A PHENOMENOLOGICAL STUDY OF THE NURSE LEADER:
BEFORE, DURING, AND AFTER MERGER

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ABSTRACT

Mark A. Earley, Advisor

The purpose of this qualitative phenomenological research study was: (a) to understand nurse leaders’ lived experience before, during and after a merger; (b) to explore and gain insight and understanding into the experiences of nurse leaders who have led, managed, and guided others through a merger in healthcare; and (c) to appreciate the attributes of the merger experience that led to meaning-making for the nurse leaders. Sixteen nurse leaders were interviewed two times as they all had experienced the merger phenomena.

Study findings emerged using the Stevick-Colaizzi-Keen (1978) phenomenological data analysis process in examining the participants’ narrative transcripts. The descriptions of how I arrived at the significant statements, the formulated interpretive meaning statements, and the explanation of the analysis of textual theme clusters were provided. Data from this study generated an exhaustive description. The four structural descriptions or essential themes of masking, mirroring, mitigating and moving on, and; the universal essence of the phenomena was discovered and validated as accurate by the participants.

The nurse leaders’ lived experience of merger exposed not only the strong beating heart of nurse leadership, but its brain, muscle, and nerve endings: alert, throbbing, raw and exhausted. The study findings contributed to an understanding of how the narrative of the merger experience is laid down in the layers below our everyday awareness in which the self is always changing, always growing, and always discovering itself.

This research raised further questions to be explored in understanding other factors nurse leaders experienced with organizational change through merger: loss of control; loss of identity,
and resilience and may provide ample background in which to approach additional qualitative research in the study of leadership. All of the nurse leaders in this study were female serving in the subordinate community hospital organization. Further research with a more diverse gender base may reveal interesting findings.

The accumulated expertise and experience of this group of nurse leaders is untapped in terms of mobilizing organizational change in hospitals and healthcare delivery systems. Three policy issues were offered to assist with the achievement of healthcare organizational change through merger and acquisition: (a) improved communications, (b) appropriate learning and development, and (c) individual experiential change journeys. Changing an organization is fundamentally and undeniably an emotional human process.

Keywords: qualitative, phenomenological, nurse leader merger experience, Stevick-Colaizzi-Keen method of analysis.
This dissertation is dedicated to all registered nurses
and in particular, a very special one
my daughter: Kristin, RN

“The symptoms or the sufferings generally considered to be inevitable and incident to the disease are very often not symptoms of the disease at all, but of something quite different.”

— Florence Nightingale, *Notes on Nursing* (1859)
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The quest for the doctorate degree in education equates to completing a warrior dash, as it requires extensive preparation, steady endurance, and an absolute commitment to the journey with other people. It seems fitting then, “to remember that there are a number of people who come in our lives...they awaken us to new understanding with the passing whisper of their wisdom and make the sky more beautiful to gaze upon. Some people stay in our lives awhile and leave footprints on our hearts, and we are never, ever the same” (author unknown). My educational endeavor would not have been possible without the support and encouragement of many, including my committee members, leadership studies and policy professors, research participants, cohort and colleagues, friends and family. So it is with humble and heartfelt appreciation that I acknowledge the constellation of people who guided and walked with me along my educational path.

Committee Members: If you go to the dictionary and look up “catalyst” you find this definition: “a person or a thing that precipitates an event or change,” as my committee you have been my catalyst on so many levels, and it has been an honor and a privilege to be your student. To Dr. Joyce Litten: the dance is between emotion and logic; passionate intensity and reasoned logic. Great dancing requires both. You have helped me become clearer in my consciousness about how shifting the lens through which we view things, a whole new world appears. Thanks to you, here is my six-word story: Seeking the fullest expression of self. Dr. Patrick Pauken: the seasonal metaphor deepens our understanding of others. Through you, I have slowed down to examine my life as eighteen seasons have passed since meeting you, and I have learned that life is neither a battlefield nor a game of chance but something infinitely richer, thank you for encouraging me to embrace it all. Dr. Penny Soboleski: I could not have dreamed for a more amazing Graduate College Representative. Your quality of enthusiasm for me and my topic has
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Research Participants: Nursing as a caring profession is steeped in stories. Stories are how we make sense of things and help us understand how and why things change and what we might do to make a difference. When we are no longer able to change a situation, we are challenged to change ourselves; as this becomes the currency of our character. It is a great honor and privilege to know all of you. Our sacred soul to soul experience has helped redefine me as a woman, leadership student, and human resource development practitioner. Each one of you is an extraordinary nurse leader that has made the lives of countless patients better, and the narratives
of your experience made this dissertation possible. Through your many gifts, I have been changed for good: thank you.

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CHAPTER ONE: INTRODUCTION

Eighteen years of human resource development work in healthcare has taught me that the real challenges in organizations are not traditional business deliberations such as understanding trends in spreadsheets, improving supply chain management, or reducing expenditures by ten percent. The real tests are relationship challenges: getting people engaged and entrusted, as well as bringing all of who they are to what they do; helping them adapt to changing circumstances in a volatile, uncertain, chaotic world, and translating their leadership potential into sustained high performance with a sense of meaning. Emotions play a critical role in every person’s life as they are always present and enrich our experiences. Just as the nature of change is varied so are the human responses and reactions to change. As such, mergers and acquisitions are highly emotional events for all those affected.

Across the continuum of health care, leadership responsibilities are compounded by the need to juggle multiple priorities, work long hours, balance work and home life, maintain personal and staff morale, mediate conflicts, influence policies, keep abreast of the latest information and technology, and inspire others to serve. There are over 2.7 million working registered nurses in the United States compared with about 690,000 physicians and surgeons (U.S. Department of Health and Human Services, 2010). Nurses are indispensable and anchor our healthcare system; yet, at the core of all health care operations is the nurse leader. Playing a pivotal role in ensuring clinical quality, recruiting and retaining staff nurses, managing fiscal operations and clinical services for patients; the nurse leader is accountable for significant and increasing responsibilities in today’s shifting health care environment.

Organizational changes in healthcare work settings occur in a myriad of ways including merger and acquisition. The emotions we experience during significant organizational change shape the anticipation, the experience, and the aftermath of the stories we share about the
experience. With words, we can recognize ourselves in each other’s lives. Events become real when we organize experience into the narrative: we literally cannot think without words. Words break us into pieces, shatter or enhance our understandings, connect us with each other, and outline our relationship with everything.

Wondering about the meaning of a certain moment of our lived life may turn into a phenomenological question: what is this experience like? (van Manen, 1990; 2014). In the broadest sense, the purpose of phenomenology is to describe particular phenomena, or the appearance of things, as lived experience (Moustakas, 1994; van Manen, 1990). Phenomenology orients to the meanings that arise in experiences (van Manen, 1990; 2014). Van Manen (2014) asserts “Phenomenology is so fascinating as any ordinary experience tends to become quite extraordinary when we lift up from our daily existence and hold it up through a phenomenological gaze” (p. 38).

The interpretation of an experience creates a constant awareness of what it means to be human and aids in the quest to reach our full humanity. Phenomenology highlights an experience as ‘unique’ and describes what all participants have in common as a universal essence (Moustakas, 1994; van Manen, 1990; 2014). Lived experiences involve the immediate awareness of life events prior to reflection and without interpretation. Those things that are carried internally and externally by those that experienced the phenomenon further influence these lived experiences. It is the lived experience that gives meaning to each individual’s perception of a particular phenomenon (Giorgi, 1997; Moustakas, 1994; van Manen, 1990; 2014).

In organizations that are merging, managers at all levels face complex challenges. They must deal with their own uncertain future and simultaneously manage employees exhibiting a range of emotions from shock and disbelief to anger and indifference (Brodbeck, 2012). The reality that acquisitions, mergers and consolidations develop in highly variable patterns and
complexity frame the issues faced by nurse leaders dealing with a merger process, and these realities or challenges can be overwhelming in how it is experienced in practice.

**Background of the Problem**

During the first half of the 20th century, there was a huge increase in the number of free-standing general hospitals in the United States (Starr, 1982). There are strong parallels between the evolution of the nursing profession and the growth of hospitals as the central structure in the U.S. healthcare system (Clifford, 1998). By the 1980s, a variety of initiatives were implemented to curtail the rapid rise in health care costs (Bazzoli, Dynan, & Burns, 2004; Shortell & Hull, 1996). Based on the assumption that hospital care was very expensive, cutting inpatient care was a central strategy in efforts to control the cost of health care (Reinhardt, 1996). Cost-cutting initiatives during the past twenty years have contributed to transformation in health care (Barry-Walker, 2000).

Efforts by hospitals to control labor costs have had major effects on nurses: one of the largest components of hospital expenditures (Needleman & Hassmiller, 2009). Nurses develop substantial knowledge of the strengths and weaknesses of hospital systems (DeLucia, Ott, & Plamieri, 2009). Nurses spend more time with patients than do any other health care provider and patient outcomes are affected by nursing care quality (DeLucia, Ott, & Plamieri, 2009). As hospitals focus on increasing patient safety and reliability, patient-centeredness and efficiency, nurses’ knowledge and commitment to their patients and workplace need to be mobilized (Jennings, 2008; Needleman & Hassmiller, 2009; Tucker, 2008) not marginalized (Carney, 2009) and understanding the impact of the merger experience may be disconnected with the role of nurse leaders. Moreover, while the importance of the nurse leader role in delivering quality care is recognized, less is known about the nurse leaders’ involvement and experience within change.
Also contributing to changes in health care was the rapid growth in managed care, which prompted the integration of health services and providers (Barry-Walker, 2000). Through horizontal integration, free-standing hospitals merged into multihospital systems, and physicians in private practices into group practices (Barry-Walker, 2000). Through vertical integration, a broad array of health care services that covered the healthcare continuum (birth to long-term care) was pulled together into comprehensive integrated delivery systems. These mergers helped to streamline functions, reduce administrative redundancies and/or bureaucracies, and provided economies of scale when purchasing supplies, equipment and pharmaceutical products (Baumann, Giovannetti, & O’Brien-Pallas, 2001). The focus on fiscal challenges shifted the health care industry into a business model that altered the experiences of patients, as well as the roles of nurses and nurse leaders (Aiken, Clarke, & Sloane, 2000; Weinberg & Gordon, 2004). During the past decade, insurers, government, and businesses began tightening health care reimbursements and affected hospitals began to cut costs. Cost constraints led hospitals to lay off more experienced (more expensive) nurses, replacing nurses with less expensive nurse assistants. Patients were given less time in the hospital and the remaining nurses in hospital units were asked to care for more and far sicker patients (Gordon, 2009).

The U.S. healthcare industry has reached a turning point and will continue undergoing radical, unprecedented change due to increased regulations found in the Affordable Care Act which was passed in 2010: including the Meaningful Use and HITECH regulations which require health care organizations to comply with electronic health record conventions in the U.S., combining with global and national economic pressures, and advancing technologies have created a perfect storm with reduced revenues and workforce shortages for a majority of healthcare professionals (American Hospital Association, 2012; American Organization of Nursing Executives, 2011; Institute of Medicine, 2003; Ramanujam & Rousseau, 2006). To
withstand these powerful forces and operate in a highly competitive environment, health care organizations needed to achieve even greater economies of scale through merger, acquisition and consolidation (AHA, 2012; Ramanujam & Rousseau, 2006; Reinhardt, 1996). Over one hundred merger and acquisition deals have been reported through 2013 that involved over two hundred and forty-seven hospitals in the United States (AHA, 2013). Turbulence and variance remain a strong external pressure in health care, but on an almost continuous basis, there is rapid, complex, major, and unpredictable change. Discontinuities are normal and are often of a magnitude deserving the label of “breakpoint change” (Land & Jarman, 1998) which guarantee that tomorrow will be nothing like today. In response to the breakpoint change, health care organizations are making radical shifts with their shared values, structures, systems, staffing, work roles and skill bases (AHA, 2012; Suhonen, Stolt, Vertanen, & Leino-Kilpi, 2012).

There is growing agreement as to the implications of this new order of change in terms of what is demanded of health care organization members if the organization is to remain a community asset (Goes, 2011; Marks & Mirvis, 2003; Reinhardt, 1996; Suhonen et al., 2012). Organizational changes, like mergers and acquisitions, are exceedingly emotional events for all those involved. While several scholars agree on this statement (Cartwright & Cooper, 1992, 1994, 2000; Huy, 1999, 2002; Marks & Mirvis, 2001; Sinetar, 1981), emotions of leaders are not considered explicitly in research on organizational changes (Jennings, 2008; Marks & Mirvis, 2001). The concept of emotion is usually limited to stress research or viewed as resistance (Goes, 2011; Jennings, 2008; Keifer, 2002). Day-to-day perceptions confirm that mergers/acquisitions are emotional events for all those involved and approximately 70 percent of all mergers fail to reach their initial goals (Jennings, 2008; Marks & Mirvis, 2001; 2003). Employee morale suffers as a result of uncertainty about job security (Charan, 2005) among other things. However, these radical changes proceed with little empirical evidence to guide
them (Bazzoli, Dynan, & Burns, 2004). According to Aiken, “What we know about changes in organization and structure and the potential for those changes to affect patient outcomes pales by comparison to what we do not know” (2003, p. 463).

In 1990, when Peter Senge was about to publish the first edition of The Fifth Discipline, he wrote to W. Edwards Deming to ask if Deming would consider writing a paragraph that could be used on the book’s dustcover. Senge did not fully expect that Deming (who was 80+ years old then) would respond or even consider the request. However, Senge wrote that he did receive a response from Deming. According to Senge, “[I]t took my breath away…Dr. Deming had summarized in one sentence what it had taken me 400 pages to write” (2006, p. ii). That one sentence that Deming wrote as an introduction to Senge’s book was the following: “Our prevailing systems of management have destroyed our people” (Senge, 2006, p. ii). Taking into account the trend of restructuring in healthcare, the literature reveals the misunderstanding and the undervaluing of the nurse leader (Embertson, 2006; Mikesell & Bromley, 2012). Their importance in strategic formulation and organizational change implementation has been largely overlooked (Embertson, 2006). Nurse leaders have been perceived as intermediaries that slow organizational efficiency (2006). Considering the high merger and acquisition failure rates and the insufficient attention to the critical role played by processes and people inside the health care organization (Goes, 2011; Kieffer, 2002; Kusstatscher & Cooper, 2005), leaders have to ask themselves what they can do to reduce the daunting process of the merger experience into a more successful transition for all those affected.

Many have described nursing work as invisible: Wolf (1989) listed interpersonal work, comforting work, privacy work, dirty work, body work, and death work as invisible, and thus unrecognized work performed by nurses. In hospitals, as a normal part of the routine, people suffer and die (Chambliss, 1996) (emphasis added). For nurses, adapting themselves to the
routine of pain and suffering is the most distinctive feature of their work (Sudnow, 1967). Nurses’ work is cognitively demanding and relies on procedural and prospective memory skills amid frequent interruptions (DeLucia, Ott, & Palmieri, 2009). Nurses anticipate and monitor changes in the health status of multiple patients in the hospital over time (2009). Moral distress permeates nursing due to the nature of the profession, especially in light of the increasing complexity of the healthcare environment that may include performance expectations, finite resources, technology advancement, aging of the population, and the competitive globalization of healthcare (Edmondson, 2010; Goes, 2011; Sekerka, Bagozzi, & Charnigo, 2009). The acute manifestations of moral distress for nurses, if not acted upon and resolved, lead to moral residue (Edmondson, 2010), or the additional development over time of regret, anger, and frustration. To date, studies have not examined the effects among caregivers and between caregivers and patients (Jennings, 2008). A number of studies of mergers in healthcare follow a sociological view of the organization and the psychological framework has been used less often (Jennings, 2008; Kusstatscher & Cooper, 2005; Marks, 2007).

Nurse leaders play a pivotal role in healthcare and their actions are known as essential precursors for building and sustaining safe and healthy workplaces (American Association of Critical Care Nurses, 2005; Institute of Medicine, 2000; Shirey, McDaniel, Ebright, Fisher, & Doebbeling, 2010). Performance expectations for nurse leaders in acute-care hospitals are complex and often unrealistic (Shirey, McDaniel, Ebright, Fisher, & Doebbling, 2010). Although the important role nurse leaders play in the healthcare workplace has been documented in the literature (Anthony, Standing & Glick, 2005) little research has been undertaken examining the nature of nurse leader work to better understand the complexities, individual factors (experience) and difficulties unique to this role within healthcare systems (Kahn, 2005). Just how are nurse leaders experiencing their current world of considerable organizational
change? This is an imperative question for all those charged with designing, implementing and managing necessary, radical, far-reaching and continuous change in health care organizations (Brodbeck, 2012; Institute of Medicine, 2003).

Studies of mergers and restructurings revealed unfavorable employee perceptions of restructuring. Most studies considered the effect(s) of merger and restructuring on staff nurses (Jennings, 2008). Other health care professions such as physical therapy and social work also explored how restructuring affected their perspective roles (Lopopolo, 2002). For example, one study examined the views of top and middle managers as well as physicians and patients from various disciplines at a Veterans Administration hospital (Rubenstein, Lammers, & Yano, 1996). Business literature and nursing literature are silent about the personal experience of the nurse leader who must make decisions that have major impacts on employees’ lives (Jennings, 2008; Laschinger, Almost, Purdy, & Kim, 2004). To date, studies have not examined the effects or the experience of restructuring on the dynamics of caregivers and their nurse leaders.

**Purpose of the Study**

The purpose of this qualitative study discovered and described the experience of nurse leaders who had been involved in the merger and acquisition of their community hospital with an integrated healthcare delivery system. The intention of the study was to build rich descriptions of complex circumstances (that have been previously unexplored in the literature) and to understand the extent to which nurse leaders internalized the meaning and how it contributed to, or limited their nursing leadership practice. This research captured and described the nurse leaders’ experiences of a merger, bringing awareness and understanding of the direct experience of nurse leaders taking part in the complex and dynamic tensions of merging healthcare organizations. This study uncovered how nurse leaders in merging organizations experienced
and understood their world, how they felt, what they believed and how they described perceived barriers to maximize their potential in service to their new integrated healthcare delivery system.

Roundy (2010) recommended that researchers further investigate the role for making sense of the organizational merger experience but also a means for exacting legitimacy from employees. Further, Papadakis (2005) urged for investigation of organizational development interventions and the understanding of the human resource characteristics preceding the success of merger. Other research studies have attempted to gain understanding of a merger or acquisition from the media (Leonardi & Jackson, 2004; Vaara & Tienari, 2002), within their industry (Massey, 2001), and more generally, within their organizational field (Suddaby & Greenwood, 2005). Research has devoted little or no attention to understanding specifically, the nurse leaders’ experience by integrating topics.

Merger and acquisition has been an important strategic choice for healthcare organizations to survive and prosper (Reinhardt, 1996). Nurse leaders are responsible for implementing the operational integrations that are required during mergers, but little is known about the lived merger experience for this type of leader. Interpersonal relationships and transactions are at the core of caregiving (Kahn, 2005). Thus, advancement in managing and understanding the experience of health care merger and acquisition processes cannot be accomplished without enhancing our understanding of the human side of merger(s) as experienced by nurse leaders. As well as revealing individual nurse leader experiences, this study opened up and highlighted possible helping strategies for nurse leaders and organizational practitioners remitted to design, assist, and lead organizational change efforts such as merger(s) and acquisition(s).

Further, this study informs and assists individual agencies, such as the cooperating integrated healthcare delivery system, healthcare administrators, healthcare human resource
development practitioners, and policymakers in identifying policy practices in need of improvement, including systemic, planned interventions to ease the human integration process or to lessen the emotional effects of mergers.

**Overview of Methodology**

This study used a qualitative, phenomenological methodology, involving first, reflection on my own experience; and second, inquiry into the experience of nurse leaders before, during and after a merger. Qualitative research is pragmatic, interpretive, and grounded in people’s lived experiences. It is enacted in naturalistic settings, focused on context, and is emergent and evolving (Creswell, 2007).

This research was based on the assumption that the richest information comes from the words of the nurse leaders themselves as they described and understood their experience of a merger/acquisition. Empirical, nor intuitive-based evidence does not exist that accurately or effectively described the personal experience of the nurse leader who must make major decisions that impact employees’ lives and how they expressed these decisions to themselves and to the caregivers (nurses) that they led. Health care organizational change and transformation and the inherent complexity and spirit that it possesses, is one of the most meaningful and complex challenges facing us all. This phenomenological study serves as an exemplar for continued discussion, with the study of lived experience of the nurse leader during extreme organizational change, such as a merger, acquisition and consolidation.

**Guiding Research Questions**

Through this phenomenological research study, I explored the complex set of factors surrounding the central phenomenon of the lived experience of merger for nurse leaders and therefore, this study was guided by the following research questions:

1. What is the nurse leaders’ experience before, during and after a merger?
2. What does it mean to nurse leaders to lead, manage, and guide others through a
   merger in healthcare?

3. What aspects of the merger experience lead to meaning-making for nurse leaders?

Consistent with the tenets of phenomenological research, the field of experience for the
dissertation student is first partitioned into structure and style: the *what* of the merger experience
and the *how* of experiencing it. Uncovering the structure and style of the field of experiencing
are preliminary to uncovering the phenomenon of self-discovery for the dissertation researcher
(Moustakas, 1994; van Manen, 1990).

**Conceptual Framework**

graphically or in narrative form, the main things to be studied: the key factors, constructs or
variables, and the presumed relationships among them” (p. 18) and it also guides study
development and initial data analysis. Qualitative approaches to inquiry are uniquely suited to
uncovering the unexpected and discovering new possibilities. The conceptual framework for this
study attempted to connect to all aspects of inquiry. The conceptual framework draws on theory,
research, and experience and examines the relationship among constructs and ideas. As such it is
the structure or heuristic that guided my research. Essentially, the conceptual framework
provided the theoretical and methodological bases for development of my study and the analyses
of findings. A comprehensive synthesis of the literature is presented in chapter two.

In this section, I describe three relevant interrelated components (causes, mediators
[emotions], and outcomes) deemed ‘merger syndrome’ understood within the context of what is
normal and the expected human reaction to the experience of an organizational merger. The
merger syndrome is a phenomenon first documented by Marks and Mirvis (1985; 1986; 1988).
This term describes employees’ and managers’ reactions triggered after an organizational
announcement of a merger. Scholars assert that the ‘merger syndrome’ is felt more intensively in the ‘weaker’ or subordinate organization (Appelbaum, Gandell, Yortis, Proper, & Jobin, 2000b; Marks & Mirvis, 1986). It is also not surprising that organizational members going through a merger are shaken by intensive emotions (Appelbaum, Gandell, Shapiro, Belisle, & Jobin, 2000a; Appelbaum et al., 2000b; Marks & Mirvis, 1986). The literature mentions different emotions in mergers; however, these emotions are only mentioned and never fully defined, poorly described, hardly ever brought into context, and never listed or analyzed completely.

The literature does not clearly distinguish between causes and consequences when describing the occurrences of the merger syndrome. In an attempt to highlight the structure from a variety of authors the following structured summary is provided in Figure 1, a framework based on cognitive appraisal theory.
Figure 1. Structured summary of various research findings found in the context of ‘merger syndrome.’

Moreover, Weick’s (1979) model of organizational theory is concerned with how individuals interpret their world and reconstruct reality on an on-going basis. Seidman (2006) stated, “Every whole story, Aristotle tells us, has a beginning, a middle and an end, people must reflect on their experience. It is this process of selecting the details of experience, reflecting on them, giving them order, and thereby making sense of them that makes telling stories a meaning-making experience” (p. 7). Most efforts at sense-making involve interpretation of previous happenings to current reality. We therefore, link our observable experiences to our
thoughts/knowledge, add meanings through our filters of cultural and personal experiences or attributions, and draw conclusions and adopt beliefs about the world, and reflexively loop through the process again, and again.

The diagram in Figure 2 illustrates individual approaches to sense-making and/or meaning-making and is used as my conceptual framework to position this phenomenological research study. The outer edge makes up experiences of our thoughts, knowledge, feelings and behaviors. These are the same categories under which the data are sorted in chapter four, and as such, these categories continued to evolve and become further refined as the data emerged. The inner circle is informed by the ladder of inference, from Peter Senge (1990), which explains where our deepest perspectives come from.

Figure 2. Nurse Leader Experience: Pre- During- and Post Hospital Merger (adapted from Peter Senge’s reflexivity loop, 1990).
A number of emergent insights found in the literature are particularly relevant to understanding the phenomenon of merger as it relates to the human side of merger/acquisition or the emotional reactions as a major reason for problems occurring during the implementation of change: anxiety, social identity (professional identity), emotional labor, role conflict, acculturation, organizational justice, and job characteristics theories. Cooper (1989) has identified four major kinds of literature review relevant to a topic: integrative, theoretical, methodological and thematic. In conducting a review, Cooper (1989) emphasizes utilizing multiple channels in literature reviews, which is provided in more detail in chapter two.

**Significance of the Study**

This study contributes to knowledge by describing how it fits into theoretical traditions in leadership studies in ways that are new, insightful and creative. Health care organizational leaders find themselves increasingly challenged by the complexity of extreme change. Paradoxically, the working conditions in healthcare organizations are generally not healthy (Institute of Medicine, 2001) as characterized by workforce shortages, nurse burnout, higher patient acuity levels and a lack of resources through which the nurse leader need to attain a culture of contribution, engagement and quality. There is little doubt that hospitals and health systems are at a crossroads (American Hospital Association, 2012) as a number of factors are converging to make the next decade likely one of the most turbulent in the history of the industry (AHA, 2012; Lee, 2010). Healthcare costs are destabilizing our economy, changing demographics are increasing the need for health care services, workforce shortages prevail, new reimbursement models require adjustment to operating models and social determinates of health sets the stage for transformation. Alder, Hecksher and Prusak (2011) emphasize that an ethic of contribution means going beyond one’s formal responsibilities to solve broader societal problems, not just applying greater effort. Thus, making the nurse leader job very challenging.
The significance of the study for practical and policy considerations will be discussed in chapter five. Every part of the healthcare industry is being asked for transformational change. Taking the entire industry to the next level is certain to test all of healthcare leadership (Brodbeck, 2012; Garman, 2011) especially nurse leadership. This inquiry is valuable to those that participated, as well as to others committed to organizational change found through healthcare merger, acquisition, and consolidation. Finally, this study illuminates the lived experiences of nurse leaders by providing rich descriptions that fosters taking action.

**Definition of Terms**

The following terms will be used in this study:

1. Acquisition – the process of acquiring an organization with investment for an exchange for governing rights to build on the strengths or weaknesses of an acquiring organization (American Hospital Association, 2009).

2. Affordable Care Act (ACA) – Federal law that was enacted on March 23, 2010; the law puts in place comprehensive health insurance reforms that will roll out over four years and beyond, with most changes taking place by 2014 (The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §2 U.S.C. 551, 2009).

3. Compassion Fatigue – refers to secondary traumatic stress disorder that may affect healthcare professionals. Compassion fatigue can occur during normal expressions of empathy with caregiving due to the stress of an involuntary response of shared emotion. Empathy is a hallmark of the caregiving profession that provides the capacity to automatically perceive and share others’ feelings. Caregivers who lose themselves in other people’s pain, may experience “personal distress.” While empathy is “other-oriented,” personal compassion fatigue turns inward (Beck, 2011; Figley, C.R., 1995; Smith, 2012).
4. Community Hospital – defined as a hospital accessible to the general public, that is not part of a university, a health system, or a chain of private hospitals (American Hospital Association, 2013). For purposes of this research, the non-profit community hospital under study served its community independently for over a century prior to the acquisition and merger with an integrated healthcare delivery system.

5. Consolidation - refers to the integration of many smaller companies into much larger ones (American Hospital Association, 2009).

6. Emotion – refers to a construct that includes both a mental state and a behavior. Some researchers define moods and emotions as different, but both are subsumed under “affect.” Other theorists argue that cognitive activity in the form of judgments, evaluations, or thoughts are necessary for emotion to occur. One of the main proponents of this view is Richard Lazarus who argues that emotion must have some cognitive intentionality (1991). The cognitive activity involved in the interpretation of an emotional context may be conscious or unconscious and may or may not take the form of conceptual processing. For purposes of this research, the view that emotions are the result of cognition provides an influence of culture and personal experience on which emotions may be felt in response to a given set of stimuli, such as merger or acquisition (Ashkanasy, Hartel, & Zerbe, 2003; Forgas, 1995; Lazarus, 1991).

7. Informant – A nurse leader chosen to take part in this study was referred to as co-researcher and/or participant throughout this dissertation document (Creswell, 2012).

8. Integrated Healthcare Delivery System – refers to a network of acute care hospitals, physician providers, and continuum of care services (ex: pharmacies, long-term care, home health care, hospice, durable medical equipment) and managed care insurance companies in a geographic location under the same parent company (American Hospital Association, 2009).
9. Integration – refers to the business amalgamation that focuses on improving the efficiency and effectiveness of the processes that run the business (American Hospital Association, 2009).

10. Merger Syndrome – a phenomenon first documented by Marks and Mervis (1985; 1986). The term describes employees’ and managers’ positive and negative experiences during an organizational merger. The merger syndrome is characterized by different emotional stages from the news of an organizational merger to the commitment of the situation. These emotional process stages may consist of: denial, fear, anger, sadness, acceptance, relief, interest, and commitment. The merger syndrome may be triggered as a starting point for an individual journeying through a change process. The triggers (or phases) of the organizational change may include: a change of identity, higher centralization of decision-making, coping with high levels of stress, formalization of communications on one side and rumor on the other, power games, motivation, commitment, decreased productivity, feelings of insecurity and ineffectiveness, anxiety, and mistrust with simultaneously occurring phenomena (Applebaum, Gandell, Yortis, Proper, & Jobin, 2000a; Marks & Mirvis, 1985; 1986).

11. Nurse Leader – a person employed by the merged hospital who is responsible to provide the best possible care to patients (and their families). Care is the starting and ending point for everything a nurse leader achieves. A nurse leader:

   a. coordinates patient flow;
   b. manages clinical safety, quality, service and expectations of hospital administrators;
   c. handles the care teams who make nursing care possible and analyzes care outcomes;
   d. organizes staffing for patient unit(s) 24 hours a day, 365 days a year;
   e. maintains a flexible staffing schedule and manages labor costs;
   f. apportions the individual complexities of every patient;
   g. handles the relationships of very high achieving group of individualists: physicians;
h. oversees implementation of education for staff; and
   i. remain **key agents of change** within the healthcare organization.

Nurse leaders make significant contributions across the healthcare organization in their roles of entrepreneur, communicator, therapist, change agent and stabilizer (American Organization of Nurse Executives, 2005; Brodbeck, 2012; Embertson, 2006; Studer, 2010).

12. Merger - Merger is defined as two or more entities combining to form one new entity (American Hospital Association, 2009).

**Potential Limitations of this Study**

All research projects have limitations; none are perfectly designed. As Patton (1990) notes, “there are no perfect research designs; there are always trade-offs” (p. 223). As such, I make no overweening claims about generalizability or conclusiveness about what I have learned. Phenomenology is a form of inquiry that does not yield generalizations in the usual empirical sense (van Manen, 1990). This study is limited in its generalizability for several reasons. First, the population for this study includes only nurse leaders from a non-profit community hospital, which recently merged. Political climates, contextual personal histories of nurse leaders, state policy and health care resources may vary across geographies; and as a result, nurse leaders may respond to and experience mergers differently.

Second, health care research suggests that institutional mergers are difficult (AHA, 2010). The literature indicates the integration process takes place over a period of time with no set timeline for completion (Marks & Mirvis, 2010). In this study, through interview conversation, I gained insight into the nurse leader’s experience in the merger process thus far. The existential generalization made it possible to recognize recurring aspects of the meaning of the phenomenon of merger faced by nurse leaders. It is expected that the nurse leaders’ understandings will continue to change over time. Since the nurse leaders’ experiences continue
to change, it is expected that the results of this study would vary if it were conducted at a different time in the merger process.

Finally, the U. S. Federal Trade Commission issued an administrative complaint challenging this merger as violating Section 7 of the Clayton Act. Thus, the normal integration period is stayed pending an administrative appeal seeking review. This extended duration of integration activities may have had an impact on the merger experience by these nurse leaders due to prolonged litigation that is not often accorded during mergers and acquisitions in the healthcare industry.

**Researcher Perspective in Relation to Research Area**

My background as a human resource development practitioner during the prolonged and difficult merger of my organization with an integrated healthcare delivery system led me to this study. Many of my experiences corresponded to the literature including the uncertainty I felt during an extended period of high stress and organizational turmoil. In every merger, there is a dominant partner, and my site was viewed as subordinate. My own position was one of considerable responsibility, yet ambiguous authority post-announcement. The frustration that I experienced at many stages of this merger led to hours of self-evaluation and self-recrimination. The literature offers little about the experience of merger solely from the perspective of a nurse leader. This study was motivated by a desire to understand the nurse leaders’ experience in and through the merger process.

I am not a nurse leader, but a human resource development practitioner who finds great pride in serving caregivers in the healthcare industry. My life and attitude strongly reflect my belief that work is meaningful and achieving excellence is a motivating goal. My sense of self-worth and self-image is intertwined with my beliefs about work and my identity as a human resource development practitioner. I have gained insight into my own beliefs about what it
means to be a person by considering Heideggerian perspectives (van Manen, 1990). These Heideggerian perspectives include the discussion of ‘world’ as the meaningful set of relationships, practices, and language that we have by virtue of being in a work culture (van Manen, 1990) and, it is especially appropriate to the study of merger. This definition of ‘world’ is consonant with the notion of a work-world or culture. The person must be studied in context and as a being for which time includes the past and the future (van Manen, 1990). These ideas are particularly relevant to my experience in merger. The person is in constant reaction to her world, and in a merger situation: that world changes constantly.

I am acquainted with the literature on leadership, organizational behavior, and change management, as well as the humanistic, educational, and social psychology research. However, moving beyond these familiar frames of reference into a variety of other disciplines revealed individual change process methodologies in order for me to seek and understand more about the cycle of the experience and self-discovery of change itself. Together, my readings enabled me to assemble a very broad, if not disjointed perspective on nurse leaders’ experiences with significant organizational and personal change involved throughout a merger.

Summary and Organization of the Remaining Chapters

This dissertation study is presented in a linear fashion with chapter one, an introduction to the study, offering a background to my study and a statement of the research question. The succeeding chapters provide specific information about the research. In chapter two, an overview of the literature is provided on hospital mergers, organizational change theory and perceptions of change by leaders. Chapter three provides a summary of the research methodology. Chapter four provides analysis of the data. Finally, chapter five reflects on the findings.
CHAPTER TWO: LITERATURE REVIEW

Through phenomenological research study, I explored the complex set of factors surrounding the central phenomenon of the lived experience of mergers for nurse leaders. The purpose of this study was threefold: (a) to understand the nurse leaders’ experience before, during and after a merger; (b) to explore and gain insight and understanding into the experiences of nurse leaders who have led, managed, and guided others through a merger in healthcare; and (c) to describe what aspects of the experience lead to meaning-making for nurse leaders. In order to provide a framework for understanding the meaning ascribed to the phenomena of the merger, acquisition or combination of a large community hospital by an integrated healthcare delivery system as experienced by nurse leaders, this chapter presents a review of the related literature which provides an underlying framework for understanding concepts that are essential to this study.

This chapter has been organized into three sections. Part one presents a shared historical context of nursing and hospitals and the perception of change by leaders in charge of change implementation and the current healthcare reform and hospital mergers, acquisitions and consolidations. This was done in order to contextualize the problem. Part two reviews relevant literature articulating the theoretical foundations of organizational and change theory, the conceptual and theoretical framework of change phenomena, relevant literature that addresses theoretical approaches to change (including organizational culture/climate) and emotions with competing contextual bases of change. Part three reviews the literature on the factors that influence the merger experience for the nurse leader and its potential impact to patient care. Finally, it presents a synthesis of the literature reviewed in the previous sections to establish the conceptual framework for understanding the experience of organizational change in this project. Moreover, it provides concluding remarks.
Healthcare: A Brief Primer

Healthcare is considered the largest sector in the United States economy (Reinhardt, Hussey, & Anderson, 2004). Approximately 10.9 percent of all employed American civilians work in healthcare or in allied health settings (U.S. Department of Health & Human Services, 2010). Healthcare organizations manifest striking fragmentation and turbulence that impede their capacity to provide quality care, improve patient safety, and retain the skilled professionals critical to both (Institute of Medicine, 2003). To deliver care that is safe, effective, patient-centered, timely, efficient and equitable are the core objectives of a healthcare system as spelled out by the Institute of Medicine (IOM) and the healthcare advisory group affiliated with the U.S. Congress (Institute of Medicine, 2003). Nevertheless, most hospital missions are broader than the IOM’s list, indicating that their mission’s complexity and scope exceed those of other comparably-sized enterprises in other industries. A challenge facing researchers, practitioners, and policy makers is identifying ways to improve care by understanding the organizations that provide this care; given the complexity of healthcare organizations and the role organizations (and the people in those organizations) play in influencing systems of care (Hearld, Alexander, Fraser, & Jiang, 2008).

The issue of health insurance reform in the United States has been the subject of political debate since the early part of the 20th century. Healthcare reform typically attempts to expand the population that receives health care coverage through either public sector insurance programs or private sector insurance companies; it widens the array of health care providers that consumers may choose among; and, it improves the access to healthcare physicians and/or specialists with the ultimate goal of improving the quality of healthcare (Cameron & Quinn, 1999). After nearly a century of failed attempts to provide Americans with universal healthcare, comprehensive health care reform was enacted on March 23, 2010, with the Affordable Care Act
(ACA) (The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §2 U.S.C. 551, 2009). In attempting to modernize and improve a large part of the health care system, healthcare reform may be one of the most ambitious and consequential pieces of legislation in U.S. history (Orszag & Emanuel, 2010). In addressing health care reform, many researchers have claimed that the law focuses mostly on coverage and contains little in the way of cost control (Orszag & Emanuel, 2010), however, hospitals are merging or being bought and sold at an increasing rate (Irving Levin & Associates, 2011), and these trends are likely to continue.

Approximately 40 percent of hospitals today break even on Medicare inpatient payments. Medicare represents approximately 53 percent of all hospital revenue; that percentage is expected to increase in the future (O’Dell, 2012). With a predicted 8 to 12 percent decrease in Medicare and Medicaid support over the next five years, it is imperative that hospitals pursue strategies to improve operational performance by delivering strong operating margins (O’Dell, 2012). Additionally, hospitals and health systems will need to be much leaner in order to optimize the delivery of quality care as required by a number of national, state and local quality regulators. Leadership teams will need to take proactive steps beyond traditional approaches to restructure the organization and its care processes for more favorable outcomes in both operational performance and operating margin. Strategies include merging and divesting business lines that cannot be effectively and efficiently operated, optimizing service distribution across facilities and geographies, and redesigning clinical processes to reduce variation and duplication (Blanchfield, 2010) all of which will require leadership to effectively lead the human side of consolidation (whether that merger and consolidation is organizationally vertical or horizontal).

With the former in mind, the transformation of the health care industry will continue to be hard work, requiring significant investments and resources. Of great demand will be highly
skilled people, especially nurses and nurse leaders with specific job experiences and relevant talent (Fisher, 2011). The next section will summarize the literature on hospital mergers, acquisitions and consolidations (noting the importance of the complexity, difficulty, and intricacy of how leadership connects previous competitors as collaborators in a newly merged organization) in a dynamic transforming industry.

**Hospital Merger, Acquisition and Consolidation**

The American Hospital Association (AHA) identifies a merger when hospital A and hospital B consolidate to form hospital C, and similarly denotes an acquisition if hospital A merges into hospital B (2009). A hospital merger is the consolidation of formerly independent hospital(s) through both the dissolution of one hospital and its assimilation by another or the creation of a new hospital or from the combination of all participating hospitals to a healthcare system (Ferrier & Valdmanis, 2004).

Over the past few decades there have been sweeping changes in the American healthcare system. As previously stated, for hospitals the two most influential and significant changes have been increased cost containment and healthcare reform; healthcare operations will continue to consolidate (Brown, Werling, Walker, Burgdorfer, & Shields, 2012; Guterman, Ashby, & Green, 1996). The reasons for such change are varied, but chief among them are reduced revenue and improved clinical quality expectations by employers, insurers and government. Meeting those expectations requires building a continuum of care to replace the current fragmented system of healthcare (American Hospital Association, 2012) and to significantly reduce costs.

Merger, acquisition and consolidation are important strategic choices for healthcare organizations to survive and prosper (Ferrier & Valdmanis, 2004). Over one hundred merger and acquisition deals have been reported through 2013 that involved over two hundred and forty-seven hospitals in the United States (AHA, 2013). There exist several theoretical reasons why
through hospital mergers in particular, they might improve productivity and efficiency (Ferrier & Valdmanis, 2004). First, mergers may reduce non-price competition (sometimes referred to as the 'medical arms race'), which has resulted in an extensive duplication of services, which in turn has led to higher costs (Ferrier & Valdmanis, 2004). Second, an increased patient base could lead to higher utilization rates (in part by smoothing out the 'peak load' demand problem), increased marginal productivity of labor, and enhanced revenues (Lynk, 1995). Third, administrative costs should decrease due to consolidation of business-related services (for example, laundry, supply chain, finance, human resources, facility management and information systems) (Lynk, 1995). Based on these constructs, merging hospitals theoretically would exhibit improved productivity, technical efficiency, and scale efficiency, thereby lowering costs, all things being equal (Ferrier & Valdmanis, 2004; Lynk, 1995) granted this does not appear in the majority of healthcare mergers.

Alternatively, even though there has been agreement by earlier research scholars regarding the possible benefits of hospital mergers, previous empirical results have been mixed. Using quantitative random matching study of merging and non-merging hospitals, Starkweather (1971) reported that no statistically significant differences exist between the pre-merger/post-merger group of hospitals and the control group. Dranove (1998) used a semi-parametric model in which the functional form for the relationship between cost and hospital non-revenue cost-center characteristics to verify the assertion that mergers generate economies of scale and found minimal savings generated by the merger. Equally important, another well-documented quantitative study examined the market determinants of mergers and the effects of horizontal mergers on organizational costs and consumer prices and offered explanations for the lack of savings indicated by the complexity and already large-size of healthcare institutions (Conner, Feldman, Dowd, & Ratcliff, 1999).
The increased cost of health care contributes to the increased number of merger and acquisition activities (Roy, 2011). The flow of increased health costs to consumers is explained in Figure 3 below.

Figure 3. Flow of Increased Health Costs that Contribute to Merger/Acquisition (Roy, 2011).

As indicated by the flow of increased health costs to consumers above, the incentives for hospital consolidation are long-standing and extremely complex (Roy, 2011). Many of the incentives reflect structural problems with the American healthcare system. In 2011, there were 89 hospital mergers and acquisitions; 441 across healthcare services and 103 in long-term care (Levin & Associates, 2011). A conservative estimate is that approximately 11.9 percent of the U.S. workforce is currently involved in either a merger, an acquisition, a spinoff, or a
consolidation (Marks & Mirvis, 2010). This assessment means that 30.8 million workers are directly affected by organizational transformations of this magnitude. Moreover, another 117.2 million are closely related to those experiencing combination-related tensions and traumas previously described as ‘merger syndrome’ (Marks & Mirvis, 2010). More specific to this study, this community hospital under inquiry struggled in a competitive market and did not have access to several health insurance networks. For a number of business reasons, the community hospital worked persistently to reduce costs, increase revenues, improve quality and service, yet coupled with the external regulatory pressures of the ACA, its leadership recommended a merger with an integrated healthcare delivery system.

The previous section provided a general review of healthcare reform and hospital mergers, acquisitions and consolidations. Mergers and acquisitions have become a high-risk form of business activity that involves the collective annual financial investments and influences the working lives of millions of employees. Financial synergy is dependent upon people synergy (Cartwright & Cooper, 1993) and merging organizations is a challenging experience for leaders. The following subsection discusses the shared historical context of nursing and hospitals.

**Nursing and Hospitals: A Shared History**

Nursing has been described as “a noble profession but too often a terrible job” (Weinberg & Gordon, 2004, p. 15). At its best, nursing is a calling, albeit a physically and emotionally challenging, humanly fulfilling moral mission. Nurses encounter patients in their most vulnerable moments, sharing an intimacy found in few other human relationships. Sometimes nurses serve within a personal commitment that goes beyond technological performance, a dedication rarely found in other professions (Weinberg & Gordon, 2004).

Nursing and hospitals in the United States have shared an unbalanced relationship since the latter part of the 19th century. The modern nursing school, patterned after the Nightingale
Schools in England, provided an avenue to education and a way to find “respectable service work for the daughters of the ‘middle classes’ and a means for improving the lot of the ill in hospitals” (Reverby, 1989, p. 3). Nursing, therefore, became for some women a less elite equivalent of an education in womanly virtue that is caring for others, rather than their richer sisters received in the developing women’s colleges (Reverby, 1989). Additionally, as part of the social reform movements of the late nineteenth century, the early nurse superintendents (leaders) in nursing recognized the importance of separate, woman-controlled institutions. But the nursing diploma school arrangements situated squarely within the hospital framework did not provide that separateness and became subordinate to hospital administration.

Reverby (1989) and Melosh (1982) argued that sick care evolved from a duty borne by practically every wife and mother into an adjunct activity that was relegated to paid helpers. The rise of nursing as a form of gainful employment was burdened from the outset by an association with other domestic work. Conflicts arising from the hospital’s dual role as an employer and as a training site for nurses created constant tension (Reverby, 1989). The nursing schools embedded in hospitals were forced to rely on hospital boards and administrators who wanted the training programs to pay their own way. Thus, the field was flooded with graduates of hospitals that exploited cheap student labor to help hospitals maintain both patient care and cost effectiveness (Reverby, 1989).

By the turn of the century, physicians and hospital administrators linked nursing schools with the hospital’s bottom line. The hospital could not function without its apprentice labor force of nursing students (Ashley, 1976). Nursing superintendents of that time were forced to choose between their responsibility to educate the nursing students and predictable pressures to do whatever was necessary to get the work done. Appeals to the womanly virtues of caring and altruism served as a social control mechanism on these early nursing superintendents, usually
ensuring the “correct choice,” or what would be of the best interest of the hospital (Ashley, 1976).

Trained nursing began as an occupation based on the duty to care. Neither ethical dilemmas nor questions of role were anticipated because it was assumed that duty would make such conflicts impossible (Reverby, 1989). The nurse as an individual and nursing as an occupational group, were to conform to a given set of rules. Thus, nursing did not need a code of ethics as physician John Shaw Billings told nursing leaders at the turn of the century, “because a good nurse should merely be told to be a good woman” (Dock, 1912, p. 129). Given the obligation to care and in their position as a womanly occupation, nursing was kept from being the moral standing with which to make this claim as a professional group. Nursing’s educational philosophy, ideological underpinnings, and structural position made it difficult to create the circumstances by which to gain such recognition (Reverby, 1989).

Chambliss (1996) explains that the hospital nurse has three contradictory missions to be simultaneously achieved. These include being: (a) a caring individual; (b) a professional; and (c) a relatively subordinate member of the organization. Nurses are subordinated to hospital authority in numerous ways such as, being subjected to its policies, directed by its physicians and administrators, and acting as nursing leaders (Chambliss, 1996). Nurses are subordinate as well to the orders of numerous physicians and must work within the doctor’s vision of the patient’s needs and their plans for the patient’s life or death (Reverby, 1989). In this dual subordination to the hospital’s bureaucracy and the physician’s orders, nurses may forget their profession’s distinctive goals (Weinberg & Gordon, 2004). As nurses express it, nursing’s moral core and moral identity, as its commitment to the welfare of the patient as a “whole person,” has been buried under medical directives as well as the financial and administrative imperatives of the modern healthcare delivery system (Chambliss, 1996).
As Reverby (1989) helps us to understand the history of the nurses’ moral bind and although the purposes of such a history do not usually include prescriptions for contemporary problems, these historical issues do hint at some of the moral issues nurse leaders encounter in modern medical settings. For example, Chambliss (1996), Weinberg and Gordon (2004), argue that clearly identifies nursing’s central dilemma as being ordered to care in a society that refuses to value caring (emphasis added).

In the previous paragraphs, I discussed that a nurse is inherently a part of the hospital of which, she is a part. Neither the hospital nor the nurse can entirely distinguish itself from the other. In this context, the nurse’s self and the role are intertwined with her experience of the hospital, her patients, and her work. The next section provides context to nursing’s demographics that add to the experience of the nursing profession.

Registered nurses are the largest group of health care providers: 2.7 million (Bureau of Labor Statistics, 2008). The registered nurse’s core function includes assessing and educating patients, administering treatments, supervising and coordinating care (2008). There is a shortage of nurses (Institute of Medicine, 2004) which is exacerbated by an aging nursing workforce, in which the majority of registered nurses are more than 45 years of age (Page, 2004). Additionally, the turnover rate for registered nurses is in the U.S. is expected to reach a mean of about 24% per year in 2011 (Ulrich, Quan, Zimring, Joseph, & Choudhary, 2004). Partly because of the nursing shortage and turnover rate, the nursing workforce is overloaded in terms of the number of patients that nurses’ oversee, the number of hours that nurses work, and the number of tasks that nurses perform (DeLucia, Ott, & Palmieri, 2009). Many nurses work twelve hours or more per day (Hourle, 2001) and often work without breaks or meals (Rogers, Hwang, & Scott, 2004). Nursing continues to be predominately a feminine occupation, measured by the numbers of practitioners. In 2008, 92 percent of the total U.S. population of
registered nurses was female, and, women comprised 90.6 of employed nurses and the remaining 8 percent of the profession are men in the profession and this percentage is only slightly higher than in the past (U.S. Department of Health and Human Services Health Resources and Service Administration Report, 2010). The higher percentage of woman in the profession is predictable as discussed previously; nursing exemplifies the style of the historically feminine occupations: an emphasis on caring for others, especially dependents; and an emphasis on helping those in charge (physicians) rather than making substantive policy decisions themselves (Chambliss, 1996; Weinberg & Gordon, 2004; Reverby, 1989). Given that, it would make sense that nurses would view and experience the moral world of the hospital in characteristically female ways.

A number of researchers have argued that women and men not only have different ideas of right and wrong, but that the sexes actually have different grounds for moral judgment. They live in different moral worlds. The standout example of this position is Carol Gilligan’s argument that while men value independence from others and have a reliance on abstract principles in making moral decisions, women put their priorities on maintaining relationships and carrying out an ethic of care in making moral decisions. This argument led Gilligan to find different conceptions of what is moral maturity in the sexes, and to argue that women’s different voice on these matters deserves a recognition and legitimacy that traditional scholars, like Kohlberg, have denied (Gilligan, 1993). Nell Noddings (1984) suggested that an ethic based on care for concrete others not adherence to logically derived abstract principles; is characteristic of women versus men, and is preferable.

In this section, the historical literature provided context in the dilemma of the nurse’s role within the three components of the nurse’s function: caring, professionalism, and subordination, which all represent in some degree what nurses empirically do and how they interpret or experience what they do. In some ways they are conflicting requirements fortified by conflicting
parties: nursing education, hospital administrators with their efforts of controlling nurses, and professional associations with their duty or calling to “care.” In the case of nursing, much of the nurse’s work is determined by others. Embedded in the organization, the nurse typically works on tight schedules with a long list of quality mandated tasks to be completed within a limited time with fairly severe consequences to not only the patient but to the hospital’s bottom line if she fails to complete her quality work.

The preceding section provided a historical review of the shared history of nursing and hospitals. The following section will provide relevant literature articulating the theoretical foundations of organizational and change theory, the conceptual and theoretical framework of change phenomena, and relevant literature that addresses theoretical approaches to change, including organizational culture, climate and emotions with competing contextual bases of change.

**Organizational Theory**

Organizational theory describes how individual efforts contribute to the form, function and existence of organizations. Through organizational theory, insight is gained about how organizations use resources, develop and implement policies, manage human resources, provide leadership and reorganize (Greaves & Sorenson, 1999). Organizational theory helps us understand the transformation of conflict into cooperation. According to Hui-Chao (2002), organizational theory provides a framework for analyzing the effectiveness of organizational change. This subsection will provide a review of the literature including healthcare complexity theory, organizational theory, and organizational change theory.

**Complexity Theory**

Theories around organizational change are numerous, rich and varied. Complexity theory has proved popular in the healthcare literature and complex systems have been referred to
in a wide range of contexts, including healthcare management (McDaniel & Driebe, 2001), achieving change in healthcare organizations (Cooper & Geyer, 2008; Sargeant, 2009), medical education (Rees & Richards, 2004) consultations in general practice (Innes, Campion, & Griffiths, 2005), clinical governance (Sweeney & Mannion, 2002), evidence-based practice (Petros, 2003), nursing leadership, and decision-making (Clancy & Delaney, 2005; Minas, 2005; Porter-O’Grady & Malloch, 2011). Many researchers cite one or more of a series of articles which draws on Plsek’s contribution to the IOM report, *Crossing the Quality Chasm: A New Health System for the 21st Century* (Institute of Medicine, 2001), and which has been effectively endorsed by what may be called the perceived interpretation of complexity in healthcare.

However, the apparent confidence by which complexity theories are being deployed in the literature does not match the caution being exercised by social theorists, many of whom express reservations about the possibility of transferring an ill-defined something called “complexity science” – as a loose grouping of unsynthesized ideas with no unified theory, from biology, dynamics or artificial life to social structures and organizations (Paley & Eva, 2011). From this more skeptical perspective, the adoption of complexity thinking is suspected of being another intellectual fad (McKelvey, 1999; Stacey, 2000).

Theoreticians Nicholas Negroponte (1995) and Kevin Kelly (1995) have delved into the dynamics of organizational complexity to make it understandable and applicable to human enterprises. All health services are provided within the context of the “I-Thou” relationship: someone provides a service, someone receives it. Through this fundamental human equation, care and healing emerge, and everything from structure to equipment, competence to relationship, are reflected in it. The point of service is driven by the culture of the patient population, and the system is driven by the culture of its community, which gives it purpose, and the culture of its members or workers, who give it, focus (Kelly, 1995). These constituencies
converge to drive the system to thrive. Anything that adds value to any part of a system adds value to the whole system (Berwick, Nolan, & Whittington, 2008). The claim of Berwick, et al., rests upon a questionable assumption as recent research has shown that complex problems are messy, ill-defined, and more complex than we fully grasp and open to multiple interpretations based on one’s point of view. The sustainability of the system requires the aggregation of numerous additions of value. The triadic relationship between purpose, person and performance is the cornerstone of any measure of vitality in any kind of complex system (Kelly, 1995).

Many theoretical approaches have emerged to define the structure and processes associated with an organization’s work. From bureaucratic theory through the human relations, contingency and resource dependent approaches, strategic, population and institutional models, theorists have written extensively on how and why organizations function as they do (Porter-O’Grady & Malloch, 2011). According to the complexity approach, Burke (2011) maintained that the foundation for understanding the two overlapping organizational domains as the interdependence of the organization and its environment. Moreover, Katz and Kahn (1978) argued that open systems maintain themselves through constant commerce with their environment that is a continuous flow and outflow of energy through permeable boundaries. Organizations are also made up of internal parts such as buildings, equipment and people. Every system must possess structure and cultural foundations and must be able to respond flexibly to the environment and relationships, create value, improve it, and interface directly with the external processes that influence its future. In other words, each theoretical approach contributes at some level to our understanding of how systems operate and how to make them effective.

**Social Cognition Theory**

The use of social cognition model as an organizational theory is growing among scholars in healthcare organizational development (Kezar, 2001). The appeal of these models is that they
lend themselves to the ambiguousness of healthcare organizations. Earlier typologies such as teleological, evolutionary, life-cycle and political were developed out of a functional approach to understanding organizations (Kezar, 2001). Functional theorists maintain that organizations have one reality, which all individuals within the organization perceive similarly. Conversely, most social-cognition models stem from a “phenomenological or social constructivist view of organizations,” (Kezar, 2001, p. 44). Change, through social-cognition models, comes through cognitive dissonance. The change process is a result of learning, altering paradigms, and is interconnected and complex. Kezar notes several criticisms of social cognition models, which include: a de-emphasis of the environment and an over-emphasis of the ease of change (2001). In contrast, the benefits of social cognition models are that they emphasize individuals in a socially constructed nature.

**Sense-making as Organizational Theory**

Weick’s (1979) model of organizational theory is an open systems theory that focuses on the environment at the social psychological level. This model is concerned with “how people interpret their world and reconstruct reality on an ongoing basis” (Kezar, 2001, p. 47). Employees organize information to: process, reduce uncertainty, and cope with equivocality in an effort to make sense of the environment (Weick, 1979). A key premise of sense-making is that it is connected to situations in which stimuli are noticed, interpreted and acted on (Weick, 1995). Weick (1995) distinguishes sense-making from interpretation as it emphasizes the focus on how people generate what they interpret. Sense-making is about sizing up a situation, trying to discover what you have while you simultaneously act and have some effect on what you discover (Weick, 2001). Sense-making is seldom an occasion for passive diagnosis. According to Weick (2001), it is an attempt to grasp a developing situation in which is hard to separate subject and object.
Most efforts at sense-making involve interpretation of previous happenings and of developing plausible histories that link previous happenings with current outcomes; organizations then, have a major hand in creating the realities from perceived facts to which they must accommodate (Weick, 1979). Smirchish and Stubbart (1985) argue that organizations and their environments are “convenient labels for patterns of activity” and that what is referred to as the environment of an organization is really the outcome of the actions of people and the accompanying efforts of those people to make sense out of those actions (emphasis added). From the viewpoint of enactment, rather than talking about an organization adapting to an external environment, it may be more correct to adopt the stance that organizing consists of adapting to an environment which is constituted by the actions of interdependent human actors (Weick, 1979). The formula or recipe for organizing the world, from an organizational perspective is shown in Figure 4, from Weick (1979).

![Weick's Model of Retrospective Sense-making](image)

*Figure 4. Weick’s Model of Retrospective Sense-making (1979).*

Enactment is “bracketing some portion of the stream of experience for further attention” (Weick, 1979, p. 45); selection is imposing a set of interpretations on the bracketed portion in order to reduce its ambiguity or equivocality. This part of the model is named ‘selection’ to denote that there are usually only a limited number of interpretations in an individual’s or organization’s repertoire that are built up from previous experiences. The component of the organizing model, retention, is the “storage of interpreted segments for future application” (Weick, 1979, p. 45) and contains the previous “products of successful sense-making” (Weick, 1979, p. 131). Another term used to refer to the retained content is ‘cause map’ which implies
that the content is subject to deciphering and reading just as is a road map. The enactment-selection-retention model for conceptualizing the organizing process is not a one-way process. The more in the stream of experience in which the individual or organization must make sense, the more interpretations are usually called forth to produce the required meaning. The retention process affects both the future enactment and selection processes in either positive or inverse ways “depending on whether the person decides to trust past experience or disbelieve it” (Weick, 1979, p. 132).

The basic reason for this type of organizing relates to the needs of the individuals to rectify their frames of reference: two or more individuals enact equivocal raw talk, the talk is viewed retrospectively, sense is made of it, and this sense is then stored as knowledge in the retention process (Weick, 1979). Since the action precedes the sense-making application of the individual and collective frames of reference, a crucial characteristic of the concept of enactment is that the environment is viewed as an output than an input. “Once that enacted environment exists, it serves as a plausible guide for subsequent actions and interpretations” (Weick, 1979, p. 229). The very reason for the existence of organizations is to produce stable interpretations of ambiguous displays of the stream of raw experience. The concept of ‘enactment’ then is even more basic than the common concept of organization (Weick, 1979).

Garfinkel (1967) did not actually use the term enactment, yet discussed the relativity of rationality: the grounds on which a person makes a choice among alternatives flows from the environment and through reflection legitimizes the choice. However, the grounds of choice may be “those which he quite literally finds through retrospectively interpreting a present outcome” (Garfinkel, 1967, p. 266). In the manner of a self-fulfilling prophecy, the features of the social environment are produced by a person’s compliance with expectancies, or frame of reference, which precedes social interaction and which determines how one’s experience will be organized.

In organizations, the concept of sense-making was first used to focus attention on the largely cognitive activity of framing experienced situations as meaningful (Piaget, 1972; Weick, 1979). As it relates to mergers in healthcare, it is a collaborative process of creating shared awareness and understanding out of different individuals' perspectives and varied interests. The work of Weick (1979) in particular has dealt with sense-making at the organizational level, providing insight into factors that surface as organizations address either uncertain or ambiguous situations. Therefore, people act their way into their values, which paves the way for groups to act their way into their identities, which paves the way for the organizations to act their way into their missions. Sense-making emerges as a retrospective activity that is sensitive to conditions of choice, irrevocability and visibility (Batchelor, 1997). Sense-making has seven properties:

1. **Personal Identity.** Identity and identification are foundational: who people think they are (example: profession, organizational identity/status) within that context shapes what they enact and how they interpret events (Currie & Brown, 2003; Pratt, 2000; Thurlow & Mills, 2009; Watson, 2009; Weick, Sutcliffe, & Obstfeld, 2005).

2. **Retrospect.** Retrospection provides the opportunity for sense-making: the point of retrospection in time affects what people notice (Dunford & Jones, 2000), thus attention and interruptions to that attention are highly relevant to the process (Gephart, 1993).

3. **Social Context.** People enact the environments they face in dialogues and narratives (Bruner, 1991; Currie & Brown, 2003; Watson, 2009). As people speak, and build narrative accounts, it helps them understand what they think, organize their experiences, and control or predict events (Abolafia, 2010; Isabella, 1990; Weick, 1995).
4. *Salient Cues*. Sense-making is a social activity in that plausible stories are preserved, retained or shared (Isabella, 1990; Maitlis, 2005). However, the audience for sense-making includes the speakers themselves (Watson, 1995) and the narratives are “both individual and shared, an evolving product of conversations with ourselves and with others” (Currie & Brown, 2003 p. 565).

5. *Ongoing Projects*. Sense-making is ongoing and individuals simultaneously shape and react to the environments they face. As they project themselves onto this environment and observe the consequences they learn about their identities and the accuracy of their accounts of the world (Thurlow & Mills, 2009). Experience is a continuous flow, and it becomes an event only when efforts are made to put boundaries around some portion of the flow or when some interruption occurs. As Weick argued, “The basic idea of sense-making is that reality is an ongoing accomplishment that emerges from efforts to create order and make retrospective sense of what occurs” (Weick, 1993, p. 635).

6. *Enactment*. People extract cues from the context to help them decide on what information is relevant and what explanations are acceptable (Brown, Stacey, & Nandhakumar, 2007; Salancick & Pfeffer, 1978). Extracted cues provide points of reference for linking ideas to broader networks of meaning and are “simple, familiar structures that are seeds from which people develop a larger sense of what may be occurring” (Weick, 1995, p.50).

7. *Plausibility*. People prefer plausibility over accuracy in accounts of events and contexts (Abolafia, 2010; Brown, 2005; Currie & Brown, 2003). Plausible sense is constrained by agreements with others, consistency with one’s own stake in events, the recent past, visible cues, projects that are demonstrably under way, scenarios that are familiar, and actions that have tangible effects.
Each of these seven aspects of sense-making coalesces as individuals internalize events, or experiences. These interpretations become evident through narratives, whether written or spoken, and convey the meaning, gist, significance or the sense they have made of events (Currie & Brown, 2003; Weick, 1995).

**Organizational Frames Theory**

Similar to Weick’s perspectives, Bolman and Deal’s (2003) theory of organizational frames are useful to draw upon when considering organizational change. Bolman and Deal’s four frames include: structural, human resource, symbolic, and political (2003). These frames or perspectives are pluralistic, allowing an assorted view of an organization. According to Bolman and Deal, organizations are complex and ambiguous; by understanding the four frames leaders are able to “find clarity and meaning amid the confusion of organizational life” (2003, p. 40).

The structural frame assumes that the correct formal structure will minimize problems and maximize performance (Bolman & Deal, 2003). Typically structures in stable organizations are grounded in rules and are hierarchical. Since the emergence of new technology and business innovations, organizations grounded in a structural frame have become more flexible in implementing new technology and business plans (Bolman & Deal, 2003).

Bolman and Deal state that the human resource frame “highlights the relationship between people and organizations” (2003, p. 132). The concept of needs (specifically how needs are satisfied or frustrated at work) is a key attribute of the human resource frame. Organizations that prescribe to the human resources frame utilize activities and practices that are guided by a comprehensive resource management philosophy (Bolman & Deal, 2003).

The political frame is concerned with a scarcity of resources, the distribution of power and diverging interests. The political frame emphasizes that organizations are coalitions made up of diverse individuals and groups (Bolman & Deal, 2003). These individuals have their own
values, beliefs, information, interests and perceptions of reality (Bolman & Deal, 2003). Conflict within organizations is common due to scarce resources and divergent interests. According to the political frame, “conflict is not necessarily a problem or a sign that something is amiss” (Bolman & Deal, 2003, p. 197), conflict is seen as normal and is expected. In organizations characterized by the political frame, goals and decisions “emerge from bargaining, negotiation and jockeying for position among competing stakeholders” (Bolman & Deal, 2003, p. 183).

The symbolic frame is grounded upon meanings, beliefs, hopes and faiths, and utilizes these symbols to define the organizations culture (Bolman & Deal, 2003). This frame centers on complexity and ambiguity, whereas traditional views emphasize rationality and objectivity. Activity and meaning are loosely connected because differing interpretations of events have multiple meanings. To deal with uncertainty and ambiguity, symbols are created as a way to alleviate confusion and find direction (Bolman & Deal, 2003).

Organizational theories provide a framework from which to consider the diverse structure and function of healthcare organizations. According to Collins and Hill (1998) the ability to effectively implement organizational change theory affects the success or failure of the change. When it comes to organizational change, one size does not fit all (Birnbaum, 1991; Bolman & Deal, 2003). The section that follows discusses organizational change theories, process models and research.

**Organizational Change Theories, Models and Research**

There is a vast amount of literature examining organizational change; over 1.2 million articles about change from disciplines including psychology, sociology, education, business, economics and medicine have been published. The pace and scale of change in organizations continue to evolve and rapidly change (Strickland, 1998) resulting in an overabundance of
theoretical perspectives and frameworks to explain and guide organizational change (Hewison, 2012; Van de Ven & Poole, 1995).

Change in organizations is an event like a merger, acquisition, reorganization, a new policy, technology, decision or promotion into a new position; produces a human response to organizational change and thus, is a process (Bridges, 2009). The event itself is the change; the psychological response to the event is a process of transition that occurs over time (2009) (emphasis added). People do not rapidly change their beliefs, feelings or attitudes during organizational change; that happens gradually. Bridges states, “it isn’t the changes that do you in, it’s the transitions” (2009, p. 3). Organizational change can be deeply unsettling to people and people tend to resist when faced with letting go of the existing state (2009). People cling to what they already know how to do in organizations and what has brought them success in the past (Quinn, 2004).

According to Hershey and Blanchard (1996), individuals operate at different levels of readiness for change. Fear of change is one of the factors that affect an individual’s acceptance of change (1996). Readiness for change research suggests that a clear need for the change, a sense of one’s ability to accomplish the change, and an opportunity to participate in the change process contribute to readiness for organizational change (Bridges, 2009; Cunningham, 2002, Kotter, 1996).

In an organization, change is often associated with a loss of routine, security, and control (Bridges, 2009). When change is driven from a top-down approach, individuals have a natural fear of change that is imposed by others (Evans, 2001; Kotter, 1996). Control that is mandated from management above creates a sense of fear due to a loss of control (Evans, 2001). Moreover, the fear of the unknown is one of the key reasons that individuals resist change
(2001). At the individual level, fear of change is often related to the perceived danger associated with change.

Kotter (1996) has suggested that the methods used in successful transformations are based on one “fundamental insight: major organizational change will not happen easily” (p. 13). Kotter recognized the gap with his seminal work of producing successful change that has eight stages designed to address and overcome the common errors associated with failed change efforts (1996). The first four stages are used to unfreeze the status quo. These stages are: (a) establishing a sense of urgency - identifying and exploring crises and opportunities; (b) creating the guiding coalition - assembling a group that can work as a team and with enough power to lead the change; (c) developing a vision and strategy and directing the change effort; (d) communicating the change vision by communicating and modeling the change vision, strategies, and behaviors (Kotter, 1996). The next three stages are used to introduce new behaviors and practices. These stages are: (e) empowering broad-based action by removing obstacles, changing structures and systems, encouraging new ideas and actions; (f) generating short-term wins by planning and reinforcing visible performance wins; (g) consolidating gains and producing more change with more changes to systems, structures, and policies (Kotter, 1996). The last stage is used to make the change sustainable: institutionalizing new approaches in the culture, which creates improved performance and lasting change in the system (Kotter, 1996). However, Kotter’s theory lacks conceptualization around dealing with the psychological transitions in the change process effectively.

Significant research that has been conducted on organizational change can be categorized according to the themes or aspects of change being studied, the nature or the content of change, the implementation processes associated with change, and the environmental factors that may motivate organizations to change (Caldwell, Herold, & Fedor, 2004; Lewin, 1951). Of these
change processes *organizational procedural fairness* or organizational justice, has received more attention from researchers and practitioners than any other change-related construct and has been shown to be powerful determinants of individuals’ reactions to major organizational changes (Kotter, 1996) (emphasis added).

There is a significant body of research suggesting that when change recipients perceive that implementation was handled fairly, reactions to the change and the organization are more favorable than when the same change is perceived to have been implemented in an unfair manner (Caldwell et al., 2004). Such fairness judgments are based on leadership attending to procedural consistency, providing accurate information, and involving the employees in the change (Caldwell, et al., 2004).

Meyers, Goes, and Brooks (1993) developed a model to classify change along three dimensions: (a) level of change, (b) type of change, and (c) the mode of change. The level of change represents where the change occurs, either at the organizational or industry level (Meyers, et al., 1993). Type of change reflects a continuum from episodic to radical discontinuous change (Meyers, et al., 1993). Mode of change addresses whether the change is voluntaristic, or deterministic and imposed, or intentional (Barger & Kirby, 1995; Meyers, et al., 1993). Being aware of the level and mode of change helps leaders to better plan and support others to successfully navigate the change process. The leader can carefully match his/her approach and behavior to each level and mode of change to reduce some of the predictable impediments and obstacles associated with change.

There is agreement in the organizational change literature that people are concerned with the impact of change on themselves, their job, and their work colleagues (Rafferty & Griffin, 2006; Remoussenard, 2007). When discussing the impact of change in the workplace, these authors make a fundamental distinction between incremental or first-order change and
transformational or second-order change (Rafferty & Griffin, 2006). Transformational change, by its very nature, involves a dramatic shift in basic aspects of an organization (Rafferty & Griffin, 2006). They refer to transformational change as the impact of change on the individual and an individual’s perception regarding the extent to which change has involved modifications to the core systems of an organization including traditional ways of working, values, structure, and strategy (Rafferty & Griffin, 2006). Periods of transformational change are likely to be experienced as highly novel events in which people are required to act in completely new ways and to adopt new values (Rafferty & Griffin, 2006).

**Types and Stages of Change**

Based on fifteen years of studying and observing change in a wide range of organizations, Lawrence, Dyck, Maitlis, and Mauws (2006) developed a framework for understanding the underlying structure of continuous change. Continuous change occurs in cycles, not in the linear programs associated with planned-change projects, and not in random or chaotic flows (Lawrence, et al., 2006). Real lasting change occurs only when it cycles through four distinct phases: influence, authority, technology, and culture (2006). Each phase requires a specific type of champion, the evangelist to disseminate the idea; the autocrat to ensure that authority is properly exercised; the architect to embed change in organizational structure and systems; and, the educator to build revitalization into the change process (Lawrence, et al., 2006). “An understanding of the phases of change can help leaders transform their companies into organizations that experience change not as a tumultuous, anxiety-inducing event but as part of an everyday routine” (Lawrence, et al., 2006, p. 60).

Claes Janssen (1982), a social psychologist, presented a four-stage model for explaining the process of change. In *Productive Workplaces*, Weisbord (1987, pp. 266-268) summarized Janssen’s model as denial, confusion, renewal and contentment. Similar to Janssen’s process of
change, Scott and Jaffee (1990) created a widely used four-stage change model for individual life transitions that was applied in the workplace setting. The Scott-Jaffee model (1990) incorporated the work of Dr. Elisabeth Kubler-Ross (1969) on death and grieving with their own observations of behaviors during mergers, downsizing and company closures.

Musselwhite and Ingram (2003) in their seminal work proposed a four-stage model of transition: acknowledging, reacting, investigating, and implementing. This model proposed a need for specific leader behaviors for each phase and stage of change as suggested. Effective and ineffective behaviors are described for the predictable stages of change in both the affective and cognitive domains of experiencing change. The Discovery Learning Transition Change Model (Musselwhite & Ingram, 2003) shown in Figure 5 describes and explains the stages of change and recommended leader behaviors and actions that can be applied to manage change initiatives and leader-follower interactions.

*Figure 5. Discovery Learning Change Transition Model (Musselwhite & Ingram, 2003).*

This model depicts two types of transitions. The first transition refers to an orientation in time in which focus moves from a past to a future orientation (Musselwhite & Ingram, 2003).
The second transition refers to a shift that occurs from a cognitive orientation to an emotional orientation, and then returns to a cognitive orientation (Musselwhite & Ingram, 2003).

There is a great deal of consistency among the change theories which have a common element, indicating that change is a process comprised of steps or stages (Musselwhite & Jones, 2004). The stages or steps in each change model present common and predictable themes and patterns. Regardless of the particular change theory, change appears to move through a series of phases that usually require a great deal of time (Bridges, 2009; Kotter, 1996). Skipping phases, steps, or transitions will not yield the desired transformation or renewal of the organization (Bridges, 2009). Table 1 presents a brief history of organizational change theories and transition stages.

Table 1:

<table>
<thead>
<tr>
<th>Theorist</th>
<th>Description or Stages of Change</th>
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<tbody>
<tr>
<td>1947</td>
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<tr>
<td>Lewin</td>
<td>1. Unfreezing</td>
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<td></td>
<td>Unfreezing triggered by social problems or conflict (e.g., anxiety, fear, unconscious behaviors)</td>
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<td></td>
<td>2. Moving</td>
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<td></td>
<td>Transition or moving, changing values, attitudes, structure, feelings, behaviors (e.g., uncertainty, excitement)</td>
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<td></td>
<td>3. Refreezing</td>
</tr>
<tr>
<td></td>
<td>Refreezing new support mechanisms, new perspectives, new status quo, new identity</td>
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<tr>
<td>1969</td>
<td></td>
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<tr>
<td>Kubler-Ross</td>
<td>1. Denial &amp; Isolation</td>
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<tr>
<td></td>
<td>Belief life as it was before as our loss</td>
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<tr>
<td></td>
<td>Re-enact rituals</td>
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<td></td>
<td>Flashbacks to past experiences</td>
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<td></td>
<td>Blame others or ourselves for our loss</td>
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<td></td>
<td>Easily agitated, emotional outbursts</td>
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<td></td>
<td>Making deals with ourselves or with God</td>
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<td></td>
<td>Feeling listless and tired</td>
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<td>Feeling guilty</td>
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<td>Feelings of being punished</td>
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<td>5. Acceptance</td>
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<td></td>
<td>For dying: resignation, withdrawal, lack of emotion</td>
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<tr>
<td></td>
<td>For survivors: realization that life has to go on, acceptance of loss, new focus on future goals and activities, renewed energy</td>
</tr>
<tr>
<td>1980</td>
<td></td>
</tr>
<tr>
<td>Bridges</td>
<td>1. Letting Go</td>
</tr>
<tr>
<td></td>
<td>Letting Go –</td>
</tr>
<tr>
<td></td>
<td>Expressing sadness, fear, depression, and grieving</td>
</tr>
<tr>
<td></td>
<td>2. Neutral Zone</td>
</tr>
<tr>
<td></td>
<td>Neutral Zone – Experiencing high anxiety, self-doubts, lower energy, disorientated, confused, polarized, lost, uncertainty</td>
</tr>
<tr>
<td></td>
<td>3. New Beginning</td>
</tr>
<tr>
<td></td>
<td>New Beginning – Demonstrating new understanding, new values, new identities, finality of the past, and taking accountability.</td>
</tr>
<tr>
<td>Theorist</td>
<td>Description or Stages of Change</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td>Prechaskta &amp; DiClemente</td>
<td>Thinking about preparing for change</td>
</tr>
<tr>
<td>1982</td>
<td>Contemplation for Action</td>
</tr>
<tr>
<td>Commitment</td>
<td>Commitment to change and then into a maintenance phase</td>
</tr>
<tr>
<td>Janssen</td>
<td>1. Denial, Lack of awareness, Fear of change, Insensitive to events</td>
</tr>
<tr>
<td>1982</td>
<td>2. Confusion, Out of touch, Scattered, Unsure, Different</td>
</tr>
<tr>
<td>3. Renewal</td>
<td>Sincere, Open, Exploring, Willing to Risk</td>
</tr>
<tr>
<td>4. Contentment</td>
<td>Satisfied, Calm, Realistic, Life the status quo</td>
</tr>
<tr>
<td>Scott &amp; Jaffe</td>
<td>1. Denial, Focused on past, Neglecting future, Lack of awareness</td>
</tr>
<tr>
<td>1988</td>
<td>2. Resistance, Self-doubt, Depression, Anxiety, Frustration, Fear</td>
</tr>
<tr>
<td>3. Exploration</td>
<td>Internal creative, Energy increases, Excitement, Exhilaration</td>
</tr>
<tr>
<td>4. Commitment</td>
<td>New bonds created, Chaotic, Everything in question, Stress &amp; uncertainty</td>
</tr>
<tr>
<td>Kotter</td>
<td>1. Lose Focus, Sense of confusion, Denial, Act as if everything is normal</td>
</tr>
<tr>
<td>1990</td>
<td>2. Minimize Impact, Most difficult and painful stage, Feeling of sadness, anger and fear</td>
</tr>
<tr>
<td>3. The Pit</td>
<td>Focus on opportunities and creating a new future, Releasing energy, Increased optimism, enthusiasm and vitality</td>
</tr>
<tr>
<td>4. Letting Go</td>
<td>A sense of mastery, Improved self-esteem, The change is now a part of your life</td>
</tr>
<tr>
<td>5. Testing the Limits</td>
<td>6. Search for Meaning, Improved self-esteem, The change is now a part of your life</td>
</tr>
<tr>
<td>7. Full Integration</td>
<td>Anchor Change, anchor change, anchor change, anchor change, anchor change</td>
</tr>
<tr>
<td>Musselwhite &amp; Ingram</td>
<td>1. Acknowledging, People are shocked and feel threatened and deny that a change has happened</td>
</tr>
<tr>
<td>2003</td>
<td>2. Reacting, People express various reactions - anger, depression, withdrawal, and try to “bargain” to do things the “old” way</td>
</tr>
<tr>
<td>3. Investigating</td>
<td>People may express grief/sadness over loss, but they begin to explore the possibility of future options</td>
</tr>
<tr>
<td>4. Implementing</td>
<td>People appear ready to establish new routines, adapt to new systems, and help others learn new ways</td>
</tr>
</tbody>
</table>

There are striking similarities among the change models of Bridges (1991), Prechaskta and DiClemente (1982), Janssen (1982; 1996), Spencer and Adams (1990) and Musselwhite and Ingram (2003), suggesting that transitional change is not a linear process in which one completes a stage and progresses to the next stage. Rather, transition is viewed as a fluid and more circular
multi-step process. Therefore, one of the biggest problems in the research is that there is little empirical evidence available that provides policymakers and practitioners with understanding the construct of factors that influence the merger experience.

The following subsection will address the organizational culture, change and emotions, and the factors that influence the merger experience that are found in the literature. This section will also address the cognitive or emotional responses of employees related to experienced organizational change.

Organizational Culture, Change and Emotions: Managing Meaning

This section of the literature review will focus on how elements of organizational culture influence the emotional responses to organizational change of employees. Organizational change is fundamentally about emotions or affects/feelings. Organizational culture and change has cognitive, affective, and behavioral components, the emotional aspects are frequently overlooked (Piderit, 2000; Smollen, 2006; Szabla, 2007). Emotions are direct responses to events, issues, and relationships that are important to people (Frijda, 1988; Lazarus, 1991; Smollen, 2006).

Cognitive, Affective and Behavioral Components

Organizations that want their employees to contribute with their heads and their hearts have to accept that emotions are central to a new leadership style. The most successful change programs reveal that large organizations connect with their people and most directly through values (Duck, 1993) and values are ultimately about beliefs and feelings (Smollan & Sayers, 2009).

Organizational culture is imbued with emotion and, therefore, cultural change is especially emotional (Jordan, 2005; Kiefer, 2005; Smollan, 2006; Wanberg & Banas, 2000). A change in culture can be the goal of management and can occur indirectly as a result of strategic,
tactical or operational changes found in acquisition, merger or consolidation. An organization’s affective culture influences how these emotions are experienced and expressed.

Emotions are not defined, discussed, explicitly studied or measured in the merger and acquisition literature (Kusstatscher & Cooper, 2005). The concept of emotion has been limited to the level of stress research and are generally viewed as resistance (Kiefer, 2002). While Schein (1990) indicates that there are many elements of an organizational culture, it is substantially about values (Duck, 1993; Kabanoff, Waldorsee, & Cohen, 1995; Ryan, 2005). Values may evolve or be deliberately determined, be articulated in mission statements and websites and included during induction and or in “employee handbooks” (Kunda & van Maanen, 1999). In using the values in this way, they are overt guides to behavior, and the messages and mechanisms may be more subtle and act as forms of normative control (Kunda, 2006). These cultural elements may also be communicated in management briefings, performance reviews or informal conversations. Communication about these aspects of organizational life, often become emotional language (Smollan & Sayers, 2009).

Organizational culture has been considered by various theorists to be socially constructed by multiple managerial and employee discourses (Strandgaard, Pedersen, & Dobbin, 2006). The social processes that enact the values “endow them with meaning” (Rosen, 1991, p. 6), and as Allen (2003) put it, organizational actors produce but are also constrained by organizational meaning. While managerial intentions have stronger currency, the ways in which employees resist managerial framing of culture (Bean & Hamilton, 2006), constructively and deliberately modify it, or less consciously shape it by their own actions, contribute to its shifting landscape.

A number of researchers have studied the ‘emotions-culture’ connection. Schein contends that one of the factors contributing to the development of culture is the “emotional intensity of the actual historical experiences” organizational or group members have shared
together (2004, p. 11). According to van Maanen and Kunda (1989) “any attempt to manage culture is therefore also an attempt to manage emotions” (p. 46). The role of emotions is emphasized somewhat idealistically by Bratton, Grint, & Nelson (2005) who contended, “the most critical function of corporate culture is to generate commitment and enthusiasm among followers by making them feel they are a part of a ‘family’ and participants in a worthwhile venture” (p. 51).

The social constructivist perspective of emotion takes the view that emotions are phenomena that are culturally mediated (Antonacopoulou & Gabriel, 2001) and developed through interactive social relationships. Callahan and McCollum (2002, p. 14) indicate that “emotions are created or constructed as part of a common sense-making process in social structures” and that “social constructionism knits together the personal and the social.” Social constructionism underlies much of the literature on emotional labor, which focuses on the requirement to express or suppress emotions at work (Bolton, 2005; Fineman, 2005 & 2008; Hochschild, 1983; Mann, 1999). Zembylas (2006) notes that the feeling and display rules that operate in organizations are both contributors to, and outcomes of organizational culture.

Organizational Communication/Language: Shared Meaning

Organizational values are often reflected in the language that is used, and the language of culture in the context of change can be suffused with emotion. Martin (2002) explains that jargon both defines a culture and shapes it. For example, in researching mergers and acquisitions, Martin noted that the informal use of terms such as ‘shark,’ ‘ambush,’ ‘stud,’ ‘cupid,’ ‘rape,’ and ‘afterglow’ reflect themes of sex and violence and that these metaphors tap into the emotional aspects of life in particular kinds of organizations and industries, alluding to emotions that may not be socially acceptable to express more directly. Further, Marks and Mirvis (1998) describe those who lead, assist, study, or simply write about mergers or
combinations use many metaphors and genres to characterize the activities: the old west (shoot-outs); the high seas (piracy); chivalry (knights and damsels); warfare (raids and rescues); medicine (surgery); family (parent and child, sibling rivalry); and of course courtship, love and marriage. This speaks to how mergers and acquisitions occur and how they play out and how the integration activities are communicated. Marks and Mirvis (1989) describe an organizational integration process this way: “Managing a merger is a lot like killing a moose. The hunt is fun. But then you have the dirty, smelly work of gutting, cleaning and preparing the carcass” (p. 272).

Change has also been the subject of social constructionist approaches. The way(s) that change is framed by various organizational actors (for example as an exciting opportunity or a response to a problem) can stimulate discourses about change (Bean & Hamilton, 2006; Ford, Ford, & McNamara, 2002; Mills, 2000) that may or may not result in shared understandings. Resistance to change may be seen as culturally acceptable and negotiable, or as unacceptable and as a barrier to be ‘dealt with’ or ‘managed’ (Dent & Goldberg, 1999; Ford et al., 2002; van Dijk & van Dick, 2009). The emotions that people experience, express or suppress during organizational change are shared by social relationships inside and outside the organization (Bryant & Wolfram Cox, 2006).

**Organizational Identity**

The literature on identity provides insight into the psychological dynamics of cultural and other forms of organizational change. A person’s sense of identity is partly determined by his/her values, which can mesh or clash with organizational values (Ashforth & Mael, 1989; Pepper & Larson, 2006). Culture represents the unwritten sense of identity or the feeling part of the organization, and to be a part of an organization, to pursue a lasting career offers that opportunity (Kets de Vries & Balazs, 1997). It provides a ‘glue’ and understanding in that it can help individual members make sense of events and change undertakings (Ryan, 2005).
Most people work for more than just money, they have intrinsic motivators as well. One of these is the need for belonging. To have a sense of belonging to something is important in the establishment of a person’s identity (Kets de Vries & Balazs, 1997). According to Carr (2001), “the process involved in the relationship between employee and organization are deep-seated, largely unconscious, intimately connected to the development of identity and have largely emotional content” (p. 422). Ryan (2005) further contends that change ‘dislodges’ identity and leads to anxiety and grieving.

Van Knippenberg, Van Knippenberg, Monden and de Lima (2002) reported from a study of a merger that members of the dominant company felt a much stronger form of organizational identification than the members of the subordinate company. Similarly, Pepper and Larson (2006) found in a takeover that members of the acquired company resisted the values of the acquiring company, as a result of what they termed ‘identity tensions.’ Equally important, Van Dijk and van Dick (2009) found that organizational change could undermine an employee’s identity, particularly in terms of social status, while resistance to change undermines a change leader’s identity as a person with power.

The role of emotion is frequently ignored or discounted in the literature or considered irrational (Domagalski, 1999). This is surprising, given that in the context of cultural change, the affective elements wrapped as they are in organizational values and identity, are particularly significant.

**Affective Response to Change**

Organizational change, principally related to an organizational merger, acquisition or combination, can ignite emotional reactions that the affective culture of the organization are experienced, expressed and/or regulated (Alvesson, 2002). As previously stated, scholars have described the emotional aspects of an organization’s culture as affective culture (Barsade &
Gibson, 2007), emotional culture (Zembylas, 2006) and affective climate (Tse, Dasborough & Ashkanasy, 2008). Beyer and Nino (2001) assert that culture both engenders emotions and provides for their expression in socially accepted ways and that culture acts as the ‘glue’ that binds people. According to Pizer and Hartel (2005), a healthy organizational culture is one where emotional expressiveness is encouraged and value is placed on the emotional elements of work. Conversely, organizational culture can be seen as a mechanism for the cynical manipulation of the employees’ emotions, which need to be controlled for the benefit of the organization (Fineman, 2001; Zembylas, 2006). Consequences of an affective culture that experiences emotional turmoil during a merger and acquisition can be; decreased employee motivation, lower job satisfaction, and a reduced commitment to the company (Kusstatscher & Cooper, 2005). In order to cope with these challenging events people start to talk, gossip, and distract each other from their work. This happens especially when top-down information is not clear or considered to be insufficient. The rumor-mill starts and worst-case scenarios boom because ‘no news’ is usually decoded as bad news (Cartwright & Cooper, 2000; Marks & Mirvis, 1999).

A natural reaction of people, who are hurt, shows up as anger. Conceptually, Kets de Vries and Balazs (1997) argued that we manage aggression by turning it either inward or outward, depending on the disposition of the individual.

**Emotional Labor**

Other interlocking constructs provide insight on the affective nature of organizational culture: emotional labor, and perceived organizational support. Research into affective culture has focused on emotional labor as it seldom attempts to incorporate the construct of organizational support. Moreover, the organizational change literature has paid little attention to how organizational culture and in particular, affective culture, relates to these constructs. There
is extensive literature on how emotional labor has indicated how the experience, display and suppression of emotions at work is determined by a host of societal, organizational, professional and individual factors (Alvesson, 2002; Bolton, 2005; Hochschild, 1983; Mann, 1999; Turnbull, 1999).

The affective or emotional culture of an organization can result in feelings being ‘captured,’ ‘harnessed,’ ‘managed,’ ‘controlled,’ ‘sanitized,’ ‘codified,’ and ‘commodified,’ by organizations for their own objectives, and often at the expense of the employee (Fineman, 2000; 2001; 2003; 2005; 2008; Kunda & Van Maanen, 1999; Sturdy & Fineman, 2001; Zembylas, 2006). Emotions become ‘cultural prerogatives’ (Fineman, 2008) when some are deemed appropriate for display, and others must be contained. Callahan (2002) found in a qualitative study that employees were expected to hide their emotions and that the emergences of newer and healthier norms were being stymied by an unresponsive organizational culture.

Emotional actions can be required to lead and implement change since those entrusted with these tasks need to inject the appropriate type of emotion into selling or pushing change (Fox & Amichai-Hamburger, 2001). Change initiatives can also lead to emotional labor appearing in those that lead and implement the change as well as with the change recipients. Bryant and Wolfram Cox (2006) found a number of their respondents in a qualititative study felt the need to hide their emotions about organizational change since their expression was construed as an unwelcome form of resistance.

Turnbull (2002) studied the ways individuals responded to an organization’s attempts to deliberately change its culture to one of trust, openness, innovation and loyalty, in workshops laden with emotional appeals. Turnbull (2002) found that managers experienced both cognitive and affective reactions but often in unintended ways: with mistrust, anger, and embarrassment
often eventuating from awkward situations. The study reported the need for managers to hide their feelings and to pretend to comply with the changes (Turnbull, 2002).

Naumann, Bennett, Bies, and Martin (1998) had applied the concept of organizational support to a variety of organizational contexts, including change. Masterson, Lewis, Goldman, and Taylor (2000) found that how employees perceive the support of their managers when encountering difficulty with the organizational change was broadly related to perceptions of organizational systems and culture. Supportive organizations provide employee assistance programs (Alker & McHugh, 2000) and outplacement programs, such as psychological and career counseling (Rudisill & Edwards, 2002) that help with methods of job search and interviewing skills. However, there is little research about the emotional effects of perceived organizational support during periods of change. This omission in the literature is surprising given that organizational change is often very stressful (Moyle & Parkes, 1999; Robinson & Griffiths, 2005) or least emotionally demanding.

These empirical works are aimed at providing evidence of how the constructs of emotional labor and perceived organizational support add to the understanding of affective culture and how it influences employee reactions to everyday events and in particular, with the experience of change. My discussion of organizational cultural, change and emotions in healthcare mergers, acquisitions and consolidations has important consequences for the narrower domain related to factors that influence the merger experience outlined below.

**Factors that Influence the Merger Experience for the Nurse Leader**

The literature that explores the *nurse leaders* experience before, during, and after merger phenomenon is limited within healthcare research. I choose to explore these considerations as outlined in the organizational behavior and change management literature and focused my research in the nursing management, education and business (healthcare) writings.
The role of the nurse leader is complex. Nurses are considered the heart and soul of hospitals. Nurses are the cornerstone of the U.S. health care industry as they not only offer care and comfort, but also serve as role models for good health care (IOM, 2011). The American Organization of Nursing Executives has contended that nursing leadership/management is as much a specialty as any other clinical nursing specialty (American Organization of Nursing Executives, 2011). Nurse leaders are expected to have competency in: communication and relationship building; knowledge of the healthcare environment; leadership; professionalism; and business skills (American Organization of Nursing Executives, 2011). Additionally nurse leaders are experienced at providing interdisciplinary care coordination, facilitating care planning, serving as a physician liaison, encouraging quality improvement and adhering to evidence-based practices, mentoring and coaching less experienced nurses, and communicating with the patient and family (American Organization of Nursing Executives, 2011; IOM, 2011).

In understanding the nurse leader’s experience related to healthcare merger and acquisition the following seven theories (appraisal theory, anxiety theory, identity theory, acculturation theory, role conflict theory, job characteristics theory, and organizational justice theory) uncovered the complexities of the relationships and the myriad of personal, sociocultural, physical and contextual layers or dimension of experience.

There are few research studies focused on emotions in mergers and acquisitions. One of the few exceptions is Keifer and Eicken’s (1999) research in the banking industry. They viewed emotions as an essential and helpful part of a working experience instead of considering emotions as a disturbing factor. The outcome of this study is a framework based on four categories from organizational psychology: work tasks, personal situation, and relationship(s) with organization and social relationships (Keifer & Eicken, 1999). A shortcoming of this study
was that only one company was involved and within the company, and only two departments were approached.

Another example of emotion research in the context of a merger and acquisition was through a quantitative study by Fugate, Kinicki and Scheck (2002). This research relied on cognitive appraisal theories and emphasized that appraisal and emotions are not identical. A drawback of this study is it limited in context which consisted of a single merger and involved only one group of employees.

Although not driven by theory, the existing literature focused on the human side of merger and acquisition contained a large accumulation of descriptive data regarding how employees respond to stressors of the experience with merger and acquisition-related organizational change. Based on the review of books, articles in the academic and practitioner literature, seven theoretical themes have implicitly or explicitly formed the basis for explaining employees’ psychological and behavioral responses to merger and acquisition-related organizational change. By extension, it is logical that nurse leaders may experience these same constructs as “employees” and additionally, when they are leading nurses who care for patients; as such, they are presented as factors that may influence the merger experience.

**Emotional Labor Theory/Appraisal Theory**

In Hochschild’s (1983) seminal work on emotional labor theory, she asserted that “beneath the difference between physical and emotional labor there lies a similarity in the possible costs of doing the work: the worker can become estranged or alienated from an aspect of self – either the body or the margins of the soul – that is “used” to doing the work” (Hochschild, 1983, p. 7). There are two kinds of emotion regulation: antecedent-focused emotion regulation, which modifies initial feelings by changing the situation or the cognitions of the situation; or a response-focused emotion regulation, which modifies behavior once emotions are experienced
by suppressing, faking or amplifying an emotional response. Appraisal theory is the idea that emotions are extracted from our evaluations (appraisals) of events that cause specific reactions in different people (Hochschild, 1983). Essentially, the internalized appraisal of a situation causes an emotional, or an affective response that may be based on that interpretation (Marks & Mirvis, 1999). Many current theories of emotion now place the appraisal component of emotion at the forefront in defining and studying emotional experience. The spectrum of emotions experienced ranges from very “negative” to quite “positive.” Most of the affected organizational members feel irritated and insecure. They are not (immediately) able to see the upcoming changes as a positive challenge. According to the appraisal theorists, employees’ anxieties seep over to their personal lives to partners and children, and become also the latter’s problem (Applebaum, 2000; Cartwright & Cooper, 1996; 2000; Marks, 1999). In a merger, employees may feel overcome by a sense of helplessness, degradation, impotence, and worthlessness and respond with bitterness, anger, and rage against the decision-makers and the acquiring organization (Cartwright & Cooper, 2000).

In most of the merger and acquisition cases, the acquiring company takes it for granted that they are doing better than the “weaker” organization (Marks, 1999). This situation is similar in more ‘equal’ relationships when persons in a leading position meet their new colleagues in order to find potentials for future synergies. They have to check who produces the better potentials for future synergies. The internal conflicts for positions, privileges and projects lead to emotions like jealousy, mistrust, and suspicion (Applebaum, et al., 2000; Cartwright & Cooper, 1996; 2000; Marks, 1999) (emphasis added). Considering the stressful situation and people’s high involvement and vulnerability, it is difficult to come to objective assessments and valuations. Staff from the acquired or subordinate organization can often feel disappointed and
ashamed of being judged ‘unsuccessful’ and of feeling exhausted (Cartwright & Cooper, 1996; 2000) (emphasis added) by their new acquiring organization.

In merging organizations, there are usually not many individuals who experience joy and pride after the announcement, and if so, they are more likely to be found within the acquiring organization (Marks & Mirvis, 1993) (emphasis added). Many employees fear to lose their position, power or even jobs. Emotional reactions (in others and in ourselves) contain information that we use in our everyday lives and help us understand emotions during change. Most of the psychology of emotions suggests that emotions in theory are best viewed as rule based (Lazarus, 1991; Parkinson, 1995; Scherer, 1984) and not chaotic or irrational, as most of the change literature implies. This means that there is a specific logic behind the experience of emotions. The quality and intensity of emotions gives us some insight into the way in which the person interprets the events in the environment (Lazarus, 1991). Emotion is always a result of an individual’s appraisal of the environment (Lazarus, 1991). Experiencing emotion means that the ongoing events are important to our life and our identity and these emotions may be for a period of yearning and searching for what has been lost (Kets de Vries & Balazs, 1997).

**Anxiety Theory**

Within the merger and acquisition-related emotion studies the examination of anxiety seems to be relatively popular (Cartwright & Cooper, 1993; Marks & Mirvis, 1999). Within this literature there is a noticeable tendency to focus on fears of employees in the acquired organization: fear of losing jobs, power, company names and work-related identity. It is a general observation that employees experience a high degree of anxiety when facing the possible occurrence of merger and acquisition (Cartwright & Cooper, 1993; Ivancevich, Schweiger, & Power, 1987). This anxiety can manifest itself in different ways for different organizational members at different times during the merger and acquisition process. Employees experience
anxiety as they try to cope with uncertainty by predicting the impact of the merger and acquisition on their future jobs and careers (Marks & Mirvis, 1985; Rentsch & Schnieder, 1991). The perceived threat of job loss can lead to increased worry and feelings of distress (Bockner, Grover, Reed, & Dewitt, 1992). This anxiety can result in self-survival instincts in which employees engage in political maneuvering to protect their status, power and prestige (Schweiger, Ivancevich, & Power, 1987). This maneuvering can create destructive competition that negatively impacts organizational performance (1987).

In a hospital merger and acquisition setting this can be a challenge for all staff and especially, with leaders. Managers tend to isolate themselves from employees because they do not know what to tell their staff or how to share with staff (Gutknect & Keys, 1993; Mirvis, 1999) information that is unclear or ambiguous. It follows that managerial emotion(s) influences employees’ emotions, attitudes and behaviors based on this iterative and/or reflexive process.

Identity Theory

According to identity theory (Ashforth & Mael, 1989; Kramer, 1991), there are parts of an individuals’ identity that is derived from membership in groups, organizations and professions. Several social identities can be impacted by a merger or acquisition process including: organizational identity, professional identity, and work group identity. Employees in the subordinate organization who believe that the other organization has a negative image can attempt to de-identify with the new organization and continue to honor the old organization (Terry & O’Brien, 2001).

Mergers and acquisitions can have a considerable impact on the psychological bond between employees and the organization. The re-composition of organizational identification after a merger (or during the integration process) is not easy, particularly when the two organizations have perceived each other as competitors in the past (Irrmann, 2002). Social
identification can be defined as a sense of belonging to a group and sharing its fate (Hogg & Abrams, 1988). In a hospital merger, this means that the individual considers group success as a personal success and group failure as an individual failure (emphasis added). According to Irmann (2002), social identification is composed of three factors: (a) how intensely individuals identify with the group; (b) how proud they are of the group; and (c) whether or not they feel themselves to be typical group members. Van Kippenberg (2002) analyzed social identity processes in mergers and acquisitions and results suggest that organizational identification after a merger depends on the members’ perceptions of both the pre- and the post-merger identities. This sense of continuity is argued to be dependent on the extent to which the individual’s own pre-merger organization dominates (or is dominated by) the merger partner (Van Kippenberg, 2002).

**Acculturation Theory**

As applied from anthropology, acculturation is defined as changes in both groups that occur as a result of contact between cultural groups (Berry, 1980). Merger and acquisition researchers have argued that the acculturation process also applies during merger and acquisition that involves the combination of different organizational cultures (values, beliefs, or practices that define an organization) or imposing one over another (Elsass & Veiga, 1994; Nahavandi & Malekzadeh, 1988). Cultural integration deals with the question of how far two organizational cultures should be maintained or assimilated. It tries to solve the question of according to which norms and values the merged organization should live and work, and which messages should be transmitted to the environment.

Cultural fit plays a role: two very similar cultures will have fewer conflicts in agreeing on a common integration mode to adopt than two dissimilar cultures. According to identity theory, the extent of identification with their own in-group influences staff member commitment, the
readiness to leave one’s own organizational culture and the willingness to adopt another identity (Terri, Callan & Sartori, 1996). In hospital mergers this can be particularly complex because in hospital settings, different cultures exist within each hospital (within an individual hospital unit level) and at the healthcare system level.

**Role Conflict Theory**

Role conflict theory suggests that psychological tension occurs when individuals are engaged in multiple roles that are incompatible (Katz & Kahn, 1978). Role ambiguity refers to uncertainty about what is expected in a role. The merger and acquisition integration process may involve disrupting the existing cultural, structural and job arrangements and creating new arrangements. However, the literature indicates that the integration transition processes are not clear-cut or short term, often meaning that there could be long periods of organizational drift (Marks & Mirvis, 1992), which may result in role conflict and ambiguity. For example, in hospital merger and acquisition, a considerable conflict issue may be found in role redundancy and the need to flatten organizational hierarchies, or with changing managerial span of control, or role clarification issues.

In a hospital, nurse leaders are situated in a unique position as they are sandwiched between the front-line caregivers and senior level administrators. Their challenge is to define the parameters within which team member’s function. Nurse leaders uphold and model the organizational value system and focus on the core business of patient care (Dunham-Taylor & Pinczuk, 2010). Nurse leaders bind the organization together within the internal environment so that team members are galvanized into compassionate action for patient-centered care. In a hospital merger, this role can breed conflict as organizational values change and new role definitions make old paradigms dysfunctional.
Organizational Justice Theory

Merger and acquisition involve decisions regarding reselecting and displacing employees. Organizational justice theories provide important theoretical insights regarding how decisions can affect the surviving employees’ perceptions and behavior (Cobb, Wooten, & Folger, 1995). Employee reactions to organizational change can be influenced by the following three types of fairness perceptions: (a) distributive justice (Adams, 1965), which is the fairness of outcomes received compared to an individual’s standard of fairness; (b) procedural justice (Thibaut & Walker, 1975), which is the fairness of procedures used to determine the outcomes; and (c) interactional justice (Tyler & Bies, 1990), which is how the organizational members are treated by those responsible for determining procedures and outcomes and how they are communicated to throughout the process. For example, hospital staff may perceive and/or differentiate the frequency of merger processes (like benefit and compensation calibrations) with the integration process (who stays in the unit/who leaves the unit), the planning involved in change (how well it is communicated), and the impact of the merger integration (positive or negative), as it provides new ways of conceptualizing and measuring salient features of change that individuals encounter in organizations.

Alternatively, organizational injustice perceptions may lead to powerful negative emotional reactions that can be contagious and lead managers into silence (Abraham, 2000). Organizational injustice perception is also known as organizational cynicism (2000), which is defined as a negative attitude toward one’s employing organization and has a tendency to be disparaging with critical comment and behavior toward the acquiring organization consistent with this belief and affect (Dean, Brandes, & Dhwardkar, 1998). In the example of a hospital merger, the belief that the principles of honesty, fairness, and sincerity may be sacrificed to further the self-interest of the acquiring organization, may lead to perceptions of action based on
hidden motives and deception (mistrust). The affective component of cynicism suggests the arousal of powerful negative emotions including contempt, anger, distress and shame (Abraham, 2000) by nurses and/or their nurse leaders. Cynical beliefs and negative emotions may be both overtly and covertly expressed through harsh criticism of the acquiring organization (Marks & Mirvis, 2010). The motives of even the most genuinely proactive integrative activities of the merger in terms of organizational actions (including patient care, quality imperatives, community initiatives, and employee empowerment), are frequently questioned and pessimism is expressed about their success (Abraham, 2000). During this phase of appraisal, cynicism may overwhelm nurse leaders and futility may deny them the ability to empathize with the acquiring organization’s inability to live up to expectations. These actions can intensify job dissatisfaction and hasten nurse leader withdrawal (Marks & Mirvis, 2010).

The previous section provided information found in the literature that focuses on the human side of merger and acquisition in response to potential stressors of the experience with merger and acquisition-related organizational change. Predominant in the literature are seven theories: emotional labor theory/appraisal theory, anxiety theory, identity theory, acculturation theory, role conflict theory, job characteristics theory, and organizational justice theory, which uncovered the complexities of the relationships and the myriad of personal, sociocultural, physical and contextual layers or dimensions of experience. The following section will provide an empirical review of the literature related to merger, acquisition and consolidations and its potential impact on patient care.

**Mergers, Acquisitions, and the Potential Impact to the Patient Experience**

There has been little research that has investigated the direct impact of hospital mergers on measures of clinical quality (Capps, 2005; Ho & Hamilton, 2000). Two studies use similar methodology, which analyzed the difference in clinical quality measures before and after a
merger (utilizing publicly reported data), as compared to those for non-merging hospitals. Both studied mergers across a five-year time period. Neither finds mergers to have a significant effect on clinical quality, though the relatively small number of mergers and short time period studied may have reduced the power of their analyses (Urden & Walston, 2001).

The evidence that non-merging hospitals raise prices in response to a nearby merger (Dafny, 2009) suggests that non-merger hospitals are responding to quality dimensions. Consolidation may provide access to more additional expertise and resources, the research on the perceived changes in quality affecting post-merger patient access (choice), than this research may yield biased estimates on improving patient care. Nurses spend more time with patients than do any other health care provider and patient outcomes are affected by nursing care quality (DeLucia, Ott, & Palmieri, 2009). Nurses engage in multiple tasks under cognitive, perceptual, and physical overloads that include frequent interruptions of nursing performance, communications on patient handoffs which have a direct impact on patient safety and clinical quality outcomes (DeLucia, et al., 2009).

The data on Medicare hospital admissions for 1997 – 2008 show an annual increase in the complexity of cases treated in acute care hospitals as measured by the Medicare case mix index (AHA, 2012). For the nurse, there is no downtime in the day and no ability to get a few minutes to catch one’s breath, take a lunch or go to the bathroom (Gordon, 2009). While nurses are juggling all these demands, they are under escalating pressure to get the patient out of the hospital. Nurses leaders today are asked to become enforcers of the very ‘throughput’ that they feel jeopardize the patients they care for and which make their job so frustrating (AHA, 2012; Gordon, 2009).

There are no published empirical studies to date that indicate lower patient satisfaction scores that are correlated to hospitals involved in a merger. However, in the present case, there
is anecdotal evidence that patient and employee stakeholder satisfaction and engagement survey scores declined, and markedly so during the timeframe in which this study is investigating.

The conclusions in this section provided substance to the argument of the caring nature of nursing, the undervaluing of that kind of work and the assignment of such work that shape the nurses’ moral view of the issues in a hospital. Nurse leaders play a pivotal role in leading others in pursuit of fulfilling the mission of their organization, and the pressures they face in doing so. The nurse leader has the additional task of making sense of and explaining the effects of organizational changes to the nursing staff, patients and their family members, to hospital administration and physicians.

**Summary**

This chapter was organized into three parts: part one included a review of the shared historical context of hospitals and nursing along with the current healthcare reform and hospital mergers, acquisitions and consolidations. Part two, reviewed relevant literature articulating the theoretical foundations of organizational and change theory, the conceptual and theoretical framework of change phenomena, addressing theoretical approaches to change (including organizational culture/climate) and emotions with competing contextual bases of change. Part three presented an examination of the perception of change by leaders in charge of change implementation and its potential impact to patient care.

This chapter summarized the gap in the existing knowledge on this subject and the topic under investigation. Thus, the qualitative, phenomenological approach involved a return to the experience in order to obtain comprehensive descriptions that provided the basis for a reflective structural analysis that portrayed the essences of the experience of a merger for the nurse leader. The literature reviewed provided the context in which the experience occurred. Understanding the personal experience of the leader who must make decisions that have major impacts on
caregivers’ lives and how they explain the decisions themselves is a leadership imperative for healthcare. The gaps in the literature support the purpose and aims of this study. The following chapter will review the qualitative research methodology used for this study.
CHAPTER THREE: METHODOLOGY

This chapter describes the qualitative phenomenological methodology that was used to research nurse leaders before, during, and after merger and includes discussions around the following areas: rationale for phenomenological research design, sample and selection of participants, methods of data collection, methods and procedures for data analysis and synthesis, issues of trustworthiness and credibility, and limitations of the study. The chapter ends with a brief summary.

Throughout this study, I explored the lived experience of merger for nurse leaders. The aim of this phenomenological study was as follows: (a) to understand the nurse leaders’ lived experience before, during, and after a merger; and (b) to explore and gain insight and understanding into the experiences of nurse leaders who have led, managed, and guided others through a merger in healthcare; and (c) to appreciate the attributes of the experience that led to meaning-making for nurse leaders. In seeking to understand this phenomenon, this study addressed three research questions:

1. What is the nurse leaders’ experience before, during and after a merger?
2. What does it mean to nurse leaders to lead, manage, and guide others through a merger in healthcare?
3. What aspects of the merger experience lead to meaning-making for nurse leaders?

Rationale for Qualitative Research Approach

The leadership literature has largely been quantitative in orientation and a qualitative approach (Creswell, 2007) provides a deeper understanding of leadership and the way it plays out within particular contexts or settings. Qualitative leadership studies, when conducted with the same degree of rigor and concern for validity and quality, have distinct advantages over quantitative approaches by offering opportunities to explore leadership phenomena in significant
depth, and answer “why” types of questions about leadership as opposed to “how” or “what”
types of questions that are answered by quantitative research. Van Manen (1990) argued
compellingly for the unrealized value of qualitative research and called on organizational
researchers to utilize more qualitative techniques.

The qualitative process helps us to find out whether our conceptual framework, which
was extrapolated from literature, made sense or how far it has to be adapted in order to become a
reliable framework. To explore themes, discover patterns and better understand processes and
situations within the merger and acquisition process, a qualitative method approach was the most
suitable (Kusstatscher & Cooper, 2005) for this study of nurse leaders. Since my research
objective was to understand the nurse leader experience, it was clear that a descriptive
interpretative phenomenological approach was applicable.

**Distinct Features of Phenomenology**

There are at least three features of phenomenology that distinguish it from other
qualitative traditions. First, the phenomenological approach involves a return to the experience
by qualitative inquiry in order to obtain comprehensive descriptions that provide the basis for a
reflective structural analysis to portray the essence of the experience (Creswell, 2009;
Moustakas, 1994; van Kaam, 1966). The approach “seeks to disclose and reveal the phenomena
of behavior as they manifest themselves in their perceived immediacy” (van Kaam, 1966, p. 15).
The researcher determines the underlying structures of an experience by interpreting the
originally offered descriptions of the situation in which the experience occurred (Moustakas,
phenomenology is to transform lived experience into a textual expression of its essence in such a
way that the effect of the text is at once a reflexive reliving and a reflective appropriation of
something meaningful” (van Manen, 1990, p. 36). A good description that comprises the
essence of an experience is constructed so that the structure of the lived experience is revealed to
the reader who may then grasp the nature and significance of the experience.

“Phenomenological themes may be understood as the structures of experience” (van Manen, 1990, p. 79). The aim is to determine what an experience means for the persons who have had
the experience and are able to provide a comprehensive description of it. Moustakas (1994)
viewed experience and behavior as an integrated and inseparable relationship of a phenomenon
with the person experiencing the phenomenon.

Second, phenomenology is considered to be both a philosophy and a qualitative research
Phenomenology attempts to explain the meaning of the human experience (Husserl, 1967). “The
phenomenologist views human behavior, what people say and do, as a product of how people
define their world” (Taylor & Bogdan, 1984, p. 8). Phenomenology, like the concept of
enactment (Weick, 2001), is based on the assumption that reality is socially constructed.
Therefore, an attempt to understand the experience of a person or group must “capture” it as they
see it by using their own words and phrases through in-depth interviewing (Creswell, 2009;

Third, the phenomenologist asks, “What is the meaning, structure and essence of this
phenomenon for this group of people?” (van Manen, 1990). In contrast, an ethnographer can
study the same group, but when asking the same question, “What is the culture of this group of
people,“ they would be more interested in how the group interacts with each other rather than the
experiences they have with one another (van Manen, 1990). What can be uncovered by a
phenomenological approach is not sweeping generalizations but contextual findings (Maykut &
Morehouse, 1994). In-depth interviewing as a qualitative research technique means face-to-face
encounters between the researcher and informants and was directed toward understanding
informants’ perspectives on their lives, experiences and situations as expressed in their own words (Moustakas, 1994). This phenomenological methodological approach was open and emergent to permit exploration, rather than rigid and fixed (van Manen, 1990; 2014).

Similar to ethnography, phenomenological researchers use “bracketing” which ensures that the research is not affected by researcher bias (Moustakas, 1994; Munhall, 1994; van Manen, 1990). Because analysis ultimately rests with the researcher, qualitative studies are limited by researcher subjectivity. Therefore, an overriding concern was that of my own researcher bias, framing it as my assumptions, interests, perceptions and needs. Throughout this research study, I have attempted to set aside my experiences and suspend my beliefs so that a description about the phenomenon was not contaminated with my own researcher bias.

**Phenomenological Methodological Design**

Phenomenology seeks to explore, describe, and analyze the meaning of individual lived experience: “how they perceive it, describe it, feel about it, judge it, remember it, make sense of it, and talk about it with others” (Patton, 2002, p. 153). Analyses proceeds from the central assumption that there is an essence to an experience that is shared with others who have also had that experience (Moustakas, 1994; van Manen, 1990). The methodological design for conducting this phenomenological research study was informed by Moustakas’ (1994) approach. Data was collected from the individuals who experienced the phenomenon. Often data collection and phenomenological studies consist of in-depth interviews and multiple interviews with participants (Moustakas, 1994; Polkinghorne, 1989). Van Manen (1990) mentions making sense or meaning-making requires that the participants look at how the factors in their lives interact to bring them to their present situation. It also requires that they look at their present experience in detail and within the context in which it occurs. The combination of exploring the past to clarify the events that led participants to where they are now, in describing the concrete details of their
present experience, establishes conditions for reflecting upon what they are now doing in their lives. The very process of putting experience into language is a meaning-making process (Vygotsky, 1987). When we ask participants to share the narrative of their experience, they frame some aspect of it with a beginning, middle, and end, and thereby make it meaningful (van Manen, 1990).

Methods of Data Collection

This study utilized a semi-structured interview protocol as the primary approach for data collection. The purpose of interviewing is to allow researchers to enter into the other person’s perspective. This study incorporated the ideas presented by Seidman (2006) in his book, *Interviewing as Qualitative Research: A Guide for Researchers in Education and the Social Sciences 3\textsuperscript{rd} Edition*, for the interview protocol for this study. Vygotsky (1987) stressed that; “every word that people use in telling their stories is a microcosm of their consciousness” (p. 236). “It is this process of selecting the details of experience, reflecting on them, giving them order, and thereby making sense of them that makes telling stories a meaning-making experience” (Seidman, 2006, p. 7).

There are no absolutes in the world of interviewing. Relatively little research has been done on the effects of following one procedure over others; most extant research has conceived of interviewing in a stimulus-response frame of reference, which is inadequate to the in-depth procedure (Brenner, Brown, & Canter, 1985; Hyman, Cobb, Fledman, Hart, & Stember, 1954; Kahn & Cannell, 1960; Mishler, 1986; Richardson et al., 1965).

The participants were asked two broad general questions: *Describe what have you experienced in terms of the phenomenon [what does it mean to lead, manage and guide nurses through a merger]? How can you describe the contexts or situations that have typically influenced or affected your experiences of the phenomenon [before, during or after a hospital*
Other open-ended questions were also asked, but these two focused attention on gathering data that led to a textural description and a structural description of the experiences, and ultimately provided an understanding of the common experiences, of all the study participants, and ultimately provided understanding of the common experiences of the participants. Further, I followed HSRB protocol and have safeguarded all my data collected throughout all phases of this research study and post-study.

**Interview Protocol**

The semi-structured interview is a qualitative data collection strategy in which the researcher asks informants a series of predetermined but open-ended questions (Ayres, 2008). I conducted the first interview utilizing Interview Protocol # 1 (see Appendix A) to learn about the experience of the participants to lead, manage and guide others through a merger and Interview Protocol # 2 (see Appendix A) to learn about aspects of the experience that leads to meaning-making before, during and after the merger. These types of open-ended questions give participants an ample opportunity to guide the conversation and talk about what seems salient to them. In order to ensure interpretive validity, I avoided asking leading questions, and also avoided them during the actual interview process.

**Sample and Selection of Participants**

The community is one that is defined by its population: where people live, where they gather, the places that are important to them; and the characteristics of those places can tell you a great deal about the people who make up the community. Their self-image, many of their attitudes, and their aspirations are often reflected in the places where they choose to live, work and play. For greater than a century and classified as a large community hospital, caregivers from this study delivered coordinated medical services to patients presenting with complex acute and chronic problems specialty care from birth to end of life for people who may have acute
needs or who live with chronic illnesses such as diabetes, cancer, heart and respiratory disease, neurologic disorders, renal disease and digestive disorders.

Purposive sampling was used for this study. Sixteen nurse leaders were selected for participation in this research study as they all had experienced the phenomena of acquisition and merger of their community hospital by an integrated healthcare delivery system. All sixteen nurse leaders were willing to talk in-depth about their merger experiences and they voluntarily participated in the study, knowing that I would protect their identity by referring to them as “nurse leader” or by a selected pseudonym and not by their actual names.

As previously stated, my primary data were obtained from two in-depth, open-ended interviews with each nurse leader, in which I used a prepared interview protocol to explore the participant experience (Appendix A). Prior to commencing the interviews, we discussed the research study consent form (Appendix B) and signed it prior to the first interview. The nurse leaders were audio-recorded during each interview. Participants selected the date(s), time(s) and location(s) of their interviews. Each individual interview lasted between sixty and ninety minutes. Once the study was approved (see Appendix C), the data collection of interviewing was completed within a three-month period, thus increasing the quality of the relationship that had to be established between the participants and myself. Each participant was given an opportunity to select a pseudonym to protect her identity.

The second interview for each nurse leader was scheduled at least four days but no more than fourteen days from the first interview setting (Seidman, 2006; van Manen, 1990). Seidman (2006) described spacing of the two interviews as important as this “allows the participant to mull over the preceding interview but not enough time to lose the connection between the two” (p. 21). An open-ended timeframe can produce undue anxiety for the informants. Given that the purpose of this approach is to have the participants reconstruct their experience, put it in context
of their lives, and reflect on its meaning, anything shorter than 60- to 90-minutes for each interview seemed too short. The two-interview structure works best when the researcher can space each interview from one week to two weeks apart (Moustakas, 1994). This allowed time for the participant to mull or cogitate over the preceding interview but not enough time to lose the connection between the two. In addition, the spacing allowed the researcher to work with the participants over a two to three-week period. This passage of time reduced the impact of possibly idiosyncratic interviews. That is, the participant might be having a terrible day, be sick, or be distracted in such a way as to affect the quality of a particular interview.

Approximately forty-two hours of face-to-face interviewing took place from May 31, 2013 through July 3, 2013 with the nurse leaders. Upon completion of the interviews, the audiotapes were transcribed verbatim. In total, over 645 pages of single-spaced transcripts or 25,579 lines of transcripts were derived from the qualitative interviews.

**Narrative Structure**

Patton (1989) mentions that people’s behavior becomes meaningful and understandable when placed in context of their lives and the lives of those around them. Marshall and Rossman (2010) described that, “qualitative in-depth interviews are much more like conversations than formal events with predetermined response categories” (Marshall & Rossman, 2010, p. 108). They also mention, “interviewers should have superb listening skills and be skillful at personal interaction, question framing, and gentle probing for elaboration” (Marshall & Rossman, 2010, p. 110). Bertaux (1981) stated that “if given the chance to talk freely and openly, people appear to know a lot about what’s going on” and have a desire to share their experiences (p. 24). Creswell (2009) added, “asking appropriate questions and relying on participants to discuss the meaning of their experiences requires patience and skill on the part of the researcher” (p. 130). I provided the participants with enough time to reflect and to form clear answers to the questions.
This allowed the participants to fully describe and share the meaning of their experiences without being rushed.

Munhall (1994) suggested that listening is an art, and silence or stillness is very important: “both the researcher and the participant can gain reflection about the experience” (p. 90). Colaizzi (1978) stated that when researchers listen to the participant, they should use what is termed as imaginative listening. Colaizzi (1978) affirmed that “the researcher listens to participants with more than just her ears; she must listen with the totality of her being and with the entirety of her personality” (p. 64). At the heart of what it means to be human is the ability of people to symbolize their experience through language (Heron, 1981). It was my desire to be wholeheartedly present with the narratives of each nurse leader during each and every interview.

Eliminating my influence was impossible (Hammersley & Atkinson, 1995), and my goal in my study was not to eliminate my influence, but to understand my perspectives and the essence of my own experience and to use it productively. I treated each participant with the utmost respect for their well-being above the research itself, and ensured the trusted relationship between the participant and myself as researcher, with their description of their experience shared with me, and in support of the mutual respect we demonstrated to each other (Munhall, 1994).

I described my epochal personal experience with the phenomenon under study and outlined my full description of my experience of the merger. This was completed in an attempt to set aside my personal experiences so that the focus of my study can be directed to the participants in my research. My analysis was ongoing and iterative in order to interpret and identify emergent themes, patterns and additional questions. I used coding and matrices for comparison across interviews and interview summaries to retain the context of the information that I received from the nurse leaders.
Codes anticipated and developed from theoretical frameworks may have been used to frame some data collection efforts (*emic*: perceptions, impressions, conceptions, beliefs that are expressed by participants in making sense of their experience; *theoretical* – theoretical terms that may be inferred from the data). In order to represent and/or visualize my data analysis, information collected was presented narratively and augmented by figures that are presented in chapter four, and through an infographic sketch (see Appendix D) that depicts my entire doctoral dissertation journey with this topic. Based on qualitative methodology, I incorporated *emic* perspectives with the participants in making sense of their experience (Maxwell, 2005).

**Role of the Researcher**

The focus of this research study was from the participant’s perspective on the phenomenon of interest and unfolded as the participant viewed it, not as I viewed it (Marshall & Rossman, 2011; Moustakas, 1994). As an employee of a community hospital, the subject of mergers captured my interest and attention for several reasons. First, since I had never been involved in a merger and because I eventually found myself living these experiences, the topic of merger took on a new meaning and level of importance for me. Second, I experienced a range of emotions from excitement and intrigue, fear and frustration, to relief through personal transformation. Third, my doctoral studies in leadership studies and policy within the context of education and human development, my work experience, and recent consolidation within the healthcare sector, led me to the topic of mergers for nurse leaders and its impact on their followers/caregivers, namely nurses. It was my hope to further the literature of knowledge to understand the experience for greater emphasis on the human implications in health care merger-related strategies.

My role as the researcher primarily used open-ended interview questions with a major task to build upon and explore my participants’ responses to those questions. The goal was to
have the participant describe and reconstruct her experience of merger as a nurse leader. A hallmark of qualitative interviewing is its emergent design (Maxwell, 2005). The design remains flexible as the interviewing process continues with few or no a priori assumptions.

In addition, my role as the researcher assured the participants and the audience at large, that I had taken the necessary steps to protect the rights of the participants and that the participant’s voluntarily participated in the research. It was my role as the researcher to anticipate sensitive ethical issues that may have arisen which are described in the next section.

**Ethical Considerations**

I received approval from the Human Subject Review Board (HSRB) on campus (see Appendix C), and obtained the appropriate cooperation agreement through authority at the integrated health system institution. The HSRB exists on campuses because of federal regulations that provide protection against human rights violations. These review board requirements helped me assess the potential risk, such as physical, psychological, social, economic or legal harm to participants in my study.

Informants were assured of confidentiality, both for themselves and for the institution. The informed consent for the study consisted of a statement introducing the study, explaining the benefits and risks of participation and an outline of the protection of confidentiality and the right to withdraw from the proposed study. All interviews were coded, with no names appearing on transcripts, and I maintained a separate file of code identities.

All information was reported in aggregate format; any quotations used as exemplars were de-identified. Personal information about the participants included, among other things, name, current position, number of years as a nurse leader, the informants educational preparation (initial and current), and memberships in professional associations. It is important to note that
ethical issues for this study did not stop with approval of the study, the data collection process or with data analysis (Creswell, 2012).

**Methods and Procedures for Data Analysis and Synthesis**

Phenomenological data and analysis procedural steps are generally similar to the phenomenological discussions regarding the methods (Moustakas, 1994; Polkinghorne, 1989). Building on the data from the first and second research questions, data analysis or data transformation included the *Stevick-Colaizzi-Keen Method* (Moustakas, 1994) and highlighted “significant statement” sentences, or quotes that provided an understanding of how the participants experienced the phenomenon. Moustakas (1994) calls this step *horizontalization* or delimiting to invariant horizons and meaning units. Next, I developed *clusters of meaning* from these significant statements into themes. These significant statements and themes were used to write a description of what the participants experienced or the *textual description*. These were used to write a description of the context or the *structural description*.

From the structural and textural descriptions, I developed a composite description that presented the structural meanings and *essence* of the phenomenon, these are the universal invariant structural themes of a merger that facilitated a description of leading through merger as it is experienced by nurse leaders and/or the focus of the common experiences of the nurse leaders (Moustakas, 1994) which will be further developed and discussed in chapter four.

Following the organization, presentation, and analysis of data derived from my phenomenological investigation as described in chapter four, I summarized the study in its entirety and considered possible limitations. I returned to literature and distinguished my findings from prior research, outlined future research projects that may advance knowledge on the topic, and discussed the outcomes of this investigation in terms of social meaning and implications as well as personal professional values. Further, findings from this study inform
human resource development practitioners and policy related to strategies for mitigation of nurse leader burnout and retention, and is presented in chapter five.

**Issues of Trustworthiness and Credibility**

A critical moment in the development of qualitative methodologies occurred when Lincoln and Guba published *Naturalistic Inquiry* in 1985. Their work addressed central questions that determine the trust we have in research: Do we believe in the claims that this dissertation report will put forth? On what grounds do we judge these findings as credible? Are the results potentially useful for the problems we are concerned with? Lincoln and Guba (1985) put forth alternative constructs to capture concerns as: *credibility, dependability, confirmability and transformability*. Moreover, they offered a set of procedures to help ensure that these standards of trustworthiness would be met. The following paragraphs outline procedures that were used in producing this generative report while ensuring trustworthiness and are further articulated in chapter five.

**Credibility**

The criterion of credibility suggests whether the findings are accurate and credible from the standpoint of me (as the researcher), the participants, and the reader(s) of this report. This criterion becomes a key component of the research design (Creswell, 2009; Maxwell, 2005; Miles & Huberman, 1994; Moustakas, 1994). I did not seek to verify conclusions, but rather to test the validity of conclusions reached, which entailed a concern for both methodological and interpretative validity.

The focus of this research was on what it means to nurse leaders’ to lead, manage and guide others through the experience of a hospital merger. In order to capture this experience and enhance credibility of the results, I consulted a number of different sources. I used a number of different media for data collection: interviews and a variety of hospital generated data. I talked
to various nurse leaders in the merged hospital in an attempt to consider the situation and experience from different viewpoints and considered this triangulation of the data. Eliminating my influence was impracticable (Hammersley & Atkinson, 1995), and my goal with this study was not to eliminate my influence, but to understand my perspectives and the essence of my own experience and use it productively. Hammersley and Atkinson (1995) called reactivity “reflexivity” as I was part of the phenomenon (merger/acquisition) that was studied.

The credibility or truth value of findings were ascertained by spending significant time with participants in exploring the nurse leaders’ experience in sufficient detail, audiotaping interviews for comparison with coded data, clarifying tentative findings with the participants, and checking multiple sources of data, written records, field notes and, so on. These procedures add to the credibility of this study and will be further described in chapter four.

As my study progressed, I sought “member verification” as an appropriate way to counter the possibility of misinterpreting the meaning of what participants said and described, and the perspective they had on what I found and observed through respondent validity. Throughout my study I enhanced credibility and reduced bias by extending the time to study and observing the nurse leaders; building trust with the nurse leaders to access more detailed and honest information; identifying my biases and experiencing preferences, and offering participants an opportunity to validate the accuracy of the verbatim.

**Dependability**

Reliability in the quantitative tradition refers to the extent that research findings can be replicated by other similar studies. Qualitative research generally does not cover enough of an expanse of subjects and experiences to provide a reasonable degree of reliability. As argued by Lincoln and Guba (1985), the more important question becomes one of whether the findings are consistent and dependable with the data generated. Thus, it became incumbent upon me to
document my procedures and demonstrate that my selection of meaning statements, coding schemes, and interpretative meaning statements that I generated were appropriately constructed and checked by my expert dissertation methodologist and will be more fully expanded on in chapter four.

**Confirmability**

The concept of confirmability corresponds to the notion of objectivity in phenomenological research. The implication is that the findings are the result of the research, rather than an outcome of the biases and subjectivities of myself, as the researcher. To achieve objectivity, I had to be reflexive and illustrate how my data could be traced back to its origins. As such, the audit trail (Lincoln & Guba, 1985) or transparency I highlighted to my expert dissertation methodologist was done to demonstrate dependability. Additionally, I included ongoing reflection in my journaling, as well as recording my transcripts, and field notes as a means to offer the reader an opportunity to assess the findings of this study.

Furthermore, in order to judge the quality of this phenomenological study I inferred criteria from the core facets of transcendental interpretive phenomenology (Moustakas, 1994, p. 58). Polkinghorne (1989) identified five questions that researchers should ask themselves in order to judge the quality of the findings, which I included, reviewed and captured throughout my research study:

1. *Did the interviewer influence the contents of the participants’ descriptions in such a way that the descriptions do not truly reflect the participants’ actual experience?*

2. *Is the transcription accurate, and does it convey the meaning of the oral presentation in the interview?*
3. In the analysis of the transcriptions, were there conclusions other than those offered by the researcher that could have been derived? Has the researcher identified these alternatives?

4. Is it possible to go from the general structural description to the transcriptions and to account for the specific contents and connections in the original examples of the experience?

5. Is the structural description situation specific, or does it hold in general for the experience in other situations (Polkinghorne, 1989).

Additionally, throughout my study I journalized my own reflections, concerns, and uncertainties during the study and referred to them while examining the data and I carefully examined unusual or any contradictory results for explanations and considered them as “outliers.” I utilized a variety of data sources to confirm and/or to corroborate participant information and considered this the triangulation of my study.

**Transferability**

Although generalizability is not the intended goal of this study, what was addressed was the issue of transferability (Lincoln & Guba, 1985). Transferability shares the ways in which the reader determines whether and to what extent this particular phenomenon and this particular context can transfer to another particular context. As previously mentioned, the context of this study was bound by a community hospital (subordinate organization) joining a large integrated healthcare system. With regard to transferability, Patton (1990) promotes thinking of “context-bound extrapolations” (p. 491), which he defined as “speculations on the likely applicability of findings to situations under similar, but not identical, conditions,” (p. 489).

In order to advance transferability, I attempted to address the issue by way of thick, rich descriptions provided by the participant nurse leaders, and the context in which they described it.
Depth, richness, and detailed description provide the basis for a qualitative to advance the broader context (Maxwell, 2005; Moustakas, 1990).

**Limitations of Study**

As mentioned in chapter one, all research projects have limitations; none are perfectly designed. As Patton (1990) notes, “there are no perfect research designs; there are always trade-offs” (p. 223). As such, I make no overweening claims about generalizability or conclusiveness about what I have learned. Phenomenology is a form of inquiry that does not yield generalizations in the usual empirical sense (van Manen, 1990). This study is limited in its generalizability for several reasons. First, the population for this study includes only nurse leaders from a non-profit large community hospital, which recently merged. Political climates, contextual personal histories of nurse leaders, state policy and health care resources may vary across geographies; and as a result, nurse leaders may respond to and experience mergers differently.

Second, health care research suggests that institutional mergers are difficult (AHA, 2010). In this study, through interview conversation, I gained insight into the nurse leader’s experience in the merger process thus far. The existential generalization made it possible to recognize recurring aspects of the meaning of the phenomenon of merger faced by nurse leaders. It is expected that the nurse leaders’ understandings will continue to change over time. Since the nurse leaders’ experiences continue to change, it is expected that the results of this study would vary if it were conducted at a different time in the merger process.

Finally, the U. S. Federal Trade Commission issued an administrative complaint challenging this merger as violating Section 7 of the Clayton Act. Thus, the normal integration period is stayed pending an administrative appeal seeking review. This extended duration of integration activities may have an impact on the merger experience by these nurse leaders due to
prolonged litigation that is not often accorded during mergers and acquisitions in the healthcare industry.

This qualitative phenomenological study offered a way of interrelating subjective and objective factors and conditions, a way of utilizing nurse leader description, reflection, and imagination in arriving at an understanding of what is, and seeing the conditions through which what is common to be, and in utilizing a process that in its very application opens possibilities for awareness, knowledge, and action. I returned to the literature in chapter five and distinguished my findings from prior research, and developed a future research agenda to advance knowledge on the topic, discussed the outcomes of the study in terms of social meanings and implications as well as personal and professional values.

**Summary**

In this chapter, I have explored the basics of phenomenological methodology as my chosen philosophical underpinning chosen for the research method of this project. Phenomenology can be quite difficult to grasp, yet due to its humanistic and ineffable qualities, it was useful in gaining a deeper understanding of nurse leadership experience and inquiry within the context of healthcare acquisition, merger and consolidation.
CHAPTER FOUR: ANALYSIS OF DATA

This chapter organizes and reports the study’s main findings, including the relevant qualitative narrative data. Phenomenology does not just aim for the clarification of meaning; it aims for meaning to become experienced as meaningful (van Manen, 2014). Meaningfulness happens when narrative speaks to our existence in such a way that it stirs and touches us. This study intimately explored the lived experiences of nurse leaders before, during, and after the merger of their community hospital into a large integrated health care delivery system. The study was based on these three overarching research questions:

1. What is the nurse leaders’ experience before, during, and after a merger?
2. What does it mean to nurse leaders to lead, manage, and guide others through a merger in healthcare?
3. What aspects of the merger experience lead to meaning-making for nurse leaders?

Discovering the essence of merger came through understanding the narrative and unlocking the meaning of these nurse leaders’ experiences. In this chapter, I present the findings of this study and will include: (a) participant composites; (b) the Stevick-Colaizzi-Keen (1978) phenomenological data analysis process which I applied in analyzing the participants’ transcripts including the description of how I arrived at the significant statements, the formulated interpretive meaning statements, and the explanation of the analysis of textual theme clusters; (c) presentation of the structural descriptions or essential themes, (d) the universal essence of the phenomena; and, (e) verification of the findings from the research participants. This chapter is the foundation for the analyses, conclusions and recommendations that appear in chapter five.

As previously explained in chapter three, my primary data collection methods were obtained from two in-depth, open-ended interviews with each nurse leader, in which I used a prepared interview protocol to explore the participant experience (Appendix A). Participants
selected the date(s), time(s) and location(s) of each of their interviews. Each of the two nurse leader interview(s) lasted between sixty and ninety minutes. The second interview for each nurse leader was scheduled at least four days but no more than fourteen days from the first interview setting (Seidman, 2006; van Manen, 1990). Seidman (2006) described spacing of the two interviews as important as this “allows the participant to mull over the preceding interview but not enough time to lose the connection between the two” (p. 21).

In collecting my data, approximately forty-two hours of face-to-face interviewing took place from May 31, 2013 through July 3, 2013 with the nurse leaders. Upon completion of the interviews, the audiotapes generated were transcribed verbatim. In total, over 645 pages of single-spaced transcripts or 25,579 lines of transcripts were derived from the qualitative interviews.

Though my focus was capturing the descriptions of merger experience from each nurse leader I found each interview offered a warm and tender interaction. As I interviewed each nurse leader, I found that I was transported to a variety of encounters and shared history with each of these very special nurse leaders. I identified with the feelings they conveyed, and understood the emotion, but could only visualize their circumstances. Experience is more perplexing, more complex, more nuanced, and more ambiguous than any written description can do it justice (van Manen, 2014). With the experiences they articulated, I could conjure up in my mind the physicians, staff nurses, ancillary staff, and patients they were detailing, and understood the complexity and density of their feelings. At times, we shared profound emotions together and there were not only tears of sadness, but joy in our laughter. It was particularly important to understand my own researcher biases and as such, I engaged in preliminary self-reflection prior to each interview to uncover my own personal subjectivities. Adhering to, and respecting my semi-structured interview protocol with each nurse leader assisted me toward becoming a finely
tuned research instrument whose experiential biases and insights would be understood consciously (Creswell, 2009; Maxwell, 2005; Moustakas, 1994). Furthermore, I exercised caution in distinguishing between descriptive field notes and judgmental ones. Understanding that my data analyses process included member checking added to my data quality which was situated in scholarly context. At no time did the participants want to stop the interviews, or remove themselves from the study.

I looked upon these participants with great respect, especially the bond that united them as nurse leaders. This respect comes through the shared experiences they engaged in as they were tested as leaders in the challenge of merging their hospital with an integrated health care delivery system. Embedded in these emotions was an endearing social bond they shared with one another, in which they described as loyalty to their vocation that made working for this community hospital more than just a job. What formed was something fundamentally important to their experience as a nurse leader, as they were not simply interchangeable parts in a system of organizational change processes. At the core of this group of nurse leaders was a vulnerability waiting to be recognized and released. Through this shared experience of merger, the insight that they truly valued and needed one another became visible. Their lived experience exposed not only the strong beating heart of nurse leadership, but its brain, muscle, and nerve endings - alert, throbbing, raw and exhausted. Together (but in separate interviews) they described their experiences as one of the most challenging and underappreciated jobs in healthcare: being a nurse leader before, during, and after a merger.

Demographic Data

Table 2 reflects the demographics of the study population. The nurse leader participants were all women from 47 to 60 years of age with a mean age of 54.2 years. The average years serving as a professional registered nurse was 30.8 years. The average number of career service
years at the hospital was 24.9 years. How long they were in a leadership position at the hospital varied from 2.5 to 29 years with a mean of 16.1 years. Only one of the participants had previously experienced an organizational merger; however, that nurse leader participant served at the dominant acquiring institution and had no experience leading in a merger for a subordinate acquired hospital. It is interesting to note that 75% of the nurse leader participants decided to further their personal educational aspirations during this merger experience and were enrolled in an academic program (two enrolled in a doctoral program). Of the 75% of the nurse leaders enrolled in an educational nursing or healthcare administration program, one nurse leader was pursuing a fine arts program in photography.

Table 2:

Demographic Data of 16 Participants

<table>
<thead>
<tr>
<th>Gender</th>
<th>Age</th>
<th>Years as Nurse</th>
<th>Years at Hospital</th>
<th>Years in Position</th>
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<td>1-5 years = 0</td>
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<td></td>
<td>51-55 years = 5</td>
<td>6-10 years = 0</td>
<td>6-10 years = 0</td>
<td>6-10 years = 1</td>
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<tr>
<td></td>
<td>56-60 years = 7</td>
<td>11-15 years = 0</td>
<td>11-15 years = 2</td>
<td>11-15 years = 6</td>
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<td></td>
<td>16-20 years = 1</td>
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<td>16-20 years = 5</td>
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<tr>
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<td></td>
<td>21-25 years = 2</td>
<td>21-25 years = 1</td>
<td>21-25 years = 5</td>
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<tr>
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<td></td>
<td>26-30 years = 4</td>
<td>26-30 years = 1</td>
<td>26-30 years = 0</td>
</tr>
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<td></td>
<td>31-35 years = 5</td>
<td>31-35 years = 4</td>
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<td>36-40 years = 4</td>
<td>36-40 years = 5</td>
<td>36-40 years = 1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Education</th>
<th>Certifications</th>
<th>Changes in Role After-Merger</th>
<th>Pursuing Add’l Education (Before, During, or After Merger)</th>
</tr>
</thead>
<tbody>
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<td>Associate Degree = 2</td>
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<td>Yes = 8</td>
<td>Yes = 12</td>
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<tr>
<td>Bachelor Degree = 10</td>
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<td>Master Degree = 4</td>
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<td>Cert. Case Mgr. = 1</td>
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<td></td>
<td>CEN = 2</td>
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<td></td>
<td>CNOR = 1</td>
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</tr>
<tr>
<td></td>
<td>Nrs. Mgr. Cert. = 1</td>
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</table>

Participant Profiles

In order to gain an understanding of this nurse leader collective the following participant composites allow the readers of this study a small glimpse of whom each of them are individually (each nurse leader selected her own pseudonym). These participant profile composites were developed from the descriptions the nurse leaders shared of what it meant to be a nurse leader; how they came to their vocation; the shared familiarity and meanings of their role described within the two interview settings; and the experiences and history shared with me as the researcher.

Margaret, RN
Margaret has been a registered nurse for 30 years and a nurse leader in staff professional development for 28 years. She has a bachelor of science in nursing and a master of science in nursing with an emphasis in education. Margaret discovered her ideals through a subjective interpretation of the world. Her colleagues describe her as a contemporary Joan of Arc who seeks fulfillment performing noble service through educating the novice to expert nurse. Margaret’s career has been spent helping others obtain a sense of mastery in a particular nursing practice area but also, helping those same nurses understand their limits.

Jane, RN
Jane has been a registered nurse for 34 years and she works as a nurse manager on a Medical-Surgical unit. Her merry-eyes sparkled when she spoke of her experiences in leading professional registered nurses in an acute care setting. Her curly hair swirled enjoyment with the communal energy she finds as an expressively creative nurse leader. Jane loves how we say “see you later” and “keep in touch.” In touch, as if it were a place where people arranged to meet. For Jane, saying goodbye to people who moved into new roles within the system: that was hard. “They haven't left my life but they have left my eyesight and that makes me sad.” Before the merger, Jane described herself as a nurse leader but now sees herself as a therapist, a cheerleader, salesman, and a teacher.

Lynn, RN
Lynn has been a registered nurse for 24 years and a nurse manager for three years. As an experienced critical care nurse with hours of patient explanations and
unfailingly accurate assessments, her expertise could be boiled down to a simple dictum: the worst goes first. The tricky part is to determine within a few seconds who is at death’s door and who is merely exasperated and moaning the loudest. When it comes to nursing leadership the same is often true. The tricky part of nurse leadership is learning to be compassionate and detached in the right ways and, at the right moments. Her caring hands extend not only to the hospital, but also more globally in consistently routine medical mission trips. Although Lynn graduated from nursing school many lifetimes ago, every day in the intensive care unit she starts again. The best nurse leaders are taught by their patients.

**Martha, RN**

Martha became a registered nurse 27 years ago and a nurse leader on her Medical-Surgical unit 18 years ago. She was the only unmarried nurse leader participant. Martha obtained a bachelor of science in nursing and a master of science in nursing with an emphasis in education because she felt like a financial wizard and wanted to learn how to educate others on: empathy, fortitude, knowledge and grace. Martha misses the time she used to spend at the bedside which is now the role of the unit’s patient care coordinator. Learning someone’s story helps to make the patient more real and it makes the job more personal, fulfilling. “What else didn’t we know about the naked, unrestrained man in 225-bed 2? What else about him would have made us more compassionate?” Martha explained after so many years in her unit, she has learned that we are all vulnerable, we are all a little crazy, and, we are all funny, entertaining, delicate, horrible, and fantastic. “We are all, in our unique and individual ways, as equally and universally fucked up as the next person.” Martha finds comfort in knowing this.

**Victoria, RN**

As a result of the merger and her unit closing, Victoria was transferred from the acute care setting into a leadership role in an ambulatory setting. Victoria has been a registered nurse for 22 years and a nurse leader for 8 years. She recently decided to go back to school to obtain her bachelors of science in nursing degree. Victoria expects to have a great day every day, and a great shift every shift. She knows that there will be days that are more stressful than others. She vehemently believes that by keeping a positive perspective and doing the best you can with each presenting situation you will get through any challenge. She described the nurse manager’s job as “translating the decisions made in upper administration into reality on the units.” Her reality included transferring her unit’s nursing service to another hospital within the system; re-training the staff as medical-surgical nurses (while the unit was undergoing extensive renovations); re-opening
the unit - only to permanently close it and transfer out of acute care. This experience was a completely transformational process for Victoria.

Aaronica, RN
Aaronica has been a nurse for 33 years and has enjoyed nursing leadership for 19 years. She has a bachelor of science in nursing degree and will be advancing her studies and is enrolled in a master’s of business administration program. Aaronica uses articulate words and short, strong sentences in describing her experience as a leader of nurse leaders. She plans for obstacles and strategizes ways to overcome them and she has an acute sense of purpose in leading nurse leaders. Aaronica searches for ideas on how to circumvent difficult situations but, she is most worried about the next generation of nurse managers. When she talks of these yet to be determined nurse managers, her expression beams with glowing cheeks and her eyes brighten as her reflections of becoming a nurse leader so many years ago are remembered.

Heidi, RN
Heidi has seen many changes as a nurse leader over the last 34 years when she came on board and was originally called a Head Nurse. Heidi may be described as gentle, compassionate and accepting, yet over the years a physician or two may have driven her into streaks of stubbornness. Heidi is ready to try almost anything once, as her attitude toward the world is adventurous. In combination with the open-ended way in which she relates to the outside world she takes a more active, spontaneous role as she draws on her experience and wisdom. She would never want a hospital administrator to know that their new efficiency suggestion is yesteryear’s solution, reinvented. Throughout the merger Heidi was prone to quiet, unexpected bursts of humor, a take charge attitude, or a sudden drive to fix whatever was broken. Her dedicated staff nurses adore her and she has grief for those that have moved away into the system-ness of new roles outside of the hospital.

Kelly, RN
Kelly has been a registered nurse for 39 years and has served as a nurse leader for the last 15 years. She is a certified emergency and trauma nurse. As a nurse leader, Kelly knows that she walks a fine line between saving lives and ticking people off. One of the great innovations of nursing was to bring order to the chaos in the emergency room. By instilling order where the sick are cared for, nurses address an indisputable fact: sick people are predictably unpredictable. To rescue patients from the immeasurable threats that assail them, the environment in
which a nurse works has to be stable. For Kelly, nursing is two things: the care of
the sick and the attending to the entire environment within which care happens.
When the environment in which care is delivered also becomes permanently
unstable, that is too much instability for anyone to bear. Kelly, (who self-
described as the “Radar O’Riley” of the ER), deals with the operations of the
nursing staff in the emergency room when nurses tell her they are managing
patients “only by the skin of their teeth,” or by “skating on thin ice,” or by
“dancing on the edge of chaos” or “leaving work and worrying all night whether
they’d forgotten or missed something.” Kelly has spent decades trying to explain
that ‘expertise in an emergency room’ cannot really be fast tracked. “The most
expert nurse will perform sub-optimally in an environment in which he or she is
denied resources, which is chaotic, and which is plagued by problems of
shortage…even expert nurses cannot heroically overcome the odds.”

Vanessa, RN
Vanessa began her career at the hospital 32 years ago as a nursing student because
it provided her with a scholarship that included an employment commitment.
Vanessa’s sense of identity of who she is - has become what she does, and she
radiates when she described her vocation. Describing this honor of nurse leader,
her small grin conveyed the secret knowledge of being a part of a very special
sisterhood. In her desire to escape the atmosphere of the merger she enrolled in a
master of science in nursing program. Vanessa was very excited to share ways in
which she is leading her staff through changes in understanding the ‘why’ of
those changes. Her personal life story of living through the sudden tragic loss of
both her parents in an automobile accident has prepared her in a unique way to
cope with the uncertainty and the fear that the merger produced.

Mary, RN
Mary was encouraged to become a nurse by the influence of her babysitter when
she was a very young girl. She has been a registered nurse for 27 years and a
nurse leader for the last 19 years. She is currently finishing her Bachelor of
Science degree in nursing, and she is a certified emergency nurse and a renowned
thought-leader in disaster management. The ER pace is very fast and those
exhausting necessary trauma skills can challenge and outpace any skilled nurses’
endurance. In an adrenaline-fueled atmosphere, patients come and go in a blur.
Over the years, Mary has come to understand that not all injuries are visible. Nor
do all illnesses have scientific rational roots. Some surround the heart like barbed
wire, never admitting peace or happiness, never allowing the release of residual,
unspoken, or misplaced guilt: as every person has a story. Mary has a love and
sensitivity for others, as well as sincerity in appreciation for life. Often described as a steel magnolia, this nurse leader is in touch with both herself and the world around her, and her personal mission is to encourage her staff to fulfill their greatest potential.

_Holly, RN_
Holly has been a nurse for 39 years and has been in her current position for over 12 years. She is currently completing her doctorate in nursing practice. She knew she wanted to be a nurse after being in the hospital while in high school, as her nurses (dressed in the ubiquitous starched white uniform, wearing stumpy shoes, white hose, and that forbidding yet reassuring white cap), took extra-special care of her. Holly loves her colleagues, loves the hospital, and loves her job there. Her voice vibrated with pride as she shared that “nursing is such a wonderful profession. It involves you intellectually, spiritually, and creatively. Sometimes it is sad but is also funny and uplifting.” Holly is concerned but not surprised that so many nurses report that they are dissatisfied with their work; feel burned out, and would like to leave their current position in nursing altogether. She shared that cost-cutting, downsizing, and now merging the hospital is changing what many nurses have been taught to believe is the very core of their job. “There has been nothing easy about the merger; there has been great sadness in letting go in order to move forward.” In unlearning, Holly has discovered new ways to expand her beliefs and experiences to provide the hope that her staff nurses need the most. She is an important teacher in healthcare.

_Eva, RN_
Eva has been a nurse for 36 years and has served as a nurse leader in the heart center and critical care units at the hospital for 13 years although she has been a nurse leader for the majority of her career. The heart is a complicated organ: four chambers, an aorta, and a few valves. Pressure drives blood in, pressure forces blood out. Eva’s heart is more than all that; it is filled with immeasurable compassion and courage as she joined the few living donors and gave one of her kidneys to her beloved husband. Although she is a leader of nurse leaders she ensures that they oversee the success in the achievements of patient care. “They’re the drivers.” Eva understands that nurses provide the best quality care to their patients and they need to be the best that they can be. However, the tension in her neck and shoulders was noticeable when she described how bureaucracy replaces the autonomous personality of a leader during a merger and how bureaucracy stands in the way of knowing our humankind-ness. During the merger integration, she noticed that the leadership voice changed to the powerful and
political language of “we” and “they.” Someday she wants meet the authority named System Decision, as she imagined that this person called “System,” lives in an apartment down the street. She previously left a healthcare union environment when the “we” and “they” got too confusing, misplaced and unaccountable.

Grace, RN
Grace has been a registered nurse for 29 years serving in a nurse leader role for 14 years. She has obtained the credential of Certified in Executive Nursing Practice through the American Organization of Nurse Executives. Grace has a master’s of business administration and is currently working on her doctorate in nursing practice. She thinks like a healthcare chief executive officer and understands the value and the repercussions of relationships. Grace described the changes in her role and in the role of primary nursing at the hospital. In her academic as well as professional life she is concerned with nurse executives who are asked to implement restructuring and how that deeply affects cost-cutting, patient’s length of stay, excessive nurse workloads, overwork, and job stress, and its deprofessionalization and deskill of nursing. Her insight is finely tuned-in to what may happen next in healthcare.

Jacqueline, RN
Jacqueline has been a registered nurse for 37 years and a nurse leader for 20 years in the peri-anesthesia nursing area. Jacqueline has a Bachelor of Science degree in nursing and has some master-level coursework completed. As a nurse leader, Jacqueline believes that nurses are very smart and will figure out how to fix things if they are in an environment that supports them. Caring for others comes very naturally to Jacqueline. Knowing innately that veteran nurses may not know much about researched nursing theories, they sure knew how to care for patients. Caring for patients is difficult enough but dealing with staff nurses, sometimes is worse. Over the years she has seen nurses criticize each other for doing work too slowly or too quickly, for being too disorganized, messy, and inefficient. Starting out in the ICU, Jacqueline discovered the path to become a masterful nurse. She did, and everyone gained from her expertise. For Jacqueline, the ICU was a way of doing things, a striving for excellence, and attention to detail. She is assured that she has made a difference for many nurses over the years, especially as she transitions into retirement.
Nicole, RN
Nicole is a cardiovascular intensive care manager and she has been a nurse for 34 years serving as a nurse leader for the last 7 years. She believes that all nurse leaders must display a positive attitude with staff nurses. She loves her role because she knows she is a person that is accountable to staff, patients, physicians, administration, and in balancing all of these roles. Perhaps no one is more driven by a sense of responsibility and bottom-line behavior than her, as she fulfills her calling. Nicole has acquired a social grace, an ease with words, and all the interpersonal skills demanded at any given moment. She can be so outgoing under clearly defined circumstances that she is sometimes mistaken for an extrovert. But make no mistake: she is vastly private and believes even the best nurse can be made better. For Nicole, compassion and caring for her cardiac patients is where she finds meaning in life by serving human needs for those patients who courageously manage to live another day.

Charlotte, RN
Charlotte is a cardiac step-down unit manager and she has been a nurse for 16 years serving as a nurse leader for the last 5 years. Charlotte has a Bachelor of Science in nursing and this nurse leader chose nursing as a second career. “Care” is a key term used in defining what it is to be a nurse. Essentially it states what nurses believe to be their main task. Any time a group of nurses talk with an outsider about their work or its meaning, one of the nurses will certainly utter this most positive of nursing words. The word “caring” figures centrally in the stories nurses tell of their own best work experiences. For Charlotte, coming to nursing as a second career, she related with what seems to be the four meanings of the word care: face-to-face work with patients, dealing with the patients as a whole person, the open-ended nature of the nurses’ duties, and the personal commitment of the nurse to their work. And, in asking Charlotte what she did as a nurse leader she quickly answered, “I do everything that nobody else wants to do.”

In exploring this phenomenon with nurse leaders, particular care was made to explore their experience through a conceptual framework of their thoughts and knowledge, their feelings, and their behaviors before, during, and after the merger. The following section will describe the data analysis process that was used for this phenomenological data.
Data Analysis Process

The analysis of interview transcripts and field notes was based on an inductive approach geared to identify patterns in the data by means of thematic codes. The method I applied in organizing and analyzing this phenomenological data was derived from a modification of methods suggested by Stevik (1971), Colaizzi (1973), Keen (1975), Moustakas (1994).

The following steps represent the Stevik-Colaizzi-Keen (1978) process for phenomenological data analysis that I utilized in analyzing the research narratives from the nurse leaders:

1. Each transcript should be read and reread to gain a general sense about the whole content;
2. Within each transcript, significant statements that pertain to the phenomenon under study should be extracted;
3. Meanings should be formulated from these significant statements;
4. The formulated meanings should be sorted into categories, or textual theme clusters;
5. The textual theme clusters should be developed into a structural description;
6. The fundamental structure or universal essence of the phenomenon should be described; and,
7. Verification of the findings should be sought from the research participants to compare the researcher’s descriptive results with their lived experiences.

The process of bringing order, structure and interpretation to a mass of collective data is messy, ambiguous, time-consuming, and fascinating. It did not proceed in a linear fashion: it was not neat. It was in the act of reading and writing that the insights emerged as well as interpreted, and that the fundamental answers to the research questions were perceived.

Step One: Gaining a Sense of the Whole

The first step of Stevik-Colaizzi-Keen (1978) method of analysis was to make verbatim written transcripts of each interview, over 645 pages of single-spaced transcripts or 25,579 lines of transcripts were derived from the qualitative interviews. It was through this step that I tried to
more fully understand the participants’ lived experience. I meticulously read and reread this written material so that I could arrive at a proper understanding of how the nurse leaders viewed their merger experience and to gain a sense of the whole content. During this stage, any thoughts, feelings, and ideas that arose by me due to my previous work with these nurse leaders was added to my bracketing diary or my reflexive journal. This helped to explore the phenomenon experienced by participants themselves.

The words and the meanings of their experience were endearing to me. I read these transcripts enough that I could quote several phrases in them word for word. I listened to the recordings so often that I could hear the nurse leaders’ voices as I silently read their words. I often got tearful or emotional as I read the interviews, even though I read them countless times. Though I noted the differences in each nurse leader’s perceptions and personalities, I saw the similarities in their descriptions of this merger experience.

**Step Two: Extracting Significant Statements**

In this stage of analysis, significant statements and phrases pertaining to the experience and relevant to the phenomenon of the merger were extracted from each transcript and were placed into a Microsoft Excel spreadsheet. These statements were written in separate sheets encoded based on their transcript, page, and line numbers. At this stage, I made note as to whether these statements expressed their experience before, during, or after merger, which was helpful to my reflexivity. After extracting the significant statements from the transcripts I began to develop the formulated meaning statements. Van Manen (1990) maintains that all interpretations are interpretations of an interpretation. Each time new information was gleaned from the transcripts, a new interpretation of the whole emerged.

From the thirty-two transcripts, I extracted 675 significant statements. Many statements were significant to me, but were not necessarily about the nurse leader merger experience. I had
to read carefully to extract nurse leader merger experience statements rather than statements meaningful to only my experience as a human resource development practitioner.

Examples of the significant statements included:

“*You just have to go out there and put the veneer up and the mask on. And that was really tough some days.*” - Mary, RN

“So, once the initial shock was over, of course nobody knew what the next step was. So, that's when the fear came of what am I going to do? And we had no answers, we had no direction. None of us knew if we were going to be opening our unit into something else or if we were all going to be laid off.” - Victoria, RN

“Nurses, we don’t have -- we just don’t have...our opinions in influencing policies and procedures or whatever. The decision was made and then we’re told that this is what we’re doing.” - Holly, RN

“You got to find something outside of here. Because if you don't find something no matter – I really think that no matter what your job, or what profession you belong, you have to have something else otherwise, it'll eat you up. You can't let whether it's a merger, whether it's a bad day, whether it's the doctors fighting, whether it's the nurses fighting, you can't let it consume you.....because otherwise, you won't go back in...for tomorrow.” - Lynn, RN

*Step Three: Formulating Meaning Statements*

The third step in Stevik-Colaizzi-Keen (1978) method of data analysis prescribes the formulation of interpretative meanings for each significant statement. Moustakas (1994) stated that this is the beginning of the development for the structural description or “how” the participants experience the phenomenon. Colaizzi (1978) observed that this is the most difficult step because the interpretative formulated meanings need to reflect the underlying information in the meaning statement without distorting the original description. Each underlying meaning was coded in one category as they reflect an exhaustive description. Similarly, I compared the formulated meanings with the original meanings maintaining the consistency of descriptions and compared my work with my dissertation methodologist to reach consensus. Thereafter, the whole statements and their interpretative meanings were checked by my expert dissertation methodologist, and thus keeping the meanings consistent.
Several examples of the significant statements and the associated formulated interpretive meaning statements include:

Example statement: “And so now we all became a part of this ‘worst system not to join’ the ‘evil empire’ and we already had to struggle that we were just a community hospital. And I woke up to a world that my husband was a part of, that I was always so grateful I wasn’t a part of…and that was a big bureaucratic system.” – Aaronica, RN

Interpretative meaning: The reputation of the system created a type of fear or cynicism with the nurse leader during the merger.

Example statement: “So, I would describe it as a lot of connections and the need for the system to become more integrated, when I think about it from my heart versus my head, to me maybe, it is the system that needs to merge with the system in order for it to become more integrated, and that's kind of like from a head level. So, what would that mean from the heart level? It can't happen. It's a frickin’ bureaucracy - and the strongest guy wins. No one cares about why we are here. Really, I mean it. Those bastards have forgotten that their paycheck depends on us taking care of a patient.” – Grace, RN

Interpretative meaning: Nurse Leaders become disappointed and angry with a bureaucratic approach, and with the new leadership culture of guiding others through a merger.

Example statement: “So, now that we're going to merge, I have to help staff find the positive in being on our team and it's not been difficult but it's been very necessary. We need that, and the patients need it too. Our patients ask us very direct questions about the merger.” – Jane, RN

Interpretative meaning: Nurse Leaders demonstrate positivity for staff nurses, so that the staff nurses model that behavior and conduct themselves in a way that is caring to their patients.

I agree that this is Colaizzi’s (1978) most difficult step. I kept questioning whether I had given each statement the appropriate meaning. I would rephrase, scrutinize, and then reread the original transcript to see if the meaning was correct in my perceptions as well as for the participants.
**Step Four: Textural Groupings**

After reaching an agreement toward all interpretative formulated meanings, the process of grouping all these formulated meanings into categories that reflected a unique structure of clusters of themes was initiated. Each cluster was coded to include all interpretative or formulated meanings related to that group of meanings. In total, seventy-one textural group codes emerged from the data. After that, groups of clusters of themes that reflected a particular issue were incorporated together to form a distinctive construct of theme. Several examples of the textual groupings are shown and these were selected as examples of the textual group codes highlighting before, during and after textual themes.

Several examples of the textual groupings include:

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<tr>
<td>“Nurse leaders are the quarterback for the team. They are the cheerleader. So, I like to say a nurse leader and a manager, people don't work for me, I work for them...I'm here to help them. I am here for them to give them what they need to do a good job, to feel productive, to have a good feeling when they come in to work. That's what I'm here for.”</td>
<td>Before</td>
<td>Behavior</td>
<td>Caring for Others</td>
<td>Cheerleader</td>
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<td>NLs provide reassurances to staff nurses with the many roles that they play in the work unit.</td>
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<td>“Even if I could exert some control, I couldn't exert any control because my role has been diminished. We talk about feeling marginalized. I've been marginalized. My influence is not what it once was, I don't think.”</td>
<td>During</td>
<td>Thinking</td>
<td>Unlearning</td>
<td>Loss of Identity</td>
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<td>NLs experienced dejection with role of nursing care and authority during the merger.</td>
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<td>“I have to learn how to forgive every single day, when I get up in the morning and know I have work ahead of me, I have to forget everything that happened the day before and start all over.”</td>
<td>After</td>
<td>Feeling</td>
<td>Renewal</td>
<td>Constructive Action</td>
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<tr>
<td>NLs intentionally forgive others in order to get through each day to find renewal.</td>
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Indeed, all these themes are internally convergent and externally divergent; meaning that each interpretative formulated meaning falls only in one theme cluster that is distinguished in meaning from other structures. I compared the clusters of themes and checked the accuracy of the overall thematic map with my expert dissertation methodologist.

**Step Five: Textural Theme Clusters that form Essential Descriptions**

The Stevik-Colaizzi-Keen’s (1978) fifth step requires the grouping of the formulated interpretative meanings into clusters that represent the same themes. This process involved rereading each of the interpretative formulated meanings, and assembling them according to similar categories or themes. I bracketed each of the seventy-one textual groupings into seventeen textural theme clusters that emerged from the formulated meanings which can be referred back to the original transcripts for validation purposes. In other words, by reading each interpreted meaning, I categorized each and placed it with an appropriate theme cluster. Though there were distinct themes clusters, many of them seemed to flow into each other.

For example, I arranged narrative descriptions that expressed anxiety, speculation or thoughts of unreality into a textual theme cluster of “*ruminating.*” Ruminating (a thinking construct) became one of five textual theme clusters that supported the structural description of “*Masking: Focus on others.*” Additional narrative descriptions were thematically coded: “*worry work*” (a behavior construct) was supported by the following textual group codes: on edge/nervous, pausing, masking, and avoiding the spotlight. Another textual theme cluster that supported this structural description of “*Masking: Focus on others,*” was “*caring for others*” (a behavior construct) that included: not caring for oneself, pushing positivity, cheerleader and salesman. Additional textual theme clusters are listed in Table 3.
Essential Themes

As previously stated, in Step Five, I discovered seventeen theme clusters. I further organized these seventeen textual themes into four major structural or essential themes. Only one essential theme is distinguished in meaning from the other essential theme structures. I will illustrate each of the four essential themes by actual statements made in the interviews. Table 3 shows a summary of the emergent themes or the essential structural themes which are supported by the textural theme clusters.

Table 3.
Emergent Themes or the Essential Structural Themes

<table>
<thead>
<tr>
<th>Essential Theme</th>
<th>Description of the Essential Structures</th>
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<tr>
<td>Theme 1: Masking: A focus on others</td>
<td>Nurse leaders considered the merger necessary despite the fact that they may not have been prepared and because the pressure to change and merge the hospital was external. Nurse leaders wore a mask to conceal their own personal feelings of uncertainty while outwardly displaying positivity to influence patient and nursing care as a whole.</td>
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<td></td>
<td>Textual theme clusters: <em>Ruminating</em> (thinking themes: anxiety, speculating, attribution error of reality); <em>Worry Work</em> (behavior themes: on-edge/nervous, pausing, masking, avoiding spotlight); <em>Avoiding</em> (behavior themes: influencing, evading, protecting, no voice); <em>Shock</em> (feeling themes: distress, disbelief, un-empowered); <em>Caring for Others</em> (behavior themes: not caring for self, pushing “positivity,” behaving in a cheerleader or salesman manner).</td>
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<tr>
<td>Theme 2: Mirroring: A focus on self</td>
<td>Nurse leaders experienced merger by surrendering to continually changing role obligations and uncertainty which demanded their deeper attention and focus on self (internally).</td>
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<td>Textual theme clusters: <em>Holding On</em> (thinking themes: uncertainty/ambiguity, fear, apprehension, anger); <em>Unlearning</em></td>
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<tr>
<td>Essential Theme</td>
<td>Description of the Essential Structures</td>
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<td>(thinking themes: huge loss, loss of identity, rules &amp; policies, loss of control); Trauma (feeling themes: the “pit,” sadness, guilty, dejected, disheartened, demoralized, disappointed, mistrust); Psychological Shockwaves (behavior themes: self-preservation, unwanted/no-entity, mistreated, heartbreak, isolated/dazed).</td>
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<tr>
<td>Theme 3: Mitigating: Letting go of the past</td>
<td>Nurse leaders gained greater insight and appreciation for their roles as a change agent in the merger as they realized the significance of letting go of the past through mitigating and palliating with relearning amid the growing pains of a larger, far more complex and bureaucratic organization.</td>
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<td>Textual theme clusters: Aloofness (feeling themes: palliating and letting go, politics, invisible, value congruency); Separation (behavior themes: communication tangles, productivity pains, loss of team play, power struggles); Indifference (behavior themes: new bureaucracy, layers of management, new role as “management implementer,” controlling attitude); Unbounded and Changing Role Obligations (thinking themes: role confusion, crushing time and emotional pressure, everything flowing from downhill).</td>
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<tr>
<td>Theme 4: Moving on: Visioning for the future</td>
<td>Nurse leaders achieved a profound intention to emerge from the intense organizational change experience and move on in their leadership practice with internal strength during time shifts including a desire for a hopeful future inside a caritative culture.</td>
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<td>Textual theme clusters: Time Shifts (thinking themes: relearning, finding meaning, putting things in perspective); Renewal (feeling themes: opportunities, wishful/hopeful, expecting more change); Revisit Control (behavior themes: internal strength amid changes and challenges, hindsight informs insight, sharing meaning with others); Yearning for More (behavior themes: new roles within and outside facility, school, retirement, professional practice, constructive actions, new opportunities).</td>
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Appendix E contains a sample description of the themes, significant statements, and their formulated meanings.

The following paragraphs introduce and discuss each of the essential themes. In order to harness dependability of the data I have attempted to use dense descriptions of the data by sharing the words from the nurse leaders themselves.

The four essential structural themes are:

1. *Masking*: A focus on others;
2. *Mirroring*: A focus on self;
3. *Mitigating*: Letting go of the past; and

**Theme One – Masking: A focus on others**

This structural description theme includes five textual theme clusters: (a) ruminating; (b) worry work; (c) avoiding; (d) shock; and (e) caring for others. Nurse leaders described the merger as necessary because the pressure to change and merge the hospital was external. In donning a “mask” the nurse leaders described their rumination rationally, which illustrated behavioral descriptions of worry work and avoiding the organizational change through protectionism as they focused nearly all their energies on caring for others. Nurse leaders described wearing a mask to conceal their own personal feelings of uncertainty while outwardly displaying positivity to influence patient and nursing care as a whole.

Nurse leaders described the anxiety and insecurity before the hospital was merged. Nurse leaders ruminated and thought with emotional fear that the impending merger with a different leadership culture would close nursing care units in the hospital.

“I was emotional and I was insecure. It was a huge insecurity because when you merge with someone, they could just come and wipe everybody out in this building and bring in new staff. So yeah, a lot of insecurity…a lot of anxiety.” - Eva, RN
The nurse leaders generally felt positive in relation to participating in the organizational change and understanding that the hospital needed to merge. Nurse leaders generally were positive toward the organizational change process because they could see the possibilities, but were also on edge and anxious because they did not know what it would be like to experience the impending merger.

“I was scared and I was happy. I was scared because I didn’t know what it meant for my security in my job because my nursing service is duplicative in the system. I was happy because I knew our organization would still be existing, because before we didn’t know if we were going to exist. So, I was in between.” – Vanessa, RN

The nurse leaders described their influence on their staff nurses through their words and actions and they often expressed concealing how they felt in order to positively influence patient care.

“Nurse leaders facilitate patient care through their staff nurses and they have, I think it’s one of the most important roles of the hospital. The frontline staff nurses touch the patients. They communicate with the patients, so how they feel about their positions and the leadership at their organization and the values and mission, they get that from their nurse manager, directly and indirectly through real clear communications but, more importantly, from the non-verbal behaviors that we show.” – Jane, RN

The nurse leaders concealed their own feelings of the impending merger while demonstrating cheerfulness or positivity to staff nurses. Additionally, the nurse leaders believed that they needed to demonstrate confidence while guiding others through the merger because a new leadership team may perceive their insecurity with the organizational change process as unfavorable or as resistance to change.

“I don’t always share that with my staff. I’m always like, ‘It’s going to be fine, I wouldn’t worry about it.’ I always say, ‘You’re a critical care nurse, don’t worry about it. If that happened, there are plenty of jobs. There are so many openings everywhere. Don’t worry about your job.’ But, honestly, I do worry about it. I worry for me. I worry for them.” – Charlotte, RN

“I knew from a financial standpoint that the merger is what we had to do. We’re at a point where you’ve got to come to the table with something versus you have
been bled dry and now you have nothing to come to the table with. Logically I knew the merger had to happen, it was a matter of who it was going to happen with. I understood all that, and I had a lot of fears and that became hard as a manager because the fears of the front line staff had to squelch your fears because you had to take care of them first. You didn’t have the answers and there were no answers...to give to anybody. It just created more fears. You had to put a mask on. This was really tough, and you didn’t show anyone how you really felt. You just put the happy face on and you go out there and you just try to be a good cheerleader.” – Mary, RN

“Yeah and it’s been really hard because I have to confess that I don’t feel positive every day. So then I really have to think about how am I influencing others? Because the last thing I want to do is make people feel negative because I’m feeling negative.” – Holly, RN

Nurse leaders described avoiding the spotlight or staying just under the surface with the impending merger to deflect any attention that could inadvertently be placed on them. The nurse leaders described the paradox of their leadership role in providing their positional-voice of influence for their staff and authority over patient care, and at the same time, shielding their position by quieting their voice as it may be heard as resistance.

“I think you just don’t ask the question. You just kind of sit back and say, ‘well, I guess we’ll find out eventually what happens.’ You don’t want to bring attention to yourself because of the uncertainty of what’s going to happen, what else is going to move around that you just kind of let it stay under the surface.” – Heidi, RN

The majority of nurse leaders did not know much about the merger process and their roles in it and were apprehensive that leaders above them were concealing what they knew to protect them. The nurse leaders described discomfort or fear to be in the spotlight; being leaders among leaders.

“When you’re scared I don’t think you are an effective leader and I think all of us were scared. Even our chief nursing officer and our chief executive officer were scared. They tried to hide it during leadership meetings, but, we all felt it...you could cut the fear with a knife during most of the meetings early on.” - Jane, RN

“If we don’t show each other our faces and show each other each side of ourselves, then how are we ever going to be able to get through anything together? But, we never really were able to reveal it to others.” – Lynn, RN
The nurse leaders expressed that they did not feel like their professional opinion mattered with a new leadership culture in the early stages of the merger. With new and different leadership culture the nurse leaders did not feel empowered to share their opinions freely.

“I thought sometimes that the ‘system’ wanted to hear our voice but, I learned they really didn’t want our voice. They wanted to look like we’re...collaborating. But we’re not.” – Vanessa, RN

“The loss of voice is huge. I mean the loss of voice is huge and that’s why I push to get to all those meetings at the ‘system’ – no matter where they are being held—okay, I would be there. I don’t turn down anything at the system level as it’s pulling me out of this environment that needs me more... a lot more, too. We’re not used to being out of the building all day long, but we are certainly not used to losing our voice, either.” – Eva, RN

**Theme Two – Mirroring: A focus on self**

This structural description theme includes four textual theme clusters: (a) holding on (a coping mechanism that dealt with extreme uncertainty and ambiguity); (b) unlearning through a loss of control and a loss of identity that was experienced as grief; (c) trauma as encountered through feelings of inferiority and disheartening guilt; and, (d) psychological shockwaves as grappled with feeling unwanted and mistreated.

As the nurse leaders became aware that change with the merger had begun, they experienced numbness and feelings of anger.

“So really, you know what you also hear? I mean, I hear it in myself, ‘I’m just angry.’ So, I find that I’m angry that this happened to us and angry that it has turned out to bring that kind of a boss in me – I’m not that kind of a boss, and it makes me angry that the emotion of this tends to bring this side out of me.” – Holly, RN

“That’s when I kinda get mad. I don’t think if it’s just life in general in any hospital or if it is part of this merger, because the system changes and you know only part of it. Healthcare now and healthcare 20 years ago there’s no comparison in the expectations and what you’re doing today. I mean we’re on rapid change right now. Healthcare is an unsustainable business right now.” – Kelly, RN

“I close my door every once in a while. My patient care coordinator, I have to love her because if I’m ready to blow my stack, I can just say, ‘I need somebody
to talk me down.’ And we can talk each other down and really if I’m at the point where I just can’t do this anymore, I may get out and get my car and drive around the block and come back and say, Okay, I’m ready now. I just…have to make sure that my emotions don’t get the better side of me. This job is hard enough and I have to watch the potential for my anger to get the better of me…” – Martha, RN

The nurse leaders described feeling apprehensive with significant insecurity when they explained that they did not possess authority or have any or much information on the organizational change process. Especially processes related to closing and transferring care units to another system hospital.

“So, we had to live like that for a while. Then I ended up coming to a breaking point almost, but people were starting to - they wanted to storm ship. They’re looking at the job posting board and seeing what was open, what could I do? It was very, very difficult. And at that time, I could not promote other job opportunities in the hospital or in the system because I had nothing to promote. I had no direction, nothing, because nobody knew anything. These were all things that were being discussed higher up within the system organization.” – Victoria, RN

“And I think there was a lot of confusion talking about the policies. Even as a leader going into the merger, I never knew what we should follow - our hospital policies or what we should follow from the ‘system’ or corporate policies. No one ever said what we should use and then all of a sudden you’d start getting updated policies. It was never clear to me. And, I sure as heck wasn’t going to ask about authority.” – Margaret, RN

The nurse leaders described their experience with the unease and pressure of unlearning while leading, guiding and managing staff nurses through a merger transition. Nurse leaders further described that their staff nurses felt ambiguity in not knowing how much work the organizational change would bring them in the present or the future.

“So I mean there’s transitions in everybody's life depending – it's not just hospital transitions that people need to learn to adjust to. It's life in general. It's just a transition from being a high school student to a college student, to being on your own, to being married to being married to having kids to – life is a transition and I think – unfortunately, it depends on where, how you've lived your life and what you've experienced and what you've gone through. It depends on how you deal with those transitions and those changes.” – Lynn, RN

“I literally I grew up as a young woman and blossomed in my career here at this hospital encouraging me. I don’t know how to explain this…you just feel it, you
feel the change and sometimes, I think people are just scared. They’re not sure what’s going to happen, if they’re going to have a job. There is always that cloud of fear in the background, even though you’re trying to be positive and you don’t believe in the ‘cloud of fear,’... the staff just senses there’s this cloud out there.”

– Charlotte, RN

“And now I don’t know. We’ll see when it's all said and done. Because when it's all said and done it'll be very different than it is right now for this hospital.”

– Aaronica, RN

“You know I read a lot of body language. A lot of body language and it’s interesting after a meeting one of the admission nurses called me up and apologized for her behavior at the meeting. I guess that’s another thing with our merger you’ll meet resistance more from staff.”

– Lynn, RN

The nurse leaders elicited sadness with the changes in role and responsibilities, which increased their administrative function during the merger. The nurse leaders were concerned about how the merger would influence nursing care and who would advocate for patients during and after the merger.

“There are so many things going on in healthcare with all these nurses and projects and deadlines. I'm at my computer more than I ever dreamed and I'm disappointed about that. If I could lead, if I could make my own leadership model, there'd be secretaries helping me along with schedules and payroll...as that would be more automatic and the computer which still isn't keeping track of sick time, I can't even believe that I'm doing hatch marks for 80 people and counting these manually – this is one of my pet peeves. But if I could be the best leader I would be with the staff nurses and with the patients entirely.”

– Jane, RN

“It was learning everything by osmosis. It was like they said ‘we're not going to teach you how to use this particular thing just get in there and force it around and you'll figure it out’ is kind of how it felt.”

– Holly, RN

The nurse leaders encountered loss when the hospital’s functional support staff like computer information systems, finance, payroll, supply chain, legal services, human resources, marketing and communications was transferred out of hospital into other buildings or roles within system. They described the loss as death with long periods of grief and sadness. Indeed, it might be suggested that the nurse leaders described this phase of the organizational change as organizational grieving.
“I think what’s been difficult is how it’s changed us, and the struggles that we’ve gone through, weathering through the financial situation all these years together, you know all the struggles that we as an institution had gone through. Now, it’s all the changes of seeing people leave, you know the business office...none of them are our employees anymore.” – Aaronica, RN

“A loss...a huge loss. It was like dying – too many people leaving and being pulled out of here by the system. I think that was the best way to describe it, or maybe a divorce. Then our hospital family starts breaking up with everybody going to all these new positions. It felt like a divorce or a huge death, and the process of going through a death with someone – it’s always a long process...” – Kelly, RN

“You know, it’s the people that you see every day. We were such a tightly-knit place and it was kind of hard because all of a sudden we just saw great people being plucked, like one by one and I was like, ‘Oh no, they got sucked into the big house,’ and then our house started getting smaller and smaller. And it was just because we seem to have this longevity in our place and that was the hardest, personally for me because I’ve been around long enough.” – Victoria, RN

The nurse leaders experienced a tremendous sense of loss over what “used to be” in their community hospital and felt disconnected from the new dominate acquiring organization. In listening to the narratives of the nurse leaders their distinction of identity, as emotion was very significant in how they associated with the organization and their own personal uniqueness as a nurse leader.

“Now, I call the pre-merger time “Camelot” just so you know that from my part of this. There’s so many times in history that people refer to Camelot. Well, I refer to our hospital’s pre-merged state as Camelot. I liked it, I loved it -- but it’s gone. It's the old days now, but I remember it fondly as Camelot, when we would actually go to a holiday lunch and not talk about work, and when we actually went on Management Retreats off-site. That was Camelot. We just didn't know it at the time.” – Jane, RN

“The other part I go back to is how we ‘lost our voice’ you kind of lost your identity, too. Other people dictate to you now and that’s been hard - right or wrong, that is very hard. I think the most difficult part...you were so proud of our community hospital and there’s so much good here. Now, a lot of people in the system, they don’t see our goodness, they see us as just a little small hospital that didn’t have anything to offer or bring to the plate. And there’s a lot that our community hospital has done right that we could teach other. And we just experienced immense loss – no one is in the building anymore, we toil. What I want to say to the system leadership is ‘well our community hospital could do this better, you know what I mean?’ Just listen to what we have to offer don’t just
assume that your way is the only way or the right way - it’s kind of endless, I describe it as turmoil…constant turmoil.” – Mary, RN

“The hard part is probably who and what you leave behind. And I guess, again, because it was done quickly. And, I feel like I have spent a lot of time trying to find myself in all this organizational movement and change.” – Margaret, RN

The nurse leaders described experiencing physical and emotional stress during the merger. Many staff nurses were devastated when care units were closed or relocated to a different hospital within the integrated healthcare delivery system. Additionally, the nurse leaders described feeling sadness and guilt during the merger, especially when operational decisions were made with regard to their care units. The nurse leaders voiced an emotional pain when others evaluated their skills and conditioning.

“Well, I know that the expectations from the system are very clear. When my little nursing care unit is up on the big screen and we’re not the strongest bar on the graph, you feel that – it feels overwhelming. So, it’s a little demoralizing. I mean, you can’t lose your motivation - but it makes you droopy.” – Jane, RN

“It’s probably at every level that we get more responsibilities and what have you. What was frustrating is when things come out and it’s like, this is happening tomorrow. That happens frequently. It was just not effective or a reasonable expectation that we as nurse leaders could make that happen.” – Jacqueline, RN

Nurse leaders described that they did not know much about their roles during or after the merger process. With a different leadership culture from the dominate acquiring organization, their responsibilities and accountabilities changed rapidly. They also described the demoralizing effect of being perceived as lacking management ability by the new leadership culture. Additionally, in recalling how their emotions of change could be mistaken for resistance during the merger integration, the nurse leaders all expressed the emotionality of the merger.

“Yeah and I’m trying to figure out how to put this into words. My boss is so involved in day-to-day operations. I almost feel like I’m not needed. If my boss were a nurse, they would not need me because even my direct report sometimes goes straight to her versus coming to me.” – Holly, RN

“It does hurt the heart. There are things that happen that hurt the heart and...you know, my new manager doesn’t know. It was a struggle with him understanding
our history, physicians, nursing staff, our work environment. He’s a totally different manager than what we had in the hospital.” – Jacqueline, RN

Moreover, cynicism existed regarding how the organizational changes would affect nursing care; especially in the mandate of driving nursing care forward. The nurse leaders also felt heartbreak when their role changed during the merger integration. Many nurse leaders conveyed how they cried when their leadership scope/responsibilities or oversight changed.

“We sent staff down to take a look at new vital sign machines, to answer management’s question: ‘which one would you like, the pros and cons?’ We spend all this time and the decision was ‘So, this is what the system wants so this is what you’re going to get.’ So, it’s hard if the staff are saying ‘Why are they asking us questions when they already know what’s going to happen…?’” – Heidi, RN

They articulated feeling as though their role was marginalized. The nurse leaders expressed that it was not about the volume of work, but about how they may have missed opportunities for their overall career progression.

“So, I’m supporting people who got changed from managers to specialists trying to help them feel like ‘your job hasn’t changed, your position hasn’t changed, your oversight and your pay haven’t changed.’ It’s not a demotion even though it felt like one. So, I didn’t feel that I could really complain or say anything because I’m telling them it’s all okay. But the kicker is, the system has completely different ideas on career progression and it affects them, and it affects me. Am I now in a position that doesn’t offer opportunities? Yes, I think maybe I am….it’s very challenging.” – Grace, RN

**Theme Three – Mitigating: Letting go of the past**

This structural description theme included four textual theme clusters: (a) aloofness (which helped the nurse leaders let go of the past); (b) separation; (c) indifference (especially in understanding new structures of bureaucracy); and (d) the unbounded and changing role obligations with role confusion.

The nurse leaders described that they did not feel they belonged "inside" the new integrated health system leadership culture because they were viewed as different and "outside" of it. As the new leadership culture had their own history and shared experiences that were
unfamiliar to the nurse leaders, the nurse leaders were relegated to being strangers and felt profound feelings of inferiority as they were severed from experiences they had previously shared with each other. Additionally, building relationships in this new environment was challenging for the nurse leaders.

“As leadership changed, I mean the minute they walked in, it was – ‘they’ meaning to lead within the hospital -- to me, you’re ‘them,’ and you’re not ‘us.’ You haven’t earned that yet.” – Heidi, RN

“In discussing how I was feeling with two of my peers I had to share that within our group, ‘they’re just not going to accept any of us here.’ We were just not good enough. There is that mentality that you have.” – Eva

“I think that there needs to be equal representation from the business units, and I think that if you had 12 nurse managers from the same institution, all go to that meeting and one person from the little hospital, I wonder who would be the deciding group? It doesn't turn into a group. They know it turns into a lopsided – mess of control freaks from the big hospital – and we don’t matter.” – Jane, RN

The nurse leaders experienced communication tangles with the different leadership culture. Additionally, the nurse leaders voiced limited opportunities for productive and honest communication that was valued by the new senior leadership of the system.

“They would like...they’ll ask for our opinion as an afterthought. I think the decision is usually pretty made.” – Aaronica, RN

“We weren’t seen or viewed for what we are. So, I guess, not intentionally, but we sat back as managers and I guess we let our results show how we did and how we are, as opposed to trying to tell them or make them hear us. Any other approach would have made us look defensive.” – Nicole, RN

“And there was maybe some -- it wasn't a good clear communication on really what we were still supposed to be doing. And what we were to move into doing. Or what -- it was just some confusion. So you just kind of continue on with what you always did and hope it was good and somebody will tell you otherwise if it wasn't, you know. Of course, we had sideline conversations on how incredibly stupid it was to run a business like this. But, it’s not health care, and we’re not really a hospital anymore. It’s a bureaucracy and a patient is just revenue.” – Martha, RN

“I think we would say things like – hey, listen, we need to do something different here, we need to communicate a little differently. I think we did try, but at the same time, I don’t know that we gave that much energy to it because it was
disappointing...degrading...we were outside of the system’s leadership.” – Nicole, RN

A new leadership structure added to organizational bureaucracy as it takes the decision-making function away from individuals and distributes it across the organizational structure or hierarchy. The nurse leaders conveyed a certain struggle with the new hierarchy within a different leadership culture. The description of the nurse leaders experience with the layers of management contributed to confusion regarding how decisions are made during a merger.

“You’d become a part of a system and you still have a voice but boy it sure doesn’t ripple like it did when you were just part of a community hospital. And so you learn not to fight things, you learn to just say, ‘Hey, guys this is what the ‘system’ tells us what we have to do, we have to make the best of it.’ You know, they didn’t give us adequate time to get it out to you, but this I what we have.” – Aaronica, RN

“So, the hardest part in joining in a big corporation, not everybody has the same policies. Not everybody has the same systems. There are so many different ways and trying to get through that can be difficult. I had to write down everything and I mean I had to literally keep people's names because it's too much.” – Victoria, RN

The added organizational bureaucracy may have imposed a form of social interaction incompatible with situations in which people need to know or care for each other. In this large bureaucratic complex organization, the nurse leaders described difficulty finding that place of belongingness or connectedness. One nurse leader captured this sentiment: “I don’t know who the decision-makers are.” – Margaret, RN

In addition, the nurse leaders revealed feelings of being overwhelmed by the constant tension of meeting the multiple obligations of providing care, implementing change, understanding healthcare reform and attending to their own personal lives during a merger.

“Once in a while when I can’t sleep - I mean we have some staffing issues and there’s not enough staff and I don’t know if I’m going to be the one coming in in the middle of the night to take care of a patient but to have it emotionally suck me dry, it can, but I try, for the most part... I find that the more I can try and get emotionally detached from it, the better...” – Nicole, RN
“Through good intentions nurse leaders often support too many improvement projects. I think we have too many projects on our plate period, every single nurse. That’s what changed over the years, is the amount of things that we have on our plate to complete every day.” – Aaronica, RN

“Well, you know, your HCAHPs is all about your patient’s satisfaction. Your Core Measures is all about your clinical quality scores. Your productivity is all about your finances. So, all of those metrics is…I just didn’t feel the pressure like I felt before. I mean, I feel more pressure now than I ever did before. It can be unbearable.” – Eva, RN

With the extreme amount of administrative work that comes from a merger and healthcare reform, the nurse leaders had to work to stay positive as they struggled with increased administrative tasks. Furthermore, the nurse leaders disclosed role confusion with new hierarchy with different leadership culture.

“I know there's better terms than this, but our staff nurses well…they're worn out. The change is so excessive that everything you try and create or bring or suggest is shut down because they're tired. Because they don't want one more new thing. Staying positive in this environment with our ever-changing roles – this is very complex.” – Eva, RN

“It's hard because I am not the only person who sees the new bureaucracy and layers of management overhead. What I hear a lot of other people making decisions and you just wonder how in the heck those decisions are being made and there's too many layers and too many pieces of paper you got to sign. Early on, one of our system leadership meetings, that subject came up. In fact, I remember a hospital president being the guy who spoke up about it, about how many pieces of paper we got to sign to get something done. And it's out of control, because of layers and layers and layers of approval that has to be gained. The finance people are really in control of the controls, that is for sure.” – Holly, RN

“During the merger, I found it to be a really tough transition to say I’m not a nurse leader anymore. Because I have really enjoyed that ability to impact and influence decisions that happened for all the staff nurses. Like I said, a lot of that has gone away now and it – even our nurse meetings have changed a lot. It’s not so much our ideas, improvement or whatever. It’s somebody else is telling us, this is what we’ve got to do.... We are just robots or management implementers.” – Jacqueline, RN

Integration and the implementation of new processes added considerable stress to nurse leaders including how they perceived themselves during a merger. Nurse leaders felt miserable
in their jobs by implementing new organizational changes or processes, which left them feeling cynical, frustrated and demoralized. These feelings left them drained of their energy, their enthusiasm, and their self-esteem when they went home at night. Moreover, as decision making was made by others, the nurse leaders expressed sadness and frustration with feeling like they had been relegated as an organizational implementer.

Theme Four – Moving on: Visioning for the future

This structural description theme includes four textual theme clusters: (a) time shifts or a resolution in finding meaning and putting things in perspective; (b) renewal through new change; (c) revisiting control in finding internal strength amid changes, challenges and sharing meaning; and (d) yearning for more.

As their shared experience impacted them emotionally and challenged them physically, the nurse leaders struggled to convey anything easy about the merger experience. However, they did reflect thoughtfulness about their experiences of renewal and growth after the merger. The nurse leaders aired the positive impact that others had in making things better for them after a merger, especially as they put things in perspective.

“Everybody knew I was trying so hard to encourage the staff to move our patient satisfaction up and our scores were creeping up and then one month for no reason, they plummeted and it was someone in quality who must have been watching me and I think she knew how proud I was of our good scores and how hard I was trying. So, she sent me this scorecard and instead of red squares and green squares, every little square had like a daisy or a thumbs up or a happy face, all these symbols of cheer. It was very meaningful to me.” – Jane, RN

“We’ve gotten to the point where I think all of us nursing leaders are finally learning to mesh with the rest of the system. We’re finally learning our place. We’re finally learning how to affect the changes for improvement and for our patients.” – Heidi, RN

“It’s made me feel challenged but it’s also made me, I think, have to look at different ways of doing things. I’ve had to get more creative and open-minded. I will say I’m not always the most open-minded person and it has forced me to look at different ways of doing things which the staff don’t always like but if I can show
to them how this is going to make it easier, then I’m modeling the way for them.”
– Martha, RN

“It’s been a learning experience. It made me value developing relationships.
I’ve done a lot of soul-searching and what I would’ve done differently in getting
through this merger. There are pockets of really good people out there who are
supportive and I’m trying to stay focused on those good things.”  - Grace, RN

Remembering individual core values helped the nurse leaders understand their strengths
and the gifts they needed for renewal during a merger. They reflected that the merger opened
their eyes to new ways of seeing and leading others. An important concept conveyed; of letting
things go and forgiving others so they could move forward during the organization change, was
reflected in the nurse leaders’ reflections of being intentional about their leadership.

“I have found long walks be very beneficial.” – Vanessa, RN

“I had to learn how to forgive every single day. When I got up in the morning
and know I had work ahead of me, I had to forget everything that happened the
day before….that was for me, a way to start all over.” – Heidi, RN

“I was given this great gift of being happy and wanting to have fun and make the
best out of days. And I wish I could give it away to some people because I want
them to have more of it. So, I am so full of gratitude that I feel this way. I’m
grateful for my parents – they really instilled all this in me.” – Jane, RN

Nurse leaders also revisited control and found internal strength amid changes and
challenges and were creative in sharing meaning in their communication with staff nurses. All
the nurse leaders expressed needing other nurse leaders in their personal lives to share meaning
and hopefulness. Additionally, they reflected on their past experiences to help them in
understanding the meaning of merger.

“Well, I said to my fellow nurse leaders within the system when we struggled with
some issues in the Center of Nursing Excellence, that everybody in this system
needs to shake the “Etch-A-Sketch.” Everybody needs to get their own egos out
of the way. Everybody needs to let go of all the things they think they own and
start looking at it differently. Everybody really needs to get that in their hearts
and heads that if we’re going to move forward together. And it’s hard because
you’re dealing with human beings who struggle with getting their egos out of the
way.” – Holly, RN
“So, you can see what a difference you’ve made and I reflected over if I moved out of state to be with my grandson. What would I go and talk to my next supervisor about, what would I be most happy about in what I’ve accomplished? And I hope that I’ve made a mark at this hospital. You know I helped establish nurse to patient bedside reporting, I helped institute hourly rounding. I’m very proud of that.” – Aaronica, RN

“It is all good. I’m very fortunate. I have legs that can take me to work every day. I have my health and my family. What more could I want? You know, I got a paycheck every week. I get to work with some great people. I got to learn with even more great people that are here. And outside of the hospital walls – I would have never voluntarily gone to ambulatory and I’m really glad I’m here - I couldn’t be happier. I love coming to work, I do.” – Victoria, RN

“In reality for me, when I’ve said that I’m really glad that I went to school it is so that I could do something other than hospital work. Because this may get way too hard to keep up if your internal philosophies aren’t intact to help you keep going. You have to know who you are. And living your whole career understanding and applying your core values. There is something about that that will ensure your confidence.” – Eva, RN

The nurse leaders reflected that the loss or change of some roles at the hospital allowed them to become more creative with the change process. They expressed that the merger provided them with a yearning for something more. They shared some interesting reflections on their leadership and they were worried that future nurse leaders will struggle with work/life balance. Furthermore, the nurse leaders described that the merger experience was a catalyst for deep personal change whether it was for retirement, returning to school or exploring other opportunities within the system.

“I think I can make a great team or I can make a weak team based on how I behave. So, it's important to me that they [staff nurses] feel comfortable here, supported that they got acknowledged when they do something that's great or good and that they get coached when they need coached and that they don't feel that I don't add stressed to an already very stressful job, that I do the opposite.” – Jane, RN

“I really haven’t shared this with anybody yet. Now I’ll share with you. I’m going to retire.” – Jacqueline, RN

“All these guys I work with, truly, that's a lot of it. School has helped. That really helped me start looking at just the world in a different way. I tell you, I
think about where I might be mentally right now if I haven't gone back to school.”
– Holly, RN

“I was telling you how I'm thriving - some of the reasons that I'm thriving is because there's there is no creative services left here at the hospital anymore so I get to sign up for these little creative tasks. There is no - well, HR has got a skeleton crew so I make the movies for employee engagement and I volunteered for all these things and I wouldn't have had an opportunity to do any of those things. I did a - I do posters for projects and I'm the photographer. I've made three movies. I have continued the healing images and I'm the only one on the team, which is okay. I want to demonstrate to all the other nurse leaders that we can get through this change....together.” – Jane, RN

After the initial stages of confusion and uncertainty for the nurse leaders came a growing desire for order and a sense of stability on a more personal and spiritual level. The nurse leaders described throughout this theme as looking inside themselves for some deeper answers to questions about life’s meanings. In many ways, the nurse leaders described that the merger made sense as an upheaval and allowed them the ability to look at as a “whole” and see themselves in it.

Transcending all four essential themes as described by the nurse leaders before, during, and after their merger experience were healthcare reform and communication tangles. For instance, as a result of the merger, the nurse leader’s role and responsibilities changed, which impacted them and results in a significant change to their line of sight. It was difficult for the nurse leaders to clearly identify whether these changes to nurse leader roles resulted from the merger or healthcare reform. However, all of them described that healthcare reform was the catalyst to the merger and the transformation of hospital to consolidation.

Exhaustive Descriptions that Form the Universal Essence

The sixth step of data analysis includes developing an exhaustive, comprehensive description of the merger experience as articulated by the participants. Creswell (2007) states that researchers search for essentials, invariant structures and emphasize the intentionality of consciousness where experiences contain both the outward appearance and inward consciousness
based on memory, image and meaning. Colaizzi (1978) affirms that an exhaustive description is developed through a synthesis of all theme clusters and associated formulated meanings explicated by me, as the researcher.

**Exhaustive Descriptions**

Data from this study generated an exhaustive description, which consisted of four components:

1. Nurse leaders considered the merger necessary despite the fact that they may not have been prepared and because the pressure to change and merge the hospital was external. As such, the nurse leaders wore a mask to conceal their own personal feelings of uncertainty while outwardly displaying positivity by outwardly embracing the role of team player, cheerleader and salesman to influence patient and nursing care as a whole.

2. Nurse leaders experienced merger by surrendering to continually changing role obligations and uncertainty, which demanded deeper personal reflection and focus on self (internally). For instance, many of the nurse leaders spoke emotionally of their fear regarding the potential to lose their position, power, or even their jobs amid the grief they experienced with the loss of functional staff positions to the health system, or with staff retirements, staff relocations or by reductions in force.

3. Nurse leaders gained greater insight and appreciation for their roles as a change agent in the merger as they realized the significance of letting go of the past through mitigating and palliating as well as relearning amid the growing pains of a larger, far more complex and bureaucratic organization.

4. In this merger experience, nurse leaders achieved a profound intention to emerge from the intensely personal and professional organizational change experience, and move on in
their leadership practice, with internal strength during time shifts, and including a desire for a hopeful future inside a caritative culture.

**Statement of Identification or Universal Essence**

By reflecting on these four essential structural themes, I further reduced this exhaustive description into a concise statement, which integrated the four components:

> Experiencing the meaning of mergers, nurse leaders wore masks of dualities: concealing their own feelings while outwardly exhibiting positivity to focus on others’ needs as they surrendered to continually changing role obligations and uncertainty, which demanded deeper personal reflection and focus on self, that led to a profound intention to emerge and move on with internal strength amid time shifts, with a yearning for a hopeful future.

It is challenging to consider that such an emotional and overwhelming experience for the nurse leaders could be reduced to a single statement. Yet, in speaking to nearly all the nurse leaders that I interviewed, I found they verified the universal essence of the merger experience as matching their lived experience.

**Participant Verification**

Following the seventh and final step in the Stevik-Colaizzi-Keen (1978) method of data analysis, I asked the participants to verify the statement of identification or universal essence of their merger experience. I asked each participant, “What aspects of your experience have I omitted?” The following are examples of verification statements that the nurse leader participants provided:

> “I think the universal essence sum up PERFECTLY what the experience has been.” – Holly, RN

> “I think you got it exactly right.” – Nicole, RN

> “I thought you were talking about me in the universal essence, so I believe that means you are right on target.” – Grace, RN
“This looks great to me and I agree with the universal essence of our experience.” – Vanessa, RN

“AMEN.” – Martha, RN

“I think you did a great job describing my experience. That 1 sentence is pretty intense and says a lot. It is very much my experience.” – Eva, RN

“You are right on target!” – Kelly, RN

Data Analysis Summary

It was in the act of reading and writing that the insights emerged, were interpreted, and the fundamental answers to the research questions were perceived. This section synthesized the answers to the three overarching research questions that guided this study.

Research Question 1

What is the nurse leaders’ experience before, during, and after merger? The nurse leaders’ experience before, during, and after merger was found in the universal essence of the experience: as nurse leaders wore masks of dualities - concealing their own feelings while outwardly exhibiting positivity to focus on others’ needs as they surrendered to continually changing role obligations and uncertainty, which demanded their own deeper reflection and focus on self, that led to a profound intention to emerge and move on with internal strength amid time shifts, with a yearning for a hopeful future.

The data from the study generated an exhaustive description of the essential structures previously detailed in this chapter. These included masking so that the nurse leaders could focus on others and minimize the impact of the experience to the staff nurses that they led; mirroring or reflecting on the uncertainty which demanded a deeper attention and focus on themselves; mitigating which allowed the nurse leaders to appreciate their role as a change agent as they recognized the importance of letting go of the past; and moving on in their leadership practice(s) with a new vision for the future in a cariative culture.
Research Question 2

What does it mean to nurse leaders to lead, manage, and guide others through a merger in healthcare? In searching for the nurse leaders’ experience on what it means to nurse leaders to lead, manage, and guide others through a merger in healthcare was revealed through the conceptual framework of Senge’s (1990) ladder of inference or the reflexivity loop: thoughts/knowledge, feelings and behavior. Embedded in the nurse leaders’ narratives were the organizational thought processes that carried their story. Even when story is shared it often rambles and unwinds and we count on our minds to recall the threads of the story. Every story has a beginning, middle and an end which appears very linear, and my research questions required a linear exploration of ‘before, during, and after.’ However, discontinuous organizational change includes experiences that are nonlinear and shape an iterative cycle. At times, the nurse leaders described their experiences with all three states (before, during, and after) in one fell swoop. In this way, it was challenging to analyze and code the narrative in which the nurse leaders wrestled or wrangled with their thoughts, feelings and actions. Through description, chronology and reflection, narrative made the association between thoughts/knowledge, feelings and actions, which created meaning for the nurse leaders.

The rich, thick narratives of the nurse leaders’ words and their meanings depicted in this merger experience were exceptionally profound. The merger experience affected the nurse leaders’ identities at a deeply personal level. They experienced uneasiness and anxiety in being nurse leaders, the future of their nursing service, and their mandate as patient advocates. Over seventy-one textual descriptions were summarized into seventeen textual theme clusters. These textual descriptions are the threads of narrative that created the context as the lived experience. Understanding what resides underneath the spoken word created the meaning of this merger experience for these nurse leaders. Without these rich textual descriptions, I would not have
been able to discover the four structural descriptions of the nurse leaders’ experience(s) occurring before, during, and after a merger, and thus, would have been unable to answer this research question.

The aspects of the merger that led the nurse leaders to *masking* included the recognition that the nurse leaders concealed their own feelings while demonstrating cheerfulness or positivity to staff nurses. Masking began with the triggering event of the merger announcement itself, which set in motion the uncertainty of feelings which informed their behaviors or actions.

The aspects of the merger that led the nurse leaders to *mirroring* included the recognition of change in their role and responsibilities; a loss of authority and unfamiliarity with organizational change processes; organizational grief in seeing staff (relationships) leaving the hospital through consolidation, reductions and retirements; loss of influence on nursing care and advocacy for patients during and after merger. The emotional pain experienced when others evaluated their skills and conditioning may have led to a crisis of identity which further drew the nurse leaders inward for deep personal reflection.

The aspects of the merger that led the nurse leaders to *mitigating* included experiencing the new leadership culture as complicit in the nurse leaders’ perception of their mediocrity or weak financial performance which produced the low expectations their new managers had of them, which led to profound feelings of inferiority; communication tangles; the experience of organizational bureaucracy and layers of management within the system; overwhelming and constant tension of meeting multiple obligations of care; becoming a managerial “implementer” and experiencing role confusion in a new organizational hierarchy.

The aspects of the merger that led the nurse leaders to *moving on* included the experience of the time paradox in which the nurse leaders reflected on the organizational change and their understanding of it and its loss. This intentional reflection provided them with the motivation
for something more. The merger experience and the extreme organizational change was the
catalyst for deep personal transformation that was found in professional development, exploring
other employment opportunities, or retirement. The experience of loss of control informed a
need for a sense of stability on a personal and spiritual level for the nurse leaders.

**Research Question 3**

What aspects of the merger experience lead to meaning making for nurse leaders?

Discovering the answer to this question was found in ‘the search for something more’ narratives
of the nurse leaders’ textural theme descriptions. Together, these formed the structural
description of Theme four: moving on and visioning for the future. The way we think about
work may depend on how we see the big picture of life. The significance of what aspects led to
meaning is an unwieldy question. Each of these nurse leaders’ expressed profound narratives on
what it means to serve as a nurse and as a transformational leader (which I attempted to capture
and present in the participant composite section of this chapter).

The twisted irony of merger integration is that it is often implemented by nurse leaders
who have spent years cultivating trust with the very staff they are about to affect, layoff, transfer
to another nursing service, or downsize due to redundancy; having encouraged them to serve
(work) with compassion in the organizational culture of care and collaboration. The impassioned
kinship related to the emotional trauma of merger experienced by these nurse leaders brought
meaning to their accompanying feelings of singularity, estrangement and solitude. When one
has been traumatized, the hope for being deeply understood is to form a connection with
someone who knows the same darkness. This merger experience evoked a kind of meaningful
loss that can be an emotional trauma for which it is especially difficult to find a relational home.

The *yearning for a hopeful future* formed through time and with the nurse leaders’ insight
and hindsight, as well as in sharing the meaning of loss by finding internal strength amid changes
and challenges so they could move forward with foresight into a hopeful future. Sociologist Christina Baldwin believes that “life seeks order in a disorderly way, and all the upheaval and messiness that surround us become a sign of productive busyness; and if we keep calm while life uses these processes, then we can let go of despair” (2005, p. 229).

The creative tension that brings about change in an organization can be created within the individual leader. These nurse leaders moved through an extreme organizational change transition and they have balanced and integrated transformational perspectives into an optimistic and hopeful meaning of their journey. With the passage of even more time, the nurse leaders’ narrative story will continue to change and evolve. Language substitutes itself for the phenomenon that it tries to describe (van Manen, 1990).

**Summary**

In sum, data were reduced and analyzed by means of thematic codes and concepts by utilizing the Stevick-Colaizzi-Keen (1978) method. Themes gradually emerged as a result of the combined process of becoming intimate with the data, making logical associations with the interview questions and descriptions of the nurse leaders’ experience, and considering what was learned during the initial review of the literature. At successive stages, themes moved from a low level of abstraction that became more of a major overarching theme rooted in concrete evidence provided by the data and the narratives themselves. These emerging themes together formed the universal essence of the phenomenon of the merger experience for the nurse leader. The next chapter will further reflect on the findings.
CHAPTER FIVE: CONCLUSIONS

The purpose of this study was to discover the essence of the lived experiences of nurse leaders before, during and after a merger. In choosing words to express my reflections of the findings and complexity of the data, I have engaged in the interpretative act; thus, lending shape, form and meaning into an intertwined process. Therefore, it may be best to begin with a brief summary of the whole in order to provide an introduction to this concluding chapter.

In chapter one, I detailed how I became interested in studying the nurse leader merger experience, the contributing factors in healthcare which prompted the consolidation and integration of health services, and the role for making sense of the organizational merger experience from the nurse leader perspective. Additionally, I provided a conceptual framework for this study, as well as a graphical depiction of emotions noticed in context with merger syndrome in a structured summary.

In chapter two, I researched the shared historical context of nursing and hospitals, the perception of organizational change by leaders in charge of change implementation, and the current healthcare reform environment influencing hospital merger, acquisition and consolidation. Additionally, I reviewed the scholarship articulating the theoretical foundations of organizational change theory, change phenomena and the emotions experienced with competing contextual bases of change.

In chapter three, I provided an examination of the phenomenological research approach that I utilized. I reviewed the methods of phenomenology and key concepts of its founder Edmond Husserl to the pedagogic orientation of researching the lived experience as distinguished by Max van Manen. These concepts included consciousness as a form of being, the return to the “things” themselves in search for meaning within the context in which it occurs.
Chapter four revealed the structures and textures of my research findings. I discovered the meaning of the nurse leaders’ merger experience through four themes or structural descriptions of masking, mirroring, mitigating and moving on. These structural descriptions were reduced to a universal essence that was validated by the participants and demonstrated that a qualitative method can improve one’s understanding of the meaning of the nurse leaders’ merger experience on an existential level.

In the final chapter of my dissertation, I reflected on the research findings derived from my human science research investigation; what I discovered about the merger experience of the nurse leaders before, during and after merger and its relevance to me, the field of leadership studies, and to other areas of study including healthcare organizational development and nursing administration. I critiqued my research methods and procedures, including the limits and advantages of my research design and methodology, as well as what I would do differently in future studies of this nature.

This chapter provides a summary of the significance of this study, methods of verification, implications for leadership practice, research, policy, and summary conclusions. The next section provides discussion and reflections of my findings.

Discussion and Reflection on the Findings by Theme

Phenomenology was the chosen methodology for this study because it provided a deeper understanding of the subjective merger experience of nurse leaders within the context of extreme organizational change. It is unique from other methodologies in that it does not seek to develop generalizations about a phenomenon but rather, it garners a more comprehensive view of how the phenomenon was experienced as a whole. The structure for describing the lived experience was derived from thematic analysis of the interviews and transcripts, field notes and reflective writing (Stevick, Colaizzi, & Keen, 1978). Each participant viewed the merger experience
within the framework of their values, history, and vocation as a professional nurse leader, while I came to the investigation with fore-structures shaped by my own background. Additionally, in the process of interaction and interpretation, the participants and I developed a shared understanding of merger experience. Moreover, the process of phenomenological reflection is retrospective rather than introspective (van Manen, 1990).

Thematic analysis focused on allowing themes to emerge from the data, uncovering essences that make the nature of the phenomenon as it is and without these emergent themes, or essences, it ceases to be (Merleau-Ponty, 1962). Merleau-Ponty describes speaking as the discovery of what she was thinking (as cited in van Manen, 1990). As the nurse leaders reflected on the merger experience, they discovered how each part of the experience affected the whole experience and that the whole experience was more than just each part taken together. I adopted the same technique of looking at how the sum of the experience informs the whole and reflectively how the whole informs individual aspects of the experience.

The hermeneutic interpretive process of this phenomenological study of nurse leaders before, during, and after merger resulted in an universal essence of the merger experience ‘as nurse leaders wore masks of dualities: concealing their own feelings while outwardly exhibiting positivity to focus on others’ needs as they surrendered to continually changing role obligations and uncertainty, which demanded their own deeper reflection and focus on self that lead to a profound intention to emerge and move on with internal strength amid time shifts, with a yearning for a hopeful future.’ In my research, the nurse leaders expressed the meaning of the merger under the themes of masking, mirroring, mitigating and moving on. In the next section, to illustrate these major themes, I offer some of the more evocative findings to be discussed and reflected through the literature.
Theme One – Masking: A focus on others

Nurse leaders considered the merger necessary despite the fact that they may not have been prepared and because the pressure to change and merge the hospital was external. The literature on change management is typically introduced by an explanation of the intense and relentless pressure to change that most organizations are experiencing (DeLucia, Ott, & Palmieri, 2009; Garman, 2011; Kotter & Cohen, 2002). The common causes of these external pressures include competitiveness, advances in technology, regulation, growth and industry restructures. For the health care industry, change is often driven by cost cutting and rationalization of services (Fisher, 2011). With the dominance given to economic pressures, there is little attention given to other outcomes such as the personal and social costs (Alvesson, 2002).

An increased level of uncertainty or rumors about the merger contributed to speculations about the potential organizational change processes which initiated emotions (Ashkanasy, Hartel, & Zerbel, 2000; Marks & Mirvis, 1986). In the merger syndrome literature, emotions are mentioned, but their role, antecedents and consequences are discussed only at a very general level. The merger syndrome is usually characterized by a comprehensive set of issues, such as a change of identity, centralization of decision-making, power games, decreased productivity, stress and by feelings of insecurity, anxiety, mistrust (Applebaum, Gandell, Yortis, Proper, & Jobin, 2000a; Marks & Mirvis, 1986).

From my contextual interpretation and understanding, I discerned change as a natural part of the nurse leaders’ daily work. Nurse leaders wished to be engaged as change agents, in fact, they expected to serve in this role of change agent so they could influence patient care and the surrounding context while simultaneously inspiring and encouraging staff nurses to implement change for their patients’ best interests. I found the nurse leaders’ actively engage in continuous
change on a personal and professional level and they seized any opportunity to influence clinical and service quality as a whole.

One of the nurse leaders stated, “As painful as it was to think about not being able to be independent anymore, I think all of us saw the handwriting on the wall. And so I think that was a good process, you know, multiple disciplines all got their heads in the same room and talked about what were our options” (Heidi, RN). The nurse leaders considered the merger necessary despite the fact that they may not have been psychologically prepared.

In discerning these textual themes it became easy for the nurse leaders to focus on others and mask their own feelings. Another aspect of emotions in relation to the management of organizational change was proposed by Frost and Robinson (1999) who stated that an unrecognized but very important role is played by managers who provide emotional support to staff in times of stress and change. The nurse leaders wore a mask to conceal their own personal feelings of uncertainty while outwardly displaying positivity to influence patient and nursing care as a whole, as they outwardly embraced the role of team player, cheerleader and salesman. An example of the conceptual map of the structural description of Masking: Focus on Others is shown in Figure 6.
A recent Norwegian phenomenological study by Salmela, Eriksson and Fagerstrom (2013) revealed that nurse leaders were positive toward and actively engaged in continual change in their nursing units, even though they perceived themselves as mere spectators of the change process which affected the nurse leaders’ identities on a deeply personal level. The results of this study were published after my qualitative interviews took place. However, my findings regarding the perspective that the emotional and other effects of change need to be fully acknowledged as part of the nurse leader experience, support and agrees with the results of the Salmela, Eriksson and Fagerstrom (2013) study.

**Theme Two – Mirroring: A focus on self**

The merger and acquisition literature discuss resistance to change, feelings of powerlessness in context with the regression return to primitive behaviors (Marks & Mirvis,
Many people experienced a perceived loss of control during merger transitions as dynamics beyond their influence took hold. Psychological research shows that when people perceive their control to be lessened, they assume it has been eliminated (Bridges, 1991; McPhail, 1997). The result is employee inaction and managerial paralysis. The critical mass of the unknown during a merger and acquisition (especially in the subordinate organization) provides for unclear nursing leadership vision, disjointed reporting relationships, unrealistic expectations, and an exacerbation of feelings that one cannot control one’s fate (Marks, 2007).

By conducting a contextual interpretation of the second theme, I found that nurse leaders experienced merger by surrendering to continually changing role obligations and uncertainty, which demanded deeper personal reflection and internal self-focus. Individuals can only operate for so long with their mental and emotional circuits on overload. Spencer and Adams (1990) argue that it “is natural for individuals to behave as if everything is perfectly normal, giving yourself and others the illusion of having everything under control” (p. 41).

Many of the nurse leaders spoke emotionally regarding their fear in the potential loss of their position, power or even their jobs amid the grief they experienced with the loss of functional staff positions to the health system, or with staff retirements, staff relocations or by reductions in workforce. The expectancy theory of motivation expresses this is a function of three factors: instrumentality (a person’s perceived relationship between how hard she works and how well that work is done) valence (the person’s feelings about how attractive the reward is), and expectancy (the person’s expectations that doing the job will indeed be rewarded) (Vroom, 1964). People tend to minimize the true impact of a change because there is a need to get ready on so many levels to adjust to the consequences. Spencer and Adams (1990) argue that nearly everyone moves into feeling a little more defensive than usual and denying that anything is different during a personal life change.
Philosopher and poet, David Whyte (1996), in his book *The Heart Aroused* speaks of disclosure and vulnerability with the internal willingness to wrestle with our inner demons. He states, “achievement is found when we acknowledge that these unresolved forces, or our demons, affect our lives and those who work with us tremendously, simply because everything we do is determined by the fears and hopes we bring to a situation” (p. 63). A form of healing seems to take place when we find a sympathetic ear for our more difficult struggles. Faced with the fear in the new leadership culture, these nurse leaders sunk to new and subtle forms of invisibility, perhaps sinking into the cover offered by the organization in order to engage in deep personal reflection.

Constricted communication during transition is the basis for anger, distress, and cynicism that linger after a merger (Marks, 2007). It creates a precedent that may become ingrained in the organizational culture to the extent that upward and downward channels of communication get cut off. A nurse leader shared the following “Once the initial shock was over, of course nobody knew what the next step was. So, that's when the fear came of what am I going to do? And we had no answers, we had no direction. None of us knew if we were going to be opening into something else or are we all going to be laid off?” (Victoria, RN). I perceived frustration on behalf of the nurse leaders pertaining to their roles as nurse leaders and what was expected of them as they described this phase of the merger experience.

The nurse leaders expressed anxiety regarding how the merger would affect nursing care and their authority. “It’s loss of control. Everybody has lost control. We don’t have control. We don’t have control when to roll it out [changes]. We don’t have control of the system...it’s like, ‘who made that decision’?” (Aaronica, RN). The internal contest for positions, privileges, and projects lead to emotions like jealousy, mistrust and suspicion (Applebaum, Gandell, et. al., 2006), which compelled the nurse leaders to focus on self. Arlie Russell Hochschild (1983)
emphasizes that gains in productivity, quality and ability to do “more with less” may be a work ethic of fear, as fear is the oldest way to get people to work. Subtle fear, based on the uncertainty about the future compels many to work at a frantic pace and thus, faced with fears we look inward. An example of the conceptual map of the structural description of *Mirroring:* *Focus on Self* is shown in Figure 7.

![Figure 7: Example of the conceptual map visual of the structural description of *Mirroring:* *Focus on Self* using the ladder of inference (Senge, 1990).](image)

Throughout this theme the nurse leaders perceived themselves to be spectators of the organizational change process or implementers of practices asked by a new leadership culture from the integrated healthcare delivery system. In effect, the nurse leaders did not feel like actors in the change process, they experienced strong feelings of exclusion, and a profound sense of loss which could be described as organizational grieving, or as experiencing a mourning
process. These findings from my study align with previous findings regarding organizational grieving (Handel, 1998).

**Theme Three – Mitigating: Letting go of the past**

Organizational transitions do not have to have abrupt endings. Significant and real stress came when nurse leaders struggled to meet business objectives in an environment of confusion and chaos. William Bridges (1991) model of individual transition is both a popular and profound representation of what people go through in moving from an old organizational order to the new. Bridges’ (1991) model consists of three phases:

*Letting go.* This first stage recognizes the end of something and acknowledges the experience of loss. People experience feelings like uncertainty, sadness, grief, loss, fear, anxiety, anger, disenchantment, and disillusionment during this phase.

*Neutral zone.* This is a broad category incorporating the negative emotions of resistance and more positive emotions associated with exploration and possibilities. People operating in this zone feel comfortable and emotionally awkward as they confront the unfamiliar and unknown. Some people may persevere and others may abandon the situation.

*New beginning.* This is the beginning of the new state for the individual. After contending with a neutral zone, the person settles into the new reality. People who arrive at this space are re-energized, refocused, excited about the change, engaged in their situation, and grounded.

Elisabeth Kubler-Ross (1969) outlined five commonly experienced stages for those individuals facing death or experiencing the death of a loved one. These stages include: denial and isolation, anger, bargaining, depression and acceptance. Kubler-Ross’s (1969) fourth stage is depression. Depression has two aspects: the first is related to losses in the past; and the second aspect is related to future losses. Kubler-Ross’s grief model focuses on significant individual loss; it has not been applied extensively to workplace losses such as jobs, downsizing, and reengineering (1969).
In 1990, Sabrina Spencer and John Adams published *Life Changes: Growing through Personal Transitions*. In this work, Spencer and Adams (1990) described seven stages that define the nature of *personal* transition. Like Kubler-Ross, theirs is not focused on organizational transitions, but centers on personal transitions that may or may not be work-related. The first two stages, Losing Focus and Minimizing Impact, describe a sense of confusion and disorientation followed by denial and attempts to act as if nothing has changed. Stage 3, The Pit, is the most difficult and painful stage. It includes feelings of sadness, anger and fear. The next two stages, Letting Go and Testing Limits, include shifting from the past to the future. In Letting Go there is a focus on opportunities and possibilities. With Testing Limits comes the release of energy, along with increased optimism, enthusiasm and vitality. The last two stages, Search for Meaning and Full Integration, bring a sense of self-confidence and ability to manage the future (Spencer & Adams, 1990). In their research, Kubler-Ross (1969) and Spencer and Adams (1990) expressed that the change is no longer a “thing” that is happening to you but rather a part of your new life.

All of these models of transitions want people to jump in at the end stages, thus avoiding the messier and frequently more negative part of transition: reacting. The nurse leaders described their experience as “messy.” The nurse leaders described that a negative reaction, in particular, was perceived by them as undesirable or unnecessary as they did not want the new leadership to view them negatively through this context as they would be perceived as negative, resisting, and lacking “leadership” skill as well as being unwelcome in the new organizational culture.

In discerning these textual themes, I found that nurse leaders experienced the layers of management and confusion regarding decision making during the merger as extremely stressful. Additionally, their leadership style was challenged as they transitioned into a large, complex and
bureaucratic organization. The nurse leaders were re-learning that their autonomous personality was replaced with an organizational identity of “system-ness.” The nurse leaders gained greater insight and appreciation for their roles as a change agent implementer in the merger as they realized the significance of letting go of the past through mitigating and palliating with re-learning amid the growing pains of a larger, far more complex and bureaucratic organization. The nurse leaders described their experience as a “separateness” with power struggles and a loss of team play during this mitigating phase. Marks (2007) asserts that all transitions, even relatively well-managed ones, have unintended negative consequences and that adaptation to the transition is a natural and difficult process that cannot be circumvented. An example of the conceptual map of the structural description of Mitigating: Letting go of the past is shown in Figure 8.

**Figure 8:** Example of conceptual map visual of the structural description of Mitigating: Letting go of the past using the ladder of inference (Senge, 1990).
One of the nurse leaders expressed indifference with the bureaucracies of a new system this way, “We’d become a part of a system and you still have a voice but, boy it sure doesn’t ripple like it did when you were just part of a community hospital. And so you learn not to fight things, you learn to just say, ‘Hey, guys this is what the system tells us what we have to do, we have to make the best of it.’ You know, ‘did they give us adequate time to get it out to you?’ No, but this I what we have to deal with…” (Aaronica, RN).

Trice and Beyer (1993), drawing upon concepts from anthropology, have suggested that, in order to smooth the transition from one organizational culture to another, the issue of rites should be considered. For example, they suggest conducting formal “rites of transition” and “rites of parting” events to assist leaders and employees with transition (p. 126). The rites of parting are generally focused upon the demise of the whole organization. However, in the context of this dissertation, they are being referred to as an opportunity to affirm the existence and benefits of the new organization, and the passage from the former hospital’s mission. The form that these “rites of passage” take would seem fertile ground for future research, particularly a case study experience investigating the idea that the rational and the emotional can be fused in a codependent fashion.

**Theme Four – Moving on: Visioning for the future**

This theme in the literature takes the reader through a series of steps to successfully manage the change process (Bolman & Deal, 2003; Kotter & Cohen, 2002; Kouzes & Posner, 2012); however, at the same time, there is a dearth of literature that seeks to genuinely analyze and make sense of the experience of managing change (Collins, 1998; Hartley, Benington, & Binns, 1997; Shaley, 2007). Our work lives involve loss. None of us makes it through a career without loss of a treasured sense of self that comes from work, whether it may be a loss of status or a respected position, close working relationship, valued team membership, or prominent work
location (Dutton, Roberts, & Bednor, 2010). A nurse leader shared this description, “So, intellectually, there's nothing really that's hard...it's been more of an emotional hardship I think than anything else; and knowing that we really had a good thing. It's hard to know that you had a good thing and, that 'that good thing' [the hospital] was going down the tubes because of things that you couldn't control and now you're in a thing [new integrated healthcare delivery system] that's not as good.” – Heidi, RN (bracketed information added). Work-related identity issues are aspects of identity and self-definition that are tied to participation in the activities of work or membership in work-related groups, organizations, or professions (Dutton, Roberts, & Bednar, 2010). Work losses require a surrender of the current meaning of self and realignment to a new beginning.

In discerning this theme, the nurse leaders reflected that organizational changes affect your ego on a profoundly personal level. Schein’s (2004) work also suggests that change occurs through cognitive restructuring in which words are redefined to mean something other than what had been assumed, concepts are interpreted more broadly, or new standards of judgment and evaluation are relearned. Therefore, the narrative of the nurse leaders’ story matters. Lewin’s (1951) ideas remain central in exploring this theme as the provision of psychological safety that converts anxiety into a motivation to change. For example, systems become undone, rearranged and reconstituted (unfreeze, change, and refreeze).

Cognitive psychologist Henry Cloud (2011) asserts that individuals will change behavior when the pain of staying the same becomes greater than the pain of changing. Consequences give us the pain that motivates us to change (Cloud, 2011). The nurse leaders described focusing on their professional work in a variety of ways to promote their growth on many levels as evidenced by the desire to go back to school or to pursue other professional interests. How our self-esteem flows from our judgments we make about two aspects of our nature: competence (or the ability
to handle what life throws at us) and our self-worth (the ability to respect what we want and what we need in order to be happy) provides the venue in which our thoughts connect to the possibility to grow into something more (Clark & Cafarrella, 2000; Kegan, 1994; Mezirow, 1991; Wheatley, 2006).

Robert Kegan (1994) states that formal education for adult learners can be the most fertile context for the transformation of consciousness in adulthood. The transformation of one in self-authorship, of becoming the definer of the nurse leaders’ acceptability in the new organizational culture may provide a vision for the future (Kegan, 1994). Fumia (2003) shares, “the paradox of healing is that it is both holding on and letting go…we hold onto an old way of being because the self still resides there, and we let go to a new way of being so that the self can live on” (p. 167).

In this merger experience, nurse leaders achieved a profound intention to emerge from the intensely personal and professional organizational change experience, by moving forward with their leadership practice(s) with internal strength during time shifts including developing a desire for a hopeful future inside a caritative culture. If continuous change is altered by freezing (Lewin, 1951) and rebalancing or recalibrating, then the role of the change agent becomes one of managing language; the stories we tell ourselves and each other, as well as reinventing our identity. Nurse leaders became important for their insightful ability to make sense (Weick, 1995) of change dynamics that are already occurring in the organization. As nurse leaders were able to recognize emergent changes, and reframe (Bolman & Deal, 2003) them they explained current upheavals, and inspired a shared vision (Kouzes & Posner, 2012) for staff nurses in caring and compassionate cultures.

To redirect continuous change is to be sensitive to the story. Schein (2004) argues that dialogue, enables groups to create shared sets of meanings and a common thinking process. Schein (2004) expresses “The most basic mechanism of acquiring new information that leads to
cognitive change is to discover in a conversation that the interpretation that someone else puts on a concept is different from one’s own” (p. 31). Extreme organizational change found in a merger experience places implicit demands for deep internal changes upon every person in an organization. Therefore, theories of organizational development, organizational learning, adult learning and psychological development are complementary and provide insight to the transformational change that occurs with the nurse leader. An example of conceptual map of the structural description of *Moving On: Visioning for the future* is shown in Figure 9.

![Figure 9. Example of conceptual map visual of the structural description of *Moving On: Visioning for the future* using the ladder of inference (Senge, 1990).](image)

This section provided a discussion and reflection on the structural descriptions or the four themes of the study and graphically displayed the theme(s) through a contextual frame.

**Discussion and Reflection on the Findings by Research Question**

Gadamer (1975) explained that all lived experiences have a certain immediacy that eludes every determination of its ultimate meaning because as we attempt to recover the contents of the
nurse leader experiences through memory or reflection, they are in some sense ‘always too late.’

We can never recover experience as it happened in the instant of the moment. The phenomenological interest was not a separate activity but was attempted throughout this phenomenological writing process whenever the elusive meaning of the phenomenon needed a certain form or degree of evocation. The next section reflects briefly the study’s findings by research question.

Discussion and Reflection on Research Question 1

What is the nurse leaders’ experience before, during, and after merger? The nurse leaders’ experience before, during, and after merger was discovered in the universal essence of the experience:

*Experiencing the meaning of mergers, nurse leaders wore masks of dualities: concealing their own feelings while outwardly exhibiting positivity to focus on others’ needs as they surrendered to continually changing role obligations and uncertainty, which demanded their own deeper reflection and focus on self, that led to a profound intention to emerge and move on with internal strength amid time shifts, with a yearning for a hopeful future.*

The data from the study generated an exhaustive description of the essential structures that included: *masking* so that the nurse leaders could focus on others and minimize the impact of the experience to the staff nurses that they led; *mirroring* or reflecting the uncertainty which demanded a deeper attention and focus on themselves; *mitigating* which allowed the nurse leaders to appreciate their role as a change agent as they recognized the importance of letting go of the past; and *moving on* in their leadership practice with a new vision for the future in a cariative culture.

The understanding of experience is a challenging undertaking. Van Manen (2014) explains that experience is more complex, nuanced, and ambiguous than any description can do
justice to: it is not easily captured by language. The words that the nurse leaders articulated in describing their experiences before, during, and after the merger were also reflected in the literature (Applebaum, Gandell, Shapiro, et al., 2000; Cartwright & Cooper, 2000; Gutknect & Keys, 1993). When faced with major transitions nearly everyone will experience some stages of transition with some people moving through stages faster or slower than others (Bridges, 1980; Janssen, 1982; Kotter, 1996; Kubler-Ross, 1969; Lewin, 1947; Musselwhite & Ingram, 2003; Prochaska & DiClemente, 1982; Scott & Jaffe, 1988; Spencer & Adams, 1990). The literature indicates that the speed of transition may be impacted by several factors: the degree of emotional and psychological threat posed by the change or the person’s change style preference (Musselwhite & Jones, 2004).

**Discussion and Reflection on Research Question 2**

What does it mean to nurse leaders to lead, manage, and guide others through a merger in healthcare? Revealed through the conceptual framework of Senge’s (1990) reflexivity loop was the search for meaning regarding the nurse leaders’ experience to lead, manage, and guide others through a healthcare merger. Also embedded in the nurse leaders’ narratives were the organizational thought processes that carried story. Senge’s (1990) reflexivity loop includes: thoughts/knowledge, feelings and behavior. As previously presented in chapter one, my conceptual model was designed to show how our feelings inform that our beliefs are our truth; the truth is obvious; our beliefs are based on our truth; and through this constructed truth we select, are real data (Senge, 1990).

Over seventy-one textual descriptions were summarized into seventeen textual theme clusters. These textual descriptions were the threads of narrative that created the context as the lived experience. By understanding what resides underneath the spoken word, the meaning of their merger experience for these nurse leaders was created. Without these rich textual
descriptions I would not have been able to discover the four structural descriptions of the nurse leaders’ experience before, during, and after merger which answered this research question.

The rich, thick narratives of the nurse leaders’ words and their meanings depicted in this merger experience were exceptionally profound. The merger experience affected the nurse leaders’ identities at a deeply personal level. They experienced uneasiness and anxiety with regard to being nurse leaders, the future of their nursing service, and their mandate as patient advocates. The nurse leaders first stumbled into their belongingness by realizing how desperately out of place they felt with a new leadership culture. This sense of loss has a natural way of drawing us inside our self (Whyte, 1994).

The literature reflects the relationship between emotion (feeling) and reason (thinking/knowledge) for centuries by philosophers, psychologists, novelists and organizational theorists with a number of different conclusions: emotion is the opposite of reason (Weber, 1946), emotion is deeply interwoven with reason (Ashforth & Humphrey, 1995), emotion can occur interdependently of reason (Izard, 1992; Zajonc, 1980). Lazarus (1991) suggests that the relationship between cognition and emotion is bidirectional: emotion influences cognition, cognition elicits emotion. Through reflection and description of the organizational change (Clark & Cafarella, 2000; Kegan, 1994; Lazarus, 1991; Mezirow, 1991), the nurse leaders evaluated the significance of the merger experience for themselves (Kegan, 1994; Weiss & Cropanzano, 1996) and this extends their impact on others (through nurse leader behavior) and to the organization itself.

The aspects of the merger that led the nurse leaders to *masking* included the recognition that the nurse leaders concealed their own feelings while demonstrating cheerfulness or positivity to staff nurses. Masking began with the triggering event of the merger announcement itself.

The aspects of the merger that led the nurse leaders to *mirroring* included the recognition of their change in role and responsibilities; a loss of authority and unfamiliarity with organizational change processes; organizational grief in seeing staff (treasured relationships with colleagues) leaving the hospital through consolidation, reductions and retirements; loss of influence on nursing care and advocacy for patients during and after merger. They described emotional pain experienced when others from the acquiring organization evaluated their skills and conditioning which led to a crisis of identity which further drew the nurse leaders inward for deep personal reflection (Bridges, 1991; Hochschild, 1983; Kubler-Ross, 1969; Scott & Jaffe, 1988; Spencer & Adams, 1990; Vroom, 1964).

The aspects of the merger that led the nurse leaders to *mitigating* included experiencing the new leadership culture as complicit in the nurse leaders’ perception of their mediocrity evidenced by organizational weak financial performance which produced the low expectations their new managers had of them. The multiplicity of these aspects led to profound feelings of inferiority; communication tangles; the experience of organizational bureaucracy and layers of management within the system; overwhelming and constant tension of meeting multiple obligations of care; becoming managerial “implementers” and experiencing role confusion in a new organizational hierarchy (Bridges, 1991; Kubler-Ross, 1969; Musselwhite & Ingram, 2003; Spencer & Adams, 1990).

The aspects of the merger that led the nurse leaders to *moving on* included the experience of the time paradox in which the nurse leaders reflected on the organizational change and their making sense of it as well as the grief and loss. This intentional reflection provided them with the motivation for something more. The merger experience and the extreme organizational
change was the catalyst for deep personal transformation that was found in professional
development, exploring other employment opportunities, or retirement. The experience of their
perception of loss of control informed a need for a sense of stability on a personal and spiritual
level for the nurse leaders (Bolman & Deal, 2003; Kegan, 1994; Kotter, 2003; Kouzes & Posner,
2012; Lewin, 1951; Mezirow, 1991; Schein, 2004; Weick, 1995; Wheatley, 2006).

Discussion and Reflection on Research Question 3

What aspects of the merger experience lead to meaning making for nurse leaders? The
answer to this research question was found was discovered in ‘the search for something more’
narratives of the nurse leaders’ textural theme descriptions which together formed the structural
description of Theme Four: Moving On and visioning for the future. Moreover, the yearning for
a hopeful future was formed through time and with the nurse leaders’ insight and hindsight, and
in sharing the meaning of loss by finding internal strength amid changes and challenges of their
merger experiences.

The literature indicates that cognitive responses to change are mediated by the perceived
speed, timing, organizational justice, scale of the change; and, all have affective elements
(Lazarus, 1991). The literature indicates that there a number of variables that moderate
thinking/knowledge; feeling; and behavior. Some of the moderators lie within the individual,
some within the nurse leader(s) leading or implementing the change; and, some within the
broader context of the organization itself. Judge (1999) found personality factors that predicted
reactions to change: positive self-concept, self-esteem, and positive affectivity. Wanberg and
Banas (2000) revealed that self-esteem, optimism and perceived control were related to
acceptance of change.

The literature indicates that previous experience of organizational change has the
potential of producing two opposing responses to a newly announced change. An employee who
has previously experienced a positive change may respond positively, while an employee with a negative experience would view the change with unease (Abraham, 1999; Kiefer, 2004). An individual faced with major change outside of work, or a number of minor changes, may react negatively on cognitive, affective and behavioral levels to an organizational change such as merger and acquisition. Any stress inducing issue outside of work can trigger negative responses to change at work, as nurse leaders’ coping resources are depleted (Wanberg & Banas, 2000). Nurse manager disposition, therefore, may be a related factor in understanding experience.

To summarize this section regarding the discussion and reflection of my findings, the descriptive interpretive phenomenological method was indispensable and appears to be more relevant than an experimental method. This research study has been a long and arduous journey, with many unexpected twists and turns along the way. I started with what appeared then as loose, undisciplined ideas on what I wanted to study and where I wanted to go with this research: ideas I could hardly express. The practice of thinking phenomenologically while doing phenomenology was an extraordinary experience in my own generative self-discovery as a human resource development practitioner.

**Significance of the Study**

This study was about the nurse leader experience before, during, and after merger of their community hospital with an integrated healthcare delivery system. There has been little qualitative research to describe the nurse leaders’ experience(s) of merger such as this. Furthermore, there appeared to be paucity in the literature concerning the lived experience of merger from the nurse leaders’ perspective. This research identified the nurse leaders’ descriptions before, during, and after merger as lived experience. Thus, it contributed to the qualitative literature regarding nurse leadership, as well as the literature on organizational change and culture through merger and acquisition.
The emotions people experience during significant organizational change shape the anticipation, the experience, and the aftermath of the stories we share about the experience. Nurses are the indispensable and anchoring element in our healthcare system and they must be able to manage change processes cognitively and emotionally. The environment in which a nurse works encourages the connection to a deeper meaning of work, or the “common caring” (Senge, 1990, p. 206) that binds us together rather than fragmentation that tears us apart. Moving beyond the ambiguous nature of the emotional side of change will improve outcomes to the human condition which will lead to improved organizational performance.

One of the common pitfalls of phenomenology resides in the requirement to set aside preconceptions and biases. Although I took this methodological principle seriously, the nurse leaders’ experiences at times manifested my own recollections of the merger experience as a human resource development practitioner. Alternatively, there were many surprises that came from looking at nurse leaders’ experience before, during, and after merger with fresh eyes, for example, the centrality of managing organizational change perceptions along with leadership loss of voice.

This study has made a contribution towards uncovering the universal essence and structural elements that make the experience behind those steps visible and explicit. It has contributed to an understanding of how the narrative of the merger experience is laid down in the layers below our everyday awareness (the agony and the resolution) in which the self is always changing, always growing, and always discovering itself.

**Limitations**

All of the nurse leaders consented to take part in this study and wanted to share their story. It was a homogeneous group as all nurse leaders were women, serving in the same community hospital with an average number of service years of 24.9 years. This homogeneity
created limitations within the study as it may not have reflected the life-world of nurse leaders who may experience extreme organizational change through merger. Second, research suggests (Brodbeck, 2012; Cartwright & Cooper, 1993; Garman, 2011; Marks & Mirvis, 2010; Starkweather, 1971) that healthcare institutional mergers are difficult (Jordan, 2005; Keifer, 2002; 2005; Kusstatscher & Cooper, 2005; Marks & Mirvis, 2010; Smollan, 2006; Wanberg & Banas, 2000). As previously stated in chapter one, the U.S. Federal Trade Commission issued an administrative complaint challenging this merger as a violation of Section 7 of the Clayton Act, and the extended duration for normal integration may have had an impact on the merger experience by these nurse leaders due to prolonged litigation.

The findings of this study suggest that the human response to change is a complex process and while a merger and acquisition for the nurse leader is an event (a business decision), the psychological response is an emotional one which encompasses a reflective transition over time. For most of us, the most profound change we experience and have to adjust to may be found in the experience of the death of a loved one (Kubler-Ross, 1969). As a commonly shared experience, as well as an experience where emotions, grief and reactions are accentuated, the death of a loved one provided an effective metaphor to this extended change experience.

**Methods of Verification**

Integrity measures included the methods I used to verify plausibility or to diminish interference, contamination, or degradation of any part of my research processes in order to strengthen those processes for trustworthiness and credibility. This section establishes and demonstrates the trustworthiness and credibility of the study findings.

As suggested in chapter three, Miles and Huberman (1994) argue that verification is important because “the data have to be tested for their plausibility, its sturdiness, the ‘confirmability,’ that is, its validity” (p. 11). Further they state that without this step, “we are left
with interesting stories...of unknown truth and utility” (Miles & Huberman, 1994, p. 11).

Integrity might be described in terms of generalizability. Many social science disciplines are oriented toward applied research, which is interested in the application of basic theory “to real-world problems and experiences” and “research findings typically are limited to a specific time, place, and condition” (Patton, 2002, p. 217).

**Demonstrating Trustworthiness of the Study Findings**

Essentially, qualitative research has to demonstrate trustworthiness in providing rigor and strength to the study in all stages including data collection, data analysis and phenomenological data descriptions. Trustworthiness approaches such as: credibility, dependability, confirmability, and transferability were undertaken throughout the study process.

A number of strategies were employed to add rigor to this study such as participant verification (member checking), which was achieved by receiving agreement from the participants on the results that emerged (Creswell, 2009; Marshall & Rossman, 2010; Maxwell, 2005; Moustakas, 1994; van Manen, 1990).

The phenomenological research design contributed toward trustworthiness. I bracketed myself consciously in order to focus my understanding on the perspectives of the nurse leaders that I was studying, as according to Moustakas (1990), “the focus [was] on an insider perspective” (p. 71). Additionally, the following five steps contributed to the trustworthiness of this study:

**Step 1:** Researcher epochal description and verbatim transcripts contributed to the holistic nature of the process. There was is no way to separate the parts of research from one another as data gathering includes parts of analysis; analysis leads to more data; and writing leads to a greater understanding of both analysis and data. The process is totally holistic: each piece is absolutely necessary to the whole. I approached my first attempts at coding with the
vivid analogy of being buried alive. The overwhelming nature of the volume of transcripts allowed me to consciously enter into a series of avoidance tactics that allotted me time in listening to the audio-transcripts over and over. This created somewhat of a paradox for me as a novice researcher. Eventually, pages and pages of codes flowed from my pen, words repeated on paper, through listening to the audio-tape recordings, reading and re-reading transcripts and field notes, and in my mind throughout the whole study.

Each interview transcript that was coded added fewer new codes to my listing and I found comfort in becoming a reflexive researcher. The many issues of phenomenological writing was not something in which I made peace during the year in which I undertook this study. Rather, I learned to obey its demand with the hope of an uncertain promise: to satisfy the desire to really “write” and produce something of value for scholarship and for the participants. This step added to the credibility of this research study.

**Step 2:** Developing formulated meanings. Significant meaning statements and phrases pertaining to the nurse leaders’ merger experience were extracted from each transcript and were placed into a Microsoft Excel spreadsheet. My expert dissertation methodologist found that my process was correct and the interpretive meaning statements that I developed were consistent, by checking the meaning statements that were derived. Transferability was achieved by the development of thick descriptions and relevant contextual statements. Becker (1970) argues that such data “counter the twin dangers of respondent duplicity and observer bias by making it difficult for respondents to produce data that uniformly supports a mistaken conclusion, just as they make it difficult for the observer to restrict her observations so that she sees only what supports her prejudices and expectations” (p. 53).

**Step 3:** Categories and clusters of themes integrated all the resulting ideas into the structural themes therefore adding to the dependability of the data. As previously outlined in
chapter four, detailing the in-depth methodological description processes was employed in the study. Such in-depth coverage allows the readers of this study to assess the extent to which proper research practices have been followed which contribute to dependability. The operational detail of the data gathering addressed the minutiae of what was done in the field and the reflective appraisal of the study evaluated the effectiveness of the process that this inquiry undertook.

**Step 4:** Emergent themes were reduced into an exhaustive description or universal essence of the phenomena. Miles and Huberman (1994) considered that a key criterion for confirmability is the extent to which the researcher admits her own predispositions. To that end, beliefs underpinning the decisions that I made and the methods adopted within the findings of this study have been acknowledged within this research report, along with significant “reflective commentary” that was enjoyed between my expert dissertation methodologist and me.

**Step 5:** Validation of the universal essence and its fundamental structure were verified by the participants. The settings and scenes I described and all the words I gathered through this research are not inherently meaningful in themselves. However, I attempted to make them meaningful through my analyses and interpretations. As Tomas Schram (2006) expresses, “the communication of this meaning through your interpretation is always negotiable and incomplete. In the end, it is a matter of how plausible your ideas appear to others, and how persuasively you make your case for your participants significance” (p. 13) all of which added to my research credibility.

This section outlined the trustworthiness embedded within this research. However, the judgment about the quality of my research study cannot be assured by the rigorous application of a set of agreed upon strategies and procedures. I maintain that the quality of this research was not only revealed in this dissertation report, but more importantly, it was also subject to the wise
judgment and keen insight of the reader. Quality judgments entail a subjective reading of the research text, and the responsibility for appraising research lies with the reader rather than the writer (Glense, 2011; O’Cathain, 2010). This does not preclude me from appraising the quality of my own work, but rather suggests that the readers are in a unique position to make this judgment based on their own perspective and practice.

Phenomenological approaches are good at surfacing deep issues and making voices heard. There is significant value of insight in which a phenomenological approach brings in terms of cutting through taken-for-granted assumptions, prompting action or challenging complacency. Given that perceptions create realities, those things which are perceived by the recipient are important. The next section provides suggestions and implications for practitioners, future research and policy.

**Suggestions and Implications**

Findings from this study showed the importance of gaining multiple perspectives. Moreover, this research indicated that regular, intensive and open communications throughout the merger and acquisition integration process was crucial. These interviews showed that there may be a connection between the dominant leadership communication style and positive and negative emotions for the nurse leaders taking part in leading, managing and guiding others through a merger.

The nurse leaders had committed to the change, cognitively accepted the need for the acquisition, and comprehended the merger because they believed that the organizational change would benefit patients and patient care. The nurse leaders held the responsibility for patients and patient care, so their mission during the organizational change was to create conditions for good quality care. The willingness to do what was good for their staff nurses and patients emanated from the nurse leaders’ internal attitudes as belonging to a caritative culture. The interviews
revealed that during the change process, some of the challenges nurse leaders faced included their feelings of inferiority to the dominant organizational leadership culture, perceptions of injustice and psychological shockwaves that could be described as extreme organizational grieving.

**Leadership Practice**

Healthcare executive leadership should consider the nurse leader an immense resource during a significant organizational change process. As this study indicated, the dominant integrated healthcare system did not seem to be utilizing the nurse leader human resource fully, and these nurse leaders’ experiences revealed them in a difficult position. The nurse leaders held a critical role with regard to influencing the success of organizational change but did not always possess a holistic perspective of the dominant organization or the organizational change process.

Nursing leadership needed deeper insight of change as a phenomenon because staff nurse opinions, actions, feelings and understandings of organizational cultures was informed by the nurse leaders charged to facilitate the change process. Nursing leadership requires working together to know what to expect and how they should address each phase of the change process. This research showed that people who are experiencing strong emotions cannot perform at their optimum level.

Healthcare organizational development practitioners should recognize a central lesson that effective health care depends on the development of healing relationships between health professionals and those who come to them for care, and between healthcare executives that create mergers and acquisitions and the rest of the organization that have to implement those integrations. In line with the literature to acknowledge organizational change experiences (Fineman, 2000; 2001; 2003; 2005; 2008; Kunda & Van Maanen, 1999; Sturdy & Fineman, 2001; Zembylas, 2006), nurse leaders need information on the human side of change and/or
communication improvements that highlight the emotional side of change transitions. Information or communication strategies should be provided honestly, factually and with compassion (Ashkanasy, Hartel, & Zerbel, 2000; Marks & Mirvis, 1986). When reacting to the change experience, people need support. Their emotions must be heard honestly and with empathy. When people enter into the experience of transition, nurse leaders need encouragement and reinforcement.

Wheatley (2006) asserts “to bring health to a system, connect it to more of itself” (p. 145). The culture of health care has shifted away from humanness inherent in the work and has neglected the authentic relationships, communications, and connections necessary for health and effectiveness. Consistent with the literature promoting the human factors and/or emotions in merger and acquisitions (Jordon, 2005; Keifer, 2002; 2005; Kusstatscher & Cooper, 2005; Smollan, 2006; Wanberg & Banas, 2000), this study demonstrated that people experience a great deal of emotion and they need to be a part of the visioning of the new organization, supported and encouraged to accept the major organizational changes with all its challenging consequences in order to be ready to contribute to its success.

The dominant organization can do much to deconstruct the merger syndrome by recognizing that tight controls end up hurting the subordinate organizations’ performance by undermining its motivation. Additionally, recognizing that merger syndrome may be unwound over time; however, reversing it requires health care leadership to challenge its own assumptions (Manzoni & Barsoux, 1998) and intentionality.

Further Research

Given the findings and the limitations of this research study, I propose three areas for further qualitative research into the merger experience. First, reviewing scholarship about transformational leadership and the three factors nurse leaders experienced with organizational
mergers: loss of control, loss of identity, and resilience may provide ample background in which to approach additional qualitative research. All of the nurse leaders in this study were female with varying years as a nurse leader. Further research with a more diverse gender base and varying years of nursing leadership experience may reveal interesting findings.

Second, the literature about change management tends to put emotions on a level with resistance (Jordan, 2005; Kiefer, 2002; 2005; Smollan, 2006; Wanberg & Banas, 2000). To see emotions as an individual phenomenon is in line with one of the current waves of research which recognizes that leadership has a vast influence on employees’ emotions (Csikszentmihalyi, 2000; Seligman, 2002). The notion of emotional contagion is useful for explaining negative changes in employees’ emotions as a consequence of negative emotional displays from leaders (Csikszentmihalyi, 2000; Seligman, 2002). Another suggestion is to ask both the dominant and the subordinate organizations involved in the merger and acquisition to participate in a qualitative research study to explore such topics as compassion fatigue, clinical quality perceptions and/or other explorations using the four themes of masking, mirroring, mitigating and moving on as described in this study.

Finally, I suggest that action-based researchers utilize these and similar findings to refine and design training and supporting mechanisms for nurse leaders to perhaps focus on organizational healing processes during the merger and acquisition integration.

**Policy**

The emotional health of an acquired, merged or consolidated healthcare organization is not all that it should be; in fact, I strongly believe it is depressed. It is clear that the sheer amount and rate or pace of change being attempted in healthcare organizations today as experienced by many leaders is a major hindrance to accomplishing organizational change. Yet, certainly within the prevalent paradigm of thinking in healthcare organizations, there would appear to be no
choice but to attempt such changes as the competitive and regulatory market demand it.

Nevertheless, the research demonstrates that much more could be done to facilitate and support nurse leaders in their efforts to respond to change initiatives. Three policy issues are offered to assist with the achievement of healthcare organizational change through merger and acquisition: improved communications, appropriate learning and development, and individual change journey experiential interventions which are further explained in the following paragraphs.

**Improved Communication**

Much can be done for any leader who is prepared to face up to the reality of what is involved in achieving organizational change beyond just demanding that it happen. Thus, the preparatory ground needs to be laid by communicating with managers what the experience both operationally and *emotionally* may be like (Jordan, 2005; Kiefer, 2005; Smollan, 2006; Wanberg & Banas, 2000). Organizations which do not communicate transparently and compassionately provoke unnecessary uncertainty and ambiguity (Schein, 1990), invite rumor and speculation, and prompt a huge investment of managerial energy in ‘*worry work*.’ Worry work can also be a massive waste of time and energy, and create unnecessary and nonproductive pain, disempowerment, cynicism and political maneuvering (Fineman, 2000; 2001; 2003; 2005; 2008; Kunda & Van Maanen, 1999; Sturdy & Fineman, 2001; Zembylas, 2006). Preparatory communication can lessen the stressful impact of fear and anxiety (Callahan, 2002) along with continuing organizational communication.

**Appropriate Learning and Development**

Enhanced learning and development can bolster efforts at communication by helping individuals to develop their own contextual understanding: what is going on, and why. Also training can be used to instill and enhance the new skills required of managers by their changed roles and job activities. Human resource development practitioners would also benefit in
understanding the emotional components in organizational change contexts especially in soothing the merger syndrome, restoring trust, and healing the wounds of a broken organizational pact (Clark & Cafarella, 2000; Kegan, 1994; Mezirow, 1991; Senge, 1990; Wheatley, 2002).

**Individual Change Journey Experiential Interventions**

Designing individual change interventions help leaders (a) inform their own experiences of change; (b) identify progress on their own change journeys; (c) help ground them in the here and now of their journeys; and (d) highlight outstanding issues and future directions. Utilizing the literature on organizational change and the literature on personal life transitions and amalgamating best practices would be an appropriate intervention (Janssen, 1982; Kotter, 1996; Musselwhite & Ingram, 2003; Scott & Jaffe, 1988; Spencer & Adams, 1990). This type of a program is a profound declaration of belonging as the nurse leaders’ stories are destined to serve someone else’s need.

**Conclusion**

Changing an organization is fundamentally and undeniably an emotional human process. Not fleeting moods or surface feelings but major states of emotional essences: fear, uncertainty, doubt, loneliness, courage, despair, optimism, patience, forgiveness and love. Individuals need a sense of belongingness in their work, a conversation about connecting to something larger than themselves, a felt participation, and a touch of spiritual fulfillment and the mysterious generative nature of that fulfillment. Our work lives involve loss. The philosopher and sociologist Alfred Schutz (1970) described the nature of the relationship between language, context, and knowledge as one that was “surrounded by fringes or halos.” Schutz (1970) stated that:

“Every word and every sentence is, to borrow a term of William James (physician and philosopher), surrounded by ‘fringes’ connecting them, on one hand, with
past and future elements within the universe of discourse to which they pertain, and surrounding them, on the other hand, with a ‘halo’ of emotional values and irrational implications which themselves remain indescribable. The fringes and halos are the stuff poetry is made of; they are capable of being set to music but, they are not translatable” (p. 97).

Leadership should be aware that the narratives of loss experiences are developed as a result of emotions related to that loss. Nurse leaders are intimately familiar with the fallen and the achingly vulnerable. It is astonishing how much of their everyday work lives have powerful life or death consequences. In seeking to affect change within the healthcare system, leaders are faced with multifaceted experiences and narratives that frequently possess the rhythmical and the emotional. It is an immense challenge to transform an already moving health care system. In most of our daily engagements with the world, language is transparent to us. Fluent speakers seldom stop to think about how they will assemble meaning to direct the attention and influence the interest of others with whom they interact. In many ways, the narrative transition, where the past and future facets meet, is an interesting space where the nurse leader plies her trade, shaping tone and tenor, setting change in motion. As distinctive and undecipherable as this sound may feel, this is a place where the capacity for change moves from emergence to pattern, from confusion to order, from brash noise to harmony, but it is rarely about resistance.

Healthcare is an intricate, complex and remarkable world that holds the entirety of the human condition, all of which intensifies the place within which the nurse leader moves. All of this makes the nurse leadership within healthcare an even more honorable and fulfilling endeavor: a journey of meaning and purpose.

The nurse leader story matters.
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## APPENDIX A: INTERVIEW PROTOCOL

### OBSERVATION PROTOCOL

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<th><strong>Nurse to Nurse interactions while on Nursing Unit:</strong></th>
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<th><strong>Nurse Leader to Patient interactions while on Nursing Unit:</strong></th>
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<td>Number of Employees/Nurses that Report to Position (Before Merger)</td>
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**INTERVIEW #1**

1. Can you describe what nurse leaders do? What don’t nurse leaders do?

2. Describe your experience of being a nurse leader before the merger. Take me back to your first job leading others (as a nurse) — what was this like, can you describe this time for me. Reconstruct a day?

3. If you could describe what it means to you to be a nurse leader in 1-2 sentences, what would you say?

4. Can you describe what it was like when you learned that the hospital was preparing to merge with a health system? What did you think, feel, or understand about this? (Probing question: If emotions are mentioned, follow-up on those.)

5. How would you describe your experience of the merger? (Probing questions: Did you have any expectations of this experience, if so, can you describe them?)

6. Can you describe what it was like the merger was official, what was your experience with the integration (during) process? What did you think, feel or understand about this? Can you describe what is different now? (Probing questions: Did you feel prepared to lead, manage, guide others through this time? If so, or if not, what made you feel prepared...or what made you feel like you weren’t prepared? Can you describe this?)

7. What does a nurse leader do to [lead, manage, guide] others through a merger? If you could describe this to someone in just 1-2 sentences, what would you say? What was going on in your gut, mind and heart during this organizational change process?

8. Can you describe what is easy or difficult during your merger experience? (Probing questions: your thoughts and knowledge, feelings, and behaviors?)
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**INTERVIEW PROTOCOL #2**

1. Given what you have said about your life before the merger and what you have said about your work now, how do you understand your nurse leadership today? (Probing questions: Can you describe for me what has changed?)

2. What can you share about the perspective you have after the merger? What have you learned? Can you describe what you understand about the organization now? What is your relationship like with the organization? With your leader? With your direct reports/nurses?

3. Can you describe what sense this change journey has meant for you?

4. What kind of effect do you think the merger experience has had on your life, your self-concept, or life in any way? Can you describe that? (Probing question: What did your experience mean for/to you, if it held any meaning at all?)

5. Can you describe what the merger meant to delivering quality care and compassion to your patients? (If you could describe this in 1 or 2 sentences, what would you say?)

6. Can you describe what the merger meant to an organization that is transforming to meet the requirements of healthcare reform?

7. Can you describe what is easy or difficult about understanding the meaning of your merger experience? (Probing questions: your thoughts and knowledge, feelings, and behaviors?)

8. Can you describe in 1-2 sentences what the merger has meant to you as a nurse leader?
APPENDIX B: STUDY CONSENT FORM

Informed Consent – Nurse Leader Interviews

Principal Investigator: Debra A. Ball, EDLS Doctoral Student  Phone: 419/356-2860

Project Title: A Phenomenological Study of the Nurse Leader: Before, During, and After Merger

You have been invited with no obligation to participate in a study designed to investigate nurse leader experiences before-, during- and after-merger. Specifically, I am interested in detailing and reflecting on the meaning of your experience before-, during-, and after-merger which may address the intellectual and emotional connections that you have in your work and life. The combination of exploring the past to clarify the events that led you where you are today and describing your present experience establishes conditions for reflecting upon what you are now doing as a nurse leader. Participation or non-participation will not affect your role in the organization. The study will benefit current and future healthcare leaders, and/or human resource development practitioners by informing them about best practices in guiding others through significant organizational change.

If you choose to participate, you will meet with me two times for approximately 60-90 minutes each. The first interview will focus on the details of your experience before-, during- and after-merger experience. The interview will be audio-taped with your permission so I have an exact record of what we discussed. The second interview (scheduled approximately two weeks after our first interview) will focus on reflecting on the meaning of your experience before-, during- and after-merger. Some of the questions in the interview process will cause you to focus your attention on your emotions and may cause temporary discomfort. You may choose not to answer any question with which you are uncomfortable.

The information obtained from this investigation will be kept confidential and will only be reported in statistical and/or qualitative analyses with no specific connections made to you. I will de-identify your information, and will attach a fake name to your data so no one will know it was you who gave me specific information. All interview data will be transcribed, and then the audio-file will be destroyed. Transcripts will be kept in a locked file cabinet accessible only to me.

Your decision whether to participate or not will not interfere with your future relations with Bowling Green State University, the College of Education and Human Development, me, or with your current employer. You are free to withdraw from the study at any time without explanation or penalty.

If you have questions, please contact me at the above phone number, by e-mail at debball@bgusu.edu. You may also contact my dissertation Research Advisor and Chairman Mack A. Easley, Ph.D., at easleym@bgusu.edu, or phone 419-372-0247; or the Chair, Human Subjects Review Board, Bowling Green State University at 419/372-7716 or herb@bgusu.edu, if questions arise about your rights as a research participant during the course of the study. Do not sign this sheet until these questions have been addressed to your satisfaction. Please retain a copy of this form (two have been provided) for your records.

YOU ARE MAKING A DECISION WHETHER OR NOT TO PARTICIPATE IN THIS STUDY HAVING READ THE INFORMATION PROVIDED ABOVE, AND BASED ON THE FACT THAT ALL OF YOUR QUESTIONS HAVE BEEN ADDRESSED TO YOUR SATISFACTION.

I AGREE to participate in this study:

Date: ______________________  Participant’s signature: ______________________

Participant’s name (print): ______________________
APPENDIX C: BGSU HSRB ACCEPTANCE LETTER

DATE: May 28, 2013
TO: Debra Ball
FROM: Bowling Green State University Human Subjects Review Board
PROJECT TITLE: [463629-1] A Phenomenological Study of the Nurse Leader: Before-, During-, and After-Merger
SUBMISSION TYPE: New Project
ACTION: APPROVED
APPROVAL DATE: May 24, 2013
EXPIRATION DATE: May 23, 2014
REVIEW TYPE: Expedited Review
REVIEW CATEGORY: Expedited review category # 7

Thank you for your submission of New Project materials for this project. The Bowling Green State University Human Subjects Review Board has APPROVED your submission. This approval is based on an appropriate risk/benefit ratio and a project design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

The final approved version of the consent document(s) is available as a published Board Document in the Review Details page. You must use the approved version of the consent document when obtaining consent from participants. Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require that each participant receives a copy of the consent document.

Comment: Note that Dr. Earley’s name was misspelled in the consent document. It has been corrected in the approved, stamped version of the consent form.

Please note that you are responsible to conduct the study as approved by the HSRB. If you seek to make any changes in your project activities or procedures, those modifications must be approved by this committee prior to initiation. Please use the modification request form for this procedure.

You have been approved to enroll 17 participants. If you wish to enroll additional participants you must seek approval from the HSRB.

All UNANTICIPATED PROBLEMS involving risks to subjects or others and SERIOUS and UNEXPECTED adverse events must be reported promptly to this office. All NON-COMPLIANCE issues or COMPLAINTS regarding this project must also be reported promptly to this office.

This approval expires on May 23, 2014. You will receive a continuing review notice before your project expires. If you wish to continue your work after the expiration date, your documentation for continuing review must be received with sufficient time for review and continued approval before the expiration date.

Good luck with your work. If you have any questions, please contact the Office of Research Compliance at 419-372-7716 or hsr@bgsu.edu. Please include your project title and reference number in all correspondence regarding this project.
APPENDIX D: INFOGRAPHIC SKETCH OF DISSERTATION STUDY

A Phenomenological Study of the Nurse Leader: Before, During and After Mergers

Universal Essence:
Experiencing the meaning of mergers, nurse leaders were mired in dueling: concealing their own feelings while outwardly exhibiting positivity to focus on others' needs as they surrendered to continually changing role obligations and uncertainty, which demanded deeper personal reflection and focus on self, that led to a profound intention to emerge and move on with internal strength amid time shifts, with a yearning for a hopeful future.

### APPENDIX E: SAMPLE DESCRIPTIONS OF THEMES, SIGNIFICANT STATEMENTS AND FORMULATED MEANINGS

**Masking: Focus on Others**

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<th>Significant Statement</th>
<th>Formulated Interpretive Statement</th>
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<td>“When I knew the process was going to take a long time, I kept telling my staff ‘You’re not going anywhere. The frontline is not going anywhere.’ Eventually, they will look at what positions we need, what positions can you combine, do you do it through attrition, how do you do that, but the frontline, you have to be with the patients and take care of the patients.”</td>
<td>Nurse leaders conceal their own feelings of the impending merger while demonstrating cheerfulness to staff nurses</td>
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<td>“I tend to put a smile on my face even when I didn’t have a smile on the inside. I’ve gotten to share some moments of great pride with all of our staff. I feel like I’ve seen the absolute best in people and the absolute worst in people. And in spite all of it, you still have in your heart that we can do great things.”</td>
<td>Nurse leaders conceal feelings in unlearning ways of doing things and relearning new approaches to work.</td>
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<td>“Nurse leaders always have to set a good example even when you don’t feel like setting one. Sometimes you’re really angry or you’re very upset or you’re hurt, your feelings are hurt but you’re trying to put on that face. Because you set the tone of your department…I set the tone of my unit.”</td>
<td>Nurse leaders conceal their feelings in front of staff nurses during a merger.</td>
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<td>“There’s a lot of fear, fear of the unknown, fear of if I’m going to have my job, fear because I didn’t have my BSN yet, that I would be out. Because the fear of, having initials after your name was sometimes more important than experience and loyalty. I understood all that, a lot of fears and that became hard as a manager because the fears of the front line had to squelch your fears because you had to take care of them first.”</td>
<td>The fear that staff nurses reflected back to the fears that nurse leaders’ themselves felt as they focused energy on taking care of others' needs.</td>
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<td>Significant Statement</td>
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<td>“So really, you know what you also hear? I mean, I hear it myself, ‘I'm just angry.’ So, I find that I'm angry that this happened to us and angry that it has turned out to bring that kind of a boss in me – I’m not that kind of a boss, and it makes me angry that the emotion of this tends to bring this side out of me.”</td>
<td>As nurse leaders became aware that change with the merger had begun, they experienced a numbness and feelings of anger.</td>
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<td>“It’s loss of control. Everybody has lost control. We don’t have control. We don’t have control when to roll it out. It’s like who decided that?”</td>
<td>Nurse leaders experience loss of control with implementation of change during a merger.</td>
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<td>“The people part has been hard, saying goodbye to people...that was hard. I cried about it already today, but in actuality, they all have emails, addresses and I could still stay in contact or send them a note card and you know. They haven’t left my life but they’ve left my eyesight and that makes me sad.”</td>
<td>Nurse leaders experienced loss when functional support staff was transferred out of hospital into other buildings roles within system.</td>
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<td>“It's loss of control. Even if I could exert some control, I couldn't exert any control because my role has been diminished. We talk about feeling marginalized. I've been marginalized. My influence is not what it once was, I don't think.”</td>
<td>Nurse leaders experienced dejection with role of nursing care and authority during the merger.</td>
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<td>“That was a big culture thing…it showed us that we really are a part of the system. That new logo went up and the big new organizational name sign. That was a big deal for us.”</td>
<td>When new organizational name and lights went up nurse leaders experienced loss.</td>
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<td>“It is a burden, it’s a burden sometimes, it’s a burden I don’t know anybody really does on purpose, it’s just because of the position you’re in. You have to ask people to be patient; you have to ask them to trust you when there may not be a lot of trust. Some jump ship, others come in and threaten to jump ship.”</td>
<td>Emotions to change can be mistaken for resistance during a merger.</td>
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<td>“A friend who experienced this before talked to all of us about losing that autonomy, you know I think we all realized as a nurse leaders, as a hospital all of that you do lose a part of that. This is the hand we were dealt you can choose to leave and find a better place to work or you can stay here and try and make the best that it can be and that’s how you got to look at things.”</td>
<td>Nurse leaders realized that to actually manage, you must make the best of it and refocus on a new vision.</td>
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<td>“And you got your directives from the mothership. But there were so many things that we did better, like the teach back and all these different things that now they're saying wow, this is a pretty good thing.”</td>
<td>Nurse leaders did not feel that they belong &quot;inside&quot; the different leadership culture because they were viewed as different and &quot;outside&quot; of it.</td>
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<td>“Nurses, we don’t have -- we don’t have -- our opinions in influencing policies and procedures or whatever. It’s like made and then they’re told that this is what we’re doing.”</td>
<td>Bureaucracy takes the decision-making function from individuals and distributes them across the organizational structure (hierarchy). Nurse leaders struggle with new hierarchy with a different leadership culture.</td>
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<td>“I finally had to say, &quot;Stop doing that. We are not doing that.&quot; We’re changing this grid again. I don’t care if the Nash Group likes it or not. I’m responsible for this hospital and what we’re doing is not safe for patients.”</td>
<td>Nurse leaders experienced anxiety with confronting the demands placed on staff nurse now and in the future.</td>
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<td>“Once in a while when I can’t sleep -- I mean we have some staffing issues and there’s not enough staff and I don’t know if I’m going to be the one coming in in the middle of the night to take care of a patient but to have it emotionally suck me dry, it doesn’t do that, for the most part. I find that the more I can try and emotionally detached from it, whatever...”</td>
<td>Nurse leaders described feelings of being overwhelmed by the constancy of the obligations of providing care, implementing change, healthcare reform and their own personal lives during a merger.</td>
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### Moving On: Visioning for the Future

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<th>Significant Statement</th>
<th>Formulated Interpretive Statement</th>
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<td>“It has been hard. It has just been hard. I mean, that's just the truth. I can't even really say that there have been any great moments of joy in the merger and that's just a true statement. I think about that. Sometimes I've met a lot of really nice people and a lot of really wonderful people and a lot of people who get that we need to become an integrated system.”</td>
<td>Nurse leaders are contemplative about the experience of organizational change after a merger.</td>
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<td>“One of my favorite quotes from one of my newsletters, it was Charles Dickens, ‘and these are the best of times, he said the worst of times,’ it's how the tale of two cities opens. And it goes on to describe a period of time during the French Revolution, written a hundred years later by Dickens describing the French Revolution, but when you read it, it's about today. Smart people, foolish people today is the best of times, the worst of times, you know. Technology is great, technology is a nightmare, so, same thing. Today is the best day.”</td>
<td>Nurse leaders use metaphors to describe the meaning of the merger experience.</td>
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<td>“You know, you really have to try to turn things around and find, okay, what's the bright side in this? Each event, you know, it's not even just kind of like a general, you have to almost take like each minute of the day sometimes and figure out how to turn that around.”</td>
<td>Nurse leaders take time to find meaning in the bright side of the merger experience.</td>
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<td>“It's made me feel challenged but it's also made me, I think, have to look at different ways of doing things. I've had to get more creative and open-minded. I have not always been the most open-minded person and it has forced me to look at different ways of doing things. “</td>
<td>Nurse leaders experience learning like a beginner and seeing with new eyes after a merger.</td>
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