory autonomy (the freedom to exert their professional knowledge), but often lack goal autonomy as senior leaders alone establish goals (Fulop & Day, 2010).

Power: Kanter (1979) defined power as access to resources (materials, money, and staff), information, and support (tacit permission to act independently or take a risk).

Six Sigma: Six Sigma is a performance improvement method used to improve efficiency, decrease variability, and reduce costs by eliminating error and waste (Snee, 2010). Six Sigma change management plans follow a process of defining, measuring, analyzing, improving, and controlling business operations (Pepper & Spedding, 2010). The emphasis on reducing errors and using data to make decisions contributed to Six Sigma's popularity among health care leaders (Chassin & Loeb, 2013).

Tenure: Tenure is the length of time worked in one role and is synonymous with experience (Ng & Feldman, 2013).

Assumptions, Limitations, and Delimitations

Assumptions

The design of this study depended on several assumptions (premises essential to the study, but outside of control; Bernard, 2013). The first is that the respondents answered the survey questions truthfully. As the online survey method guaranteed confidentiality of the respondents, the likelihood of honest responses increased. Second, the data obtained from managers at VA hospitals is generalizable to those in the private sector. Despite the differences in issues of reimbursement between the public and private sector hospitals, the quality and performance challenges experienced by managers in either setting are the same. This common experience increases the probability that the relationship between perceptions of empowerment and change resistant behaviors will be the same for managers in both public and private hospitals. The third assumption is that the managers chosen for the survey serve as change agents within their organizations. The study's population included managers without responsibility for managing change,

but most organizations require managers to act as primary change agents and to execute the strategy required to make leadership's vision a reality (Raelin & Cataldo, 2011).

Limitations

Limitations or weaknesses exist in every study, but if addressed properly, limitations do not necessarily detract from a study's value (Bernard, 2013). The design for this study was exploratory and nonexperimental so the results did not imply causality. The sampling method depended on nonprobability or purposive sampling, limiting generalizability of any results. The study had limits in time and scope; the data was cross-sectional and only taken from specific VA medical centers. This limitation required me to acknowledge that although the results may suggest patterns of response among health care managers, I could not apply the conclusions to a broader population. There were only two predictor variables (empowerment and years of experience), so my conclusions did not include other factors influencing the participants' tendency to resist change. A major limitation of this study was the use of self-report by survey; distortion or bias may exist in the responses. Providing complete confidentiality for respondents possibly mitigated any intentional distortion.

Delimitations

The delimitations of any research study include factors that define the scope or boundaries selected by the researcher (Bernard, 2013). The scope of this study included only an examination of the relationship between the health care managers' perception of empowerment, years of experience, and change resistant behaviors. I did not include other factors that could contribute to change resistance. The boundaries of this study

included a singular focus on the health care industry. Given this emphasis, the results may not apply to other industries. This study included health care managers only; the participants did not include senior leadership or frontline staff. I did not include any private or other public health care systems and hospitals in this study. Only managers working within the VA medical centers in the New York metropolitan region comprised the population under examination.

Significance of the Study

Contribution to Business Practice

As identified by Regan and Rodriguez (2011), research exploring and testing theories of empowerment and change resistance abounds, but most researchers examine the experience of frontline employees. Little research exists about managerial empowerment (Regan & Rodriguez, 2011) or the effect of managerial tenure on an organization's performance (Assaf & Cvelbar, 2011); similarly, the causes of managerial change resistance remain underexplored. This research question facilitated my examination of this under-investigated topic; the lens of quantitative methods permitted an assessment of the relationship between perceptions of empowerment, years of experience, and change resistance in health care managers. Reducing this gap may provide insight and solutions to the problem of change management within the health care industry.

Health care leaders have been slow to make changes needed to improve the quality and cost-effectiveness of health care (Leggat et al., 2011). Compounding this inertia, many health care leaders underestimate the role of managers in the change

process and fail to maximize the managers' potential (Regan & Rodriguez, 2011). Using

quantitative methods, I examined the relationship between the empowerment perceptions

of managers, years of experience, and the level of change resistance behaviors they

display. By broadening the understanding of the manager's perception of role power,

tenure, and change resistant behaviors, health care organizational development may

improve, facilitating industry performance.

Implications for Social Change

High-quality research has relevance extending beyond the development of

knowledge because well-designed research has significant implications extending beyond

the participants (Bernard, 2013). Inextricably linked to ethics and values, social science

research includes a contribution to stakeholder needs. Using sound methods of analysis to

examine and explore human behavior enables social scientists to improve the human

condition (Bernard, 2013). When applied to organizational development, these methods

allow scholar practitioners to enrich the work environment to the benefit of both business

and society (Bernard, 2013). Engaging in social science research epitomizes the concept

of corporate social responsibility and contributes to the likelihood of sustainability of an

organization.

Economists warn that current health care costs are unsustainable and that

significant reform must happen if the industry is to survive (Chassin & Loeb, 2013;

Leggat et al., 2011; Menzel, 2012). Financial issues are not the only threat to the health

care industry; despite dramatic technological advances in the industry, substantial gaps

exist in quality and patient safety (Birken et al., 2013; Chassin & Loeb, 2013). Costs

spiral, quality drops, and those organizations who fail to adapt achieve poor clinical outcomes despite spending more (Weeks et al., 2010). Change resistance compounds the problem, stymying the changes needed to sustain the industry (Barton & Ambrosini, 2013).

The debate over how to pay for universal health care continues in the United States (Narveson, 2011). In contrast, in the international community, few people dispute that access to quality health care is a fundamental human right (Eberl, Kinney, & Williams, 2011). Setting political opinions aside, Ruffin (2010) stated that medicine (and the allied health disciplines by extension) serves society as its primary goal. Fulfilling this mission requires a commitment to control costs while maintaining value and quality (Menzel, 2012). Meeting this dual challenge successfully calls for effective change management (Thompson, 2010). The health care industry's failure to change stands in stark contrast to the duty implicit in the industry's obligations to serve society.

In this study, I examined the relationship between health care managers' perceptions of empowerment, years of experience, and resistance to change. The results highlight ways to increase organizational change effectiveness. These strategies could reduce health care waste and expense, freeing resources to improve quality. Improved efficiency and quality promotes safety and enhances the health care industry's ability to fulfill its obligations to society.

The primary intended audience for this study is health care leaders and managers; however, this study may interest many stakeholders: health care employees, educators (undergraduate and graduate level), third party payers, government agencies, general

business leaders, taxpayers, and consumers. Despite the focus on one particular health care organization, the lessons learned through this study apply to other organizations. A gap exists in the literature regarding the relationship between change resistance, experience, and empowerment in health care managers. Developing a better understanding of this relationship may pave the way to innovation in the health care industry.

A Review of the Professional and Academic Literature

Extensive research exploring and testing theories and models of organizational change, change management, change resistance, managerial experience, and workplace empowerment exist in the organizational change literature. Despite this body of knowledge, how to define and manage change continues to challenge most health care organizations (Bonias et al., 2010; Wong & Laschinger, 2013). Each model of change offers a different perspective; the type of change under examination determines the usefulness of the selected model (Graetz & Smith, 2010). Organizational leaders must have a solid grasp of the tenets of change for change initiatives to be successful. This literature review included an overview of current models of change, change resistance, workplace empowerment, and the role of experience in organizational change and performance. This review encompassed an examination of current management literature, published within 5 years of this study, as well as seminal sources supporting the theoretical framework. Sources derived from peer-reviewed journals as well as select books written by experts in change management. Driven by the proposed study's hypothesis (a relationship exists between the manager's perception of empowerment,

years of experience, and degree of change resistance), this review focused on the

concepts of empowerment, experience, and change resistance as expressed among health

care managers.

Organizational Change

An understanding of organizational change begins with developing a broad view

of the topic of change (Ray & Breland, 2011). Change can be minor (first order) or major

(second order) and rapid or incremental (Hudescu & Ilies, 2011). According to Michel,

By, and Burnes (2013), the scale of organizational change can be small (fine-tuning at the

department level), incremental (adjustments to practice and strategy), modular (affecting

multiple divisions or departments), or corporate (widespread and radical organizational

change). The focus of change can center on organizational configuration (structural),

human interaction with structural elements (process), or emotional response brought on

by structural or process components (attitude) (Higgs & Rowland, 2011). Change may

appear as a planned process (close-ended) or emerge organically (open-ended); the

former is linear and the latter is adaptive (Michel, By, & Burnes, 2013). Each element of

change provides an alternative facet to view change through; this degree of complexity

underlies the difficulty of change management.

Despite the inherent complexity, change management is the fundamental function

of organizational leaders and managers. Change is essential; however, change represents

a threat to organizational survival and is dependent on leadership actions (Higgs &

Rowland, 2011). In most cases, managers are an organization's primary change agents

(Battilana & Casciaro, 2012). However, despite the primacy of this managerial function,

many health care managers fail to cope with this responsibility in the face of competing priorities (Leggat, et al., 2011). This management limitation traces back to the lack of formal management training for most health care managers; most managers transition into management based on clinical expertise (Leggat et al., 2011). This tendency is unfortunate because according to Higgs and Rowland (2011), managerial change success is dependent on their ability to create context and communicate terms of the change to different levels of membership in the organization. Additionally, managerial effectiveness is dependent on power conveyed through organizational rules and roles (Higgs & Rowland, 2011). This condition underscores the need for further study of how power (or the lack thereof) affects a manager's response to change.

Complicating matters further is the reality that change is rarely an either or proposition. Change frequently manifests in response to a variety of conditions (Hudescu & Ilies, 2011). Those seeking to manage change effectively must first understand those manifestations: the good, the bad, the required, and the unnecessary changes that occur across organizations of every type and size. This understanding is no easy matter; to illustrate this difficulty, Hodgson (2011) provided a cautionary explanation of organizational change.

Without decrying the need for change or lecturing against innovation, Hodgson (2011) made clear that change does not occur without significant cost. To support this position on the cost of change, Hodgson cited a National Office study of 90 U.K. government reorganizations in which gains were unclear, performance suffered, management was mediocre at best, and costs were exorbitant. The difficulties cited by

Hodgson are common; considerable evidence exists that most health care organizations worldwide struggle to implement change while maintaining quality and safety (Bonias et al., 2010). The risk inherent in an organizational change is considerable, indicating a need for strategies to mitigate this risk. A blended approach is one alternative; Hodgson stressed that most change effectiveness occurs when current practices blend with new. Knowledge transfer, preservation, and enhancement are ways for organizations to find innovation and still maintain a stable working environment. Hodgson used the metaphor of habit as the genetic building block of social evolution and transposed this principle to organizational change. In considering the role of middle managers, Hodgson made a strong case for managing stability as well as managing change. This case seems a direct contradiction of Kotter's theory (1996) and a subsequent critique of managers as the maintainers of the status quo (Kotter, 1996). Hodgson's contradictory opinion lends credence to the idea that managers are as necessary to organizational change success as leaders and entrepreneurs.

Further underscoring the complexities of managing change is the lack of consensus among experts and academics about how to manage change. Hallencreutz and Turner (2011) conducted an extensive literature review to determine if universal exemplars describing best practices in organizational change exist. Successful management of organizational change is a core business process, but most change efforts fail to meet the established goals. This failure led academics to search for a typology of best practices leadership can use to navigate change. One problem with this approach, according to Hallencreutz and Turner, is the lack of a consistent definition of best

practices. In addition to the failure to establish what *best practice* means is the similar

lack of uniformity regarding implementation of change. What works in one industry

rarely translates to another (Hallencreutz & Turner, 2011).

The management literature exemplifies this lack of consensus among experts.

Hallencreutz and Turner (2011) identified two opposing principles throughout the

literature. The first belief assumes that organizational change can be accomplished using

sequential steps, such as those described by Lewin (1976) and Kotter (1996). In contrast,

the other belief posits that change is an organic response and not subject to management,

requiring an adaptive response facilitated by organizational learning. This incongruity

highlights why experts cannot isolate the approach to just one best practice or

improvement technique. In a departure from current expert recommendations,

Hallencreutz and Turner deprecated current change management practices such as Six

Sigma and Lean as based on anecdotal rather than empirical evidence. Hallencreutz and

Turner posited that rather than expend energy searching for best practices, change agents

and researchers should explore empirical evidence of successful change efforts

(Hallencreutz & Turner, 2011). The foundation of such an exploration should include an

examination of how organizational change theory evolved over the 20th century.

The Evolution of Organizational Change Theory

Kurt Lewin, a 20th century psychologist, pioneered the study of organizational

change as an outgrowth of his work in resolving social conflict (Burnes & Cooke, 2013).

Lewin studied group behavior and change, leading to the development of field theory.

Field theory explains group behavior as the result of external forces that affect group

structure and alter individual responses (Lewin, 1976). Lewin's observations of group

behavior led to the theory of group dynamics and introduced the concept that change

initiatives should focus on the group rather than the individual (Burnes & Cooke, 2013).

In 1946, Lewin created action research as a practical tool to examine and resolve

organizational problems and group conflicts (Burnes & Cooke, 2013). Not long after this,

Lewin conceptualized the classic three-stage model for a planned approach to change

(Burnes & Cooke, 2013). According to Lewin (1976), change begins when the members

of an organization accept the need for change (unfreezing) and become willing to reject

old behaviors. The second stage (the change phase) involves the implementation of the

desired change (identified during action research). The final stage (refreezing) requires

the new behavior or process to become a permanent part of organizational behavior.

Lewin's three-stage change model remains a current approach to manage change.

In 2011, Nayahangan, Little, and Shevels explored organizational change within the

United Kingdom's National Health Service. Nayahangan et al. (2011) posited that health

care quality is dependent on successful change management, a finding echoed by Regan

and Rodriguez (2011). Nayahangan et al. used Lewin's three-stage model of change (the

Unfreeze-Move-Refreeze model) as a theoretical framework for examining a change in

the performance appraisal system, and revealed a significant correlation between

organizational and individual goals. Participants viewed the new appraisal system as

effective in increasing motivation, identifying behavioral competencies, and improving

organizational productivity. Nayahangan et al. concluded that a performance appraisal

system could help an organization unfreeze and move toward the change. This work underscores the relevance of Lewin's three-stage model within a modern organization.

Lewin's three-stage change model is teleological and operates under the premise that change proceeds rationally in a linear fashion (Burnes & Cooke, 2013). The model is not a separate approach to change management; Lewin saw it as an evolution and extensions of action research (Burnes & Cooke, 2013). According to the three-stage change model, managers are primary change agents and act in response to choices and strategies selected by senior leadership. The change model grew out of Lewin's work as a social scientist to change group behavior (Burnes & Cooke, 2013), and provided the framework for later organizational development scientists like Kotter.

Kotter enhanced the basic three-step framework created by Lewin (1976) into an eight-stage process to guide organizational transformations (Kotter, 1996). Kotter's (1996) stages include:

1. Develop an awareness of the necessity for change.

2. Designate champions to lead the initiative.

3. Define the vision and develop the plan for goal achievement.

4. Publicize the change concepts.

5. Empower individuals to take action.

6. Establish and celebrate immediate and interim successes.

7. Secure gains and use as a foothold to accomplish further change.

8. Embed advances and methods in the organizational ethos.

According to Stragalas (2010), although Kotter's model shares similarities with Lewin's, Kotter expanded each of the original three stages described by Lewin (1976), reflecting Kotter's belief that implementing change is a complicated process (Kotter, 1996). Kotter (1996) asserted the first four stages support an environment ripe for change, and are so necessary to the success of the change process that skipping or rushing through the early stages can cause the project to fail. Stages 5 and 6 involve the members of the organization thereby enabling them to take steps to make the change, and the remaining two stages embed the change within the organizational mores and traditions to sustain it (Kotter, 1996).

Despite Kotter's straightforward stepwise approach to change management (Guzman et al., 2011), the model demands significant commitment and willingness to sustain months of difficult work (Kotter, 1996). Successful application of Kotter's model requires the ability to shift nimbly between stages as change moves at different rates throughout the organization (Kotter, 1996). If seen through the lens Kotter provided, change is a process, as opposed to an event, and change management requires a fluid, adaptable strategy (Guzman et al., 2011). Kotter's model does not make change easy nor guarantee success; however, when used as a roadmap, the model helps users identify and address obstacles to change before these impediments derail the change initiative (Kotter, 1996).

Astute change agents tailor their approach based on organizational needs and use Kotter's (1996) model to drive the change desired. Used correctly, Kotter's framework can facilitate change among individuals, teams, and organizations of any type (Stragalas,

2010). Kotter's model for change has proved well suited for the health care industry, with documented successful application in medical, dental, nursing, and pharmaceutical settings (Bender, Mann, & Olsen, 2011; Guzman et al., 2011; Ray & Breland, 2011; Springer, Clark, Strohfus, & Belcheir, 2012). Health care leaders and managers can use Kotter's model to create conditions that support change and offset the frequency of failed change initiatives within the industry (Stragalas, 2010). Kotter's framework enhances understanding of change and outlines a process for health care leaders and managers to follow (Stoller, 2010), similar to clinical guidelines and protocols common to the many disciplines within health care. The stepwise nature of Kotter's framework provides a structured yet flexible roadmap in a format most health care professionals are familiar with, facilitating understanding. Understanding the change process increases the likelihood that change agents will apply the appropriate interventions to manage change successfully (Stragalas, 2010).

In addition to understanding the process of change, change agents must understand the nature of change itself. In a comprehensive review of organizational change, Weick and Quinn (1999) stressed the challenge of determining if change is episodic, continuous, evolving, intermittent, adaptive, or incremental. Such distinctions depend upon perspective; from a macro level, change may appear as episodic or incremental but if viewed up close, change is evolving, continuous, and adaptive (Weick & Quinn, 1999). According to Weick and Quinn, organizational change regularly traces back to some sort of organization failure, so change relates inherently to improvement efforts (a fundamental function of health care managers).

Weick and Quinn (1999) cited four process theories of change: life cycle (generative change), teleological (purposeful or planned change), dialectical (change born of conflict), and evolutionary (adaptive change). These processes divide again based on either unit of change (single or multiple entities) or mode (first or second order). Chronologically, change may occur in either an episodic or a continuous fashion; episodic change has a macro perspective, short-term focus, linear movement, and requires a leader who creates the change (Weick & Quinn, 1999). In contrast, continuous change has a micro perspective, long-term focus, circular movement, and requires a sensemaker to interpret change (Weick & Quinn, 1999). The complex nature of change underscores the need to understand and support the role of managers in change initiatives and improvement efforts.

In a meta-analysis that underscored this lack of understanding about the managers' response to change, Van de Ven and Sun (2011) posited that most organizational change research focuses on action strategies and leaves reflective strategies underexplored. In their analysis, Van de Ven and Sun examined theories of organizational change, as well as breakdowns and remedies associated with the models. Adopting the taxonomy of process theory of change, Van de Ven and Sun reviewed examples of teleology (planned change), life cycle (regulated change), dialectics (conflictive change), and evolution (competitive change).

According to Van de Ven and Sun (2011), change agents may circumvent change breakdown if they develop contingency plans using an alternate change process theory (or combination of such theories). This dexterity requires a comprehensive understanding

of change and resistance. Planned change requires participants to agree and move toward a common goal (Van de Ven & Sun, 2011); this consensus building requires an empowered manager (Bryant & Stensaker, 2011). As described by Van de Ven and Sun (2011), the regulated change (life cycle) model works best for recurring and foreseeable change and shares commonalities with teleological change.

In contrast, conflictive change theory facilitates change associated with conflicting parties or units (Van de Ven & Sun, 2011). An adroit manager navigates turbulent relationships to achieve a mutually agreeable approach to change; however, this requires skill and power to negotiate (Bryant & Stensaker, 2011). In evolutionary change, the organization adapts to forces in an effort to optimize scarce resources (Van de Ven & Sun, 2011); once again, the ability and influence of the manager is essential to the smooth implementation of competitive change (Raza & Standing, 2011). Van de Ven and Sun described taking the time to reflect on the process used as beneficial to overcoming resistance and obstacles to change. As change agents apply each theory of organizational change, differing organizational responses call for an alternative approach (Van de Ven & Sun, 2011). Developing a flexible approach and an understanding of the varying forms of change allows change agents to respond effectively to a dynamic change state.

One such adaptable approach uses the seminal works of Lewin (1976) and Kotter (1996) as a framework. Boyd (2011) developed a 5-step process to manage change and avert failure during times of crisis. Assuming managers as empowered to act, Boyd recommended managers:

- establish individual influence (cultivate support from the executive board, exceed expectations by over delivering on commitments, and anticipate shifts in the market through astute analysis);

- create the context (separate the chaff from the wheat to establish a unified focus, create the urgent need for change, blend realism with optimism, and use external threats to spark activity and unity);

- open communication channels (create a culture where employees share concerns and ideas, encourage constructive conflict, be visible and involved during crises and times of peak demand); and

- create stability (swiftly eliminate waste and redundancy, hire and distribute change resilient workers throughout the organization, flatten the hierarchy, share the power); and

- sow the seeds of success (see mistakes as learning experiences, establish transparent performance measures, link rewards with performance, celebrate short-term goal achievement throughout the organization).

Further exploring the connection between theory and practice, Maurer (2010) identified the problem with change management does not exist because of a paucity of change theories. Maurer argued that the problem lies with a lack of managerial knowledge about how to operationalize change theories. Most leaders and managers understate the importance of context; in an effort to find a quick solution, a narrow view of a problem leads to inadequate solutions. Maurer stated people could learn how to view problems in the proper context if organizations took a long-term view of change

management; however, managers may not have the power or influence to alter the pace of change once leadership establishes the target.

Detailing the need to appreciate context, Maurer (2010) identified the critical importance of accurately identifying organizational culture. To accomplish this, Maurer cited McGregor's model of Theory X and Theory Y; Theory X states people purposely avoid work based on an inherent dislike, whereas Theory Y concludes people want and need fulfilling work. Maurer used McGregor's model to explain change failure and stated some business leaders espouse a belief in Theory Y yet behave as if Theory X was their guiding principle. According to Maurer, when Theory X is operating, cultures exist where exclusive decision-making, micromanagement, fear, ambiguity, and paternalism abound (the opposite of an empowered workplace). Managers and leaders seeking to advance change must accurately assess the operational context. Understanding context allows change agents to select the correct approach to implement change.

To recognize how the environment influences the approach to change, Bold (2011) reviewed how changes to the business landscape necessitated new methods of change management. In this analysis, Bold's self-stated purpose was to demonstrate how to achieve sustained success by using several specific techniques. Bold described management by objectives (MBO) as an all-inclusive approach designed to guarantee that all operatives understand the organizational goals and roles. According to Bold, MBO clarifies objectives, increases commitment, and develops inherent controls to keep the change on track. The second method, ad-hoc portfolio analysis, evaluates how different internal and external elements relate to each other. The focus is on competitive

advantage; effective change must result in an improved market position. The third tactic, Boston Consulting Group Matrix (BCG), analyzes the costs and benefits of organizational products and services. According to Bold, this analysis allows leadership to direct the energy and focus required for change in an economically sound manner. The General Electric/McKinsey Matrix is similar to the BCG Matrix; Bold described it as an analysis of market attractiveness and competitive strength. The next method, Business Process Reengineering (BPR), redesigns workflows and promotes corporate level change. Bold described BPR as client-focused, so change concentrates on meeting market demands. The Balanced Scorecard method of change management aligns activity with vision, improves communication, and monitors performance against strategic goals. Bold concluded by describing change management as the management of transitions in which no single theory fits all situations. Effective application of the appropriate tactic requires knowledgeable and empowered managers.

Further exploring the evolution of organizational change theory, Smith (2011) studied the commonalities between organizational change management and organizational quality management using the framework created by Kotter (1996). According to Smith, quality improvement requires change, stasis is a threat to sustainability, and successful organizations blend change and quality management. The elements of an effective quality management program exist in successful change management plans (Smith, 2011). These elements include clear roles, effective communication, ongoing bidirectional feedback, evidence-based actions, and course correction. Consistent with previous researchers, Smith identified change as incremental

or rapid, planned or emergent, and viewed as linear or open-ended and adaptive. Similar to Maurer (2011), Smith acknowledged the high failure rate for change initiatives (50% - 70%), and stated that although no single correct approach exists, using a model like Kotter's is useful when analyzing change dynamics.

Even though organizational change inherently exists as a collective experience, the role of the individual is of significant importance. Bjerregaard (2011) explored how individuals influence organizational change and stability. Of particular interest is Bjerregaard's identification of the lack of knowledge about how middle managers and frontline staff shape the organizational response to change initiatives,supporting the need for further study. In an attempt to understand how position influences response to change, Bjerregaard questioned how managers and frontline employees in similar organizations deal with organizational change under the same institutional demands. Bjerregaard indicated that managers and employees used different strategies to implement the change based on their different work experiences and previous exposure to logics. The middle manager had considerable influence over user participation and used various professional rationales (logics) to connect the change to employee practice. Supporting the need for further study, Bjerregaard suggested more work examining the role of the individual in affecting change is necessary to improve organizational change management.

The importance of improving organizational change management extends across all industries. Battilana and Casciaro (2012) used longitudinal survey data and eight case studies to explore and examine change within the United Kingdom's National Health Service NHS). Network theory and its offshoot, structural holes theory, served as the

framework to examine organizational change that diverges from the institutional norm in varying degrees (Battilana & Casciaro, 2012). Battilana and Casciaro applied network theory to explain how an actor in a system relates and participates with other actors. A very cohesive network has few structural holes, but a low degree of structural closure has more brokerage points and is fertile ground for innovation and change. In this case study, the goal of Battilana and Casciaro was to develop a contingency theory of network closure and organizational change.

According to Battilana and Casciaro (2012), the NHS, bound by medical professionalism, has very proscriptive roles and a discrete hierarchy (like most of Western health care systems). Using eight cases of organizational change, Battilana and Casciaro looked at change scenarios with varying degrees of divergence from the status quo. Battilana and Casciaro examined the degree of network closure for each of the primary change agents involved, and their results indicated that increased structural holes in the network (with more brokerage opportunities) yielded an increased likelihood of the change agents influencing divergent change. Battilana and Casciaro found the converse was true when the change was less divergent.

In addition to adding to the theoretical body of knowledge of organizational change, Battilana and Casciaro (2012) posited that if organizations consider structural networks when selecting change agents, they enhance the possibility of successful change. Change agents are capable of altering their networks to leverage brokerage points, assuming they have sufficient organizational political power. Beyond the significance of generating a new theory, Battilana and Casciaro also provided insight into

the relationship between organizational structure and power. The NHS has a rigid power structure dominated by physicians. Battilana and Casciaro offer a way to capitalize on the social networks of other members of the health care team to advance change, creating a more diverse structure and an environment more conducive to innovation. The results of Battilana and Casciaro's study indicate a need to examine the perceptions of empowerment among health care managers, especially those at the midlevel of the organization.

A divergence of opinion marks the study of organizational change. For example, Graetz and Smith (2010) identified a number of shortcomings and biases inherent in each of the current organizational change philosophies. Graetz and Smith outlined the various schools of thought and expressed the need for a multi-philosophy approach based on the circular relationship between change and continuity in organizations. Starting with the traditional linear approach (planned change), Graetz and Smith discussed Lewin (1976) as well as a number of multiple step models, such as those proposed by Kanter (1993), Kotter (1996), and others. According to Graetz and Smith, such change moves from the top, fails to embrace resistance as a source of diverse thought, and neglects the reactive, often-irrational response of employees to change.

Moving beyond planned change, Graetz and Smith (2010) described the biological philosophy of change as evolutionary and adaptive. According to Graetz and Smith, like an organic being, change undergoes a life cycle. In a biological change view, change is dynamic but incremental in pace. The rational philosophy includes strategic choice theory in which change is specific and adaptive. In contrast, the institutional

philosophy depends on evolutionary elements responding to external stimuli. This philosophy views change as slow and incremental (Graetz & Smith, 2010). The resource philosophy accounts for divergence from the status quo, as scarce resources force organization leaders to alter responses to survive and adapt. Change can occur at any pace and scale.

According to Graetz and Smith (2010), in the contingency perspective, change is the result of behavior in response to specific circumstances. Variables such as disinterest, lack of resources, rigid structures, and industry pressure influences behaviors. Once again, change can occur fast or slow, in a large or small scale. The psychological philosophy addresses the human response to change. Derived from the behavioral sciences, the focus here is on moving participants from resistance to acceptance. Change is slow, incremental, and small-scale. This viewpoint contradicts the political philosophy, in which conflict is the source of change and reflects the shift of power between coalitions. The pace starts slow (because of the need to develop support), but accelerates and expands to a large scale.

Expanding beyond the individual's response to change, Graetz and Smith (2010) specified the cultural philosophy of change requires change agents to battle entrenched values. The cultural philosophy of change requires the development of collective experiences to move forward, and is slow and small-scale. According to Graetz and Smith, advances in systems thinking gave birth to the systems philosophy of change. Effective application of the systems philosophy of change requires change agents to develop a holistic view of the change process. According to the systems philosophy of

change, change is only effective if interventions occur system wide, and change can be fast and large scale. The final philosophy presented by Graetz and Smith, the postmodern philosophy, contrasts traditional and alternative approaches. The application of the postmodern philosophy of change requires dissemination throughout the organization, flexibility, trust, and empowerment. Once again, change can occur at any pace or scale. Graetz and Smith cited the high degree of uncertainty and inconsistency in most organizational change initiatives, and argued the plurality of change experiences requires an equally diverse arsenal of approaches. Accordingly, change agents must consider the varied experiences and responses of change initiators and recipients in any examination of change management.

Examining the Role of Managers in Organizational Change

Alternately vilified and lauded for their role in change initiatives, middle managers represent a central component of organizational change (Raelin & Cataldo, 2011). Raelin and Cataldo (2011) highlighted the need for flatter organizational hierarchy, bringing the middle manager role back under scrutiny. Birken et al. (2013) cited literature supporting the duality of the middle manager role as both manager and leader. Additionally, middle managers must respond to and influence actions from executive and frontline staff, as well as external stakeholders (Leggat et al., 2011). This role complexity requires middle managers to develop leadership and management competencies to be effective.

Competency is not the only issue in how managers respond to change; discernment is equally indispensable. Accordingly, Armenakis and Harris (2009)

identified the key theme of change management as the leadership decision of what and how to change. To illustrate, Armenakis and Harris compared their 30-year body of work (termed employee centered) against Kotter and Kanter (focused on a change agent or leader). In this comparison, Armenakis and Harris focused on how change recipients decide upon a response to change (embrace or reject) and identified the reaction of change recipients as central to the success or failure of a change project. Armenakis and Harris's conclusions support the need for additional examination of the sources of change resistance, especially among middle managers who serve as the bridge between leadership and employees.

Effective organizational change requires managers to apply theory in the workplace. In an effort to connect theory with practice, Khachian et al. (2012) used qualitative methods to explore how managers applied organizational change management theory. A variety of themes emerged; including the lack of power sharing and ineffective communication between leaders and staff. The overreliance on centralized power and reluctance to share information freely contributed to the lack of independent decision-making among the staff charged with implementing the change, resulting in change failure (Khachian et al., 2012). Supporting this conclusion is the work of Leggat et al. (2011) that indicated a lack of effective management processes hampered managerial performance.

According to Khachian et al. (2012), managers in their study identified the organizational power structure as a challenge. The centralization of power meant that external forces compelled mid-level managers to carry out change processes without

being able to modify the plans to their environment; consequently, most managers perceived a lack of control over the change process. This powerlessness rendered theory useless to the managers under pressure to respond, and Khachian et al. identified powerlessness as a significant source of change resistance for the managers. The managers indicated the need for an opportunity to communicate more freely with higher-level managers about the challenges associated with the change process. The managers consistently valued the opportunities associated with change, but stated the organizational infrastructure did support the behaviors associated with successful change. Khachian et al. indicated a lack of managerial control limits initiative and contributes to change resistance. This qualitative conclusion supports the need for an empirical study of the relationship between managerial empowerment and acceptance or resistance of change.

In an effort to advance the understanding of how to manage change, Armenakis and Harris (2009) categorized six themes indicative of change success. The first theme reflects five beliefs necessary for successful change: (a) discrepancy (the need for change exists), (b) appropriateness (the proposed change will address the discrepancy), (c) efficacy (organizational members have the capacity to implement the change), (d) principal support (senior leadership supports the change fully), and (e) valence (the change will benefit the recipient). In the second theme, Armenakis and Harris stressed the importance of engaging change participants early and consistently throughout the process. Allowing participants to select the gap (discrepancy) and develop the interventions increases the likelihood of acceptance.

As identified by Armenakis and Harris (2009), effective organizational diagnosis (the third identified theme) relates to discrepancy and appropriateness. Accurately assessing the problem and proposed solutions prevents false starts and wasted time while promoting motivation and confidence among change participants. In the fourth theme, Armenakis and Harris echoed earlier change theorists and called for the creation of a sense of urgency to create readiness for change. This theme reframes the process from one that anticipates the negative reaction of resistance to one that anticipates something positive. Consequently, change leaders have to promote the need for change to enhance this readiness (Armenakis and Harris, 2009).

Continuing their exploration of change success themes, Armenakis and Harris (2009) described the necessity of determining the change readiness level, as that level corresponds to the influence strategies needed to motivate change participants. Armenakis and Harris expanded upon these strategies in theme five, managerial influence strategies. Included in these are active participation, persuasive communication, management of internal and external information, human resources management practices, formalization activities, diffusion practices, and rites and ceremonies. The final theme (number six) presented by Armenakis and Harris addressed the need to assess or monitor change acceptance. The employee-centered perspective of Armenakis and Harris reflects their belief that even a failed organizational change initiative yields valuable information and may uncover an unconsidered alternative. A logical extension of the exploration of change management includes examining how middle managers influence change and change resistance.

A comprehensive examination of change management requires the analysis of the roles and functions of middle managers in the change process. According to Hope (2010), middle managers act as the cornerstone of organizational change, creating order, and interpreting change for frontline staff. This interpretation of change represents managerial sensemaking (Hope, 2010). A significant challenge arises when managers themselves are not clear about the initiative, often resulting from faulty communication between executive and managerial staff. Further supporting the need for additional study into the role of managers in change, Hope cited a dearth of studies examining the role of the middle manager in change and sensemaking. An examination of factors influencing middle managers' acceptance of change could provide insight into how to facilitate change more effectively.

A paradoxical nature of change initiatives exists in which managers have dilemmas not easily solved by unilateral approaches (Hope, 2010). These dilemmas include issues with performance, team development, and organizational development. Collaboration and iterative enquiry may uncover links between apparently disparate approaches to change management dilemmas, but requires participants to meet as equals (Hope, 2010). Hope (2010) concluded that ameliorating the paradoxes associated with change requires organizational changes to managerial relationships and roles. An examination of perceptions of power among managers is necessary to understanding how managers view their role in change.

Numerous challenges commonly associate with change. Bryant and Stensaker (2011) identified multiple roles middle managers play in organizational change and

negotiation processes associated with change. These roles include coach, counselor, teacher, salesperson, communicator, and sensemaker. Middle managers often occupy positions in which they must negotiate order and operations while maintaining stability, often in the face of competing priorities. Even more challenging, middle managers must remain optimistic about change initiatives even if faced with uncertain prospects (Bryant & Stensaker, 2011).

A recurrent theme in the change management literature is that middle managers lacking information about and participation in decision-making cannot function effectively as change agents and negotiators (Bryant & Stensaker, 2011). According to Bryant and Stensaker (2011), middle managers struggle with change implementation or (substantive concerns), satisfying the aims of senior leadership (political concerns), and supporting the needs of employees (relational concerns). If middle managers focus too much on political concerns, they estrange employees and lose support for the initiative. Concentrating on relational concerns hinders change implementation. Charged with the responsibility of managing the substance of change, middle managers wrestle with the futility of meeting political and relational concerns simultaneously (Bryant & Stensaker, 2011).

In an effort to advance knowledge about managers and change management, Kumarasinghe and Hoshino (2010) studied the responsibilities and experiences of middle managers and examined how manager capability affects organizational change. Kumarasinghe and Hoshino cited the strong influence managers have on frontline staff, and discussed how empowerment facilitates change whereas limiting managerial power

creates unwillingness to participate in change efforts (supporting Kanter's theory). The results of Kumarasinghe and Hoshino's study indicated that organizations that share power freely experience smoother change and have performance measures high in quality, customer satisfaction, innovation, and employee satisfaction. This description of empowerment supports the business case for determining if a relationship between managerial perceptions of empowerment and subsequent change resistance exists.

Organizational development and change management literature provide varied descriptions of the role managers play in change initiatives. Buss and Kuyvenhofen (2011) used qualitative methods to explore if three roles established by management literature are accurate descriptors of how middle managers function during strategic change. The roles Buss and Kuyvenhofen identified include implementer (the manager carries out change strategy identified by executive leadership), networker (the manager serves as an information conduit between the executive and frontline staff), and sensemaker (the manager operationalizes the change within their team).

The results of Buss and Kuyvenhofen's study supported the first hypothesis that management roles during strategic change fall into the three archival types identified in management literature. Buss and Kuyvenhofen's findings confirmed the second hypothesis as well, that the role typology in management literature was inclusive. No new middle manager roles emerged. According to Buss and Kuyvenhofen, solutions exist for the challenges middle managers face during strategic change. These include:

- Middle managers should understand explicitly the rationale of and urgency for the change initiative.

- A realistic timeline must be developed (change is time and labor intensive).

- The middle manager must communicate the need for coaching and support to senior leadership.

- Change management requires relationship building and maintenance.

- The middle manager must ensure two-way communication about the change process occurs up and down the chain of command.

Applying these solutions requires a middle manager to develop skills in each of the three roles (implementer, networker, and sensemaker) described by Buss and Kuyvenhofen.

Change Failure

Throughout the literature on organizational change and change management, the theme of change failure is omnipresent. Despite extensive study, change failure outpaces success more than two to one (Maurer, 2011). In a quantitative study involving 2,690 participants, Werkman (2009) examined the structure and agency patterns of change to understand change failure. Werkman identified five diverse patterns of response to change, including innovative (welcomes change), systematic (accepts need, but requires clear processes), unclear (lacking clarity of the goals), skeptical (often delays acceptance of change), and cynical (most negative response, often openly opposes). These responses indicate that change management requires a flexible approach.

The continued failure rate for wide-scale change, estimated at 70%, supports the need to consider alternative strategies (Maurer, 2011; Werkman, 2009). Werkman (2009) theorized failure to change results from three categories: organizational, contextual, and change process. According to Werkman, organizational and contextual change failure

stems from bureaucratic structures and power disparities. Change process failure follows problems with design and implementation and relates to communication and educational needs. Managers need to apply multiple theoretical perspectives to solve the multifaceted problem of change failure (Werkman, 2009). Stressing the need for a participative management approach, Werkman suggested change resistance improves when leaders clearly understand the characteristics of their organizations.

To understand change failure, Rosenberg and Mosca (2011) conducted a quantitative analysis of the varied obstacles to successful organizational change. They reviewed the organizational change literature, from Lewin to Kotter, and identified that, despite extensive study of organizational change, failure rates remain at the 70% rate (Rosenberg & Mosca, 2011). Citing earlier research that showed a lack of agreement in establishing the causes of change failure, Rosenberg and Mosca cataloged a list of possible sources of failure. These sources included passive resistance, active resistance, executive leadership ego protective behaviors (also known as silo mentality), organizational immunity to change (exhibited through policies, procedures, and culture), and organizational inertia brought on by earlier and repetitive change failure (Rosenberg & Mosca, 2011).

Rosenberg and Mosca (2011) surveyed 246 anonymous participants over the course of several years. The majority of the participants experienced organizational change firsthand and identified a singular lack of inclusion in the process. The survey results indicated that executive leadership ignored the participants' needs, and participants lacked the power to alter the change process, even when participants believed

their input would help (Rosenberg & Mosca, 2011). Rosenberg and Mosca recommended

an inclusive and incremental approach as a way to mitigate failure. Alluding to the need

for leadership to abandon silo mentality; Rosenberg and Mosca called for unity among

stakeholders if change is to succeed, and suggested organizations create a change resilient

culture by hiring and promoting employees who enjoy a dynamic environment.

Addressing change failure remains complex; Rosenberg and Mosca recommended using

multiple strategies to break down change barriers and stated no single change

management approach will overcome every obstacle.

Resistance to Change

Resistance to change is the most frequently cited cause of change failure (Erwin

& Garman, 2010), and change resistance is the most common reaction of change

recipients (Oreg, Vakola, & Armenakis, 2011). These negative reactions (cognitive,

behavioral, and affective) occur in response to organizational change, an inherently

psychological response to an external event (Erwin & Garman, 2010; Wittig, 2012). The

reactions of change recipients may be marked by illogical fears (Goncalves & Pereira da

Silva Goncalves, 2012), but often real and significant losses are associated with change in

the workplace (Mulki, Jaramillo, Malhotra, & Locander, 2012). Whether real or

imagined, these fears and losses result in intellectual, behavioral, and emotional

responses that create obstacles to change that many organizations cannot overcome

(Smollan, 2011). A comprehensive understanding of the varied dimensions of change

resistance (including cognitive, behavioral, and affective aspects) and the factors

associated with this resistance is a prerequisite for surmounting change barriers (Rosenberg & Mosca, 2011; Wittig, 2012).

Identifying and managing change resistance begins with defining the phenomenon and the factors associated with resistance. Change resistance is a natural response to external events (Ford & Ford, 2010) and researchers have recognized its role in change management since Lewin (1976) developed the three-stage model of planned change. Change requires participants and recipients to alter patterns, habits, and perceptions; this disruption creates discomfort even if the change offers significant benefits (Starr, 2011). Many change recipients exhibit varied responses ranging from passive to active behaviors, ranging from apathy to outright defiance or deviant activities (Agboola & Salawu, 2011).

This range of behaviors suggests change resistance occurs on a continuum, with change recipients demonstrating mild to severe responses to proposed changes. According to Smollan (2011), change recipients may resist by demonstrating a lack of interest, ignoring change directives, vocally opposing change initiatives, spreading rumors, boycotting, striking, subverting leadership, sabotaging work activities, and destroying property. Wittig (2012) extended the resistance continuum concept to include change acceptance; according to Wittig, this continuum extends from acceptance (a strong reaction) to resistance (a strong reaction), with neutrality a mild midpoint. Evidence indicates that change recipients move in and out of different stages of the continuum (Smollan, 2011; Wittig, 2012), this dynamic state of change response challenges change agents to modify how they manage change resistance.

The literature supports the concept of a change acceptance/resistance continuum (Erkama, 2010; Oreg et al., 2011; Starr, 2011), and underscores the need for organizational leadership to understand the factors associated with change resistance (Wittig, 2012). Bovey and Hede (2001) examined the role of individual psychological factors (expressed as defense mechanisms) in response to organizational change. Most studies about change resistance focus on the technical aspect of change resistance, but according to Bovey and Hede, this viewpoint fails to explain the common human reaction to change. Among these reactions are five maladaptive associated with a high likelihood of change resistant behaviors (projection, acting out, isolation of affect, dissociation, and denial; Bovey & Hede, 2001). Conversely, adaptive responses to organizational change (including humor and anticipation) predict higher levels of change acceptance. Using a quantitative survey of nine different organizations, Bovey and Hede confirmed interrelationships between maladaptive defense mechanisms and change resistance. This finding supports the need for change agents to address human factors associated with change.

Embedded within Kotter's (1996) model for organizational change are a number of factors that contribute to change resistance including: complacency, self-interest, misunderstanding, mistrust, and a low tolerance for change. These factors trace back to fears of the unknown and loss, and support Bovey and Hede's (2001) contention that change spurs the activation of defense mechanisms. Echoing Kotter, Wittig (2012) identified emotion, cognition, communication, and participation in decision-making as significant factors contributing to change resistance, and further stated these factors

influence where employee reactions fall on the change resistance continuum. The more factors at work and the degree of their expression determine the level of change resistance exhibited (Wittig, 2012).

In an effort to assess levels of change resistance, Oreg (2003) organized the varied factors associated with change resistance into six categories, including (a) fear of losing control, (b) cognitive intransigence, (c) emotional rigidity, (d) avoidance of change inconvenience or discomfort, (e) preference for predictability, and (f) reliance on habitual behavior. These factors manifest in affective, behavioral, and cognitive expressions of change resistance (Oreg et al., 2011). Oreg postulated that measuring these six sources of resistance could indicate an individual's disposition to resist change and provide a useful tool for change agents trying to manage change resistance. Oreg's resistance to change measure (validated and confirmed reliable in seven different studies) proved to be a reliable indicator of change resistance tendencies (Arciniega & Gonzalez, 2009; Foster, 2010). Identification of levels of resistance to change facilitates a targeted organizational response and promotes an increased chance a change initiative will succeed (Mulki et al., 2012).

Despite the organic and possibly inexorable nature of change and resistance, the devastating effects of resistance on change initiatives cannot be ignored (Erwin & Garman, 2010; Wittig, 2012). Raza and Standing (2011) presented an organized process to manage resistance resulting from conflicts associated with organizational change. Organizational change is a complex and dynamic process prone to conflict between stakeholders (Smollan, 2011; Starr, 2011; Wittig, 2012). This conflict increases change

resistance factors, defined by Raza and Standing as self-interest, psychological risk (perceptions of threat), tyranny of custom (custom inhibits change), redistributive factors (changes in policy or procedure), destabilization effects, cultural incompatibility, and political effect (shifts in the balance of power).

According to Raza and Standing (2011), change resistance is inevitable, but not always a negative predictor of change outcomes. Resistance offers a possible source of alternative ideas that improve the change initiative, but if unresolved, change resistance undermines change implementation. Raza and Standing posited that the real work of change agents centers on managing resistance. Conflict contributes to the likelihood of resistance. The model offered by Raza and Standing provides guidelines for managing conflict between stakeholders. The model incorporates change theory, critical systems thinking, conflict management, and network stakeholder theory. As described by Raza and Standing, participative or cooperative inquiry are a means to identify and reduce conflict and change resistance.

Exploring change resistance, Ford and Ford (2010) identified the importance of change agents' integrity, ability to communicate, resolve, and realistic appraisal of limits (for participants as well as initiatives) when addressing the phenomena of change resistance. Acknowledging, addressing, and using change resistance requires change agents to focus on relationships with change participants, rather than trying to avoid or abate resistance. Developing this focus requires engagement and participatory management, characteristics of an empowered workforce (Kanter, 1993).

In a departure from traditional thinking about change resistance, Ford and Ford (2010) proposed that some resistance serves as a resource for change and criticized current research for being change-agent centered. Seen in this light, change resistance holds positive potential. Presenting an alternative view of change resistance, Ford and Ford stated some responses to change appeared resistant because they did not conform to the agent's desired result. This view implies perception affects how change agents experience resistance. Ford and Ford concluded that sometimes change resistance produces positive results by eliminating unnecessary elements in a change initiative. This simplification of a change initiative increases the likelihood of success.

In a similar positive reframing of the change resistance paradigm, Thomas and Hardy (2011) noted the tendency in management literature to demonize change resistance. This approach fails to resolve the problems associated with change resistance, and they relate this failure to inequities in power among change participants and agents. In line with Thomas and Hardy's view of the relationship between power and change resistance, Erkama (2010) postulated that change resistance is an effort by change recipients to reclaim power. Under these circumstances, change resistance provides a source of relief for change recipients. Leaders who view resistance negatively place resistors in a position of deviance and fail to recognize the value of identifying problems with a proposed change. Resistance to change serves beneficial purposes, such as signaling something is wrong with the change process, relieving change recipient stress, and indicating commitment to the organization (Tavakoli, 2010).

Despite acknowledging the limitations of viewing resistance solely as a negative phenomenon, Thomas and Hardy (2011) recognized that merely celebrating change resistance does little to prevent negative consequences of change resistance left unaddressed. If change agents view resistance as evidence of a problem inherent to the change initiative and take action to address the problem, a more successful change approach can result (Smollan, 2011). When change resistance occurs, the change recipients are communicating with change agents, albeit in a dysfunctional manner (Erkama, 2010). The change agent is responsible for channeling the energy behind change resistance into remediating the change plan (Thomas & Hardy, 2011). Such remediation converts change resistance from destructive to constructive behavior.

Echoing Ford and Ford (2010), Lewis, Romanaggi, and Chappelle (2010) also described change resistance as a natural, predictable response. According to Lewis et al., despite the challenges, managing change resistance is possible if leaders and managers adopt the correct mindset. To that end, Lewis et al. recommended that change agents anticipate and respond to change resistance as a natural event, addressed by high-level communication, education, with simulation exercises designed to allow practice of new behaviors, and an incremental approach to implementation (to limit change fatigue). Change agents may also sustain performance by using metrics that include an analysis of change behaviors, and supporting change with rewards and recognition (Lewis et al, 2010). Overcoming change resistance requires change agents to demonstrate the personal benefits of the proposed change. Lewis et al. recommended change agents use coaching

techniques to elicit what motivates staff; understanding motivation enables change agents to connect the proposed change to the daily lives of the staff.

Underscoring the behavioral aspect of change, Lewis et al. (2010) stressed the need to understand that change is the result of behavior and not attitude. Leaders who align expectations with new processes or procedures can change behavior, and as behaviors become ingrained, attitudes change. Change agents who acknowledge and engage resistance with alternatives create resilient, healthy, and innovative workplaces. Such organizations implement large-scale changes effectively.

Managers and Resistance to Change

Staff resistance to change received considerable and consistent attention from researchers (Erwin & Garman, 2010; Muntlin, Carlsson, & Gunningberg, 2010; Oreg & Berson, 2011). Though staff resistance is a requisite part of understanding change and change resistance, this focus on frontline employees has a gap: little literature exists regarding the phenomena of the manager's change resistance (Raelin & Cataldo, 2011). Most often, the literature centers on either how managers contribute to change resistance (Erkama, 2010; Smollan, 2011; Thomas & Hardy, 2011) or what steps managers ought to take to overcome resistance (Lewis et al., 2010; Mulki et al., 2012; Peccei, Giangreco, & Sebastiano, 2011). Although both of these approaches contribute significantly to the science of organizational change management, neither address the causes underlying managers' change resistance. Given the significance of the relationship between resistance and change failure, as well as the importance of managers in the change

process, an examination of factors associated with managerial change resistance may uncover insights necessary for successful change management.

Kanter (1993) identified the need for conformity as necessary for managers to succeed in bureaucratic organizations. Bureaucracies depend upon routine behaviors to maintain stable functioning and may reward behaviors that prevent innovation (Kanter, 1993). According to Kanter's paradigm, many managers struggle with change because of tightly prescribed roles determined by organizational hierarchy. Kanter argued the most common managerial response to a problem is to rely on what worked before; most managers reject creativity in favor of stability. Seen in this light, change resistance is a survival mechanism for many managers (Kanter, 1993). In an increasingly uncertain environment, this maladaptive response fails to capture the opportunity to innovate and promotes change failure.

On occasion, managerial change resistance may take the form of a collective response, in which managers join to challenge a change initiative in an organized and reasoned manner that promotes a successful outcome (Erkama, 2010). A collective response, however, is not the norm; according to Erkama (2010), managers engage frequently in gossip, apathy, and disengagement. They fail to connect with either frontline staff or senior leadership (Smollan, 2011) and contribute to the organizational stress, undermining any success associated with the change initiative (Mulki et al., 2012). Despite the critical nature of a manager's role in change management, most organizations fail to address managerial change resistance adequately.

The importance of the manager in change efforts is a repeated theme within business research (Erwin & Garman, 2010); despite this, the factors influencing managers' change resistance is underexplored (Raelin & Cataldo, 2011). In their examination of resistance to organizational change, Erwin and Garman (2010) conducted a literature review of peer-reviewed research conducted from 1998 to 2009. Using a discrete focus on individual resistance, Erwin and Garman compiled evidence-based guidelines for change agents and managers to reduce the effect of resistance on change initiatives. The literature revealed a lack of a universal definition for change resistance and a limited understanding of change resistance over different points of time in the change process (Erwin & Garman, 2010). Reflecting the complex, dichotomous nature of change resistance, Erwin and Garman cited a number of studies that described change resistance as both passive and overt, and displayed across behavioral, affective, and cognitive domains.

As evidenced in the studies Erwin and Garman (2010) reviewed, the importance of managers in the change process is critical but not well understood. Moving beyond how staff responds to change, Erwin and Garman discussed how managers respond to and influence change acceptance and change processes. According to Erwin and Garman, managers with a solid understanding of the changes taking place are less likely to express a negative reaction about it. This conclusion indicates the need for further study of the relationship between contextual factors and change resistance among managers.

The propensity for a manager to resist change relates inextricably to organizational factors such as hierarchy and reporting structures. A rigid hierarchy does

not support open communication between managers and executive staff; managers tend to censor communication and avoid honest dialog in such settings (Kanter, 1993). Managers ought to do more than manage frontline staff; effective managers must also be encouraged to influence upwards, to question the decisions of senior leadership in a quest to improve outcomes (Regan & Rodriguez, 2011). When excluded from organizational planning, managers become weary and cynical, and more likely to resist change (Erwin & Garman, 2010). Conversely, when managers participate in change initiatives at all stages, they tend to be supportive of the changes and work harder to ensure success (Peccei et al., 2011).

The work of Barton and Ambrosini (2013) supported these conclusions as evidenced in their examination of how organizational change cynicism acts as a moderator of middle manager change resistance. Barton and Ambrosini defined the manager's role as multifaceted and demanding, requiring resilience, empowerment, and executive leadership support to succeed. These qualities act as an antidote for the sort of powerlessness that hampers organizational performance (Raelin & Cataldo, 2011). Drawing conclusions similar to those of Rosenberg and Mosca (2011), Barton and Ambrosini identified resistance and lack of ability as sources of change failure, and posited the middle manager as critical to developing support and capability among employees.

According to Barton and Ambrosini (2013), a primary reason middle managers fail in their role is the moderating effect of organizational change cynicism on the middle manager's commitment to change. Organizational change cynicism is a negative,

distrustful disposition to a change initiative and cynicism results when senior leaders blame middle managers for prior failed change efforts (Barton & Ambrosini, 2013). Anticipating further censure, middle managers withhold support and commitment. Barton and Ambrosini hypothesized high levels of organizational change cynicism occur with low levels of change commitment, and corresponds with senior management support, procedural justice, information availability, and participation in decision-making.

To examine the effect of organizational change cynicism, Barton and Ambrosini (2013) surveyed middle managers from tech organizations via an instrument comprised of five different measures (addressing organizational change cynicism and the four moderating factors). The results of a regression analysis confirmed Barton and Ambrosini's predicted relationship between organizational change cynicism and change commitment in middle managers. Participative management and shared decision-making (and by extension, empowerment) associate consistently with higher levels of change commitment. The limitations, as described by Barton and Ambrosini, included the use of one industry and possible self-reporting bias. Of note is Barton and Ambrosini's contention that when discussing perceptions, self-reporting is the most relevant method available to researchers. The work of Barton and Ambrosini underscores the need for further study into how contextual variables, such as empowerment, affect a manager's response change.

Empowerment

Social science researchers focus frequently on power and empowerment as determinants of change effectiveness and predictors of resistance. Power, as defined by Kanter (1993) within the context of structural empowerment, is the ability to summon, organize, and allocate resources necessary to achieve organizational goals. Understood in this light, power is fundamental to effective management. Empowered managers have the means to respond to changes in the organizational landscape. This response stands in stark contrast to powerlessness, described by Kanter (1993) as possessing accountability without power.

Power links inextricably with empowerment. Empowerment is a mindset or orientation that defines one's personal sense of power (Boudrias, Gaudreau, Savoie, & Morin, 2009). A complex phenomenon, empowerment exists as a social, cultural, psychological, and political process (Uner & Turan, 2010). Within the context of an organization's operations, empowering staff contributes to enhanced productivity (Abdollahzadeh, 2013). By extension, empowering employees creates an ownership mindset in which employees act to advance organizational goals without prodding, becoming innovative informal leaders (Uner & Turan, 2010). Staff empowerment requires managers to have confidence in their own empowerment (Regan & Rodriguez, 2011). Empowerment connects inseparably with leadership and innovation but requires a change in the organizational hierarchy (Regan & Rodriguez, 2011). According to Kanter (1993), managers need more than a belief of personal power; they must also have the support of organizational roles and structures. Institutions that encourage self-determination, in pursuit of organizational goals, develop managers and leaders dedicated

to sharing power (Laschinger et al., 2010). As a result, these organizations enjoy improved performance, especially regarding fiscal, quality, and operational measures, indicating a benefit to organizations that promote a culture of empowerment (Leggat et al., 2011).

To promote a culture of empowerment, leadership must develop an understanding of power, including its origins. Hopen (2010) cited a number of early studies that examined the source of power for leadership, including rational-legal (established by rules and laws), traditional (related to social structure), and charismatic (linked to inspirational ability). Power derives from varied sources and its expression is equally diverse (Thomas & Hardy, 2011). Personable managers may serve as change agents in situations requiring charisma, but their ongoing effectiveness is dependent on power conveyed through organizational rules and roles (Higgs & Rowland, 2011). The organizational structure is of importance when assessing power sharing and the extent of shared decision-making (Kanter, 1993). In the case of power, hierarchy matters.

Power exists in a variety of forms, and not all forms support participative management and empowerment. Glover (1992) conducted a longitudinal case study to explore the use of coercive power. In Glover's study, management used autocratic, transactional leadership methods that initially proved effective. The owners of the organization under examination by purposefully concentrating all decision-making power at the executive leadership level (Glover, 1992). Over time, external forces created an unstable environment that the organization's leadership failed to address (Glover, 1992). The organization lacked a diversity of ideas, suffered poor employee morale, and

experienced a drop in quality and increase in fraudulent activities (Glover, 1992). The organization suffered significant losses and leadership curtailed operations dramatically. Glover attributed this failure to the organization's refusal to collaborate, ignorance of the external environment, and the omission of the human factor from the organizational change plans. These shortcomings contributed to a change resistant organization that could not sustain growth. Glover stated that participative management or transformational leadership techniques would not guarantee success, but postulated that these could have helped the organization overcome its challenges. This example of organizational failure suggests an examination of current expressions of power within an organization and an exploration of power sharing practices could benefit organizational fitness.

Organizational power is complex and not explained simply through the context of interpersonal relationships (Kanter, 1993). Formal power involves the discretionary power associated with workplace decisions (Stewart, McNulty, Griffith, & Fitzpatrick, 2010). According to Kanter (1993), power does not always automatically follow formal titles or functions. Every organization has informal leaders who can marshal resources to meet organizational needs (Engstrom, Wadensten, & Haggstrom, 2010); these leaders draw their power from their social connections within the organization (Stewart et al., 2010). Just as common are those ineffective managers and executives who cannot achieve organizational goals in any reliable, consistent manner (Kanter, 1993). As described by Kanter, effectiveness has less to do with titles or interpersonal relationships than with an expert understanding of organizational structure.

Structural Empowerment

The overarching theoretical construct employed by Kanter (1993) is that organizational structure determines the behavioral responses of the workforce. Structure includes components such as organizational support, human resources practices, staff composition, and leadership style; these mediate organizational processes and change outcomes (MacPhee, Wardrop, & Campbell, 2010). Kanter's paradigm represents structural empowerment, as opposed to individual empowerment. Kanter did not dismiss the role of the individual, but posited that organizational structure was an important predeterminant of personal effectiveness within an organization. Power, as viewed by Kanter, can traverse an organization's hierarchy, but spreads best in flat organizations in which power sharing is common.

Analyzing structural empowerment, Kanter (1993) identified four distinct constructs, including access to information (regarding decisions, goals, and technical expertise), access to support (assistance as well as feedback from supervisors and peers), access to resources (provision of the necessary equipment, funding, and labor to accomplish the work at hand), and access to opportunities to learn and grow. In addition to defining structural empowerment, these elements describe an empowerment climate (Tuuli & Rowlinson, 2009). These constructs, according to Laschinger et al.,(2010), fit particularly well with nursing care models, and by extension to other health care delivery models. Additionally, these elements are essential to effective change management (Abdollahzadeh, 2013). Despite documented evidence of the importance of structural empowerment, many organizations fail to increase structural empowerment because of

competing priorities such as rising costs, decreasing revenues, complex regulatory requirements, and changing consumer concerns (Purdy et al., 2010). Within the health care industry, a number of studies have examined the effect of structural empowerment on organizational behaviors (Laschinger, Leiter, Day, & Gilin, 2009; MacPhee, Skelton-Green, Bouthillette, & Suryaprakash, 2011; Purdy et al., 2010), but none examine the relationship between change resistance and empowerment (Regan & Rodriguez, 2011).

Psychological Empowerment

Empowerment, like power, exists in several forms. Structural empowerment relates to power sharing, whereas psychological empowerment relates to perceptions of autonomy and competence (MacPhee et al., 2011). Expanding upon the concept of structural empowerment, Spreitzer (1995) developed a measure of psychological empowerment in the workplace. Despite sharing similarities with structural empowerment, psychological empowerment differs by reflecting an individual focus and a cognitive response to workplace conditions (Spreitzer, 1995); it exists as a distinct construct (Tuuli & Rowlinson, 2009).

According to Spreitzer (1995), psychological empowerment perceptions are particular to the work realm. Considering the effect of structural empowerment on workplace conditions (Kanter, 1993) and the characteristics of psychological empowerment as defined by Spreitzer, an argument can be made that psychological empowerment is dependent on the workplace environment (Stewart et al., 2010). Psychological empowerment is a response to organizational structure and moderated by structural empowerment (Laschinger et al., 2009; MacPhee et al., 2011). Moreover,

structural empowerment is a more significant predictor of empowered behaviors than psychological empowerment (Tuuli & Rowlinson, 2009).

Like structural empowerment, psychological empowerment has four dimensions (Spreitzer, 1995). According to Spreitzer (1995), these include competence (expertise and ability to complete the work required), meaning (awareness of the significance or value associated with the work at hand), influence (the extent of one's ability to affect work results), and self-determination (cognizance of autonomy in work decisions). Each aspect of psychological empowerment interconnects and reacts synergistically to produce a cumulative effect on the perception of empowerment (Stewart et al., 2010). According to Tuuli and Rowlinson (2009), organizations can do little to influence psychological empowerment; the extent of psychological empowerment depends upon the psyche of the individual.

In a study designed to validate a measure of psychological empowerment, Spreitzer (1995) identified psychological empowerment as occurring on a continuum. People perceive varying degrees of empowerment, as opposed to an all or none circumstance. In a validation of Kanter's argument that power grows when shared, Spreitzer ascertained that managers who rate high on the psychological empowerment scale have staff with similarly high ratings. Empowerment improves work environments and influences quality, cost, and staff retention in a positive manner (Stewart et. al., 2010). Consequentially, health care environments with high levels of empowerment (both structural and psychological) yield more innovative behaviors (Birken, et al., 2013) and better patient outcomes (Engstrom et al., 2010). Enhancing empowerment throughout an

organization is a worthwhile investment of time and resources and ought to be a priority for leaders looking to secure an organization's future.

The construct of psychological empowerment can be a managerial tool to foster self-directed performance improvement activities (Bonias et al., 2010). This benefit was evident in a study conducted by Boudrias et al., (2009) examining the links between management practices, employees' psychological empowerment, and employees' behavioral empowerment. Using a survey of 359 nonmanagerial workers, Boudrias et al. identified psychological empowerment as a prerequisite for behavioral empowerment. Managers skilled in decision-making, coaching, informing, interpersonal skills, and behavioral congruence (actions matched words) created an environment filled with valued, capable, outcome-oriented, and meaningful employees (Boudrias, et al. 2009).

According to Boudrias et al. (2009), without psychological empowerment, employees were less likely to take actions to improve efficiency, collaborate, and become involved at an organizational level, thus limiting productivity and innovation. Boudrias et al. concluded that training, access to strategic information, and a reward system linked to outcomes are necessary for sustained empowerment. Boudrias et al. concluded that psychological empowerment creates an active (as opposed to passive) work orientation that supports behavioral empowerment (a positive mindset supports proactive behaviors). The limitation of surveying nonmanagers precludes a generalization of how psychological empowerment affects management behaviors. Given the importance of managers to change initiatives (Barton & Ambrosini, 2013; Erwin & Garman, 2010; Raelin & Cataldo, 2011), further study of the influence of empowerment on management

behaviors may yield useful knowledge. Managers must first have a sense of their own empowerment before engaging in empowerment activities (Randolph & Kemery, 2011).

Empowerment in the Workplace

Empowered managers employ critical thinking and acumen when confronted by unusual circumstances (Kanter, 1993). Uncertainty, the bane of most managers, becomes less of a threat, as the empowered manager trusts leadership will tolerate mistakes made in problem-solving efforts. Creative approaches to obstacles may spread throughout the organization as empowered managers readily transfer knowledge (Birken et al., 2013). According to Kanter (1993), empowered managers share credit for ideas and innovations, knowing that their own power grows when they surround themselves with empowered peers and subordinates. This management style stimulates an environment marked by ingenuity, but requires organizational and mentor support, a chance to practice the techniques, and an opportunity to reflect on the process of power sharing (MacPhee et al., 2011).

Within a health care environment, empowerment relates directly to the provision of high-quality care (Bonias et al, 2010; Regan & Rodriguez, 2011). Better care translates into improved outcomes for patients and sustainability for health care organizations (Bonias, et al., 2010; Laschinger et al., 2010). Considering the ongoing crisis in health care and its associated financial burden (Erwin, 2009), an examination of the effects of empowerment makes sound fiscal sense. This examination becomes necessary in the face of the knowledge that more than one-third of hospital errors are preventable and related to behavioral factors (Wong & Laschinger, 2013). According to Wong and Laschinger

(2013), these behavioral factors are modifiable by the actions of management. Additionally, Wong and Laschinger identified leadership behaviors as the primary determinants of effective performance in health care environments. If health care organizations are to fulfill obligations to society, leadership must examine and correct the root causes of poor quality care. As identified in numerous studies (Laschinger et al., 2009; Laschinger et al., 2010; Regan & Rodriguez, 2011; Wong & Laschinger, 2013), empowerment is a primary consideration when seeking to improve health care quality through modification of workplace behaviors.

Changing behaviors requires leadership to connect with workers, and empowerment influences engagement (Atta, Ahmad, Mangla, & Farrell, 2012). In one case study, Boone (2012) described the early stages of an organizational change process at a community college. Using the Burke-Litwin model of change, Boone portrayed how low employee engagement stymied an attempt by leadership to changing teacher strategies. According to Boone, changes in management, coupled with increased public scrutiny, led to significant changes in how leadership communicated with staff. Leadership and employees experienced less direct and two-way communication, a dependence on electronic communication, decreased leadership visibility, and increased formality (Boone, 2012). Identifying this response as maladaptive, Boone suggested management adopted a myopic view of operations, unable to perceive beyond the obvious in a way true leadership can. The result was a disempowered, disengaged workforce that resisted efforts to improve organizational operations (Boone, 2012).

Supervisors and managers are powerless when held responsible for decisions imposed upon them, or when expected to manage staff without the ability to determine rewards or consequences, all while lacking access to senior-level information and communication (Kanter, 1993). If managers, stifled by bureaucracy, are accountable without being empowered, Kanter (1993) stated they react to the demands associated with change by clinging rigidly to the status quo and rules. The managers become judgmental, controlling, threatened by talented subordinates, and possessive of what little power they hold. They rely on coercion and domination in an effort to gain some form of power. The resulting environment does not support change or innovation. Kanter (1993) argued that powerlessness corrupts, creating poor morale, mistrust, and organizational inflexibility.

Addressing uncertainty requires a high degree of trust; faced with the unknown, the empowered manager believes resources are available to cope with change and resolve missteps or mistakes (Kanter, 1993). Alternatively, the disempowered manager trusts neither senior leadership nor staff and clings to routine to survive. Central to Kanter's theory is that power begets power: empowered individuals have more organizational influence and credibility, and as a result, they garner more power. Leaders, peers, and subordinates associate these individuals with opportunity and potential (Kanter, 1993). Employees are more likely to engage in decision-making, take calculated risks to advance performance, accept change, and trust management more (Randolph & Kemery, 2011).

Empowerment enhances an employee's need for and willingness to use power, but the benefits extend beyond that of the individual (Randolph & Kemery, 2011). A

mutual advantage of empowerment exists for employees and organization (Randolph &
Kemery, 2011). Organizations that share power are more effective (Raelin & Cataldo,
2011). In a review of empowerment in nursing management literature, Wagner et al.
(2010) described the benefits of power sharing for teams and organizations. According to
Wagner et al., power sharing behaviors, such as participative decision-making and shared
responsibility, lead to employee retention, enhanced patient outcomes, and higher levels
of positive organizational citizenship behaviors. Wagner et al. further theorized the
culture change associated with successful power-sharing facilitates innovation and
effective organizational change. The scarcity of studies examining empowerment and
managers supports the need for a study that tests the influence of empowerment on
managerial behavior.

Empowerment affects a number of contextual behaviors (Lamm & Gordon,
2010). In their quantitative study, Wallace, Johnson, Mathe, and Paul (2011) examined
the relationship between empowerment and accountability among managers. For the
purpose of their study, Wallace et al. defined structural empowerment as the delegation
of power across roles and psychological empowerment to include perceptions of power
based on meaning, competence, self-determination, and influence. Accountability,
included as a moderating factor, is an expectation that decisions and actions subject to
judgment by an external audience and is an essential component of corporate
performance and change (Wallace et al., 2011). Empowerment, fostered by leadership
activities, is a requisite condition for accountability to thrive, and Wallace et al. cited
prior work supporting the importance of leadership when creating a culture of

empowerment. Wallace et al. predicted that empowerment relates positively to performance and accountability mediates this relationship. The results indicated a significant positive relationship between empowerment and accountability (Wallace et al., 2011), and supports further study into how empowerment influences behaviors, such as change resistance.

In a rare examination of management behaviors associated with empowerment, Raelin and Cataldo (2011) demonstrated the relationship between middle manager disempowerment and faulty communication, pessimism, resistance, and failure. Using a comparison of studies examining macro and micro processes, Raelin and Cataldo explored the role of middle managers in a change initiative. Studies reflecting macro processes (strategy, structure, protocol, climate, and culture) tend to indicate middle managers are reactive, whereas those focused on micro processes (needs, motivation, tasks, skills, practices, values) depict middle managers as determinants of change (Raelin & Cataldo, 2011).

In their study of managerial empowerment, Raelin and Cataldo (2011) explored the experience of middle managers after a failed change initiative at a large financial services organization. Raelin and Cataldo focused on the intermediary position middle managers occupy between senior leadership and frontline staff. Middle managers commonly serve as the point of contact between the two closed systems represented by leadership and staff (Bryant & Stensaker, 2011; Hope, 2010; Raelin & Cataldo, 2011). According to Raelin and Cataldo, empowerment allows middle managers to facilitate communication and boost employee involvement, contributing to organizational success.

The results of Raelin and Cataldo's study supported the premise that empowerment of middle managers prevents change failure and a lack of empowerment stifles the effectiveness of the middle manager in the intermediary role. The case study conducted by Raelin and Cataldo makes a compelling case to test the interface between empowerment and managerial behaviors associated with change initiatives.

Managers frequently serve as team leaders, acting as both leaders of and participants in change initiatives. Using a survey, Chen, Sharma, Edinger, Shapiro, and Farh (2011) examined the effect of employee empowerment on team performance. Chen et al. measured the extent to which leaders' empowering behaviors influenced employees' motivation and commitment. Chen et al. surveyed 126 management students in the United States and the Peoples' Republic of China. Differentiating between individual and team-level behaviors, Chen et al. identified the importance of leadership behaviors in maintaining employee motivation and commitment during times of change. According to Chen et al., true competitive advantage lies in the optimal management of teams as well as individuals. Chen et al. hypothesized that empowerment engenders higher team performance. The statistical results supported Chen et al. hypotheses; employee empowerment positively related to team performance.

Other researchers have identified the link between empowerment and performance. Kendall and Bodinson (2010) identified the importance of empowerment as a driver of high performance in their examination of the common features of winners of the esteemed Malcolm Baldrige National Quality Award for health care organizations. Winners of the Baldrige award invested heavily in training to develop critical thinking,

decision- making, communication, collaboration, and innovation (Kendall & Bodinson, 2010). The 11 health care organizations examined by Kendall and Bodinson encouraged collaboration throughout the organization, and sought input throughout the stakeholder spectrum (clinical and nonclinical staff, volunteers, and community members) to create an environment with exemplary performance outcomes. These organizations sustained extremely low employee turnover, high patient satisfaction, high physician satisfaction, and low hospital-associated injury rates (Kendall & Bodinson, 2010). According to Kendall and Bodinson, this dedication to supporting employee empowerment yielded a high return as the winners reported growing market shares and stable finances (an anomaly in the industry).

Leadership style is a strong determinant of empowerment. In 2011, Ismail, Mohamed, Sulaiman, Mohamed, and Yusef studied the relationship between transformational leadership, empowerment, and organizational commitment. Empowerment is the movement of power down an organization's hierarchy and requires three components: (a) degree of discretion for work processes, (b) degree of control for work scheduling, and (c) degree of choice or modification for work criteria (Ismail et al., 2011). Transformative leadership supports all three components.

A gap exists in the literature about the effect of empowerment as a mediating influence on behavior (Ismail et al., 2011). The results of the Ismail et al. (2011) study confirmed that empowerment serves as a mediator for transformational leadership on organizational commitment, but the results addressed only routine situations with mitigated risk. Ismail et al. recommended managers enhance their leadership style by

using cultural competency, technical competence, values-based judgment, and merit-based rewards to increase employees' sense of empowerment, but did not examine how empowerment influenced managerial behavior.

In 2009, Van Eeden and Cilliers used psychodynamic theory as the framework to explore how an organization resisted transformational leadership collectively. Systems psychodynamics theory states that an organization's structure and members' group dynamics determine the culture and response to change (Van de Ven & Sun, 2011). According to Van Eeden and Cilliers, individual fear of change and loss of the fantasy of control create organizations dependent on authority and resist autonomy.

To support their theory, Van Eeden and Cilliers (2009) cited earlier studies that indicated the fear of change and desire for stability is inherent in organizations because of the desire to maintain a bounded system. In a single-case study explored by Van Eeden and Cilliers, the organization resisted the introduction of transformational leadership. Once challenged, members reacted with confusion and frustration; senior leadership responded by attempting to provide structure, allowing passive and change resistant behaviors to persist (Van Eeden & Cilliers, 2009). The results documented by Van Eeden and Cilliers supported the premise that transformational leadership requires the development of autonomy (a necessary element of empowerment); mutual dependency stifles transformative styles. The organization's psychodynamic structure resisted shared governance as a defense mechanism used to preserve roles and maintain the balance of power, even in the face of failure (Van Eeden & Cilliers, 2009).

Powerlessness negatively affects engagement (Kanter, 1993). In their examination of empowerment and engagement, Baird and Wang (2010) examined the influence of corporate structure and culture on the adoption of employee empowerment. Citing previous studies on empowerment, Baird and Wang linked employee empowerment with innovation, responsiveness, and flexibility (required components of successful change). Using survey methods, Baird and Wang measured four dimensions of empowerment: collaboration, formalization, directness, and degree of influence.

As postulated by Baird and Wang (2010), training and strong team structure are critical preconditions necessary to create an empowered workforce. According to Baird and Wang, training provides integral support and promotes early detection of opportunities for improvement. Strong teams promote diverse opinions, facilitating alternative solutions and implementation strategies (Baird & Wang, 2010). A managerial skill set necessary for empowered workplaces as defined by Baird and Wang, included teamwork, problem solving, communication, interpersonal, and decision-making. However, Baird and Wang did not discuss the structural factors required to empower managers. Baird and Wang identified the preconditions required for employee empowerment, but did not explore how empowerment influences middle manager behaviors.

Just as with frontline staff, managers who think they are powerless also perceive exclusion from decision-making and planning (Laschinger et al., 2010). This exclusion stands in direct contradiction to a primary recommendation that stakeholders be included in the entire change process for effective change management to occur (Bold, 2011;

Boone, 2012). Assuming the validity of Kanter's position that powerless begets

powerlessness (Kanter, 1993), managers who feel powerless cannot empower staff.

Given the connection between empowerment and the provision of quality care

(Laschinger et al., 2010; Regan & Rodriguez, 2011), as well as the interplay between

change effectiveness, health care quality, and cost effectiveness (Erwin, 2009), a social

and business need exists to investigate the relationship between empowerment and

change resistance among health care managers.

The Role of Experience in Organizational Change

Experience (also referred to in business literature as tenure) can influence a

manager's response to organizational change (Melo, 2012; Ng & Feldman 2010, 2013).

An ongoing debate exists about whether years of experience has a positive or deleterious

effect on individual or organizational performance (Ng & Feldman, 2010). Evidence

exists that long-tenured employees know their role well and may perform better, but this

contrasts with studies indicating long tenured employees lack exposure to innovation and

display reliance on established work patterns (Ng & Feldman, 2010). Employees with

years of experience may perform their roles by rote and resist alternative approaches to

completing their work (Assaf & Cvelbar, 2011). This reliance on habit and rejection of

innovation or change is characteristics of cognitive rigidity, a characteristic of a tendency

to resist change (Assaf & Cvelbar, 2011; Oreg, 2003; Oreg et al., 2011).

The dispute about the effect of years of experience on performance is evident

throughout the management literature. Ng and Feldman (2013) identified a gap in the

literature about the role of tenure in productivity and job performance. The majority of

studies examining years of experience focused on task performance as the dependent variable; less observed was the relationship between years of experience and organizational citizenship, innovation, creativity, and maladaptive work behaviors such as resistance to change (Ng & Feldman, 2013). This gap in what business leaders know about how years of experience relates to change management and resistance to change supported the decision to include years of experience as a predictor variable in this study.

Most of the literature on the effects of work experience centered on frontline staff (Ng & Feldman, 2013), but Melo (2012) looked specifically at how managerial years of experience or tenure influenced corporate social performance. The decision to focus on managers resulted from Melo's belief that managers interact with stakeholders more than any other member of an organization does, and so are critical to organizational performance and the outcome of change initiatives. Following a humanistic orientation, Melo assumed with more years of experience, the more rooted a manager would be in the corporate culture. Melo posited management tenure would positively affect corporate social performance and found that managers with more years of experience had a positive effect on corporate social performance. Although Melo's results indicated a manager's years of experience had a positive effect on performance, Melo addressed only one aspect of organizational performance (corporate social performance). The effect of management experience on innovation or change management remains underexplored.

In contrast to Melo (2012), Assaf and Cvelbar (2011) studied the hospitality industry and found as years of management experience increased, organizational performance decreased. Assaf and Cvelbar acknowledged years of experience might

enable managers to make effective decisions because of the depth of the managers'
knowledge of the organization. Despite this acknowledgement, Assaf and Cvelbar
asserted that as a manager's tenure increased, cognitive rigidity also increased and
impaired managerial decision-making. This dependence on routine and habitual
behaviors may negatively affect change management and organizational performance
(Assaf & Cvelbar, 2011). The results of their study on hotel performance indicated years
of managerial experience negatively related to organizational performance, but Assaf and
Cvelbar acknowledged that other confounding factors could affect performance and
recommended additional study on the effect of years of experience.

　　According to Ng and Feldman's (2013) meta-analyses of 141 studies on years of
experience and performance, years of experience did not relate to creativity but positively
related to innovative behaviors. This positive relationship held true whether rated by
employees or supervisor (Ng & Feldman, 2013). Ng and Feldman suggested these
relationships indicate years of experience may limit creativity because of limited
exposure to new ideas, but still enable change effectiveness through the long tenured
employee's ability to facilitate change through innovative behavior.

　　Rody and Stearns (2013) supported the conclusions drawn by Ng and Feldman
(2013). Rody and Stearns studied the effect of managerial characteristics (age, education,
and years of experience) on the performance of small-to-medium enterprises. According
to Rody and Stearns, the more years of experience a manager had, the better the manager
adapted to changes in the environment. Rody and Stearns suggested the improved
business performance resulted from managerial experience in labor negotiations, resource

allocation, trend interpretation, and networking. The study's population limited

generalizability, as most of the small-to-medium enterprises in the study were family

businesses (Rody & Stearns, 2013). The limitation of Rody and Stearns' study indicated a

need to examine how years of experience affects managerial performance in other

industries, countries, and larger organizations.

Kunze, Boehm, and Bruch (2013) investigated the relationship between age,

resistance to change, and job performance. Years of experience, while not included as a

predictor variable, had a mediating effect on resistance to change. The results of the study

indicated among white-collar workers, fewer years of experience positively related to

lower levels of resistance to change (Kunze et al., 2013). Longer years of experience did

not relate to resistance to change (Kunze et al., 2013). The study's sample included

employees from a variety of industries and organizations (Kunze et al., 2013), and

although the study targeted frontline employees, Kunze et al. validated a connection

between years of experience and resistance to change. This connection supported my

decision to include years of experience as a predictor variable in the examination of

whether resistance to change related to empowerment and years of experience among

health care managers.

Quantitative Method

Health care organizations undertake change initiatives routinely to improve

quality and enhance operations or outcomes. Sustained quality and performance depend

on rigorous empirical analysis of the health care environment; Cantrell (2011) posited

this inquiry is the responsibility of all health care professionals. In their review of the

management science literature, Subhani, Hasan, and Osman (2011) determined the empirical methods researchers used most often. According to Subhani et al. (2011), these include positivistic, interpretive, and critical methods. Positivistic methods allow researchers to test theories, examine causality, and predict relationships in an objective manner. Interpretative methods include those used in qualitative research, in which the researcher is not separate from participants in the study. Critical methods include qualitative approaches aimed at affecting change, such as action research methods. Subhani et al. determined that during 2008 through 2010, positivistic research was the overwhelming choice of management sciences researchers, with 77% to 91% of all studies designed using quantitative methods. This propensity supports using quantitative methods to analyze the relationship between empowerment and change resistance among health care managers.

The role of the manager is essentially a social role; managers serve as the link in the relationship between the executive leadership of an organization and frontline staff (Kumarasinghe & Hoshino, 2010). Patterson and Morin (2012) defined social processes as the ways people relate to others and acknowledged the difficulties associated with accurately depicting these processes. According to Patterson and Morin, a process has precursors, properties, contexts, and consequences. Researchers often implement static measures to describe social processes. Process studies describe different life experiences and are amenable to quantitative methods (Patterson & Morin, 2012). Before embarking on a study, Patterson and Morin recommended researchers consider the preferred worldview and theoretical framework. After establishing these, researchers should

develop the research question(s) and determine the techniques best suited to answer the question(s). The differences in methods extend far beyond data accumulation and examination; a positivist worldview requires a commitment to avoid engaging in the phenomena with participants and to maintain objectivity (Patterson & Morin, 2012).

The use of positivistic methods assumes empirical testing can prove the veracity of social science theories. The foundation of quantitative research, as described by Stone-Romero (2010), lies in a positivist worldview. Using quantitative analysis in social science assumes (a) the existence of objective truths inherent in the behavior or topic under study, (b) quantification of these behaviors is possible, and (c) measuring these behaviors allows observation of relations between them (Stone-Romero, 2010). According to Castellan (2010), using a quantitative approach recognizes an objective stance and distinct reality. This reality is separate from the scientist. Positivism presumes reality may be measured objectively (Welford, Murphy, & Casey, 2012). Postpositivism requires the same methods, but assumes reality is contextual (Welford et al., 2012). Postpositivism is especially useful in social science research, in which attitudes and beliefs influence responses to quantitative surveys and questionnaires. According to Welford, Murphy, and Casey (2012), postpositivism is useful when examining behaviors, as a researcher can never fully know what motivates a participant.

After establishing the suitability of positivism and postpositivism as a means of analyzing a social process, researchers must consider which techniques to use. According to Butt (2010), the choice of methods links inextricably with the accuracy of any results. The availability of resources (time, money, ability) exerts an influence on the researcher's

choice of methods, and Butt posited to produce quality research, a social scientist must use the research question(s) to drive a study's design. Cantrell (2011) described the elements of research design and stated the design determines the tactics needed to collect factual and decipherable information. The accuracy of a research design depends on how well the design generates credible and dependable data (Cantrell, 2011).

Stressing the need to fit a study's method to the research question, Hollins Martin and Fleming (2010) advised researchers to avoid the temptation of selecting a method before establishing a study's aim. Similarly, Coughlan, Cronin, and Ryan (2009) underscored the need to use the research question as the study's driver and stated every other facet of the study should trace back to the primary research question. In a demonstration of the interconnection between purpose, problem, and questions, Cantrell (2011) emphasized the importance of a study's purpose statement. Based in the rationale or problem statement, the purpose informs the research questions and hypotheses (Cantrell, 2011). I used this study to examine the problem of health care managers resisting change through the lens of workplace empowerment. Consistent with the literature, quantitative methods were apposite for determining if a relationship existed between perceptions of empowerment and change resistant behaviors among health care managers.

Transition and Summary

Section 1 established the foundation for examining the relationship between perceptions of empowerment, years of experience, and resistance to change among managers, particularly those employed in the health care industry. In addition to outlining

the reasons such a study is worthwhile, Section 1 offered a comprehensive review of
organizational change, change resistance, workplace empowerment, the role of
experience in organizational change, and the application of quantitative methods in an
examination of the relationship between empowerment, experience and change
resistance. The literature review supported the need to focus on managers as the
cornerstones of effective organizational change and to analyze if structural empowerment
and years of experience were significant factors in managers' resistance to change.

The objective of Section 2 was to explain and justify the methodology and design
selected for this study. Section 2 included an explanation of my role as researcher, the
participants selected, the sampling technique employed, the data collection instrument
used (including measurements of validity and reliability), the data management methods
applied (including security measures), the statistical analysis conducted, and ethical
considerations undertaken. The results of the study, along with a discussion of how these
results relate to current professional practice, appear in Section 3. Section 3 concludes
with a description of the implications for social change, as well as recommendations for
future actions and study.

Section 2: The Project

Given the financial and social need to improve health care (Bender et al., 2011) and the link between middle managers and change effectiveness (Raelin & Cataldo, 2011), predicting what prevents middle managers from functioning as change facilitators is relevant. Section 2 includes the roadmap used to examine the problem of change resistance in health care managers as resistance relates to years of experience and perceptions of empowerment. Among the details included are descriptions of the study's purpose, role of the researcher, participants selected, method and design, population and sampling, ethical practice guidelines, data collection (instruments, technique, and organization), data analysis, reliability and validity, and a transition to the final portion of the study (Section 3). Providing a specific account of the steps taken to conduct the study enhances the reliability of the work (Stone-Romero, 2010), an important consideration for any scholar-practitioner.

Purpose Statement

My objective for this quantitative correlational study was to determine if a relationship existed between health care managers' level of empowerment, years of managerial experience, and subsequent change resistance via an online survey. The predictor variables were empowerment and years of managerial experience; the criterion variable was resistance to change. The impetus behind the study is the crisis in health care in the United States, a crisis of cost and quality (Chassin & Loeb, 2013). The 1,181 managers of the New York metropolitan region's VA medical centers provided the proposed population. These public health managers represented a cross-section of urban,

suburban, and rural health care supervisors with experience in a variety of clinical settings (acute and long-term care; Department of Veterans Affairs, 2011), and provided a microcosm of public health care managers across the United States. Public health managers are routinely responsible for implementing changes (Thompson, 2010), making this group ideal for investigating the problem of change resistance among health care managers.

A lack of empowerment represents a barrier to accepting changes associated with quality improvement (Muntlin et al., 2010) and cost containment within health care organizations (Erwin, 2009). The longer a manager works for an organization, the higher the likelihood the manager will internalize the organizational culture (Melo, 2012). Long-tenured managers may be prone to cognitive rigidity and demonstrate higher degrees of change resistance (Assaf & Cvelbar, 2011). Change resistance carries significant financial costs and remains a challenge for organizations of all sizes and types (Rosenberg & Mosca, 2011). As health care organizations misuse resources in failed change efforts, fewer funds are available to improve quality (Erwin, 2009). Patient and staff satisfaction suffer, and stakeholder needs remain unmet. Finding solutions that reduce change resistance in health care organizations promotes both societal and business fitness, important goals for any health care leader.

Role of the Researcher

Following the universally accepted guidelines of quantitative research (Bernard, 2013), an ethical researcher must maintain an objective stance and avoid engaging with the participants of a study (Patterson & Morin, 2012). The primary role of a scholar-

practitioner is to collect, analyze, and present research data in a form usable by business and academic professionals. A potential bias was inherent to conducting a study in my own organization. To mitigate this bias, I fully disclosed my employment with the VA medical centers in the New York Metropolitan region. Scrupulous adherence to ethical guidelines may mitigate the risks associated with conducting research in one's place of employment (Hofmeyer, Scott, & Lagendyk, 2012). An example of my adherence to these ethical guidelines was disclosing my status to the participants invited to complete the study; my name, title, and organizational affiliation appeared in the prenotification e-mail sent to potential participants announcing the survey, as well as in the introduction to the online survey. Beyond this notification, I did not participate in the survey nor discuss the survey with any coworkers.

Participants

The selected population for this study included health care managers working within the Veterans Health Administration (VHA) network of hospitals in the New York metropolitan region. Using purposive sampling, I surveyed a sample of the 1,181 managers and supervisors working in this area. According to Bernard (2013), although purposive sampling limits a researcher's ability to generalize results (similar to convenience sampling), the technique remains an expedient, inexpensive, and practical method.

This group of health care managers embodied a diverse work group, with members from varied cultural and economic backgrounds, working in settings ranging from inner city to rural. The participants had varied years of experience working in

management positions. My employment within the health care network provided access to this population once senior leadership and the organization's Institutional Review Board (IRB) gave me permission to conduct the survey. Participant contact occurred through use of the health care network's global e-mail system. The organization has specific e-mail groups designed to target employee populations; this facilitated targeting managers and supervisors. By using this e-mail filter, no contact with executive leadership and frontline staff occurred.

The literature indicates that web-based surveys often produce lower response rates than traditional methods (Fan & Yan, 2010; Sauermann & Roach, 2013). Given the plan to use an online survey to collect data, establishing a connection with the desired population helped ensure an adequate response (Fan & Yan, 2010; Puleston, 2011). Most of the health care managers and supervisors working within the VHA medical centers in the New York metropolitan region share a strong affinity with the veterans they serve; many are veterans themselves. This affinity increased the likelihood the managers welcomed an opportunity to participate in a study designed to identify ways to improve the care environment (Puleston, 2011). An additional motivation for the managers to participate in this study was the opportunity to share their perceptions. Many health care managers see themselves as spectators of organizational change (Salmela et al., 2013), and this perception of exclusion is a source of stress and disengagement (McCallin & Frankson, 2010). The results from this study provided an opportunity for participants to voice their opinions, thereby prompting them to participate. My employment within VHA

also served as a motivator for the managers. The invited participants identified with me as a colleague and peer, and this connection increased the likelihood of participation.

In an additional effort to ensure an adequate response rate, the survey included an incentive offered to engender altruistic appeal to professionals working within the VA (Sauermann & Roach, 2013). For every submitted survey, I donated $1 to a VA accredited organization, the Wounded Warrior Project (WWP). This nonprofit veterans' service organization offers wounded veterans assistance ranging from retreats to job placement. Established by veterans for veterans in 2002, the organization is a recognized 501(c)(3) charity serving American veterans of the Iraq and Afghanistan wars. According to its mission statement, the WWP seeks to raise public awareness and support for men and women who sustain physical and psychological injuries while serving in the United States military. The WWP has over 31,036 registered veterans and 3,165 family members participating in their programs. The WWP relies exclusively on donations to support the services they provide. The organization has a long-standing relationship with the VA and engenders enthusiastic support from VA staff during WWP sponsored events. Offering this incentive capitalized upon this positive association and fostered participation while remaining within the bounds of ethics (Coughlan et. al, 2009; Puleston, 2011; Sauermann & Roach, 2013).

The survey design promoted protection of all participants, in accordance with ethical research principles (Bernard, 2013). The population for this study included only competent adults fully capable of understanding the purpose of the study. The study's population did not include any categorically vulnerable populations (fetuses, neonates,

children, prisoners, or individuals lacking decision-making capability). It was possible

that pregnant women completed the survey, but the data collected did not identify this

condition, and there was no risk to these women or their pregnancies. I protected

participant confidentiality, as the survey instrument (see Appendix A) did not collect any

protected health information. Following VHA guidelines, the survey did not collect any

names, home addresses, workplace locations, e-mail or internet protocol addresses, phone

numbers, or other unique identifying number, characteristic or code (United States

Department of Veterans Affairs, 2012).

The protection of survey participants' confidentiality extended to the incentive.

No names were associated with the donations to the WWP; each completed survey

resulted in a donation without any identification of the participants. This allowed the

survey to remain completely confidential, as all responses remained de-identified.

None of the intended participants had any obligation to participate, completion of

the study's survey instrument was voluntary, and all participants had the right to

withdraw at any time simply by closing the survey link before clicking "submit" and

completing the survey. The survey pre-notification email included an explanation of the

purpose of the study (see Appendix B). Those managers who decided to participate

clicked on an embedded link to the SharePoint® on a VHA secure server. The consent

form (see Appendix C) explained the purpose of the study, detailed the potential risks and

benefits of participating in the study, explained maintenance of confidentiality and

privacy, and provided information about data use, storage, and accession (Bernard, 2013).

Following ethical research practices and complying with common IRB requirements (DuBois et al., 2012), all electronic data resided in a repository at a VA facility on a VA server, accessible only by a secure password (United States Department of Veterans Affairs, 2009). I will maintain and protect the security of these electronic records for five years in accordance with Walden University IRB requirements. Similarly, security plans for any hard copies of data includes storage in a locked cabinet in a locked private office, maintained for five years. By following these guidelines, participants may reasonably expect all data collected from them will be secure.

Research Method and Design

The quantitative method may assume one of several forms. According to Castellan (2010), quantitative research is either experimental (true, quasi, or single-subject) or nonexperimental (descriptive, comparative, correlational, causal comparative, or ex-post facto). A researcher using quantitative methods remains separate and distinct from the population. The primary purpose is to gather evidence used to validate a theory. Data is quantifiable and selected based on prespecified theory. Quantitative methods permit prognostication and in some cases, determination of causality (Castellan, 2010). This research method is inherently practical and applicable to improving business practices.

Method

I conducted a descriptive quantitative correlational study to examine the relationship between health care managers' perception of empowerment and resistance to change. Quantitative analysis determines relationships between variables, permits

statistical description, and establishes facts, validation, hypothesis testing, prediction, and control (Bernard, 2013). According to Castellan (2010), in a quantitative study, the existing literature supports hypothesis development, and the hypothesis testing occurs in a planned, prescribed, and detailed way. The subsequent statistical analysis allows a researcher to determine relationships between variables and to generalize about populations to guide decisions (Stone-Romero, 2010).

Even though using qualitative methods would yield a rich description of the experiences of health care managers, such methods would not permit testing whether Kanter's (1993) theory of structural empowerment influences resistance to change among health care managers with varied years of experience. Conducting a mixed methods study permits both theory testing and in-depth exploration of the phenomenon of change resistance among health care managers, but the resources required to complete such a study exceeded my capabilities. Considering the problem of health care managers' resistance to change, the purpose of testing for a relationship between variables, and resources available, using quantitative techniques was the best option to obtain valid results.

Research Design

Consistent with Castellan (2010), Welford et al., (2012) defined the various types of quantitative research as experimental, correlational, and survey. Of interest when considering this study's design is the description of correlational research offered by Welford et al.; they stated the design is a nonexperimental method that examines the relationship between variables for either explanatory or predictive purposes. Welford et

al. stressed that explanatory studies use variables that link to the chosen theoretical framework. In a description of these links, Welford et al. stated correlational studies assess relationships between variables and statistical analysis allows predictions based on these relationships. Given the stated purpose of this study, which was examining the relationship between empowerment, years of experience, and change resistance in health care to improve organizational change management, a correlational design was ideally suited for this study.

Correlational research may take the form of retrospective, prospective, or descriptive analysis (Welford et al., 2012). Descriptive correlational research describes the relationship between variables and often replaces the terms *independent* and *dependent* variables with *predictor* and *criterion* (Welford et al., 2012). In this study, the variables of empowerment and years of experience served as the predictor variables and resistance to change was the criterion variable. In this study, a correlation analysis provided the means to examine the relationship between these variables.

To examine the problem of resistance to change (criterion variable) in health care managers, I used the role of empowerment and years of experience as the predictor variables in a descriptive, correlational quantitative study. As described by Cantrell (2011), a descriptive, correlational quantitative study is nonexperimental. A nonexperimental study lacks manipulation of the independent variable and no random assignment of participants to groups occurs. A descriptive, correlational quantitative design does not require a control or comparison group (Cantrell, 2011), and this study did not include a control group. This strategy is useful especially for describing current states

experienced by participants and exploring relationships among variables not easily manipulated by a researcher (Cantrell, 2011). The goal was to develop a better understanding the relationship between empowerment, years of experience, and change resistance among health care managers, and these factors fit well with a nonexperimental, descriptive, correlational quantitative study.

Population and Sampling

Sampling of a specified population for business research may be random or nonrandom. Bernard (2013) described the range of sampling methods and defined purposive sampling as the selection of participants based on particular characteristics. According to Bernard, random sampling provides the strongest evidence, but requires considerable time, effort, and funding to accomplish. In field research, the creation of a control cohort is not always feasible or ethical, depending on the phenomena under examination (Barends, Janssen, ten Have, & ten Have, 2014). In this study, I used a purposive sample of health care managers within the bounded system of the VA hospitals in the New York metropolitan region; this form of sampling was an appropriate method based on the chosen approach (nonexperimental, descriptive, correlational analysis).

Who takes a survey is as important as the survey design. When researchers consider the usefulness of research, they must evaluate generalizability (Bernard, 2013). Patterson and Morin (2012) stressed the need for adequate representative sampling as necessary for generalization. As described by Coughlan et al. (2009), a wide variety of sampling methods exists, including random sampling (simple, stratified, or systematic), cluster sampling, and non-probability sampling (purposive, convenience, or quota). Non-

probability sampling, though easier than probability sampling, is less generalizable (Polit & Beck, 2010). Notwithstanding this, Coughlan et al. (2009) stated that even probability samples are at risk for sampling error, and encouraged the use of a sufficiently large sample to minimize this risk. Polit and Beck (2010) confirmed that the external validity concerns related to purposeful sampling are surmountable in quantitative studies with adequate sample sizes.

The 1,181 managers and supervisors employed within the VHA medical centers in the New York metropolitan region at the time of this study included health care professionals from many disciplines. These managers had varied years of experience working in a leadership role. Clinical (i.e. medicine, nursing, social work, and pharmacy) and operational (i.e. engineering, human resources, fiscal, and logistics) managers comprised the population, enhancing the likelihood of diverse thought. The sole limitation for this population's inclusion in this study was employment within VHA as a manager or a supervisor. This criterion increased the likelihood that there will be a wide representational sample of health care managers from within this group. A descriptive statistical analysis of the demographics of the group appears in Section 3 of this study. All participants received comprehensive details on confidentiality, the consent process, and their rights to withdraw from the study in the Statement of Consent (see Appendix C). No data collection occurred without the consent of a participant.

Sample size is a criterion to determine the validity of a study. As part of the sample size calculation and confirming the population has a normal distribution, I used a confidence level of 95% and a confidence interval of 5%, and established statistical

power at 80% to ensure statistically valid results (Bernard, 2013). G*Power 3.1 software

provided a means to conduct a priori analysis to determine the required sample size.

G*Power 3.1 is an open-source power analysis program created by the faculty at the

Institute for Experimental Psychology in Dusseldorf, Germany (Faul, Erdfelder, Buchner,

& Lang, 2009). Using G*Power 3.1 and based upon a medium effect size ($f^2 = .15$), an

alpha level of $\alpha = 0.5$ and statistical power = 80%, the required sample was 103

respondents. As there were 1,181 managers employed in the VHA medical centers in the

New York metropolitan region at the time of this study, achieving the target sample of

103 respondents necessitated a response rate of 8.7%. This sample was a reasonable

expectation according to the literature indicating online surveys have an average response

rate ranging between 24% - 30% (Sanchez-Fernandez, Munoz-Leiva, & Montoro-Rios,

2012). To reach this goal, the managers employed within the VHA medical centers in the

specified region at the time of the study received a survey prenotification email. One

week later, these managers received an invitation to participate in the study with the

survey link embedded in the email. In accordance with VHA policy, the managers

completed the survey on a VA computer during their regular workday (United States

Department of Veterans Affairs, 2009). In addition to the initial invitation, the group

received a weekly reminder via e-mail to complete the survey until the survey closed (30

days after the initial survey invitation was sent).

Even though a descriptive, correlational quantitative study has advantages when

empirically examining social processes, the method does have limitations. For example,

Hollins Martin and Fleming (2010) described common biases associated with quantitative

research (including selection or sampling bias and confounders), and stressed the need to address each as they diminish construct validity. Inviting every manager and supervisor working within the VA medical centers in the New York metropolitan region at the time of the survey helped to mitigate sampling bias. I examined if empowerment and years of experience related to resistance to change in a specific population (health care managers), and the study's sample reflects this.

Ethical Research

No research plan is complete without a discussion of ethics, data management, and security. Issues of power are inherently political (Kanter, 1993), and any analysis of empowerment in the workplace carries a potential risk to participants if a researcher discloses employees' opinions to peers or supervisors (Kanter, 1993). In any quantitative research, Coughlan et al. (2009) stressed the need for informed consent and preservation of confidentiality to ensure ethical research occurs.

This study included a Statement of Consent ensuring that all participation was voluntary (see Appendix C). The survey's link opened with this Statement of Consent appearing as the first page of the survey. The study included an implied consent process and did not include a signed consent form; however, all participants received comprehensive information about their voluntary status, risks, potential benefits, nonpayment status, incentives offered, privacy, and who to contact for questions or concerns in the Statement of Consent. The survey opened only after the participants answered affirmatively that they understood they gave their consent by clicking the "start survey" option button, also known as the graphic user interface element (Bernard, 2013).

The participant pool for this study included competent adults with no requirement to participate in this research and the option to withdraw at any time. Participants could exercise the right to withdraw from the survey by deleting the e-mail invitation or exiting the survey prior to submitting their answers.

Non-response bias affects the validity of survey research, so researchers must look for ways to improve survey response rates (Sanchez-Fernandez et al., 2012). According to Sauermann and Roach (2013), a token incentive may increase the likelihood of participation. To boost the survey response rate, I donated $1 to the WWP for every submitted survey. This token of appreciation acknowledged the effort the managers and supervisors expended completing the survey, but remained within the boundaries of ethical research conduct (Coughlan et al., 2009). The WWP is an accredited veterans' service organization, a requirement of VA for any such incentive. The WWP received a three-star rating out of a possible four-star total from Charity Navigator (a recognized charity rating organization), scoring 54.18 points out of a possible 70. In addition, the Better Business Bureau (BBB) recognizes the WWP as a high performing charitable organization that meets all 20 of the BBB's standards for charity accountability. The survey consent form outlined the nature of the incentive (see Appendix C).

A secure data management plan requires a researcher to addresses privacy issues and protects respondents' identity (Coughlan et al., 2009). Participants need to know how a researcher will use their data, which individuals will have access to the data, and how this access will occur (Hollins Martin & Fleming, 2010). The Statement of Consent

included this information and detailed the requirements of VHA and Walden University.

The VHA required that (a) I maintained all electronic data on a password protected

computer, (b) I secured any hard copies of surveys or spreadsheets in a locked drawer or

cabinet in a locked private office, and (c) no one other than me accessed the raw data

(United States Department of Veterans Affairs, 2009). Walden University IRB

requirements stipulate all researchers maintain study records for 5 years, so this

information appeared in the consent. According to Reardon, Basin, and Capkun (2013),

to provide participants the promised degree of confidentiality, I must render all study data

irrecoverable. After 5 years, I will shred any hard copies of surveys or spreadsheets and

overwrite the electronic files using commercially available software designed to sanitize

digital data. This decision is consistent with information technology security guidelines

(Reardon et al., 2013).

To ensure the ethical treatment of the participants in this study, I secured the

approval from both Walden University's and VHA's IRB prior to approaching any

participants or collecting any data. The Walden University IRB approval (#04-18-14-

0252264) appears in Appendix F. The VHA IRB approval document serves as the

agreement document for this survey and appears in Appendix G. Although both

organizations adhere to the ethical principles defined by federal policy (known as the

Common Rule; DuBois et al., 2012), the standard for establishing anonymity is stricter

within VHA than Walden University. According to VHA policy, if a likelihood exists

that anyone can ascertain the identity of a respondent, no researcher can promise

anonymity to participants (United States Department of Veterans Affairs, 2012). The

demographic questions included in this survey (see Appendix A) may provide clues to a participant's identity (a risk associated with conducting research in my own organization). For this reason, the statement of consent (see Appendix C) informed participants they had an expectation of confidentiality. I did not collect any names and secured all descriptive information collected (age, gender, tenure, role, and academic degree) according to the requirements of Walden University and VHA policy (United States Department of Veterans Affairs, 2009).

Data Collection

Instruments

An online survey was the sole data collection instrument for this study. Two measures, the CWEQ-II (Laschinger et al., 2001) and the RTC (Oreg, 2003), along with a brief demographic questionnaire provided the content for the survey entitled the Empowerment, Experience, and Resistance to Change Survey for Managers & Supervisors (see Appendix A). Appendices D and E contain the email correspondence requesting and receiving permission to use these instruments in this study. The only modification made to these preexisting measures was the conversion from a paper-and-pencil data collection format to an electronic version accessible through a link to a secure SharePoint® on the VHA server. The CWEQ-II questionnaire provided data to assess the predictor variable of the study (managers' perception of empowerment) while the RTC scale supplied data on the individual manager's tendency to resist change (the criterion variable).

The survey opened with six demographic questions, with items addressing years of managerial experience, tenure in current role, gender, age, education (expressed as the highest level of academic degree attained), and current position title. According to Oreg et al. (2011), these demographic variables moderate an individual's response to change. Tenure, education, and position significantly influence a person's reaction to change, whereas gender is a weaker determinant (Oreg et al., 2011). Years of experience associates with performance, innovation, and degree of cognitive rigidity in response to change (Assaf & Cvelbar, 2011; Ng & Feldman, 2013; Rody & Stearns, 2013). Assessing demographic information is a common survey technique and the information collected provides data for descriptive and statistical analysis (Bernard, 2013). I used the nominal and interval data collected in this portion of the survey to develop a descriptive portrait of the participants and to determine the range of years of experience among the managers.

The second portion of the survey included the CWEQ-II. Using the CWEQ-II enabled the collection of ordinal data for analysis in this study. Laschinger et al. (2001) relied upon Kanter's (1993) structural empowerment theory and designed the CWEQ-II survey to quantify how respondents describe the levels of structural empowerment within their workplace. Laschinger et al. expanded upon Kanter's theory and asked respondents to quantify answers to questions covering the following topics:

1. How much of each type of opportunity do they have in their present job?

2. How much access to information do they have in their present job?

3. How much access to support do they have in their present job?

4. How much access to resources do they have in their present job?

5. How much formal power do they have related to job activities?

6. How much informal power do they have related to job activities?

7. What is their perception of empowerment in their workplace?

As developed by Laschinger et al. (2001), the CWEQ-II includes 19 items measuring six dimensions of empowerment and two items (known as the global measure of empowerment) included for construct validation. The CWEQ-II assesses structural empowerment on a five-point scale, with responses ranging from "none" to "a large amount":

- 1 = none
- 2 (no descriptive term assigned)
- 3 = some
- 4 (no descriptive term assigned)
- 5 = a large amount

The final section of this survey included Oreg's (2003) RTC scale. Oreg (2003) designed the RTC instrument to evaluate an individual's tendency to resist change across four factors through the collection of ordinal data. The questions in the RTC scale asked the respondents to quantify their level of agreement with statements addressing their a) propensity for routine seeking, (b) emotional response to change, (c) level of short-term focus, and (d) level of cognitive rigidity (Oreg, 2003). Participants completing the RTC scale indicated their level of agreement to 17 statements along a six-point scale ranging from 1 (strongly disagree) to 6 (strongly agree):

- 1 = strongly disagree

- 2 = disagree

- 3 = inclined to disagree

- 4 = inclined to agree

- 5 = agree

- 6 = strongly agree (Oreg, 2003).

Each instrument included in this measured a different concept. Laschinger et al.

(2001) developed the CWEQ-II survey using Kanter's (1993) structure of workplace

empowerment theory. According to Kanter (1993), workplace empowerment derives

from three sources, including access to information, support, and resources. Laschinger et

al. expanded upon Kanter's theory and developed six subscales of empowerment,

including: (a) access to opportunity, (b) access to resources, (c) access to information, (d)

access to support, (e) formal power related to job activities, and (f) informal power

related to organizational relationships.

Just as the CWEQ-II includes multiple subscales to measure empowerment, the

RTC scale has four factors to assess a propensity to resist change. These factors include

(a) routine seeking, (b) emotional reaction to imposed change, (c) short-term focus, and

(d) cognitive rigidity (Oreg, 2003). Oreg described routine seeking as an inclination to

adopt repetitive actions, and emotional reaction to imposed change as the levels of ease

or stress associated with external change. According to Oreg, a short-term focus implies

avoidance of long-term commitments and a predilection for task-centered behaviors, and

cognitive rigidity is the tendency to avoid questioning the status quo. These factors reflect

the common mental, emotional, and behavioral responses to change experienced by

individuals in the workplace (Oreg et al., 2011). As such, these factors represented a suitable construct to measure the propensity to resist change among the population chosen for this study.

Scoring each measure required performing basic mathematical calculations. As described by Laschinger (2012), the total structural empowerment score for the CWEQ-II instrument derives from a simple computation. I calculated the individual score for each of the subscales (access to opportunity, access to resources, access to information, access to support, formal power, and informal power) by summing the individual subscale's items divided by the number of items in the subscale (Laschinger, 2012).

Each subscale of the CWEQ-II generated a score ranging from 1 to 5. I calculated the total structural empowerment score by summing the six subscales; the total score correlated to the participant's perception of empowerment. The scores could range between 6 and 30. According to Laschinger, a high score indicates a high perception of empowerment whereas the converse is true for low scores. Accordingly, the following terms describe the scores: $6 - 13 =$ low, $14 - 22 =$ moderate, and $23 - 30 =$ high. These categories of scores (low, moderate, and high) provided the data for the CWEQ-II category scores used in the inferential data analysis portion of this study.

The construct validation items instrument (the global measurement of empowerment) included in the CWEQ-II scored similarly but did not contribute to the total empowerment score (Laschinger, 2012). The construct validation items served as a validation index and required respondents to use a five-point scale ranging from strongly disagree (1) to strongly agree (5). I calculated the global empowerment score by

summing the scores divided by the number of items with a possible score ranging from 1 to 5. A higher score indicated a stronger perception of an empowered workplace (Laschinger et al., 2001).

Similar to the CWEQ-II instrument, the RTC scale includes four factors or subscales to measure resistance to change. Within the RTC scale, items 1 – 5 address the subscale for routine seeking, items 6 – 9 examine emotional reaction, the short-term thinking subscale statements include items 10 – 13, and the final subscale (measuring cognitive rigidity) includes items 14 – 17 (Oreg, 2003). Before scoring the scale, Oreg (2003) indicated reverse coding of items 4 and 14 is necessary. Following Oreg's instructions, I scored the RTC scale by summing total points and dividing by 17 (the number of statements). Even though users can sum each subscale to determine a score for each factor (Arciniega & Gonzalez, 2009), Oreg instructed users to report the RTC results as a composite mean score, and I followed this recommendation. The range of possible scores was 1 – 6, with higher scores indicating an increased propensity for resistance to change.

Both instruments incorporated in this study have documented evidence of reliability and validity. Since 2000, health care researchers employed the CWEQ-II survey to study empowerment in a variety of settings and populations (Laschinger et al., 2010). Despite the predominant use to test perceptions of empowerment among staff nurses in hospital settings, multiple researchers applied the instrument to populations including students, educators, managers, and physiotherapists across health related settings such as long-term care facilities, home care agencies, and schools of nursing

(Laschinger, 2012.). The survey demonstrates consistently high reliability, with

Cronbach's alpha reliability coefficients ranging from .69 to .89 across factors, with a

total α = .89 and global empowerment α = .87 (Laschinger, 2012). Construct validity also

tested high, with χ^2 = 1,701, comparative fit index (CFI) = .921, incremental fit index

(IFI) = .922, and root means square error of approximation (RMSEA) = .053, all

indicative of a strong model fit (Laschinger et al., 2001).

Considerable evidence exists confirming the scientific rigor of the RTC scale.

Oreg (2003) conducted a variety of validity tests on the RTC scale, including a

confirmatory factor analysis. Using a second-order factor of general resistance to change,

Oreg loaded the four first-order factors (routine seeking, emotional reaction to imposed

change, short-term focus, and cognitive rigidity) on the second-order factor. The resulting

analysis showed χ^2 = 135.64, CFI = .968, and RMSEA = .039, all indicative of a good fit.

Additionally, Oreg statistically proved the RTC scale demonstrates convergent,

discriminate, concurrent, and predictive validity. Oreg's reliability tests demonstrated the

following Cronbach's alpha reliability coefficients:

- Routine seeking α = .75,

- Emotional reaction to imposed change α = .71,

- Short-term focus α = .71,

- Cognitive rigidity α = .69, and

- Overall reliability α = .87.

The literature supports the use of the RTC scale in a variety of settings and with a

number of populations (Arciniega & Gonzalez, 2009; Foster, 2010; Kunze et al., 2013).

In these studies, the RTC demonstrated solid construct validity, with χ^2 scores ranging from 200.02 – 358.15, CFI scores ranging from .84 - .959, and RMSEA scores ranging from .05 - .06 (Arciniega & Gonzalez, 2009; Foster, 2010; Kunze et al., 2013). According to Foster (2010), the reliability of the RTC scale remained consistent across populations and settings, with Cronbach's alpha reliability coefficients of .75 - .83.

The participants of the study accessed the survey instrument via a link to a SharePoint® on a secure VHA server. SharePoint® software appears in governmental, academic, business, and personal settings (Weldon, 2013). SharePoint® has many features, including discussion boards, blogs, and document libraries (Weldon, 2013), but for the purposes of this study, I only used the software's survey function. Using SharePoint® facilitated the distribution of the survey in a secure and cost-free manner. After creating the link and designing the survey on the SharePoint®, I set the parameters to prevent the collection of respondent names or IP addresses and preserve confidentiality.

I embedded the SharePoint® link in an invitational e-mail and sent it to the participants' work e-mail address (associated with their position in the VA). Participants clicked on the embedded link to enter the SharePoint®. After consenting to participate in this study, participants answered six demographic questions and 38 items using a Likert-type scale (the CWEQ-II uses a five-point scale, and the RTC scale uses a six-point scale). Participants could only enter one response to each statement and had to answer all statements before advancing to the next screen, but had access to go back and change an answer until the point they finished or exited the survey. The survey contained no text

questions. The measures represent a Flesch-Kincaid reading grade level of 7.9 – 8.2, so none of the participants experienced trouble reading or comprehending the concepts covered by the survey. Upon completing the survey, participants viewed a brief thank you screen and exited the SharePoint® site.

Raw data generated by the survey and collected via the SharePoint® was not available to anyone except me. The survey function of the SharePoint® site has the capability of recognizing a respondent's internet protocol (IP) address without recording that information, so confidentiality of responses remained assured. These surveys are only available by request and released only to parties with valid cause to review the raw data (e.g., the IRB of either Walden University or the VHA).

The instruments in this study facilitated an investigation into the existence of a relationship between the predictor variables (empowerment and experience) and the criterion variable (change resistance) within a single group, following a nonexperimental, correlational design. There were 21 predictor items and 17 criterion items; the data collected by these items permitted descriptive and statistical analysis consistent with a quantitative research study's requirements (Bernard, 2013). I tested Kanter's (1993) theory of structural empowerment in a specific population in an objective manner; this supported my decision to use quantitative methods (Bernard, 2013).

The decision to use previously tested instruments (the CWEQ-II survey and the RTC scale) with proven validity and reliability precluded the need for a pilot study (Stone-Romero, 2010). Both measures demonstrate satisfactory Cronbach's alpha reliability coefficients (Laschinger et al., 2001; Oreg, 2003). The confirmatory factor

analyses for both the CWEQ-II and the RTC scale indicate a low risk of common method bias (Laschinger et al., 2001; Oreg, 2003), minimizing a threat to internal validity. Limiting participation to only health care managers in a real-world setting increased the construct validity of the survey (Stone-Romero, 2010). The decision to use a brief, easy-to-understand survey introduced by a personalized email, coupled with an altruistic incentive helped to mitigate non-response bias (Coughlan et al., 2009). I required participants to answer each question before advancing to the next screen, so the risk of individual non-response errors decreased (Coughlan et al., 2009). I applied additional controls to limit the likelihood of internal threats, including soliciting a larger than necessary sample to take the survey and selecting the appropriate statistical test (correlation analysis) to infer the existence of relationship between variables. Both of these strategies minimized threats to statistical validity (Stone-Romero, 2010).

External validity depends on the ability to generalize results across populations (Stone-Romero, 2010). As the design was not experimental or quasi-experimental, the results will not generalize to other settings or populations (Campbell & Stanley, 2010). Despite this limitation, I expect the results of this survey to generate a discussion of opportunities for future research. This future examination of the relationship between empowerment, years of experience, and change resistance among other management populations may establish the validity of this survey instrument.

Data Collection Technique

The data collection technique was a self-administered online survey accessed via an e-mailed link and collected using a SharePoint® on a secure VHA server. A common

quantitative data collection procedure, Coughlan et al. (2009) described survey research as a nonexperimental form of quantitative analysis useful in examining the relationship between variables in a specific population. In addition, Castellan (2010) differentiated between surveys and scales. A scale measures a discrete variable (which is often an abstract concept such as empowerment or change resistance). Researchers tally and analyze responses to provide a score representing the degree of expression of the variable by the participant. Surveys generally collect data on several topics (usually related) and may include scales (Castellan, 2010; Bernard, 2013). The online survey developed for this study blended a survey and a scale to collect data on perceptions of empowerment and propensity to resist change.

When choosing a measure, researchers must consider reliability and validity (Stone-Romero, 2010); to this end, Coughlan et al. (2009) recommended the use of a previously developed (and tested) measure. According to Coughlan et al., any measure used should be evaluated using reliability tests (including test-retest, Cronbach's Alpha, and pilot studies). This study combined two instruments with proven reliability and validity, Laschinger et al. CWEQ-II survey (2001) and Oreg's RTC scale (2003). Based on the strong evidence of reliability and validity, I did not need to administer a pilot survey to test the proposed online survey.

The characteristics of surveys, as defined by Coughlan et al. (2009), include descriptive (offering a one-time view of an attitude, behavior, or event), or correlational and comparative (examining the relationship between variables). According to Coughlin et al., the theoretical framework determines variable selection; additionally, they argued

against including too many variables (as this contributes to survey length, which in turn affects participant response rates). This study included an examination of three variables, permitting me to design an instrument comprehensive enough to examine the relationship between variables without requiring participants to answer a lengthy survey.

As described by Fan and Yan (2010), a well-designed survey measures the intended topic, elicits participants' desire to partake, and captures the desired data. By selecting two measures with high construct validity (Laschinger et al., 2001; Oreg, 2003), the survey allowed me to measure the selected variables of empowerment, years of experience, and change resistance. As previously described, I promoted participation via the use of an altruistic incentive (a $1.00 donation to the WWP for every submitted survey). The use of the secure SharePoint® as the data collector also ensured data capture. Managers invited to participate in this survey routinely access SharePoint® on their facilities' intranet sites. This familiarity with the SharePoint® enhanced the participant's level of trust, thereby decreasing the risk of non-response bias (Fan & Yan, 2010).

The use of an online survey to collect data, although inexpensive and relatively easy, is not without limitations. A researcher can take steps to minimize these limitations. Fan and Yan (2010) stated that a well-crafted survey has an identifiable focus, uses clear language, and is not too lengthy (this discourages participation). Coughlan et al. (2009) described the different survey formats (self-administered, structured interviews, and online) and detailed the challenges and limitations of each form. According to Sanchez-Fernandez et al. (2012), self-administered surveys have low response rates; many self-administered surveys achieve only 25% - 30% response rates. Sauermann and Roach

(2013) place this estimate even lower, at 10-25%. Low response rates limit generalizability and contribute to non-response errors. Sauermann and Roach offered several suggestions to improve response rates, such as making multiple contacts soliciting participation, personalizing the appeal, and offering a small incentive prior to survey completion. I included these strategies in the data collection plan for this study. Strategies to improve response rates warrant attention as incomplete responses and participant bias limits generalizability. In addition to those mentioned above, Coughlan et al. recommended using brief surveys and simple, concise language to minimize these limitations. This study included these recommendations as well. Structured interviews reduce the amount of non-responses and incomplete responses, but are costly and time-consuming, and were not part of my data collection techniques.

Online surveys are ubiquitous; Coughlan et al. (2009) described the various online survey forms to include email, embedded links, and computer-assisted personal, telephone, and self-administered. The benefits include lower costs and easier data management (Coughlan et al., 2009). I used a secure SharePoint® on the NPT VAMC server to collect data. The survey design function available on the SharePoint® permitted the creation of an electronic version of the CWEQ-II instrument and the RTC scale. This survey feature also enabled the development of a survey with unlimited questions. There was no limit on the numbers of responses and de-identification of responses was possible. No names, IP addresses, or email addresses of participants associated with survey responses. SharePoint's® survey option facilitated electronic data acquisition and I downloaded all collected data directly to a spreadsheet for ease of analysis.

Limitations to online surveys include non-response errors, attributed in part to survey fatigue, and sample bias (Coughlan et al., 2009; Sanchez-Fernandez et al., 2012). The successful use of survey methods requires a participant pool with computer access and literacy (Coughlan et al., 2009). The participants identified in this study all have adequate knowledge of common computer programs (allowing easy navigation of a survey website) and have computers with internet access at their workstations. As I obtained VHA approval prior to commencing data collection, this study had senior leadership approval for VHA managers and supervisors to complete the survey while on duty. Requiring participants to complete the survey at work enhanced data security (all data transmitted via secure servers) and increased the likelihood of participation, as respondents did not have to use their own time to participate.

Once participants accessed the survey link from the survey invitational email, they entered the SharePoint® and saw an introductory page explaining the purpose of the survey and outlining the consent process (see Appendix C). The statement of consent detailed the minimal risk associated with the survey and the voluntary nature of participation. I required participants to acknowledge they read and understood the consent before accessing the survey content. Once they accessed the survey content, participants saw three distinct pages, one for each section: the demographic questions, the CWEQ-II survey, and the RTC scale. I required participants to answer all the statements before advancing to the next page and participants could only select one response for each statement. This mitigated item non-response bias (Stone-Romero, 2010). Participants had the option to go back and change an answer until they submitted or

exited the survey. As an additional protection against threats to validity, I restricted

multiple responses from individual computer workstations. The survey closed with a brief

thank you page and reminder their submission would result in a $1 donation to the WWP.

Data collection occurred for 30 days. Following recommendations to boost

survey participation, the e-mail invitation contained information highlighting my

connection with participants, indicating the need for this study, and spotlighting the

altruistic incentive donated on behalf of participants (Anseel, Lievens, Schollaert, &

Choragwicka, 2010; Coughlan et al., 2009). In addition, all e-mails related to this study

generated from a work e-mail account associated with VHA, reinforcing the connection I

shared with the participants (Fan & Yan, 2010; Puleston, 2011). The identified

population received weekly reminders indicating the minimum number of responses

needed (103) and the number of responses to date (Sanchez-Fernandez et al., 2012). The

reminder encouraged non-respondents to have their voices heard in addition to doing

something to benefit the WWP.

Data Organization Techniques

Data storage initially occurred on the secure SharePoint® located on the VHA

server. Once the survey closed, I exported all data exported to an Excel spreadsheet.

Responses had numeric labels and appeared in reverse order of receipt. There was no link

between the number and the subjects' identity. All reports and analyses occurred using a

VHA secure server. Once the 30-day data collection period closed, I closed the access to

the SharePoint® link.

In accordance with VHA policy on the organization and storage of data (United States Department of Veterans Affairs, 2009), all electronic data associated with this study (completed surveys, raw data spreadsheets, and statistical analyses) resided in a secure server located at a local VHA facility in the New York metropolitan region. Any printed copies of data or surveys will remain in a locked desk drawer or file cabinet in my private office behind a locked door. As required by Walden University, I will retain all research records in a secure fashion for five years. Preserving the integrity of all collected data is critical to maintaining the confidence of potential respondents and upholding ethical standards (Anseel et al., 2010; Fan & Yan, 2010; Puleston, 2011)

Data Analysis Technique

Valid quantitative research requires statistically sound data analysis. Driven by deductive reasoning, quantitative research tests theories via data analysis to confirm or refute a prediction about how the theory operates in a given setting (Hollins Martin & Fleming, 2010). This study's purpose was to test for the existence of a relationship between the variables of empowerment, years of experience, and resistance to change among health care managers. Kanter (1993) postulated that empowerment is a prerequisite for effective organizational change to occur and powerlessness contributes to resistance to change. Kotter (1996) did not dispute the importance of empowerment to organizational change, but theorized that managers often resist change to maintain the status quo. Years of experience may relate to resistance to change (Kunze et al., 2013); the management literature reveals mixed results regarding the role of tenure in change initiatives (Ng & Feldman, 2013). Considering the possibility of a connection between

empowerment, years of experience, and resistance to change led me to the question: what is the relationship between health care managers' perceptions of empowerment, years of experience, and resistance to change? Using a quantitative design enabled me to test if there was a relationship between empowerment, experience, and resistance to change among the health care managers in the sample population.

Coughlan et al. (2009) discussed how survey data analyses occurs using descriptive or inferential statistics. The demographic questions of this study yielded nominal data suitable for descriptive research. Descriptive research permits a view of the sample population at a discrete moment in time and is useful for establishing context (Bernard, 2013). Descriptive statistics describe single variables (frequency distribution, central tendencies, and variability) or multiple variables (bivariate or multivariate, contingency, and correlations). The responses to the demographic questions facilitated the collection of data on the years of experience among the managers surveyed. The participants' answers to the demographic questions, as well as the CWEQ-II and RTC instruments, produced ordinal and nominal, non-dichotomous data suitable for testing for association by the use of inferential statistics (Nayak & Hazra, 2011). Inferential statistics use parametric (such as t-test, ANOVA, linear regression analysis, and Pearson's coefficient) and non-parametric (such as Chi-square test, Spearman's rank correlation coefficient, or Mann-Whitney U-test) for predictive purposes (Bernard, 2013). As I examined the association of three variables (empowerment, years of experience, and resistance to change) in a single group without manipulation, the most suitable statistical tests were the Pearson's coefficient for parametric data or Spearman's rank correlation

coefficient for non-parametric data distribution, analysis of variance (ANOVA), and

multiple linear regression (Du Prel, Rohrig, Hommel, & Blettner, 2010).

According to Hollins Martin and Fleming (2010), in high quality quantitative

research, the data analysis section includes a detailed description of techniques used.

Providing a comprehensive explanation of the techniques allows replication of the study,

an important requirement of rigorous, reliable, and valid research. The data analysis plan

for this nonexperimental study included the use of descriptive statistics such as central

tendency, measures of variance, and correlation coefficients. These analyses permitted

the summarization of the characteristics of the population under study (Bernard, 2013).

No discussion of causality occurred, based on the non-experimental design selected for

this study (Stone-Romero, 2010). This limitation represents an opportunity for future

study. In addition to the descriptive statistics, I conducted an inferential analysis that may

be useful in predicting the relationship between the selected variables. The overarching

question of this study asked: what is the relationship between health care managers'

perceptions of empowerment, years of experience, and resistance to change? To answer

this question, correlational analysis and multiple linear regression analysis occurred to

determine if the perception of empowerment and years of experience related to the

tendency for resistance to change in the specified population. The decision to use

purposive sampling and a nonexperimental design made these tests statistically valid

techniques to use in this study.

Prior to conducting the inferential analyses, I tested the assumptions of

multicollinearity, normality, linearity, homoscedasticity, and independence of residuals to

ensure these assumptions remained unviolated (Pallant, 2010). As per Bernard (2013) and Stone-Romero (2010), no violation of the requisite assumptions can exist for an accurate analysis of inferential statistics to occur. A further discussion of these tests of assumption is in Section 3 of this study.

As indicated by Castellan (2010), quantitative researchers use statistical formulas and inferential reasoning to analyze the collected data. This testing includes a significance test, in which the *p*-value either accepts or rejects the null hypothesis. In a discussion of data analysis, Berben, Sereika, and Engberg (2012) detailed how to determine an adequate sample size (using a formula that determines the statistically acceptable degree of error in testing the null hypothesis). In addition, Berben et al. recommended setting statistical significance and power at 0.05 and 0.8 respectively. Result summations are neutral in tone, and include the types of tests used, the p-value relative to the significance level, and the confidence interval (Berben et al., 2012). Upon summarizing results, quantitative researchers provide conclusions (as they relate to the statistical results), describe limitations, and identify the need for further study (Berben et al., 2012). Based on the research literature (Berben et al., 2012; Bernard, 2013; Castellan, 2010; Stone-Romero, 2010), I set the following parameters for the statistical analyses: confidence level = 95%, confidence interval = 5%, statistical power = 80%.

During the early stages of designing a study, researchers should consider conducting a power analysis to ascertain the number of participants needed to produce a reliable result (Hollins Martin & Fleming, 2010). According to Hollins Martin and Fleming (2010), the greater the effect size desired, the larger the sample population needs

to be. A power analysis helps a researcher offset the aim of the study with the resources available to the researcher (Hollins Martin & Fleming, 2010). Coughlan et al. (2009) recommended a sample have a level of power equal to at least 0.8 (an 80% chance of overcoming Type II errors). In accordance with this reasoning, Berben et al. (2012) recommended all correlational studies should include an effect size. Including the effect size in the statistical power analysis permits readers of research studies to understand the magnitude of the relationship between variables (Berben et al., 2012). According to Berben et al., researchers cannot predict this magnitude based only on a *p*-value. Using G*Power 3.1 and based on a sample size of 103, this study has a medium effect size (f^2 = .15; Faul et al., 2009). This effect size means the average reader of this study could discern the magnitude of the relationship between the selected variables (Faul et al., 2009).

As recommended by Bernard (2013), the use of software such as the Statistical Package for the Social Sciences (SPSS) eases the computational burden on researchers conducting analyses of the relationships between variables. Researchers use SPSS, a proprietary software produced by IBM©, to conduct statistical functions, account for missing data (protecting validity), and create graphic representations of results (IBM, 2012). After reviewing the raw data collected by the survey and downloading the results into an Excel spreadsheet, I exported this data into SPSS. No data coding occurred beyond the assignment of a respondent number.

I used SPSS software to determine the existence of a relationship between the established predictor variables (empowerment and years of experience) and criterion

variable (change resistance) among the specified population via the computation of the correlation coefficient (the Pearson Product Moment Correlation or Pearson's *r*) and multiple linear regression analysis. These analyses were consistent with the requirements of a quantitative, nonexperimental, correlational study (Bernard, 2013) designed to test Kanter's (1993) theory of structural empowerment relating to change resistance. The results of these analyses will appear in Section 3, along with a discussion of their implications.

Reliability and Validity

The value of any research depends on the reliability and validity of the work. Several forms of reliability and validity exist, and each carry threats requiring consideration and planning to address (Bernard, 2013). Though not exhaustive, the following sections provide a discussion of the reliability and validity in the instruments, processes, and content of this proposed study.

Reliability

Reliability reflects the consistency of a study or instrument. Even though an instrument must display reliability to have validity, a reliable measure may lack validity (Stone–Romero, 2010). A separate discussion of validity follows this portion of Section 2.

The reliability of this study increased by my decision to use two tested instruments to collect data. As discussed in the preceding section on data collection instruments, both the CWEQ-II survey and the RTC scale underwent repeated tests of internal consistency (Cronbach's α) and demonstrated satisfactory or higher results

(Arciniega & Gonzalez, 2009; Foster, 2010; Laschinger, 2012; Oreg, 2003). Additionally, the provision of clear instructions to participants on how to complete the survey increased the likelihood of obtaining reliable data from respondents (Fan & Yan, 2010). The risk of researcher error diminished and study reliability increased because of such controls (Barends et al., 2014; Fan & Yan, 2010).

Validity

To categorize quantitative methods, Butt (2010) stratified quantitative studies based on the degree of evidence produced, from true experimental to non-experimental, and described the non-experimental studies as having the weakest ability to generalize results (external validity). The associated increase in confounding factors in descriptive, comparative quantitative studies threatens internal validity. Cantrell (2011) stated this risk is always present if no random assignment of participants occurs. Using inclusion and exclusion criteria (standards for who can or cannot participate in the study) improves internal validity. By excluding executive and frontline staff and focusing exclusively on middle managers, the likelihood of confounding factors decreased.

The lack of random sampling is a known threat to internal validity, especially in studies attempting to prove causality (Bernard, 2013). The intent of this study is to establish the existence of a relationship between the predictor variables (empowerment and years of experience) and the criterion variable (change resistance); there was no assumption of causality. In this case, the selection of a nonexperimental design remained appropriate (Stone-Romero, 2010). As a result, I focused on construct, statistical, and external validity during the planning stages of this study.

Construct validity in a nonexperimental study depends on if the theoretical construct selected corresponds with the participants selected and the setting they operate in (Stone-Romero, 2010). By deciding to study if a relationship existed between managerial perceptions of empowerment, years of experience, and change resistance, I tested Kanter's (1993) theory of empowerment. The CWEQ-II instrument demonstrated high construct validity through common factor analysis (Laschinger et al., 2001), as did the RTC scale (Oreg, 2003). The literature supports the use of these instruments with managers in a variety of health care settings (Arciniega & Gonzalez, 2009; Foster, 2010; Laschinger, 2012; Oreg, 2003), and thus ensures construct validity (Bernard, 2013).

Statistical validity depends on a number of factors (Barends et al., 2014; Stone-Romero, 2010). According to Barends et al. (2014) and Stone-Romero (2010), these include an adequate sample size, employing the appropriate statistical tests to analyze the data, using adequate statistical power, and selecting an accurate Type I error rate estimation. By basing the sample size on a reliable sample size calculator, selecting the measurement of Pearson's *r*, ANOVA, and multiple linear regression as the statistical tests, and establishing the statistical power and confidence interval according to established guidelines, the statistical validity of this study improved.

The external validity of this inquiry related to how well the study's results generalized across populations (Stone-Romero, 2010). Given the aforementioned efforts to improve internal validity, I noted that Cantrell (2011) cautioned that improving internal validity diminishes external validity. According to Bernard (2013), a researcher can take steps to improve external validity. These steps include increasing the sample

size, selecting a population representative of the general population, and conducting a longitudinal study (Bernard, 2013). In an effort to increase the sample size, every manager employed within the New York Metropolitan Region VA medical centers received an invitation to participate in this study. In this manner, I achieved a response rate 20.7% (well above the target of 8.7%) and garnered a sufficiently large sample size to ensure external validity.

Given the variety of regional characteristics (urban, suburban, and rural) and the federal government's commitment to hire and promote candidates without regard to ethnicity or gender, the participants were representative of health care managers across the United States. The resulting descriptive statistics derived from demographic data obtained in the survey support this premise. This was not a longitudinal study, so this threat to external validity remained.

Transition and Summary

The intent of Section 2 is to provide a rich description of the methods selected for this study. By presenting the reader with a clear explanation of the quantitative methods selected to study the problem of change resistance among health care managers through the lens of structural empowerment, the validity and reliability of this work is evident. Section 2 also provides future researchers with the means to replicate this study in other populations.

The objective of Section 2 outlined the research method and design; in addition, it included a detailed description of the population and sampling, ethical protections taken, and elements of data collection planned for this study (instruments, techniques, and

organization). It included a discussion of the data analysis plan, as well as steps taken to ensure the reliability and validity of this work.

An overview of the research study and description of the research results and their application to business practice appears in Section 3. In addition, Section 3 includes a discussion of the implications for social change associated with this research, as well as recommendations for action and future study. Section 3 closes with a brief description of reflections on the study process, a summary of the study, and conclusions.

Section 3: Application to Professional Practice and Implications for Change

Section 3 includes an overview of the study, a presentation of the results, a discussion of how these results are pertinent to professional practice, and an exploration of how the findings may influence health care leaders, managers, employees, and the communities they serve. In addition, this section includes evidenced-based recommendations for action, as well as a discussion of opportunities for further study. Section 3 concludes with my personal reflections on this study and closing remarks.

Overview of Study

The purpose of this quantitative correlational study was to ascertain if there was a relationship between health care managers' level of empowerment, years of experience, and resistance to change. This study included the use of inferential statistics (Pearson's coefficient and multiple linear regression analysis) to test for the existence of a relationship between the variables of empowerment, years of experience, and resistance to change among health care managers. Following the recommendations for ensuring statistically valid results, the p-value for this test was 0.05 (Berben et al., 2012; Bernard, 2013; Castellan, 2010; Stone-Romero, 2010). There was a significant association measured between perceptions of empowerment and RTC ($r = -.132$, $p = .05$). There was no association between years of experience and RTC ($r = .060$, $p = ns$). The regression model showed that years of experience and perceptions of empowerment together in one model was not a significant predictor of RTC ($F(2,242) = 2.82$, $p = .062$, $R^2 = .023$). Although the model using both variables was not a significant predictor of RTC, I noted that in the model, perceptions of empowerment was a statistically significant predictor of

RTC (β = -.136, p = .03). Years of managerial experience did not provide any significant variation in RTC (β = .074, p = ns).

Presentation of the Findings

In an attempt to improve the incomplete understanding health care leaders have about managerial empowerment, managerial tenure, and change resistance, this study focused on answering the research question: what is the relationship between health care managers' perceptions of empowerment, years of experience, and resistance to change? The hypotheses for this study were:

$H1_0$: There is no relationship between the health care managers' perception of empowerment and degree of resistance to change.

$H1a$: There is a relationship between the health care managers' perception of empowerment and degree of resistance to change.

$H2_0$: There is no relationship between the health care managers' years of managerial experience and degree of resistance to change.

$H2_0$: There is a relationship between the health care managers' years of managerial experience and degree of resistance to change.

An online survey (see Appendix A) generated the data used to test for a relationship between the variables of empowerment, years of experience, and resistance to change among health care managers. Tests included Pearson's coefficient and multiple linear regression analysis. Data collection occurred over a 30-day period, and 331

managers employed in VA medical centers in the New York metropolitan region responded to the survey. Of these 331 responses, 245 were complete and usable, so the sample size for this study was 245. Based on a population of 1,181 managers, the response rate for this survey was 20.7%. This response rate exceeded the minimum sample needed for statistically valid results, established as 103 respondents per G*Power 3.1 software (Faul et al., 2009). Following the guidelines described by Bernard (2013) and Sanchez et al. (2012), the returned sample size of 245 was robust enough to support the study with a confidence level of 95%, confidence interval of 5%, and statistical power of .80.

Descriptive Statistics

Table 1 depicts the demographic details for the participants of this study. Among this sample of respondents, two in three were female (63.7%). The gender breakdown among this study's participants is similar to gender patterns found in studies examining empowerment among managers, including studies by Leggat et al. (2011), Randolph and Kemery (2011), and Wallace et al. (2011). Those in their fifties represented four in ten (40.9%) respondents, followed by those in their thirties (28.1%) and over 60 (19.8%). In this study, the distribution of participants' age mirrored those of other studies of empowerment, as evidenced in the research conducted by Randolph and Kemery (2011) and Tuuli and Rowlinson (2009). The highest education level reported included Master's Degree (41.6%) followed by a Bachelor's (10%), Doctorate (15.2%), Diploma (14.7%) and Associates (10.2%). The educational background of this study's participants was similar to other studies of empowerment among managers, including the work of Regan

and Rodriguez (2011), as well as Tuuli and Rowlinson (2009). This similarity extended to studies examining resistance to change, including studies conducted by Arciniega and Gonzalez (2009), Foster (2010), and Peccei et al. (2011).

As shown in Table 1, the majority of the respondents worked in their current role for ten years or less, with 38% ($n = 93$) in their current position for 0 to 5 years, followed by those who had been in their current role for 6 to 10 years at 35.5% ($n = 87$). Only 6.1% ($n = 15$) of the participants had worked in their current role for more than 21 years. The demographic data collected in this portion of the survey provided the means to assess the predictor variable of years of experience. Table 1 illustrates the majority of the participants had been in a managerial role for 6 to 10 years (30.2%, $n = 74$), followed by 22% of those in management for 0 to 5 years ($n = 54$), and 20.4% of participants in management for 11 to 15 years ($n = 50$).

The demographic data depicted in Table 1 revealed the respondents were all current managers, predominantly female, established in their role, and higher educated. Most respondents were middle-aged. These descriptive statistics summarize the conditions surrounding the variables under investigation, empowerment, years of experience, and change resistance, within the specified population of this study (Bernard, 2013).

Table 1

Demographic Description of Sample

Variable	*n*	*%*
Gender		
Female	156	36.3
Male	89	63.7
Age Range (in years)		
21 – 29	2	.8
30 – 39	25	10.3
40 – 49	68	28.1
50 – 59	99	40.9
60 +	48	19.8
Education		
Diploma	36	14.7
Associate's	25	10.2
Bachelor's	44	18.0
Master's	102	41.6
Doctorate	38	15.5
Years in Role		
0 – 5	93	38.0
6 – 10	87	35.5
11 – 15	32	13.1
16 – 20	18	7.3
21 +	15	6.1
Years in Management		
0 – 5	54	22.0
6 – 10	74	30.2
11 – 15	50	20.4
16 – 20	20	8.2
21 +	47	19.2

Note. N = 245.

The second portion of the online survey, the CWEQ-II (Laschinger et al., 2001),

provided data used to assess the managers' perception of empowerment. The CWEQ-II

scores had a mean of 20.16 and a standard deviation of 4.26, indicating the participants

had a moderate to strong perception of empowerment in their workplace (Laschinger et

al., 2001). As shown in Figure 1, the distribution for the CWEQ-II scores was normal; the

statistics for skewness of the CWEQ-II scores was low at .456. This indicated parametric

methods such as Pearson's coefficient and multiple linear regression analysis were

appropriate choices to test for a relationship between empowerment, experience, and

resistance to change (Bernard, 2013; Du Prel et al., 2010).
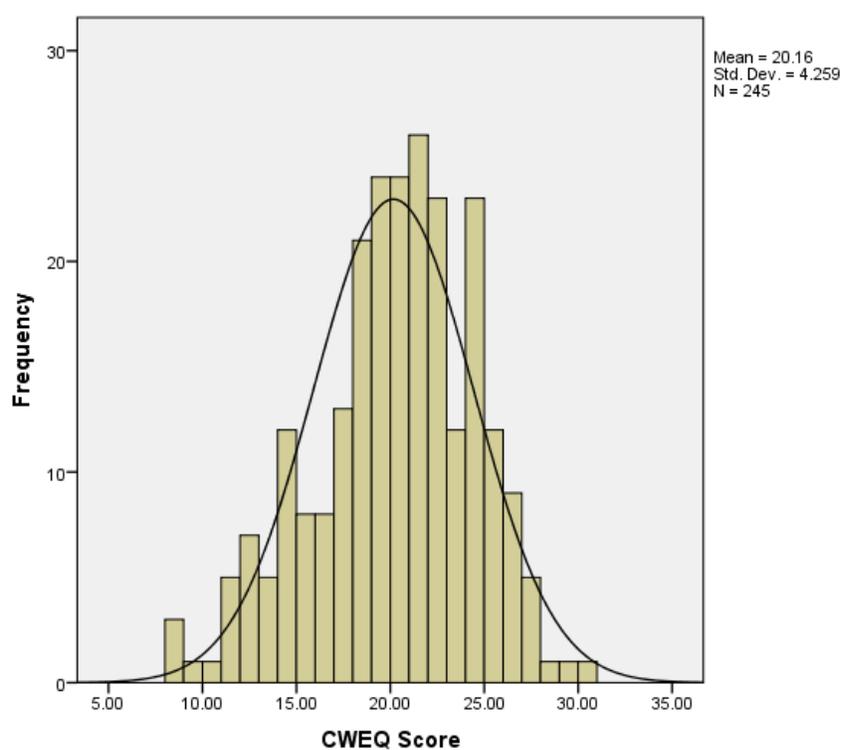
Figure 1. Histogram showing the distribution of the CWEQ-II scores.

The final portion of the online survey was Oreg's (2003) RTC scale. The data generated from these answers permitted the analysis of the participants' propensity to resist change. The range of composite scores was 1 – 6, with higher scores indicating an increased propensity for resistance to change. The mean score was 2.47, indicating the participants had a low to moderate propensity to resist change (Oreg, 2003). Among this sample, managers with 6 to 10 years' experience had the lowest average score (2.36) when compared with their peers.

As shown in Figure 2, there was a normal distribution of the RTC scores. As noted with the CWEQ-II scores, the statistics for skewness of the RTC scores was low at .407. This supported my decision to use parametric tests such as Pearson's coefficient and multiple linear regression analysis as an appropriate way to determine if a relationship between empowerment and resistance to change existed (Bernard, 2013; Du Prel et al., 2010).
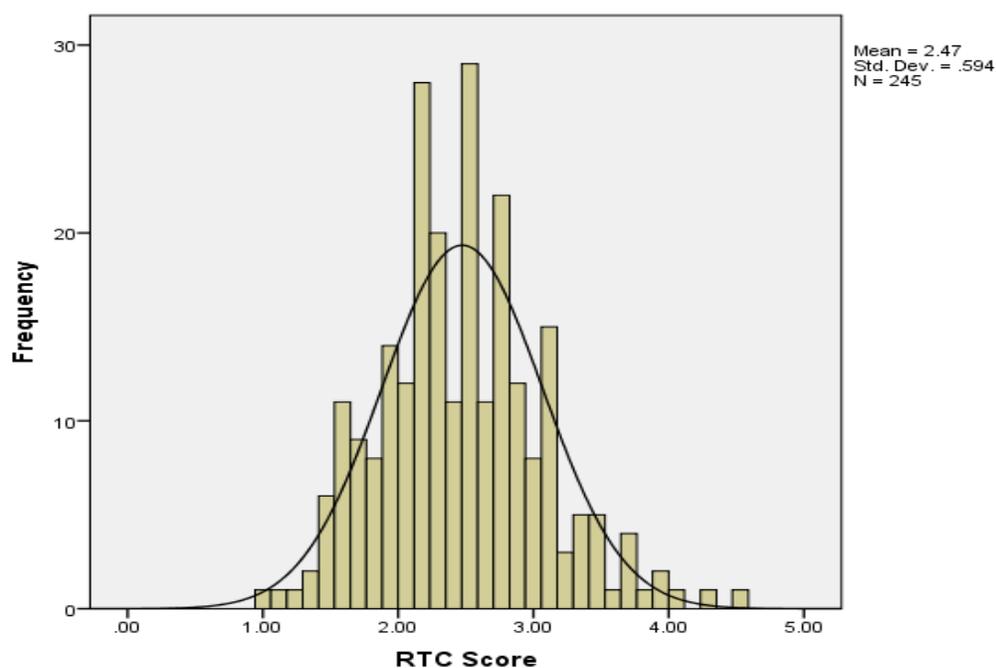
Figure 2. Histogram showing the distribution of the RTC scores

Tests of Assumptions and Reliability

The assumption of normality requires the application of statistical modeling to establish the normal distribution of the data under analysis (Siddiqi, 2014). An accurate analysis of inferential statistics requires the assumptions of multicollinearity, normality, outliers, linearity, homoscedasticity, and independence of residuals remain unviolated (Pallant, 2010). Multicollinearity occurs when a high degree of correlation between independent variables exists; multicollinearity negatively affects multiple regression analysis (Pallant, 2010). A scatterplot of the independent variables facilitated an evaluation of the association between variables (see Figure 3). The lack of a clear association between variables indicates no violation of the assumption of multicollinearity. This lack of relationship is confirmed by the non-significant outcome of

the Pearson's Coefficient ($r = .097$, $p = ns$). The t-tests for each variable and the F-test for the slopes were not significant. Both predictor variables have a variance inflation factor (VIF) of 1.014, suggesting a lack of collinearity. These results confirm there was no violation of the assumption of multicollinearity.
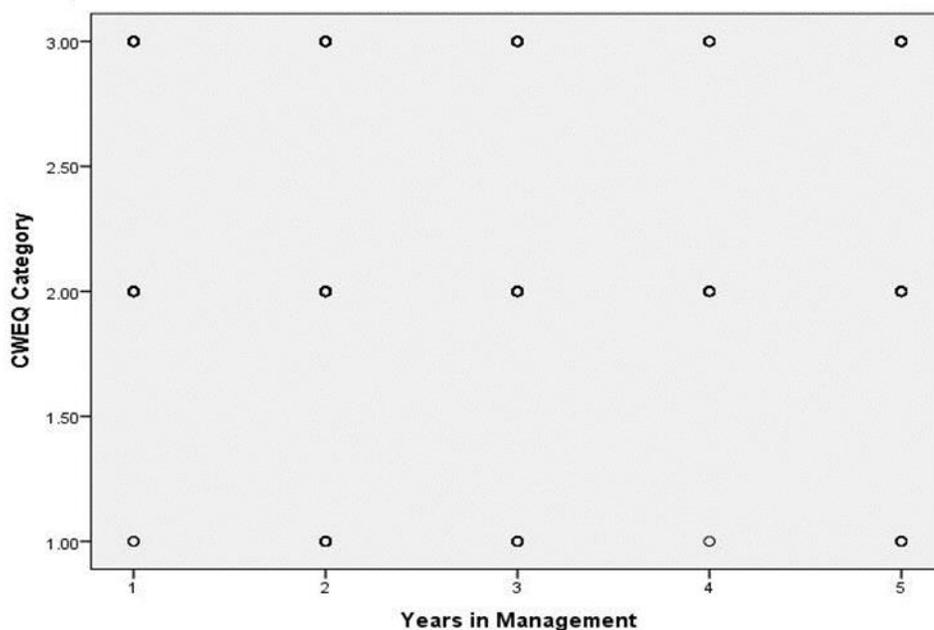
Figure 3. Scatterplot showing the relationship between CWEQ-II scores and Years of Experience. Years of Experience scale: $1 = 0 - 5$ years, $2 = 6 - 10$ years, $3 = 11 - 15$ years, $4 = 16 - 20$ years, and $5 = 21 +$ years in management.

The Normal Probability Plot (P-P) of the Regression Standardized Residual for this study's RTC scores showed no violation of the assumptions of normality, outliers, linearity, homoscedasticity, and independence of residuals (see Figure 4). As seen in Figure 4, the residuals of the RTC scores have a normal distribution and display a clear linear pattern with little variation. As per Pallant (2010), I concluded there was no

violation of the requisite assumptions for an accurate analysis of inferential statistics to occur.
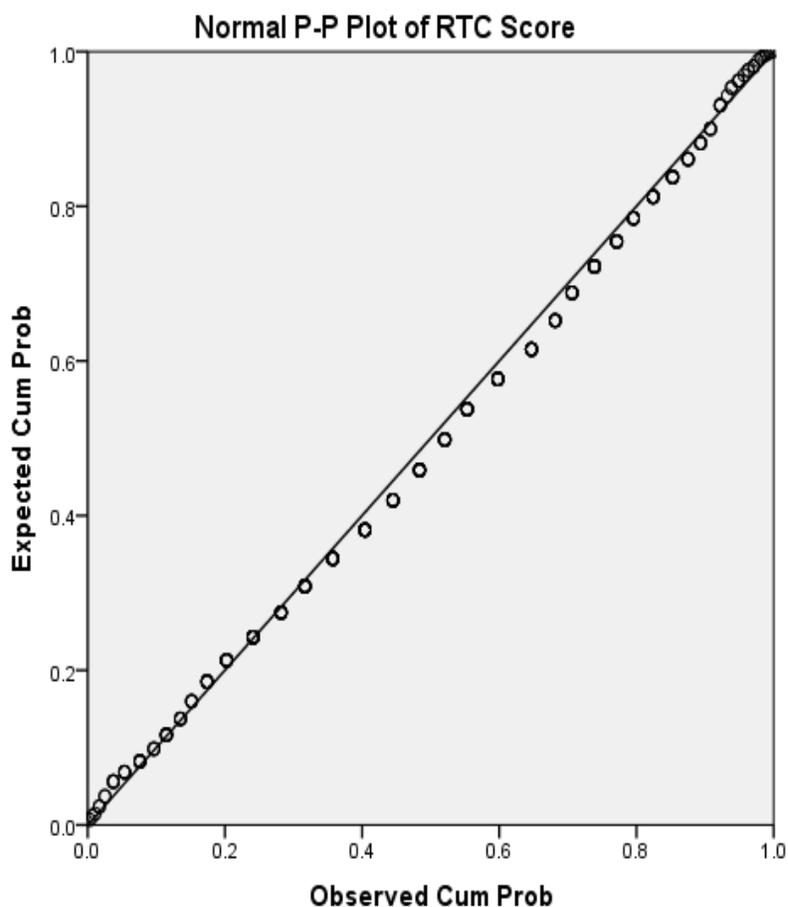
Figure 4. Normal Probability Plot (P-P) of the RTC Scores Regression Standardized Residual.

To demonstrate satisfactory reliability, studies designed with multiple scales require an estimate of the variance of true scores to observed scores (Geldhof, Preacher, & Zephyr, 2013). Cronbach's α is a traditional and respected method of estimating reliability (Geldhof et al., 2013). As displayed in Table 2, the instruments used in this study showed high reliability among the sample.

Table 2
Reliability Coefficients for Study Instruments

Variable	Cronbach's α
CWEQ-II	.89
RTC	.87

Note. N = 245.

Inferential Statistics

Based on the normal distribution of the response data, I selected Pearson's coefficient as a statistical approach to test for the existence, strength, and direction of a relationship between the variables of health care managers' perceptions of empowerment, years of experience, and resistance to change (Bernard, 2013; Du Prel et al., 2010). The results of the correlation testing appear in Table 3. An analysis of correlations between the predictor and criterion variables showed that there was not a significant relationship between Years in Management and perceptions of empowerment (r = .097, p = .129). Additionally, there was no significant association between Years in Management and RTC (r = .060, p = .348). However, there was a significant association measured between perceptions of empowerment and RTC (r = -.132, $p \leq$ .05). The negative value of the r coefficient indicated that the perceptions of empowerment and RTC move in opposite directions. As the perceptions of empowerment increases, RTC decreases.

Table 3

Correlations of Associations Between Years of Managerial Experience, Perceptions of Empowerment, and Resistance to Change

Variable	1	2	3
1. Years of Managerial Experience	1	.097	.060
2. Perceptions of Empowerment		1	-.132[*]
3. Resistance to Change			1

Note. N = 245.
[*]*p* < .05 level (2-tailed).

I used standard multiple linear regression, α = .05 (two-tailed), to examine the

relationship between perceptions of empowerment and years of managerial experience in

predicting resistance to change. The predictor variables were perceptions of

empowerment and years of managerial experience. The criterion variable was resistance

to change. The first null hypothesis was that there was no relationship between health

care managers' perceptions of empowerment and degree of resistance to change. The first

alternative hypothesis was that there was a relationship between health care managers'

perceptions of empowerment and degree of resistance to change. The second null

hypothesis was that there was no relationship between health care managers' years of

managerial experience and degree of resistance to change. The second alternative

hypothesis was that there was a relationship between health care managers' years of

managerial experience and degree of resistance to change.

I conducted preliminary analyses to assess the validity of the assumptions of

multicollinearity, normality, outliers, linearity, homoscedasticity, and independence of

residuals. Testing indicated there were no serious violations (see Tests of Assumptions

and Reliability). The regression model was not a significant predictor of resistance to

change, $F(2,242) = 2.82$, $p = .062$, $R^2 = .023$ (see Table 4). Years of managerial

experience and perceptions of empowerment together predicted only 2.3% of the variance

in resistance to change. In the final model, perceptions of empowerment was a

statistically significant predictor of resistance to change ($\beta = -.139$, $p = .03$). Years of

managerial experience did not explain any significant variation in resistance to change (β

$= .074$, $p = .249$). The predictive equation is as follows:

Resistance to change $= 2.694 + .031$(years of managerial experience) $- .136$(perceptions

of empowerment).

The negative slope for perceptions of empowerment (-.136) as a predictor of

resistance to change indicated there was about a .136 decrease in resistance to change for

each one-point increase in perceptions of empowerment. In other words, resistance to

change tends to decrease as perceptions of empowerment increases. The squared semi-

partial coefficient (sr^2) that estimated how much variance in resistance to change was

uniquely predictable from perceptions of empowerment was .019. This result indicated

that 1.9 % of the variance in resistance to change is attributable to perceptions of

empowerment, when controlling for years of managerial experience.

Table 4
Regression Analysis Summary for Years of Managerial Experience and Perceptions of Empowerment

Variable	B	SE B	β	t	p
Constant	2.694	.157		17.181	.000
Years of Managerial Experience	.031	.027	.074	1.148	.249
Perceptions of Empowerment	-.136	.062	-.139	-2.180	.030[*]

Note. $N = 245$. Outcome variable: Resistance to Change
[*]$p < .05$

Analysis summary. The purpose for this study was to ascertain if there was a relationship between health care managers' level of empowerment, years of experience, and resistance to change. I used Pearson's coefficient and multiple linear regression analysis to test for the existence of a relationship between the variables of empowerment, years of experience, and resistance to change among health care managers. I assessed assumptions surrounding multiple regression; testing for these assumptions showed no apparent violations. The correlation results showed there was an association between empowerment and resistance to change among health care managers working within the VA medical centers in the New York metropolitan region ($r = -.132$, $p \leq .05$). The regression model was not a significant predictor of resistance to change, $F(2,242) = 2.82$, $p = .062$, $R^2 = .023$. In the final model, perceptions of empowerment provided statistically significant predictive information about resistance to change ($\beta = -.139$, $p = .03$). The conclusion from this analysis is that perceptions of empowerment significantly associated with resistance to change among this population, after controlling for years of managerial experience.

After analyzing these results, I rejected this study's first null hypothesis ($H1_0$; no relationship existed between the health care managers' perception of empowerment and degree of resistance to change. Kanter (1993) postulated managers with perceptions of powerlessness would resist change and Kotter (1996) proposed that empowerment is a key requirement for managers to effect change. Kanter and Kotter's positions on power and change resistance indicated a relationship between empowerment and change

resistance exists; as shown by these results, such a relationship exists among the participants of this study.

Neither the Pearson's correlation coefficient nor the regression model showed any significant association between years of experience and resistance to change among this study's sample of health care managers. As a result, I did not reject this study's second null hypothesis ($H2_0$; no relationship exists between the health care managers' years of managerial experience and degree of resistance to change). The results of this study stand in contrast with findings of Assaf and Cvelbar (2011), who postulated that long-tenured employees might resist change. I did not find evidence of any relationship between the variables of years of experience and resistance to change for my study's population.

Applications to Professional Practice

I used this correlational study as an opportunity to test for a relationship between empowerment, years of experience, and a tendency to resist change among health care managers. Change is an unremitting reality for modern organizations, but resistance to change remains an obstacle to effective change. The constancy of change makes it necessary for business leaders to understand and manage change resistance to sustain a successful organization.

According to the responses received in this study, the managers perceived their work environment as empowering. Furthermore, their perceptions of empowerment related significantly to the managers' resistance to change. As perceptions of empowerment increased, resistance to change decreased. These results are important for leaders to consider when planning a new change initiative. Ensuring managers continue

to have the necessary empowerment to meet the requirements of an organizational change effort may reduce resistance to change initiatives undertaken by VA and general business leaders.

The relationship between years of experience and resistance to change was not statistically significant, but worthy of consideration. The managers participating in this survey had a variety of years of experience. Of interest to VA and general business leaders may be the responses of managers with 6 to 10 years of experience. Among this sample, managers with 6 to 10 years' experience had the lowest average RTC score in the sample. This finding indicates the mid-career managers in this study were less resistant to change when compared to their peers. Managers are the primary communicators and operational leaders of change initiatives, so leaders must consider which managers can communicate the need for change most effectively. Business leaders should consider mid-career managers when looking for champions for organizational change initiatives.

The local leaders of the New York metropolitan region VA medical centers made excellence and innovation cornerstones of their plan to provide care to the military veterans they serve (Department of Veterans Affairs, 2011). The results of this examination offer the VA leaders evidence that a relationship exists between the health care managers' perceptions of empowerment and tendency to resist change. VA leaders can apply this knowledge about how empowerment relates to change resistance and improve their change management plans. This application may positively affect the outcome of change initiatives within VA, helping leaders to achieve the excellence and

innovation they seek. In addition, adopting a similarly empowering organizational structure may help leaders of other organizations reduce resistance to change.

Implications for Social Change

The results of this study indicated an empowering environment related to a reduction in the tendency to resist change. Because of this study, the leaders of VA have an evidence-based reason to promote workplace empowerment. The application of empowerment practices contributes to enhanced organizational performance and employee morale (Randolph & Kemery, 2011). These enhancements could create a benefit for the VA, the employees, and by extension, the veterans served by the VA.

Given the results of this study, I was able to provide healthcare leaders with an awareness of the relationship among managerial empowerment, years of managerial experience, and change resistance. The data resulting from this study indicated that increases in empowerment reduce the propensity to resist change. This relationship is important information for VA and other business leaders. By identifying how empowerment relates to resistance to change, leaders can employ empowerment strategies to reduce change resistance. Developing a better understanding of how empowerment relates to change resistance may benefit society through the creation of innovative solutions to organizational problems, enhanced responsiveness to consumer needs, and lowered costs. This study may provide health care and general business leaders with information useful for improving change management plans, empowering managers, and promoting change effectiveness in various organizations. This benefit may promote social change for all of the stakeholders.

Recommendations for Action

Several recommendations for VA and general business leaders flowed from the information this study generated. The data indicated the managers surveyed believed they worked in an empowering environment and this empowerment negatively correlated with resistance to change. An empowering environment occurs when leaders encourage managers to share decision-making and engage in participatory management. Empowering environments result when leaders support the free flow of information, opportunity, support, and resources throughout the organization. Leaders can also promote empowerment by rewarding managers who demonstrate empowering behaviors with frontline staff. Additionally, leaders should offer managers mentoring from leaders who understand the benefits and challenges of an empowering management style. Finally, leaders should address any concerns about empowerment whenever they initiate a new organizational change.

Although the results of this study indicated empowerment relates negatively to resistance to change, the data were not generalizable to other organizations or populations. A different relationship may exist between empowerment and resistance to change among other groups. This possibility indicates the need for further investigation. No matter what the relationship is between empowerment and resistance to change, organizational leaders need to develop a better understanding of the factors that contribute to change resistance. Business leaders from all industries should support additional research on the causes of change resistance. Such investigation could uncover ways for leaders to address change resistance and facilitate change.

Despite the lack of a relationship between experience and resistance to change in this study's sample, VA and business leaders should note that mid-career managers were less resistant to change than their peers were. Leaders should consider appointing mid-careers managers to lead change efforts. Engaging mid-career managers in this fashion may help reduce resistance to change and promote smoother change implementation.

The results of this study and the subsequent recommendations should be of interest to health care leaders, but a wider need exists for any organizational leader to consider the findings of this research. Prior to this work, there was a paucity of research about managerial empowerment. Broadening the understanding of the benefits of empowerment is important for all business leaders. Effective change requires effective leadership, and knowledge is a prerequisite of sustained effectiveness. The plan to disseminate the results of this research includes the publication of a white paper for the Department of Veterans Affairs. To reach a wider business audience, I intend to submit the results of this work to a scholarly journal. In addition, I will present my results at a VA-sponsored symposium on nursing leadership development. By using a variety of means to propagate these results, I hope to spark interest in the topics of empowerment, experience, and resistance to change among managers.

Recommendations for Further Study

When considering potential areas for further study, readers should consider this study's limitations of time and scope. Future researchers may uncover different relationships between empowerment, years of experience, and resistance to change by expanding this study to other settings such as those in the private sector and unrelated to

health care. I recommend the use of the same survey tool in other settings and with other populations such as frontline staff. Another area for further study is to delve deeper into the relationship between empowerment, years of experience, and resistance to change would be to conduct a correlational analysis to compare the responses of managers with frontline staff.

In addition to the limitations of time and scope, I selected only two predictor variables (empowerment and years of experience). My conclusions did not include other predictor variables for the participants' tendency to resist change. The nature of change resistance is multifactorial (Oreg et al., 2011). An opportunity exists to expand the variables to include other possible predictors of resistance to change, such as organizational commitment, culture, and perceptions of justice within the organization. A qualitative or mixed methods study may provide an opportunity to explore the phenomena of resistance to change to develop a deeper understanding of employees' experiences and their potential relationship to other variables.

Finally, future researchers could consider adapting this study's nonexperimental design to either a quasi-experimental or an experimental design. This sort of design would strengthen the internal validity of the study. Having satisfied the requirements for a quasi-experimental or experimental design, future researchers could use statistical tests such as analysis of variance (ANOVA) to establish the existence of causality among the variables. This deeper examination may yield insights that researchers can use to promote more effective change management.

Reflections

Conducting this study required me to consider carefully what I believed about managerial empowerment, years of experience, and the causes of change resistance. I expected to find a negative association between empowerment, experience, and change resistance among the participants. Although I found a relationship between empowerment and resistance to change, I was sure a relationship would exist among all three variables. My certainty was so strong; I retested the data when my initial analyses did not show such a relationship existed. Once I acknowledged my confirmation bias and considered the complexities of change resistance, I became excited at the possibilities my results engendered. Rejecting a null hypothesis is not the only way to advance understanding about organizational change; eliminating causes of change resistance can be just as important as identifying them.

I also experienced unexpected consequences of my research. Researchers must proceed cautiously when conducting research in their own organizations (Hofmeyer et al., 2012), but doing so permitted me to develop relationships with members of my organization with whom I would not normally interact. In addition to the networking opportunities that resulted from this study, I developed a deeper appreciation of the optimism and resiliency of the managers who participated in this study. Despite the challenges inherent to managing a health care division or department in a turbulent environment with limited resources, my peers within the VA were positive and committed to carrying out the organizational mission to promote quality care for the veterans they served.

Summary and Study Conclusions

Successful organizational change remains an unrealized goal across industries (Birken et al., 2013; Lewis et al., 2010; Maurer, 2011). Change failure links inextricably with resistance to change (Ford & Ford, 2010), but despite 60 years of study, the remedies for resistance to change continue to elude most business leaders (Oreg et al., 2011). The need for a cost-effective, responsive, and reliable health care system magnifies the issue of change failure. This need compels health care leaders to identify and eliminate the barriers to effective change (Salmela et al., 2013).

In contemplating the challenges associated with managing organizational change in a health care setting, I recognized managers as key agents of change. The existing literature supported my assumption about the role of managers in change initiatives (Kanter, 1993; Khachian et al., 2012; Kotter, 1996; Leggat et al., 2011). Considering the evidence about resistance to change and the gap in the literature about what contributes to managerial resistance to change, I designed this study to test for a relationship between empowerment, years of experience, and resistance to change among health care managers.

This study's data analyses lead me to conclude empowerment correlates negatively with resistance to change. The results of this study indicated a relationship exists between empowerment and resistance to change among the managers of the medical centers in the New York metropolitan region. Understanding the nature of the workplace environment is vitally important for effective change to occur and sustain (Kanter, 1993; Kotter, 1996; Ng & Feldman, 2013; Randolph & Kemery, 2011).

Recommendations for action stemming from these results include promoting empowerment among all VA employees so the benefits of empowerment can spread throughout the organization (Kanter, 1993; Kotter, 1996; Leggat et al., 2011). In addition, VA leadership should involve mid-career managers in change initiatives as this group has the lowest tendency to resist change. In recognition that all organizations, not just VA medical centers, struggle with change management (Birken et al., 2013; Lewis et al., 2010; Maurer, 2011), all business leaders should consider the implications of this study's results.

The results of this quantitative correlational study did not indicate a relationship existed between the variables of years of experience and resistance to change among the managers surveyed. At first glance, these results could indicate no further need exists to study the problem of managerial experience and resistance to change. This action would ignore the complex nature of resistance to change as well as the limitations of the study. Resistance to change is multidimensional (Oreg et al., 2011; Smollan, 2011), and I studied only one sample of managers at one specific time. Rejecting the possibility of a relationship between years of experience and resistance to change would require additional studies using the survey tool with different groups in a variety of industries. This need for further study represents an exciting opportunity to uncover concrete solutions to the complex problem of managing resistance to change in an effective manner.

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Appendix A: Survey Invitation: the Empowerment, Experience, and Resistance to

Change Survey for Managers & Supervisors

I am a fellow manager within VA ▉/▉ Veterans Health Network (formerly known as VISN ▉) and a Doctorate of Business Student at Walden University. I am conducting an empirical study of the relationship between empowerment, experience, and resistance to change among managers and supervisors in the VA ▉/▉ Veterans Health Network. I believe the results of this research will foster evidence-based recommendations that could lead to enhanced outcomes for health care organizations, health care professionals, and patients.

I ask you to help me by voluntarily completing this survey via the embedded link. I estimate it will take you between 15- 30 minutes to complete it. As an incentive, I will donate $1.00 for every submitted survey to the Wounded Warrior Project (WWP). This VA accredited nonprofit veterans' service organization offers wounded veterans assistance ranging from retreats to job placement. Established by veterans for veterans in 2002, the WWP is a recognized 501(c)(3) charity serving American veterans of the Iraq and Afghanistan wars. The WWP seeks to raise public awareness and support for men and women who sustain physical and psychological injuries while serving in the United States military. They have over 31,036 registered veterans and 3,165 family members participating in their programs. They collect no dues or fees and rely on donations to support the services they provide. It is my honor to offer you this small token of appreciation for taking the time to complete this survey.

I want to study health care managers and supervisors in the context of their work sites so I ask you to complete this VA approved survey from your regular VA computer workstation. I alone will access the surveys and will not collect your name or IP address. I will share my analysis only at the aggregate levels. I will not share any individual level data and assure you of complete confidentiality.

Should you have questions or comments, please feel free to contact Rita Burgess, RN (tel: ██-██-███ extension ███, or ██-██-███) at ████████ VAMC, █ ████████ Rd, ████████ NY ███x. If you cannot contact me, or if you wish to talk to someone other than a member of the research team to discuss problems, obtain information, or offer input, you may contact the Research Compliance Officer at ██-██-███ extension ███. You may also contact the Research Compliance Officer to verify the validity of the study or that the individual that contacted you has authorization to do so.

Your participation is voluntary. If you choose not to participate, do not complete it. I will treat any information obtained about you as confidential and will safeguard it in accordance with federal and state laws and medical center policy. The data will be secured in locked cabinets in the locked office of Rita Burgess. Electronic records will be stored in a password-protected file on the VA server. All records will be retained in accordance with the VA records control schedule. However, the research records may be reviewed by the Institutional Review Board (the committee that oversees all research in human subjects) at ████████ VAMC if required by applicable laws or regulations. This

research has been reviewed and approved by the ▮▮▮▮▮▮ VAMC Institutional Review

Board.

Desired Population: Please complete this survey <u>only</u> if you are a manager or supervisor

working for VA ▮/▮ Veterans Health Network (including: time and leave approving

officials, chiefs, associate chiefs, assistant chiefs, managers, assistant managers, Patient

Care Team Coordinators, supervisors, and Nurse Officer of the Day/NOD). This

information will <u>not</u> be used in any way to identify any individuals who participate in this

study.

Survey Questions

Demographics: The following questions will provide me with background information I
will use to add context to the study. No names or e-mail addresses will be associated with
your responses.

1. How long have you been in management? Please indicate a range:

   0-5 years____   6-10 years____   11-15 years_____   16-20 years____
   >21 years____

2. How long have you been in your current role? Please indicate a range:

   0-5 years____   6-10 years____   11-15 years_____   16-20 years____
   >21 years____

3. What is your gender?   □ Female   □ Male

4. How old are you? Please indicate a range: 21-25 years____   26-30 years____

31-35 years_____   36-40 years____   41-45 years____   46-50 years____   51-55 years____   56-
60 years____   61-65 years____   66-70 years____   >71 years____

5. Highest Degree Earned: _____Diploma   _____AD
____BS or BA   _____MA or MS   _____ MD, PhD, or Doctorate

6. Current Position Title: Chief___   Associate Chief___   Assistant Chief___

Manager___   Assistant Manager___   Patient Care Team Coordinator___   Supervisor___

Nurse Officer of the Day/NOD___

Conditions of Work Effectiveness Questionnaire-II (CWEQ-II)

Laschinger, H.K.S., Finegan, J., Shamian, J., & Wilk, P. (2001). Impact of structural and

psychological empowerment on job strain in nursing work settings: Expanding

Kanter's model. *Journal of Nursing Administration, 31*, 260-272. Retrieved from

http://journals.lww.com/jonajournal/pages/default.aspx . Reprinted with

permission.

HOW MUCH OF EACH TYPE OF <u>OPPORTUNITY</u> DO YOU HAVE IN YOUR PRESENT JOB?

		None		Some		A Large Amount
1.	Challenging work	1	2	3	4	5
2.	The chance to gain new skills and knowledge at work.	1	2	3	4	5
3.	Tasks that use all of your own skills and knowledge.	1	2	3	4	5

HOW MUCH ACCESS TO <u>INFORMATION</u> DO YOU HAVE IN YOUR PRESENT JOB?

		No Knowledge		Some Knowledge		High Knowledge
1.	The current state of the hospital.	1	2	3	4	5
2.	The values of top management.	1	2	3	4	5
3.	The goals of top management.	1	2	3	4	5

HOW MUCH ACCESS TO <u>SUPPORT</u> DO YOU HAVE IN YOUR PRESENT JOB?

		None		Some		A Large Amount
1.	Specific information about work you do well.	1	2	3	4	5

		None		Some		A Large Amount

2. Specific comments about work you could improve. 1 2 3 4 5

3. Helpful hints or problem solving advice. 1 2 3 4 5

HOW MUCH ACCESS TO <u>RESOURCES</u> DO YOU HAVE IN YOUR PRESENT JOB?

	None		Some		A Large Amount

1. Time available to do necessary paperwork. 1 2 3 4 5

2. Time available to accomplish job requirements. 1 2 3 4 5

3. Acquiring temporary help when needed. 1 2 3 4 5

IN MY WORK SETTING/JOB:

	None		Some		A Large Amount

1. The rewards for innovation on the job are 1 2 3 4 5

2. The amount of flexibility in my job is 1 2 3 4 5

3. The amount of visibility of my work-related activities within the institution is 1 2 3 4 5

HOW MUCH OPPORTUNITY DO YOU HAVE FOR THESE ACTIVITIES IN YOUR PRESENT JOB?

	None		Some		A Large Amount

1. Collaborating on patient care with physicians. 1 2 3 4 5

2. Being sought out by peers for help with problems 1 2 3 4 5

3. Being sought out by managers for help with problems 1 2 3 4 5

4. Seeking out ideas from professionals other than physicians, 1 2 3 4 5

   e.g., Nurses, Social Workers, Physiotherapists, Occupational Therapists, Dieticians.

GLOBAL EMPOWERMENT PERCEPTION

	Strongly Disagree				Strongly Agree

1. My current work environment empowers me to accomplish my work in an effective manner. 1 2 3 4 5

2. I consider my workplace to be an empowering environment. 1 2 3 4 5

Resistance to Change Scale

Oreg, S. (2003). Resistance to change: Developing an individual differences measure.

Journal of Applied Psychology, *88*, 680-693. doi:10.1037/0021-9010.88.4.680

Statement	Strongly disagree	Disagree	Inclined to disagree	Inclined to agree	Agree	Strongly agree
1. I generally consider changes to be negative.	1	2	3	4	5	6
2. I will take a routine day over a day full of unexpected events any time.	1	2	3	4	5	6
3. I like to follow the same routines rather than try new and different ones.	1	2	3	4	5	6
4. Whenever my life forms a stable routine, I look for ways to change it.	1	2	3	4	5	6
5. I would rather be bored than surprised.	1	2	3	4	5	6
6. If there was going to be a significant change in the routines at work, I would probably feel stressed.	1	2	3	4	5	6
7. When I am informed of a change of plans, I tense up a bit.	1	2	3	4	5	6
8. When my schedule does not go according to plans, my stress level rises.	1	2	3	4	5	6
9. If my supervisor changed the performance evaluation criteria, I would probably feel uncomfortable even if I thought I would do just as well without having to do extra work.	1	2	3	4	5	6
10. Changing plans is irritating to me.	1	2	3	4	5	6
11. I am slightly uncomfortable even about changes that may improve my life.	1	2	3	4	5	6
12. When someone pressures me to change something, I tend to resist it even if I think the change may benefit me.	1	2	3	4	5	6

Statement	Strongly disagree	Disagree	Inclined to disagree	Inclined to agree	Agree	Strongly agree
13. I sometimes find myself avoiding changes that I know will be good for me.	1	2	3	4	5	6
14. I often change my mind.	1	2	3	4	5	6
15. I do not change my mind easily.	1	2	3	4	5	6
16. Once I come to a conclusion, I am not likely to change my mind.	1	2	3	4	5	6
17. My views are very consistent over time.	1	2	3	4	5	6

Appendix B: Survey Prenotification E-mail

Greetings!

I am a fellow manager within VA ██/██ Veterans Health Network (formerly known as VISN █) and a Doctorate of Business Student at Walden University. I am conducting an empirical study of the relationship between empowerment, experience, and resistance to change among managers and supervisors in the VA ██/██ Veterans Health Network. I believe the results of this research will foster evidence-based recommendations that could lead to enhanced outcomes for health care organizations, health care professionals, and patients.

I ask you to help me by voluntarily completing this survey via the embedded link. I estimate it will take you between 15- 30 minutes to complete it. As an incentive, I will donate $1.00 for every submitted survey to the Wounded Warrior Project (WWP). This VA accredited nonprofit veterans' service organization offers wounded veterans assistance ranging from retreats to job placement. Established by veterans for veterans in 2002, the WWP is a recognized 501(c)(3) charity serving American veterans of the Iraq and Afghanistan wars. The WWP seeks to raise public awareness and support for men and women who sustain physical and psychological injuries while serving in the United States military. They have over 31,036 registered veterans and 3,165 family members participating in their programs. They collect no dues or fees and rely on donations to support the services they provide. It is my honor to offer you this small token of appreciation for taking the time to complete this survey.

Appendix C: Statement of Consent

You are invited to take part in a research study of the relationship between perceptions of empowerment, experience, and change resistance in health care managers. The researcher is inviting all health care managers working for the VA ██/██ Veterans Health Network (formerly known as VISN █). This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named Rita Burgess, who is a doctoral student at Walden University. You may already know the researcher as a nurse manager within the ██/██ Veterans Healthcare Network, but this study is separate from that role.

Background Information:
The purpose of this study is to determine if a relationship exists between empowerment, experience, and resistance to change among managers and supervisors in the VA ██/██ Veterans Health Network. The researcher believes the results of this research will foster evidence-based recommendations that could lead to enhanced outcomes for health care organizations, health care professionals, and patients.

Procedures:
If you agree to be in this study, you will be asked to spend between 15-30 minutes participating in an online survey. Completing this survey will require you to:
- Log into the Microsoft SharePoint® web site by clicking on the embedded link.
- Answer 6 demographic questions.
- Use a five or six point scale to answer 39 questions. These questions ask you to rate on a scale how much you agree with a statement about either empowerment or resistance to change.

Here are some sample questions:
- On a scale, how much access to information do you have in your present job?
- On a scale, how much access to support do you have in your present job?
- On a scale, to what extent do you feel that you as a manager are able to get early information about decisions and policy shifts?
- To what degree do you agree with this statement, "If my supervisor changed the performance evaluation criteria, it would probably make me feel uncomfortable even if I thought I'd do just as well without having to do extra work."

Voluntary Nature of the Study:
This study is voluntary. Everyone will respect your decision of whether or not you choose to be in the study. No one at ██/██ Veterans Healthcare Network will treat you differently if you decide not to be in the study. If you decide to join the study now, you can still change your mind later. You have the right to withdraw at any time simply by

closing the survey link before clicking "submit" and completing the survey. You may stop at any time.

Risks and Benefits of Being in the Study:
Being in this type of study involves some risk of the minor discomforts that can be encountered in daily life, such as fatigue, stress, or becoming upset. Being in this study would not pose a risk to your safety or wellbeing.

A lack of empowerment represents a barrier to accepting changes. Years of experience may relate to a manager's response to change. As health care organizations waste resources in failed change efforts, there are fewer funds available to improve quality. Patient and staff satisfaction suffer, and stakeholder needs remain unmet. Finding solutions that reduce change resistance in health care organizations promotes societal and organizational fitness, important benefits for any health care leader. This study may uncover ways to improve how the ██/██ Veterans Healthcare Network empowers managers and promotes change. It will provide a means for you to describe how you view your role in relationship to power and change resistance.

Payment:
You will not receive any form of payment for participating in this study. As an incentive, Rita Burgess will donate $1.00 for every submitted survey to the Wounded Warrior Project (WWP). This VA accredited nonprofit veterans' service organization offers wounded veterans assistance ranging from retreats to job placement. Established by veterans for veterans in 2002, the WWP is a recognized 501(c)(3) charity serving American veterans of the Iraq and Afghanistan wars. The WWP seeks to raise public awareness and support for the men and women who sustain physical and psychological injuries while serving in the United States military. They have over 31,036 registered veterans and 3,165 family members participating in their programs. They collect no dues or fees and rely on donations to support the services they provide. In recognition of the time you spend taking this survey, the researcher offers you this small token of appreciation.

Privacy:
Any information you provide will be kept confidential. The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. Any information obtained about you will be treated as confidential and will be safeguarded in accordance with federal and state laws and medical center policy. The data will be secured in locked cabinets in the locked office of Rita Burgess. Electronic records will be stored in a password-protected file on the VA server. All records will be retained in accordance with the VA records control schedule. Data will be kept for a period of at least 5 years, as required by Walden University.

Contacts and Questions:
You may ask any questions you have now. If you have questions later, you may contact the researcher via ██-██-██ extension ██; ██-██-██; or ██.██████@va.gov. If you want to talk privately about your rights as a participant, you can call the ██████ VAMC Research Compliance Officer at ██-██-██ extension ██. ██████ VAMC IRB approval number for this study is **00422** and it expires on **09/30/2014.**

Please print or save this consent form for your records.

Statement of Consent:

      I have read the above information and I feel I understand the study well enough to make a decision about my involvement. By clicking the link below, I understand that I am agreeing to the terms described above.

Appendix D: Laschinger CWEQ-II Permission Approval

Western

NURSING WORK EMPOWERMENT SCALE
Request Form

I request permission to copy the Nursing Work Empowerment Scale as developed by Dr. G. Chandler and Dr. Heather K. Spence Laschinger. Upon completion of the research, I will provide Dr. Laschinger with a brief summary of the results, including information related to the use of the Nursing Work Empowerment Scale used in my study.

Questionnaires Requested:
Conditions of Work Effectiveness-I (includes JAS and ORS): Yes
Conditions of Work Effectiveness-II (includes JAS-II and ORS-II): Yes
Job Activity Scale (JAS) only:
Organizational Relationship Scale (ORS) only:
Organizational Development Opinionnaire or Manager Activity Scale: Yes
Other Instruments:

Please complete the following information:
Date: 01/15/2013
Name: Rita Burgess
Title: Examining the Relationship Between Empowerment and Change Resistance Among Health Care Managers
University/Organization: Walden University, College of Management and Technology
Address: ███████████████████████
Phone: ████-███-████
E-mail: ████.██████2@waldenu.edu

Description of Study: Dear Dr. Laschinger,

Hello, please permit to introduce myself; my name is Rita Burgess and I am a doctoral candidate at Walden University's College of Management and Technology. I am writing today to request your permission to use your Conditions for Work Effectiveness Questionnaire II and Manager Activity Scale. Your work has provided me with a myriad of ideas and prompted me to examine how empowerment relates to change resistance among health care professionals.

I am proposing a Doctor of Business Administration (DBA) study examining the relationship between health care managers' perceptions of power, years of experience,

and subsequent change resistant behaviors. The general business problem I am studying is that health care organizations do not implement process change well. The specific problem I want to address is the health care manager's perceptions of empowerment and subsequent resistance to change. As a nurse manager, I am struck by how often colleagues believe they are powerless to effect change and actively or passively resist organizational change initiatives. My experience and education have shown me that the role of the manager in change is critical, but requires empowerment and development for success, elements often missing from health care organizations' change management plans. I believe that understanding the relationship between the manager's perceptions of empowerment and change resistance is critical to engaging managers and advancing organizational change.

The purpose of my quantitative study is to examine the relationship between the health care manager's perception of empowerment, years of experience, and levels of change resistance. The specific population selected for this study includes health care managers in the Veterans Affairs health care system in the New York metropolitan region. The central research question for this study is *What is the relationship between the manager's perception of empowerment, years of experience, and degree of change resistance?* I hope to use two measures in my study, Resistance to Change Scale (designed by Dr. Oreg) and your own Conditions for Work Effectiveness Questionnaire II and Manager Activity Scale.

I would be happy to answer any questions you may have about my work, and look forward to hearing from you soon.

Permission is hereby granted to copy and use the Nursing Work Empowerment Scale.

Date: January 18, 2013
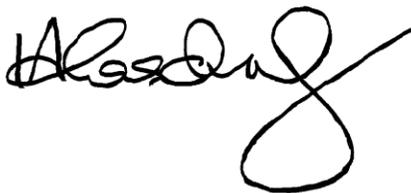
Dr. Heather K. Spence Laschinger, Professor
School of Nursing, University of Western Ontario
London, Ontario, Canada N6A 5C1
Tel: ext.   Fax:
E-mail:

Appendix E: Oreg RTC Scale Permission Approval

Subject : RE: SPN Profile Message: request for permission to use your resistance to
change scale

Date :   Tue, Jan 15, 2013 01:55 PM CST

From :   Shaul Oreg <░░░░@huji.ac.il>

To :   <░░░.░░░░░2@waldenu.edu>

```
Hi Rita,

The study you propose sounds very interesting and you are most welcome
to use
the scale.

Best of luck with your work.

Shaul Oreg


_____
Shaul Oreg, Ph.D.
Associate Professor of Organizational Behavior
School of Business Administration
The Hebrew University of Jerusalem
Mt. Scopus, Jerusalem 91905
Israel
Phone:
Email:
Website:



-----Original Message-----
From: Rita Burgess [mailto:░░░░.░░░░░2@waldenu.edu]
Sent: Tuesday, January 15, 2013 9:48 PM
To: ░░░░@huji.ac.il
Subject: SPN Profile Message: request for permission to use your
resistance to
change scale

Dear Dr. Oreg,

Hello, please permit to introduce myself; my name is Rita Burgess and I
am a doctoral candidate of Walden University's School of Management and
Technology. I am writing today to request your permission to use your
Resistance to Change Scale. Your work has provided me with a myriad of
ideas and prompted me to seek confirmation of causes for change
resistance among health care professionals.

I am proposing a Doctor of Business Administration (DBA) study
examining the relationship between health care managers' perceptions of
power, years of experience, and subsequent change resistant behaviors.
```

The general business problem I am studying is that health care organizations do not implement process change well. The specific problem I want to address is the health care manager's perceptions of empowerment and subsequent resistance to change. As a nurse manager, I am struck by how often colleagues believe they are powerless to effect change and actively or passively resist organizational change initiatives. My experience and education have shown me that the role of the manager in change is critical, but requires empowerment and development for success, elements often missing from health care organizations' change management plans. I believe that understanding the relationship between the manager's perceptions of empowerment, years of experience, and change resistance is critical to engaging managers and advancing health care organizational change.

The purpose of my quantitative study is to examine the relationship between the health care manager's perception of empowerment, years of experience, and levels of change resistance. The specific population selected for this study includes health care managers in the Veterans Affairs health care system in the New York metropolitan region. The central research question for this study is "What is the relationship between the manager's perception of empowerment, years of experience, and degree of change resistance?" I hope to use two measures in my study, The Conditions for Work Effectiveness Questionnaire (designed by Dr. Laschinger) and your own Resistance to Change Scale.

I would be happy to answer any questions you may have about my work, and look forward to hearing from you soon.

With sincere regard,
Rita Burgess

Appendix F: Walden University IRB Approval

Dear Ms. Burgess,

This email is to notify you that the Institutional Review Board (IRB) has approved your application for the study entitled, "Examining Empowerment, Experience, and Change Resistance Among Health Care Managers." Your approval # is 04-18-14-0252264. You will need to reference this number in your doctoral study and in any future funding or publication submissions.

Your IRB approval expires on April 17, 2015. One month before this expiration date, you will be sent a Continuing Review Form, which must be submitted if you wish to collect data beyond the approval expiration date. Your IRB approval is contingent upon your adherence to the exact procedures described in the final version of the IRB application document that has been submitted as of this date. This includes maintaining your current status with the university. Your IRB approval is only valid while you are an actively enrolled student at Walden University. If you need to take a leave of absence or are otherwise unable to remain actively enrolled, your IRB approval is suspended. Absolutely NO participant recruitment or data collection may occur while a student is not actively enrolled.

If you need to make any changes to your research staff or procedures, you must obtain IRB approval by submitting the IRB Request for Change in Procedures Form. You will receive confirmation with a status update of the request within 1 week of submitting the change request form and are not permitted to implement changes prior to receiving approval. Please note that Walden University does not accept responsibility or liability for research activities conducted without the IRB's approval, and the University will not accept or grant credit for student work that fails to comply with the policies and procedures related to ethical standards in research.

When you submitted your IRB application, you made a commitment to communicate both discrete adverse events and general problems to the IRB within 1 week of their occurrence/realization. Failure to do so may result in invalidation of data, loss of academic credit, and/or loss of legal protections otherwise available to the researcher. Both the Adverse Event Reporting form and Request for Change in Procedures form can be obtained at the IRB section of the Walden web site or by emailing irb@waldenu.edu: http://researchcenter.waldenu.edu/Application-and-General-Materials.htm

Researchers are expected to keep detailed records of their research activities (i.e., participant log sheets, completed consent forms, etc.) for the same period of time they retain the original data. If, in the future, you require copies of the originally submitted IRB materials, you may request them from Institutional Review Board.

Please note that this letter indicates that the IRB has approved your research. You may not begin the research phase of your doctoral study, however, until you have received the **Notification of Approval to Conduct Research** e-mail. Once you have received this notification by email, you may begin your data collection.

Both students and faculty are invited to provide feedback on this IRB experience at the link below:

http://www.surveymonkey.com/s.aspx?sm=qHBJzkJMUx43pZegKlmdiQ_3d_3d

Alex Dohm

Research Service Specialist
Center for Research Quality
Walden University
100 Washington Avenue South, Suite 900
Minneapolis, MN 55401

Appendix G: VHA IRB Approval

Department of Veterans Affairs

Memorandum

Date: October 30, 2013

From: ACOS/R&D (151)

Subj: Approval of Initial Protocol

To: Burgess, Rita, RN

Re: *Examining the Relationship Between Empowerment and Change Resistance Among Health Care Managers*

MIRB#:   00422

Ms. Burgess,

Your study has been approved by all required committees and subcommittees.

You may now initiate the study.

If you have any questions, please call Dorothy Baker, Research Committees Coordinator, at ext. 2850.

Attachments:

SRS	Approval letter dated:	7/12/2013
IBC	Approval letter dated:	N/A
IACUC	Approval letter dated:	N/A
IRB	Approval letter dated:	7/8/13 and 10/4/13
R&DC	Approval letter dated:	10/29/2013

VA FORM 2105 Automated

DEPARTMENT OF VETERANS AFFAIRS
Medical Center
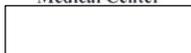
March 20, 2014

RE: Letter of Cooperation from a Community Research Partner for Data Collection when Researcher has Dual Roles

Dear Ms. Rita Burgess,

We are pleased to work with you in your capacity as the Nurse Manager/Staffing Coordinator who will be conducting a research study titled "Examining the Relationship Between Empowerment and Change Resistance Among Health Care Managers" as part of our organization's operations during 10/30/13-9/30/14. We agree to assume responsibility for these activities within the scope of our regular operations.

We understand that you will also be undertaking a Walden University student researcher role that is separate from your Nurse Manager/Staffing Coordinator role. In your student researcher role, I authorize you to invite the civilian managers and supervisors from VISN☐ to participate in completing the Empowerment and Resistance to Change survey. You will recruit individuals to participate in the survey via the VISN☐ Outlook e-mail address global address book. Data will be collected via Microsoft SharePoint without names or e-mail addresses collected. Results of the study will be available to interested parties within VISN3. Individuals' participation will be voluntary and at their own discretion.

We understand that you will allow participants to volunteer and decline anonymously in order to minimize conflicts of interest and other potential ethical problems. As per permission of

the Medical Center Directors, managers and supervisors may participate in the survey during regular working hours.

      We understand that our organization's responsibilities include: the use of the Microsoft SharePoint for data collection. We reserve the right to withdraw from the study at any time if our circumstances change.

      I confirm that I am authorized to approve research in this setting. The VA assumes responsibility and is willing to fully sponsor this program evaluation conducted within VISN3. I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the student's supervising faculty/staff without permission from the Walden University IRB and the [   ] VAMC.

Sincerely,

[   ] MD

ACOS R&D

[   ]@va.gov

Curriculum Vitae

Rita Burgess BSN, MBA, RN-BC, CCRN

Professional Experience

Staffing and Recruitment Coordinator/ Nurse Manager
2/2012 – Present: ███████ VA Medical Center, ███████ NY

Accountable for the overall administration of staffing. Responsible for assisting the nurse managers with providing nursing care units with the appropriate nursing staff to meet patient care hours. Provides support and guidance to Unit Nurse Manager, applies staffing methodology principles, and is responsible for managing the services FETE budget.
Serves as facility Coach – Mentor Core Training Facilitator; works closely with Workforce Development to ensure the facility maintains a successful leadership succession plan. Actively involved in the organization's LEAD program. Participated in the VA Enterprise Mentoring Pilot Program.

Acts as liaison to Human Resources, ensuring that personnel actions are completed accurately and efficiently. Screens all applicants for current work history, skill level, character, and interpersonal skills. Supports and coordinates with Learning Systems in order to insure that new employees receive orientation and competency verification in order to sustain a high standard of nursing care. Acts as liaison to the Medical Center's Credentialing and Privileging Office to ensure effective recruitment and placement of qualified nurse practitioners.

Accountable for the management, supervision, and evaluation of care delivered by nursing and other allied health staff for an assigned area on a 24-hour basis. Responsible for contributing to the establishment and implementation of nursing standards. Uses appropriate consultation with experts of each discipline supervised to ensure that practice and performance issues are addressed and resolved. Develops policies and procedures and ensures staff competency. Collaborates with the medical staff and the support services to coordinate and improve patient care. Responsible for meeting regulatory agency requirements and for ensuring the appropriate standard of care is utilized in the patient care area.
Assumes administrative responsibility for the Acute Care and Outpatient areas as needed.

Accomplishments

- Responsible for core aspects of successfully implementing the Staffing Methodology Program to all inpatient areas. Provided insight and support to VA ██/██ Veterans Healthcare Network (██/██ VHN) Executive Leadership Committee in developing a network wide report on staffing methodology implementation status.

- Developed a process checklist used to streamline screening, boarding, and hiring RN and NP candidates to assist HR and C&P in meeting hiring timeline performance measures.
- Assisted HR staff in the development of the Medical Support Assistant Professional Standards Board at ▮▮▮▮▮ NY.
- Collaborated with Learning Systems to expand recruitment for VALOR student program to additional Long Island schools of Nursing.
- Acted as facility liaison to local schools of Nursing and NY State Board of Cooperative Education (BOCES). Served as consultant for BOCES annual review of LPN and NA educational program.
- Chaired the 2012 ▮▮/▮ VHN Nurse Managers Conference, coordinating with EES to ensure full compliance with evolving conference guidelines. Validated the need for face-to-face training and developed program focused on improving change management. Responsible for providing oversight for all aspects of the conference including program development, creating the agenda and securing faculty to lead the sessions. Developed program evaluation, incorporating Kirkpatrick's Level 1, 2, 3, and 4 learning outcomes to determine program effectiveness.

Nurse Manager
2/2009 – Present: ▮▮▮▮▮ VA Medical Center, ▮▮▮▮▮ NY

Provides for the overall leadership and direction for the Telemetry and Transitional Care Units. Assumes administrative responsibility for the Acute Care and Outpatient areas as needed.

Supervises and evaluates the work performance of staff (51 employees/40.7 FTEs). Develops and implements strategies to improve patient/customer satisfaction and to improve staff morale. Develops policies and procedures and ensures staff competency. Demonstrates strength in interpersonal communication, serves as a liaison between physicians, staff, patients, and families to provide optimal coordination of care. Serves on a variety of clinical committees (Nursing Procedure, Acute Care Group, Restraint Reduction).

Accountable for the fiscal and operational aspects of the units, participates in developing and administering the capital, operational, and staffing budget. Displays flexibility and creativity in responding to the variable staffing needs of the units.
Maintains an effective performance improvement program. Collaborates with the medical staff and the support services to coordinate and improve patient care. Responsible for meeting regulatory agency requirements and for ensuring the appropriate standard of care is utilized in the patient care area.

Accomplishments

- Responsible for all aspects of opening the new Transitional Care Unit; a 4-bed unit designed to accommodate those patients requiring a higher level of nursing care (i.e. airway management, complex wound care, progressive mobilization and fluid volume management) thereby decreasing the ICU length of stay. Developed unit admission and discharge policies and staffing protocols based on patient acuity and staff competencies.

- Facilitated staff development of a transfusion safety performance improvement project that led to a revision of the blood product transfusion protocol facility wide, reducing the amount of time needed for monitoring and documentation (following current evidenced based practices nationwide). Mentored staff throughout the process culminating in staff leading a workshop on transfusion safety at the facility's Nursing Skills Day (annual competency validation).

- Co-chaired the 2010 Veterans Integrated Service Network (VISN) ▮ Nurse Managers Conference, coordinating VISN wide planning meetings to translate the network director's objectives and performance measures into meaningful learning sessions for the frontline management team; thereby providing the managers with the tools necessary to achieve those goals. Responsible for providing oversight for all aspects of the conference including program development, creating the agenda and securing faculty to lead the sessions.

- Inpatient Nursing Liaison for the facility's Medical Team Training (MTT) Throughput initiative; an interdisciplinary team that designed and implemented team huddles to decrease Emergency Department length of stay and improve the organization's time-to-bed thereby improving patient safety and satisfaction.

- Coordinator for the ▮▮▮▮▮▮ VAMC Bedside Care Collaborative Committee, a multidisciplinary team responsible for reducing the average length of stay and readmission rates for congestive heart failure patients by over 50%. Spearheaded nursing initiatives that contributed to this decrease (enhanced patient education, prompt identification of discharge planning needs, improved caregiver communication, and timely after-care referrals). Presented team findings and successful results at two different national conferences.

Assistant Vice President of Nursing
5/2006 – 2/2009: ▮▮▮▮▮▮▮▮▮, ▮▮▮▮▮, NY

Assisted in the overall management and direction of the Nursing Department, with around-the-clock responsibility for the department's 375 FTEs. Participated in strategic and long term planning; established goals and objectives for the Nursing staff. Provided direction and oversight to the organization's Nursing Directors and Supervisors to insure the provision of quality care; acted as a resource regarding Nursing or patient care issues for the organization. Developed, implemented, and interpreted Nursing policies and procedures. Actively involved in recruitment and retention strategies; worked

collaboratively with the organization's collective bargaining units to insure harmonious relationships.

Promoted positive relationships when interacting with patients, families, physicians, and other departments. Displayed effective communication style. Attended and chaired various committees to advance the Hospital's goals and objectives. Directed the department's performance improvement initiatives, with a special emphasis on customer service.

Directed the planning and monitoring of the fiscal plan for the Nursing Department. Monitored staffing patterns, trends, and requirements for the department. Assured compliance with regulatory standards, actively involved in the organization's preparation for a regulatory agency site survey.

Acted on behalf of the Vice President for Patient Care Services as needed. Assumed administrative on-call responsibilities for off-shift hours and weekends.

Accomplishments

- Created and implemented a comprehensive three-tiered Fall Prevention program, incorporating evidence-based practices that addressed the varying needs of patients with escalating interventions to address those needs in an effective manner that reduced the risk of injury.

- Developed and oversaw a successful pressure ulcer prevention program that prepared the organization to meet the challenges of new CMS regulations regarding reimbursement for nosocomial pressure related injuries. Facets include the addition of Nursing educators certified in wound care, a collaborative medical/nursing pressure ulcer screening tool for point of admission, a comprehensive daily assessment tool and a tracking tool used by the unit leadership to determine effectiveness of interventions. Worked closely with Materials Management to insure staff access to the most effective and cost efficient treatment modalities available to reduce or eliminate the risk of pressure injury. Nosocomial rates dropped to an average of 2%, with the vast majority (97%) being Stage I. Since the program's inception, there were no nosocomial injuries more severe than Stage II.

- Established effective working relationships with both the New York State Nurses Association (NYSNA) and the 1199SEIU United Healthcare Workers unions. In May 2007, successfully negotiated a collective bargaining agreement with 1199SEIU that capped the cost of benefits while allowing for the cross training of staff, creating a more favorable economic environment for the hospital. In March 2008, was instrumental in settling a mutually beneficial NYSNA contract, controlling economic costs at a 3% increase while allowing for restructuring of patient care areas. This enhanced staffing flexibility and avoiding downsizing.

- Implemented a management training program for the Director of Nurses (DNS) and Assistant Head Nurses (AHNs), allowing for the advancement of former staff nurses into leadership positions.

- Instituted a program where the DNS participated in off shift rotation, creating a more supportive environment for the evening and night shift staff. Feedback was consistently positive, with both staff and leadership members reporting enhanced labor-management communication and greater staff cooperation and buy-in for new programs and initiatives.

- Enhanced patient care and satisfaction as well as collaborative multidisciplinary relationships through the formation of the Patient Care Model Committee, an interdisciplinary workgroup that identified and addressed barriers to excellent patient care. The primary focus of this group was reducing ED overcrowding and improving patient throughput.

- Facilitated the organization's Management Rounding Program, an initiative that provides all in-patients with a customer service liaison. This program contributed to the organization achieving and sustaining its highest-ever Press Ganey scores since the third quarter of 2007.

Director of Patient Care Services, Critical Care and Telemetry

10/2002 – 5/2006: ██████████, █████, NY

Provided for the overall leadership and direction for the Critical Care/Telemetry Units and the EKG Department. Assumed administrative responsibility for the organization as needed. Supervised and evaluated the work performance of staff (142 employees/118.3 FTEs). Accountable for the fiscal and operational aspects of these units, developing and administering the capital, operational, and staffing budget. Responsible for meeting regulatory agency requirements and for ensuring staff followed the appropriate standard of care in the patient care area.

Accomplishments

- Reduced Telemetry unit vacancy rate from 80% to less than 5%. I accomplished this through the use of creative recruitment and retention strategies. The cost savings (through reduction of premium labor used to meet staffing ratios) has been in excess of $300,000 annually, and patient satisfaction scores have improved dramatically.

- Developed and coordinated the reorganization of the Telemetry unit, including overseeing a major renovation of the physical plant.

- Coordinated the interdisciplinary team that developed a major throughput initiative that reduced ED-to-inpatient bed times by over 25%.

- Implemented an aggressive PI program in the Critical Care units that reduced the incidence of ventilator-associated pneumonia by over 50%.

Associate Nursing Supervisor
      8/2000 - 10/2002: ████████████, ██████, NY
Assistant Director of Nursing
      2/2000 - 8/2000: ████████████, ██████, NY
Critical Care Staff Nurse
      8/1997 - 2/2000: ████████████, ██████, NY
Assistant Nursing Care Coordinator
      2/1995 - 8/1997: ████████████, ██████, NY

Education

9/2010 – present Walden University, Minneapolis, Minnesota
Doctor of Business Administration (Leadership), anticipated date of completion: 12/2014

9/2002 - 6/2007 Keller Graduate School of Management of DeVry University, Oakbrook Terrace, Illinois
Master of Business Administration (with distinction) with an emphasis in Health Care Management.

9/1998 - 1/2002 Excelsior College, Albany, NY
Bachelor of Science in Nursing (Summa Cum Laude), winner of the Mildred Montag Award and the Northeastern New York Organization of Nurse Executives Leadership Award (2002).

9/1986 - 6/1989 Suffolk Community College, Brentwood, NY
Associate Degree in Nursing Science (with Highest Honors), winner of the SCCC Outstanding Achievement in Health Sciences Award (1989).

Affiliations and Certifications

- 6/2000 – Present ██████ County Association of Critical Care Nurses
- 7/1999 – Present American Association of Critical Care Nurses
- 6/2002 – Present Sigma Theta Tau International Honor Society of Nursing (440 Tau Kappa)
- 10/2013 – Present Golden Key International Honor Society
- 2/2007 – Present Professional Member American Heart Association
- 8/2009 – Present Volunteer ████████ Blood Services (Donor Services/Canteen)
- AACN Adult CCRN certified, CCRN # ██████, exp. 6/15