

7-13-2017

# The Voices of Nurses Who Serve: A Dissertation Examining Nurses on Governing Boards

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Lisa Joy Sundean, PhD  
University of Connecticut, 2017

Healthcare governance practices rely on a range of key stakeholders to inform discussions and decisions resulting in processes and policies to achieve organizational mission and improved healthcare. Missing on most healthcare boards are nurses, most of whom are females. The purpose of this manuscript style dissertation was to examine nurses on boards through a feminist lens, contributing to understanding through the voices of nurses who serve.

The first scholarly paper is a published manuscript describing the philosophical foundation of feminism as a framework for understanding nurses on boards. This manuscript addresses nurses' knowledge as power for disrupting traditional board practices, and advancing nurses' social justice contract as board leaders. The argument is guided by feminist tenets of equality and action for social change. This manuscript calls for board composition diversity inclusive of nurses acting to transform healthcare and supportive of social justice.

The second scholarly paper, a published manuscript, is a metasynthesis describing the central issue of nurses and women on boards. *Proving our worth* is the outcome of analysis of results of qualitative research describing the marginalizing barriers nurses and women face in traditional male dominated boardrooms. This manuscript exposes the discourses to be disrupted to advance nurse board appointments and offers practical advice for overcoming boardroom challenges.

The third manuscript, an explanatory sequential mixed methods study, articulates the rationale for nurses on boards in the voices of 38 nurses who serve. The classical Delphi method was utilized for the quantitative strand to develop consensus agreement about the reasons for nurses on boards followed by the qualitative strand, focus groups, to validate the quantitative strand results. Results from both strands were connected to arrive at the final rationale for nurses on boards clustering in four themes; nurses offer unique knowledge, skills,

and perspectives to advance healthcare through board leadership. Board leadership benefits the nursing profession and provides opportunities to influence health policies.

Board leadership leverages nurses' professional repertoire useful for modernized healthcare governance practices and healthcare transformation. This dissertation provides a compelling argument for nurses as equal board members and critical contributors to healthcare transformation through governance leadership.

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A Dissertation  
Submitted in Partial Fulfillment of the  
Requirements for the Degree of  
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APPROVAL PAGE

Doctor of Philosophy Dissertation

The Voices of Nurses Who Serve:  
A Dissertation Examining Nurses on Governing Boards

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## Acknowledgements

I acknowledge the support of Sigma Theta Tau International Mu Chapter for funding the dissertation research study titled, *The Rationale for Nurses on Boards: A Mixed Methods Study*.

I wish to express deep gratitude to my committee for their support, guidance, encouragement, mentorship, and probing questions. To Dr. Jacqueline M. McGrath, thank you for encouraging me to pursue a PhD at University of Connecticut School of Nursing, for your mentorship, for creating opportunities, and for being the wind beneath my wings. To Dr. Carol Polifroni, thank you for stretching me to think more rigorously than I ever thought possible. To Dr. Kathryn Libal, thank you for your gentle ways in guiding me to think deeply about feminist scholarship. To Dr. Donna Nickitas, thank you for your thoughtful insights, your guidance, and for being a positive role model for nursing leadership. To Dr. Barret Katuna, thank you for enlightened conversation and guiding me in the process of feminist inquiry.

I am grateful to all the nurse board leaders across the country who participated in this research. I appreciate your time and generosity in making this research possible.

Thank you to my student colleagues, work colleagues, and friends. It takes a village – thank you for being part of mine! You helped me see the forest for the trees and the trees for the forest.

To my family, John, Luke, Jake, (and Lucky Boy), and my parents – thank you for your enduring love and support. I could not have done this without your understanding.

And to all the empowered women and nurses out there, thank you for inspiring me to do this work! Onward and upward!

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## **CHAPTER I**

### **Introduction**

## CHAPTER I

### INTRODUCTION

The call for nurses' participation in healthcare transformation is well established, most notably in the recommendations of the 2010 *Future of Nursing* report by the Institute of Medicine (IOM) and reiterated in 2016 progress report (National Academies of Sciences, Engineering and Medicine [NAM], 2016). Moreover, the role of nurses in healthcare transformation is perfectly situated within the metaparadigm of nursing; nurse-human being-environment-health (Fawcett, 2005). Nurses lead, advocate, and influence change at many levels along the health-healthcare continuum. From bedside leadership advocating for patients to boardroom leadership advocating for organizational structures and policies that support quality patient outcomes to political leadership advocating for public health policies that support healthy communities, the critical need for expanded leadership roles for nurses is essential for broadening the spheres of nursing influence supportive of healthcare transformation.

The role for nurse leaders in the boardroom exists on the continuum of leadership expansion and is necessary to support broad change and innovation in healthcare organizations as outlined by the NAM (2016). However, operationalizing the imperative for governance leadership roles for nurses has been met with a variety of barriers. In an integrative review by Sundean, Polifroni, Libal, and McGrath (2016), findings showed nurse board leadership is stymied by traditional (mostly male) board leaders who view nurses as unprepared and disinterested in organizational governance roles (Khoury, Blizzard, Moore & Hassmiller, 2011; Mason, Keepnews, Holmberg & Murray, 2013). These status quo assumptions and perceptions are not commensurate with the recommendations of the IOM (2010) and NAM (2016), or other healthcare experts who advocate nurse board leadership (Benson & Hassmiller, 2016; Prybil, Dreher & Curran, 2014). Obstructionist views that create barriers to nurse board leadership are deeply rooted in traditional and gendered perceptions of nurses (Sundean & McGrath, 2016). McMillan (2016) describes such marginalizing views in the context of prevailing discourses that



disqualify the voices and knowledge of those deemed less dominant. In this case, traditional male board leaders disqualify the voices and knowledge of potential nurse board leaders, most of whom are female. In general, these perceptions not only create specific barriers for expansion of nurse leadership influence, they also create barriers to advancements in healthcare transformation because nurses are key knowledge leaders in healthcare. Specifically, healthcare boards that do not include nurses in voting membership limit decision-making capacity (Sundean & McGrath, 2016) and; therefore, curb capacity to improve healthcare.

Ninety-two percent of US registered nurses are females (Budden, Moulton, Harper, Brunell & Smiley, 2016). Compared with US physicians, registered nurses comprise 89% of the healthcare workforce (Budden et al., 2016; Kaiser Family Foundation, 2017). Females comprise 58% of the US labor workforce and 51% of the US population (US Bureau of Labor Statistics, 2014). However, females occupy only 28% of US hospital board seats and nurses occupy only 5% of hospital board seats (AHA, 2014). The argument for nurses on boards as an issue of occupational and gender is clear.

Considering the roles and responsibilities of nurses for achieving the Triple Aim in healthcare (cost containment, patient experience, and health outcomes), nurses are exceptionally situated to lead at the board level (Institute for Healthcare Improvement, 2016). With firsthand patient care experiences, nurses have unique understandings of cost containment, patient satisfaction, and health outcomes that many other board members do not have. However, few nurses are appointed to board positions, marginalizing their experiences, voices, knowledge, and influence over the direction of healthcare, and potentially restricting the effectiveness of healthcare boards. In a recent panel discussion, Jack Needleman, PhD, FAAN, UCLA Professor of Health Policy and Management and Associate Director of the UCLA Patient Safety Institute stated, “[Healthcare organizations] that do not have nurses on their boards are simply incompetent to do their jobs.” (Mason, Thibault, Needleman, Apold & Sundean, 2016). In

today's environment of healthcare transformation, nurse board leaders are essential for advancing change and generating improvements at the governance level.

Healthcare boards of directors are charged with setting organizational mission, vision, strategy, regulatory oversight, and executive compensation (Curran, 2015; Salmon, 2016). In addition, boards of directors demonstrate commitment to stakeholders through fiduciary responsibilities of care, loyalty, and obedience. Board leaders demonstrate these responsibilities on behalf of the organizations they serve and, specifically for nonprofit organizations like most American hospitals, on behalf of the people who are served by the organizations (Curran, 2015; Salmon, 2016). Board structures and processes, including the composition of the board, aim to support governance goals. Therefore, structures and processes that impede inclusive governance practices, prevent boards from fully meeting their obligations to stakeholders.

In her seminal work, Acker (1990) describes the structures and processes of organizations as the root of marginalization for women. This is particularly tacit for individuals in caring professions. For example, in hospital environments, these structures and processes include hourly wages for nurses, traditional shift work that does not allow for professional development flexibility, organizational policies that are imposed upon nurses rather than negotiated with them, and organizational restrictions to scope of practice. Traditionally fixed within the lower end of the hierarchy of healthcare organizational structures and processes with little influence over strategic decision-making, the belief that nurse leaders can influence organizational change at the board level represents an unfamiliar concept for traditional, albeit mostly male, board members (Khoury, Blizzard, Moore & Hassmiller, 2011; Mason, Keepnews, Holmberg & Murray, 2013; Sundean & McGrath, 2016). The concept of nurses on boards within the traditional, patriarchal boardroom setting is disruptive to dominant discourses and disruptive to status quo board practices (Acker, 1990; McMillan, 2016).

This dissertation is guided by the philosophical underpinnings of feminism. As a philosophy, feminism addresses complex issues associated with gender (generally, but not exclusively referring to women), equality for social groups, and action toward social change and justice (Sprague, 2005; Superson, 2011). According to Diprose (2000) and Superson (2011), feminist philosophy engages a thoughtful journey toward concept development triggered by social experiences that conflict with prevailing lines of reasoning. The nature of triggering experiences imposed upon non-dominant groups typically include oppression, marginalization, and power differentials resulting in social inequities. Prevailing reasoning, social structures, and systems of dominant groups support social inequities as normative. Feminist philosophers examine these norms and experiences to re-conceptualize realities and develop strategies for equitable, inclusive social change (Diprose, 2000; Sprague, 2005; Superson, 2011).

Feminist theories aim to uncover and explain the genesis of social inequalities systematically, and suggest strategies for social change according to various and sometimes overlapping viewpoints (Lorber, 2012; Mann, 2012; Sprague, 2005). For example, standpoint feminist theory emphasizes the differences between women and men, arguing that the realities of women are only experienced by women, and therefore, should only be described by women. Societal structures, processes, and policies based on the experiences and reasoning of men create inequities according to standpoint feminist theorists (Lorber, 2012). Often attributed to Crenshaw (1991), intersectionality theory, describes inequities associated with complex interactions between race, class, and gender within sociohistorical and sociopolitical contexts. Originally describing the marginalization of women of color, contemporary iterations of intersectionality theory have expanded to account for other social groups and forces of marginalization, including occupation, power and politics, and their influences on knowledge development (Cho, Crenshaw & McCall, 2013; Collins, 2012).

The various feminist theories notwithstanding, the treatise of this dissertation is grounded in the philosophy of feminism. NOB are examined through the philosophical lens of

feminism to uncover and conceptualize the reality of nurses' board experiences different from the patriarchal norms of traditional board environments. The feminist philosophical tenets of marginalization, equality, action for social change, and justice guide the inquiry into NOB.

The purpose of this dissertation is to provide a feminist perspective about nurses on healthcare boards and to increase the understanding about the value of nurses on boards through the voices of nurse board leaders. Considering nursing is a female-dominated profession (Budden, et al., 2016), opportunities for nurses to navigate organizational hierarchies, particularly at the board level, is challenging and often met with gendered and occupational barriers. Even for nurses who do become engaged as board members, much energy is expended in measuring up to traditional norms in an environment that favors status quo governance over innovation and change in board composition (Sundean & McGrath, 2016).

Three distinct and synergistic scholarly works developed into manuscripts for publication comprise this dissertation. Chapter two is a published manuscript that sets the stage with an analysis of nurses on boards via a feminist philosophical perspective. The standpoint of this manuscript is that feminism is a lens through which to view the issues of nurses on boards relative to power distribution in healthcare hierarchies, transformation, and social justice (Sundean & Polifroni, 2016). Sundean and Polifroni (2016) posit that nurses as board leaders play "...a pivotal role ...by disrupting the status quo and advocating for more just health care organizations that place people and the actions of caring for their health at the center and not at the margins of business" (p. 397). This framework lays the groundwork for further theory development about nurse board leadership and other emerging leadership roles for nurses.

*Proving our worth* (Sundean & McGrath, 2016) describes the central issue facing nurses and women on boards (Chapter three). In this published metasynthesis, *proving our worth* is the frustrating truth for nurses and women whose entrée into board service and whose contributions on boards are measured with unequal parity against traditional male board leaders. The results of this metasynthesis demonstrate the marginalization of nurses by traditional board members,

and therefore, disqualification of nurses' knowledge contribution in board governance (McMillan, 2016). Furthermore, the issues of nurses and women on boards described in this manuscript validate Acker's theory about women who aspire to high levels of organizational influence and who are fully qualified for the roles, yet face marginalizing, gendered barriers associated with dominant norms of patriarchal organizations that are structured to maintain status quo (Acker, 1990).

Results also describe advice offered by female board members to other females and nurses interested in board service. The advice is summarized by preparation, networking, creating alliances, and seeking formal mentorship (Sundean & McGrath, 2016, p. 459). This manuscript adds to the extant literature about NOB by illuminating the challenges faced by nurses and women in the board space, yet also offers practical tips for surmounting challenges.

Chapter four is a scholarly paper describing the results of an original mixed methods study to articulate the rationale for NOB. The quantitative strand utilized the Delphi method and developed consensus agreement from a panel of nurse board leader experts about the reasons for nurses to have a seat on healthcare boards. The qualitative strand engaged a separate sample of nurse board leaders in focus groups to validate the results of the quantitative strand. True to the mixed methods research model, results of the two strands were connected to develop a synthesized and comprehensive rationale for nurses on boards generated from nurses who serve as healthcare board leaders, and therefore, quantifies and qualifies nurses' voices, experiences, and value in the boardroom. Although the value proposition for nurses on boards is promoted by expert opinion leaders (Benson & Hassmiller, 2016; Prybil, Dreher & Curran, 2014; Weiss & Pettker, 2015), this is the only study of its kind to describe the rationale for nurses on boards from a research based approach and is consistent with the feminist tenets of emancipatory thinking and political social agency (Chinn & Kramer, 2011).

Together, the three distinct manuscripts contribute to the body of nursing knowledge by demonstrating the application of nurses' ways of knowing and acting within the sociopolitical

realm as described by White (1995). The provision of nursing care includes the strategic use of knowledge and voice to advocate for patients, populations, and policies that support health and healthcare (White, 1995). Nurse board leadership is one way to enact sociopolitical knowing for the health of populations and for the advancement of the nursing profession. Finally, the scholarly works shared through the manuscripts in this dissertation collectively provide a foundation for a program of research to promote nurse board leadership and to further examine the contributions of nurses on boards as related to healthcare transformation, patient outcomes, and promotion of health.

Operational definitions of key terms:

1. Boards/Boards of Directors: The appointed or elected fiduciaries who exercise strategic decision-making on behalf stakeholders of nonprofit organizations or shareholders of for profit organizations (Curran, 2015). For purposes of this dissertation, nonprofit healthcare organizations are the entities for which boards are referenced.
2. Governance leadership: The fiduciary leadership provided by boards of directors in alignment with responsibilities for care, loyalty, and duty to an organization and its stakeholders. Governance leadership aims to set and meet the mission, vision, and strategy of the organization within set values and within the terms of external forces and regulations (Curran, 2015).
3. Feminism: A philosophical worldview that addresses social inequalities typically associated with gender. The aim of feminism is to expose social marginalization and inequalities, and to provide a pathway through awareness and activism for social change (Lorber, 2012).
4. Metasynthesis: The outcome of the meta-ethnography research method whereby results of qualitative studies are analyzed and synthesized to develop a deeper understanding of a specific phenomenon (Noblit & Hare, 1988).

5. Mixed methods research: A research method that utilizes quantitative and qualitative data that are systematically mixed together to enhance and strengthen understandings about a phenomenon (Creswell, Plano & Clark, 2011).

This dissertation examines the issues associated with nurse board leadership and articulates the rationale for nurses on boards. Together, the three distinct manuscripts aim to support the call for nurses on boards by providing a framework for understanding its importance as it relates to gender and occupational equality in healthcare, and as it relates to the charge for nurses to contribute to healthcare transformation. The examination of the problem within a feminist framework emphasizes board governance practices inclusive of nurses and supports board practices that contribute to a more equitable healthcare system in the United States. Consistent with feminist philosophy, this dissertation draws upon the experiences and voices of nurses who serve as board leaders to articulate their challenges, to articulate their value to healthcare board governance, and to articulate their unique role as board leaders within the metaparadigm of nursing.

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## CHAPTER II

### **A Feminist Framework for Nurses on Boards**

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Figure A1.

# A FEMINIST FRAMEWORK FOR NURSES ON BOARDS



LISA J. SUNDEAN, MSN, MHA, RN\* AND  
E. CAROL POLIFRONI, EdD, CNE, NEA-BC, RN, ANEF†

Nurses' knowledge, skills, and expertise uniquely situate them to contribute to health care transformation as equal partners in organizational board governance. The Institute of Medicine, the 10,000 Nurses on Boards Coalition, and a growing number of nurse and health care scholars advocate nurse board leadership; however, nurses are rarely appointed as voting board members. When no room is made for nurses to take a seat at the table, the opportunity is lost to harness the power of nursing knowledge for health care transformation and social justice. No philosophical framework underpins the emerging focus on nurse board leadership. The purpose of this article is to add to the extant nursing literature by suggesting feminism as a philosophical framework for nurses on boards. Feminism contributes to the knowledge base of nursing as it relates to the expanding roles of nurses in health care transformation, policy, and social justice. Furthermore, a feminist philosophical framework for nurses on boards sets the foundation for new theory development and validates ongoing advancement of the nursing profession. (Index words: Nursing philosophy; Nurses on boards; Board governance; Feminism; Social justice; Power) *J Prof Nurs* 32:396–400, 2016. © 2016 Elsevier Inc. All rights reserved.

NURSES ARE CRITICAL to the health care workforce and are uniquely situated at the nexus of direct patient care, cost considerations, quality goals, and population needs. The knowledge, skills, and expertise of nurses position them as imperative health care board members. [American Hospital Association, Center for Healthcare Governance \(2014\)](#) recommends best practicing boards appoint a diverse range of stakeholders including women, minorities, and nurses. *The Future of Nursing* report ([Institute of Medicine, 2010](#)) recommends that nurses engage as equal partners on health care boards to transform health care. However, nurses are rarely considered as voting board members.

According to the [American Hospital Association report \(2014\)](#), nurses represent only 5% of hospital board seats even though nurses represent the largest segment of the national health care workforce totaling more than 3 million. Space must be made at the board table to represent the voice of nursing knowledge as power. Power sharing in the boardroom

among all key stakeholders, including nurses, is essential for comprehensive health care improvement and social justice. When no room is made for nurses to take a seat at the table, the opportunity is lost to harness the power of nursing knowledge for health care transformation and social justice.

The 10,000 Nurses on Boards Coalition aims to coordinate a national movement to increase nurse board appointments at the national, state, and local levels, both in for profit and nonprofit organizations ([Center to Champion Nursing in America, 2014](#)). Similarly, a growing body of nursing scholarship emphasizes the critical role for nurses on health care boards ([Bleich, 2014; Hassmiller & Combs, 2012; Prybil, Dreher, & Curran, 2014](#)). The January/March 2015 issue of *Nursing Administration Quarterly* dedicated several articles to the topic of nurses on boards. The articles address the case for nurses on boards, preparation for board service, board process, board diversity, and influence through board service ([Sanford, 2015](#)). A recent pilot study explores the experiences of nurses on boards to uncover the truth of board service in the voices of nurses who serve ([Sundean, 2015](#)). [Walton, Lake, Mullinex, Allen, and Mooney \(2015\)](#) recently reported the results of a study exploring the efficacy of board orientation processes for professional nursing organizations. These examples demonstrate the collective effort of nurses in pursuit of board appointments to advance the sphere of influence and social

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justice aims of the profession. However, none of the authors explicate a philosophical argument for nurses on boards.

Implicit in the recommendation for nurses as equal partners in health care boardrooms (Institute of Medicine, 2010) is the imperative for a philosophical framework that breaks through hierarchical barriers and power imbalances, unleashes perceived professional boundaries, and frees nurses to exercise their knowledge, skills, and expertise to improve health equity and social justice. The purpose of this article is to describe feminism as the philosophical underpinning for the phenomenon of nurses on boards and the philosophical basis for leveraging nurses' unique knowledge about health equity and social justice in boardroom decision-making. As a female-dominated profession with a pact to ensure social justice through nursing care, a feminist framework aligns with the issues of board appointments for nurses.

Feminism addresses the inequalities associated with the patriarchal norms of board governance, the power-based marginalization of nurses in health care, and the perpetuation of social structures, processes, and policies that impair health equity and social justice. As a philosophical framework for nurses on boards, feminism contributes to the knowledge base of nursing as it relates to the expanding roles of nurses in health care transformation, policy, and social justice. Furthermore, a feminist philosophical framework for nurses on boards sets the foundation for new theory development and validates ongoing advancement of the nursing profession.

Contemporary feminist initiatives build upon prior waves of feminism from the early 1900s (women's suffrage) and the 1960s (sociopolitical freedom). Today's feminism addresses issues like the wage gap, global violence against women, education opportunities for girls worldwide, opportunities for women in Science, Technology, Engineering, and Math fields, economic security, racial justice, and reproductive rights to name a few. We have seen the passing of the Lilly Ledbetter Fair Pay Act, we see women crashing through glass ceilings to take Chief Executive Officer positions in Fortune 500 companies, we see women's athletics taking center court (basketball, soccer, tennis), and we see women like Malala Yousafzai, Nobel Peace Prize recipient, standing up to terrorism and oppression against women and girls. In 2016, it is nurses who have the obligation to stand up to intersectional marginalization to join the ranks of other feminists who seek to create a more just and fair society where all can flourish.

### **Feminism and Nursing**

Feminism is a worldview that addresses the social inequities resulting mainly from gender discrimination, oppression, and marginalization. Embedded within feminism are many theories with specific and sometimes overlapping assumptions, concepts, and statements. Regardless of the differences between the various feminist theories, at a fundamental philosophic level, all feminisms view patriarchal norms and power imbalances as the central issues leading to social inequities through marginalization, oppression, discrimination, and lost opportunities (Lorber, 2012; Mann, 2012; Sprague, 2005).

Feminism assumes social power imbalances, placing emancipatory thinking and political social agency as the mechanisms for social inquiry, power redistribution, and social change (Amigot & Pujal, 2009; Buresh & Gordon, 2013; Chinn & Kramer, 2011; Falk-Rafael, 2015; Kagan, Smith, & Chinn, 2014; Mann, 2012; Mason, Backer, & Georges, 1991). This perspective is critical for addressing the social structures that oppress some while privileging others and is inclusive of all people regardless of race, class, social position, or gender. Nurses increasingly embrace feminism as a perspective for both professional advancement and practice applications. Chinn and Kramer (2011), Im (2010, 2013), Kagan et al. (2014), and McGibbon, Malaudzi, Didham, Barton, and Sochan (2014) recognize feminism as a useful model for nurses to exercise political agency, confront paternalism, and advance the profession through social change.

Feminist philosophy seeks to uncover and expose the social structures that oppress and marginalize some groups while benefiting others (Lorber, 2012; Mann, 2012; Sprague, 2005). As health care continues to become more corporatized and distanced from the business of caring for people, nurses on boards have a pivotal role in exposing the divide by disrupting the status quo and advocating for more just health care organizations that place people and the actions of caring for their health at the center and not at the margins of business. Nurses offer a unique perspective in the boardroom because their professional focus is on the social justice and health equity outcomes of institutional structures, policies, and processes that are developed and enacted through board governance. Nurses in health care boardrooms can mediate the effects of overly capitalistic discussions that marginalize human caring in favor of profits over people. The nursing profession must uphold its social pact with society at every level of the health care continuum including governance. This is nursing's "...legacy of justice-making as an expression of caring and compassion" (Falk-Rafael, 2005, p. 212).

### **Power and Nurses on Boards**

Disrupting the status quo associated with board culture and norms to gain board appointments confronts power structures in the boardroom. Conventional health care and corporate board culture is entrenched in patriarchal power norms (Groysberg & Bell, 2013; Huse & Solberg, 2006; Khoury, Blizzard, Moore, & Hassmiller, 2011; Mason, Keepnews, Holmberg, & Murray, 2013; Sundean, 2015). This is not only demonstrated through the conduct of board business but also through the social machinations of board culture. Consider the experience of a female nurse board member. In a strategic planning session, the nurse suggested that the hospital focus on ambulatory care in the community, citing the transition of health care from hospitals to nonacute care settings. The board members responded with dismissal, noting that ambulatory care was neither lucrative financially nor a strategic priority. Several months later, male executive members of the board announced plans to expand the

enterprise into ambulatory care settings with no recognition of the earlier suggestion from the nurse board member. The dismissive behavior of the executives who neglected to acknowledge the idea of the nurse illustrates the power of patriarchal norms in the boardroom. In another salient example, a female nurse was recently elected to the board of a health care foundation and attended a multiday board retreat and orientation. During the retreat, the male board chairperson befriended the nurse board member, introducing her to other board members, assisting her with logistics, and informing her about board processes. The nurse board member was appreciative of the support until the chairperson made it clear that his support came with the expectation of sexual favors. Unfortunately, this type of behavior is not isolated and is described by other female board members as a means for male board members to exert manipulative power over female counterparts (Bilimoria & Huse, 1997; Groysberg & Bell, 2013; Huse & Solberg, 2006). Sadly, Foucault describes paternalistic power as the socio-historic norm whereby women are subordinated in multiple intersectional ways (Amigot & Pujal, 2009; Foucault, 1982). Not only does this leave female board members frustrated and belittled but it also erodes collaboration and productivity of the group.

Perpetuation of paternalistic board culture directly marginalizes women and nurses and, therefore, reduces the effectiveness of boards because 50% of the knowledge pool and decision-making power is absent or dismissed. A feminist perspective questions the status quo of board membership and patriarchal homogeneity/hegemony. A shift toward more women and nurses on health care boards will change the prevailing dynamics of boards to more egalitarian dynamics (Hassmiller & Combs, 2012; Khoury et al., 2011; Mason et al., 2013; Prybil et al., 2014). Confronting power manipulation in the boardroom is essential in breaking down hierarchies and dominant patriarchal norms for social justice.

Aside from sexual power advances in the boardroom, patriarchal norms also perpetuate privileged structures, processes, and policies that lead to institutionalized barriers to health equity and social justice. Health care governance boards are charged with overseeing the business aspects of organizations in compliance with all regulatory bodies and must ensure that delivery of health care is equitable, accessible, timely, cost effective, and safe. Structures, processes, and policies that favor the privileged few over those most in need of equitable care is a blatant misuse of influence and power in the boardroom. Astute and reflective nurse board members, acting through a feminist lens, recognize overt and covert injustices and question the status quo to ensure that structures, processes, and policies reflect the needs of the population served by the organization.

Both sexualized behavior toward female board members and perpetuation of patriarchal norms at the organizational level represent misuse of board power. Foucault describes power as existing pervasively within society. Power establishes societal norms, regulating and

controlling society according to prevailing knowledge and truth. Power as a societal regulator becomes embedded and taken for granted. Foucault also describes resistance as a natural counterpart to power (Amigot & Pujal, 2009; Foucault, 1982). Just as power controls and constrains, resistance is a pathway toward emancipation and freedom. Resistance then, becomes the useful tool for disrupting status quo and leading toward social change (Amigot & Pujal, 2009; Polifroni, 2010).

In the board governance environment, power is established within the prevailing knowledge and truth of patriarchal norms. Feminists understand this as biased power that disempowers those outside the dominant group (Lorber, 2012; Mann, 2012; Sprague, 2005). Nurses and women stand outside the prevailing norms and, therefore, feel the constraints and control of such patriarchal power. However, Amigot and Pujal (2009) and Polifroni (2010) emphasize the social construction of knowledge, truth, and power according to Foucault. Polifroni (2010) posits that power is a product of knowledge and truth, socially constructed and temporally situated. As knowledge and truth change, so does the locus of power. The locus of power within patriarchal norms, truth, and knowledge must be questioned if social change in health care is to occur. And so, nurses must pose the questions: Whose knowledge? Whose truth? Whose power? For what purpose?

Feminism and Foucauldian ideas of power elucidate understanding of the location of marginalization of nurses on boards within patriarchal board norms. These philosophical perspectives also provide the pathway for action toward social change by resistance to and questioning of status quo, and expectations for equality in the boardroom for nurses. As nurses question patriarchal norms and uncover truth situated in egalitarianism and social justice, power will begin to shift toward more egalitarian governance processes. Considering that nurses have the most points of contact with those requiring health care, their knowledge is salient and powerful for boardroom decision-making to ensure that structures, processes, and policies reflect a more just health care system.

### Considerations for Securing a Board Appointment

Using knowledge as power to shape boardroom decision-making is a critical role for nurses. Gaining board appointments requires considerable strategic thought, planning, and groundwork. The strategy for gaining board appointments can be summarized by four important considerations: preparation, expertise, relationships, and networking. See Table 1. Preparing for board service can be achieved formally or informally. Some nonprofit organizations, for example, welcome novice board members and support their development. Other boards prefer candidates with previous board experience. For this reason, beginning board service in a systematic manner on smaller boards can be useful for gaining valuable experience. It is essential to understand and value the mission and goals of the organization before

**Table 1.** Considerations for Securing Board Appointments

Considerations	Notes
Preparation	Formal or informal; Consider refining skills for board service; Consider boards that nurture novice board members; Understand and align with organizational mission and goals
Expertise	Promote skills and expertise; Seek high visibility where expertise will be seen and valued
Relationships	Develop and nurture relationships; Seek out key influencers; Develop key relationships outside of nursing
Networking	Networking is an intentional process; Develop a positive social presence in person and online; Show up at social and professional events; Make your intentions for board service known to others

seeking a board appointment. In turn, it is important that your work and activities align with the mission and goals of the organization. Critically examine your intentions for a board appointment and let your intentions be known to others. Nurses have unique expertise that can be refined and promoted for board service. Identify yourself as an expert and be assertive in showcasing that expertise to the community. If needed, consider personal and professional development to refine skills such as financial skills that are meaningful for board service.

Developing and nurturing relationships cannot be understated. This includes intentional networking with key influencers and creating a positive online presence through social networking avenues like LinkedIn. Positive visibility through local, regional, and national speaking engagements allows others to recognize a shining star, a potential board leader. Finally, self-promotion can make the difference between a nurse who is invited to join a board and one who is not. Setting the intention to serve on a board and letting the right people know about that intention can set the process in motion.

## Conclusion

It is critical for nurses to collectively think, inquire, speak, and act through emancipated empowerment for board appointments. A feminist philosophic underpinning for nurses on boards creates a new landscape that questions prevailing patriarchal norms, addresses gender and intersectional inequalities in the boardroom, and paves the way for nurses to apply knowledge as power at the highest level of decision-making to influence health care transformation for social justice. Establishing a philosophical underpinning for nurses on boards also advances professional knowledge development through new nursing theory that addresses newer roles and implications for nurses in a changing health care system.

Now is the time for nurses to pursue board appointments with the intention of creating a new norm, a new expectation for nurses' rightful place on boards. As board-ready nurses prepare for governance appoint-

ments, the philosophical tenets of feminism provide the foundation for social justice practice in the boardroom.

## Acknowledgments

The authors wish to acknowledge the following individuals for their support in reviewing this manuscript and offering feedback: Peggy L. Chinn, PhD, RN, FAAN, Kathryn Libal, PhD, and Jacqueline M. McGrath, PhD, RN, FNAP, FAAN. No funding was received in the development of this manuscript. Conflicts of interest: none.

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## **CHAPTER III**

### **A Metasynthesis Exploring Nurses and Women on Governing Boards**

Permission to reprint the following manuscript was granted May 25, 2017.

Reprinted from Sundean, L.J. and McGrath, J.M., A Metasynthesis Exploring Nurses and Women on Governing Boards, *Journal of Nursing Administration*, 46(9), 455-461,  
<http://insights.ovid.com/pubmed?pmid=27556654>

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# A Metasynthesis Exploring Nurses and Women on Governing Boards

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**OBJECTIVE:** The purpose of this article is to present the results of a metasynthesis addressing significant issues relating to board appointments for nurses and women.

**BACKGROUND:** Nurses are rarely engaged as voting board members even though they are positioned to add value. When nurses and women are appointed to boards, their experiences reflect the struggles associated with traditional patriarchal board norms.

**METHOD:** A metasynthesis of qualitative studies was conducted. Seven studies from nursing and business literature were analyzed using the meta-ethnography methodology.

**RESULTS:** Proving worth is the central issue of nurses and women on boards.

**CONCLUSION:** Boardroom parity for nurses and women is an important social agenda with implications for strategic decision making in healthcare and business.

Nurses comprise the largest portion of the healthcare workforce,<sup>1</sup> and women comprise 51% of the national workforce.<sup>2</sup> In contrast, engagement of nurses and women as voting board members is limited. Participation of women on corporate boards in the United States hovers under 20% and nurses occupy 5% of

hospital board seats nationally.<sup>1,3</sup> Healthcare boards are responsible for organizational fiduciary oversight, regulatory compliance, and achievement of organizational mission.<sup>1</sup> Board directors are leadership stewards responsible to community stakeholders (for nonprofit organizations) and shareholders (for corporations).

Nurse leaders are responsible for high-level clinical and organizational decision making and understand connections between quality, safety, outcomes, costs, and meeting stakeholder needs. Nurse board leaders broaden board members' understanding of patient- and population-specific concerns in addition to operations-specific issues relating to strategic business and financial decision making.<sup>4</sup> An egalitarian and diversified approach to board composition is a recommended best practice for healthcare governance<sup>5,6</sup>; however, appointing nurses as board members is not uniformly practiced.

The Institute of Medicine<sup>7</sup> recommends nurses serve on boards as equal partners to transform healthcare. Norwegian public corporations are mandated to fill 40% of board seats with women; other European countries follow this mandate. Although the United States does not mandate women on boards, increasing numbers of women are serving on US corporate boards.<sup>8,9</sup> As nurses and women gain board appointments, they become important professional role models and stewards of boardroom leadership.

Early studies between 1988 and 1998 showed low nurse engagement on governing boards. Nurses were typically engaged as ex officio board members (without voting rights) rather than voting members.<sup>10-12</sup> As national attention focused on healthcare quality and safety, Mastal et al<sup>13</sup> showed nurse executives perceived hospital chief executive officers and board members as having low understanding about and engagement in quality and safety issues. Prybil et al<sup>6</sup> highlighted the opportunity for nurses to add critical

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Supplemental digital content is available for this article. Direct URL citations appear in the printed text and are provided in the HTML and PDF versions of this article on the journal's Web site ([www.jonajournal.com](http://www.jonajournal.com)).

DOI: 10.1097/NNA.0000000000000375

value as board member fiduciaries. Nurses occupied only 2% of US hospital board seats in 2008<sup>6</sup> and only 5% in 2014<sup>1</sup> compared with 20% for physicians. Although little research exists about nurses on boards, Walton et al<sup>14</sup> found that nurses on professional nursing organization boards were concerned about board orientation process deficiencies regarding preparation for fiduciary responsibilities. This study highlights nurses' increasing awareness and readiness for board preparation and participation.

In studies focused on women on corporate boards, researchers found gender diversity improves overall board dynamics and increases intellectual perspectives for board decision making.<sup>15,16</sup> Limitations to board appointments for women results from lack of mentoring and sponsorship from incumbent board members<sup>8</sup> and perpetuation of patriarchal board norms where women with insider knowledge are favored over women with objective knowledge and expertise.<sup>17</sup>

What are the central issues for securing and managing board appointments for nurses and women? Current studies on this topic exist in isolation and do not create an influential case for social discourse and change. Because no metasyntheses exist about this topic, this metasynthesis reports the qualitative data that are supportive of further research. Because few qualitative studies about nurses on boards are available in the literature and nursing is a female-dominated profession, the metasynthesis was broadened to include studies about women on corporate boards. The purpose of this article is to present the results of a metasynthesis to answer this question and to interpret the findings in a way that increases understanding and advances the social discourse about nurses and women on boards.

## Method

The research design used for this metasynthesis is meta-ethnography underpinned by hermeneutic philosophy. Meta-ethnography, a credible form of qualitative research, provides a comprehensive understanding of a

phenomenon through inductive interpretive analysis of qualitative study results. Translation of key metaphors (the units of analysis of qualitative study results) and identification of relationships (juxtaposition) lead to the development of overarching themes. Meta-ethnography maintains the integrity of the separate studies yet results in interpretive synthesis that advances understanding and discourse about the phenomenon of interest. Because the separate studies addressed a similar phenomenon, synthesis was generated through reciprocal translation<sup>18</sup> (Table 1).

## Sample

A systematic search strategy was conducted between January and March 2015 using the following databases chosen to capture qualitative studies about nurses and women on boards: CINAHL, PubMed, Academic Search Premier, ABI/INFORM Global, Business Source Premier, and ProQuest Dissertations and Theses. Records were also retrieved via hand search, including unpublished manuscripts. No date limits were imposed. Search terms included *nurses, leadership, boardroom, nurses roles, governing boards, health professionals, nurse administrators, board of directors, health care organizations, board quotas, corporate boards, females, women, qualitative, mixed methods, and research*. Inclusion criteria were qualitative or mixed-methods research design, English language, nurses or women and board governance, nonprofit, and corporate settings. Exclusion criteria were quantitative studies, non-English language, and shared governance. From the 31 articles screened, 5 articles were excluded because they did not address nurses or women on boards. Thirteen articles were excluded because they were quantitative studies and 6 articles were excluded because they were duplicates. The search yielded a total of 7 studies to be included in the metasynthesis; 5 qualitative and 2 mixed methods (Figure 1). Only the qualitative portions of the mixed methods studies were extracted for inclusion in the metasynthesis.

**Table 1.** Noblit and Hare's Meta-ethnography Method<sup>18</sup>

Phase	Action
1	Identify a topic.
2	Conduct a systematic search for relevant qualitative studies.
3	Constant comparative reading to develop key metaphors.
4	Identify relationships between key metaphors (juxtaposition).
5	Translate key metaphors into each other while maintaining integrity of individual studies.
6	Interpret and synthesize translations into overarching themes. <ul style="list-style-type: none"> <li>a. Reciprocal translation: useful when separate studies examine similar phenomena</li> <li>b. Refutational synthesis: useful when separate studies take opposing positions</li> <li>c. Lines-of-argument synthesis: useful for drawing inferences from sample studies</li> </ul>
7	Communicate results.

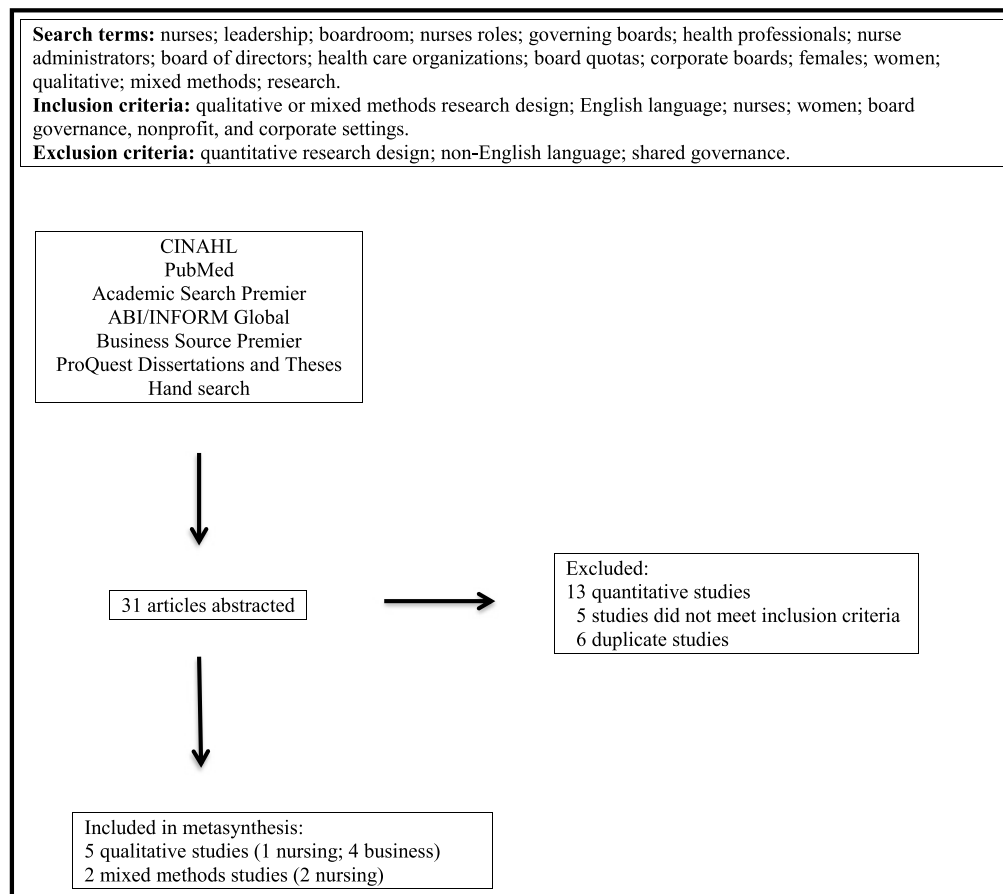


Figure 1. Search flow chart.

The 7 studies derive from the nursing ( $n = 3$ ) and business literature ( $n = 4$ ). Six of the 7 studies were conducted between 2006 and 2015; 1 was conducted in 1997. The studies were conducted in the United States, the United Kingdom, Norway, Sweden, and Ghana. The total number of participants across studies equaled 1,963 (see Table, Supplemental Digital Content 1, <http://links.lww.com/JONA/A475>).

The research designs in the sample include phenomenology, narrative analysis, mixed methods, and 3 unspecified descriptive qualitative designs. Data analysis methods in the sample of studies included narrative analysis, thematic analysis, conventional content analysis, and unspecified analysis methods. Data collection methods included interviews and surveys (see Table, Supplemental Digital Content 2, <http://links.lww.com/JONA/A476>).

## Results

Using Noblit and Hare's meta-ethnography process<sup>18</sup> (Table 1), 3 overarching themes were developed from the results of the studies: (a) power of board diversity, (b) cracking the old boys' network, and (c) take our advice (Table 2). The central issue, proving

our worth, encapsulates the 3 overarching themes. The relationships are portrayed in Figure 2 and will be discussed later in the article.

### Power of Board Diversity

Four studies provided an understanding of the positive impact of board diversity. The power of board diversity exemplifies the benefits of broad composition and perspectives, resulting in greater governance effectiveness. Nurses and women contribute skills that improve board dynamics, collaboration, goodwill, and inclusivity and broaden perspectives.<sup>19-21,24,25</sup> One participant noted, "Having broad perspectives or opinions on the board is worth it because you get to opportunities that you might not have thought of before, and you push the envelope in ways you might not have thought of before."<sup>24(p22)</sup>

Several studies repeatedly emphasized that nurses and women diligently prepare for meetings, question status quo, and push agendas more than their counterparts.<sup>19-21,24</sup> "We're not afraid to...bring up difficult questions. And we can't leave the room without resolving an issue."<sup>20(p92)</sup> A participant added, "I'm a fairly assertive person, especially when it comes to patient care. When it's right I've never had a problem pursuing issues..."<sup>24(p23)</sup> The

**Table 2. Overarching Themes and Key Metaphors From Sample Studies**

Study	Power of Board Diversity	Cracking the Old Boys Network	Take Our Advice
Bilimoria and Huse <sup>19</sup>	Contribute ideas, perspectives, goodwill, and intelligence Role modeling More prepared Ask tougher questions	Uneven power distribution  Sexualized behaviors and attitudes Stereotyped perceptions of women Gaining power and respect	Networking  Self-promotion Gain expertise Be prepared Obtain mentors
Groysberg and Bell <sup>20</sup>	Fresh perspectives Collaboration, inclusivity, empathy, and interpersonal skills Women question status quo	Need to be more qualified than men Not treated as equal members/voiceless Stereotyped expectations “Old Boys Network”	Conduct regular board assessments Formal processes to increase female recruitment and leverage intellect
Huse and Solberg <sup>21</sup>	Wisdom and diligence; Improve boardroom atmosphere (soft skills) Group cohesiveness Women ask tougher questions	Power and status games Unequal decision making  Tokenism flirtation “Old Boys Network”	Create alliances and women’s networks
Khoury et al <sup>22</sup>		Perceptions about nurses Not decision makers Not revenue generators Limited philanthropic capacity Not well positioned for boards	Preparation and skill building Leadership development Promote nurse leaders based on leadership skills and not clinical skills
Mason et al <sup>23</sup>		Perceptions about nurses Invisible to board recruiters Represent self-interests Limited financial capacity Lack knowledge and skills for board service	Build infrastructure for board preparation Mentoring Develop a personal plan
Sundean <sup>24</sup>	Broad perspectives and move agendas; “Innovator, implementer, evaluator” Confident decision makers	Tokenism “Old Boys Network” Guarding status quo Finances and philanthropy Strategy and advocacy Quality and safety	“By the way, I happen to be a nurse” Get the work done
Kakabadse et al <sup>25</sup>	Strength in numbers Diverse perspectives Problem-solving skills Improved dialogue Reduce “groupthink”	Absence of development activities Power struggles Credibility challenges Women must “prove themselves” Exclusion from social activities and decision making Tokenism	Financial acumen Effective mentoring and networks Motivation, commitment, and education Competency-based board appointments and not quotas

contributions of nurses and women on boards validate the power of diversity relating to board effectiveness. Boardroom diversity inclusive of women and nurses deepens decision-making capacity.

### Cracking the Old Boys’ Network

The old boys’ network was a recurring phrase throughout several of the studies referring to traditional patriarchal dynamics that create barriers for board diversity inclusive of nurses and women.<sup>20,21,24</sup> Khoury et al<sup>22</sup> and Mason et al<sup>23</sup> listed nurses’ lack of aspiration and preparation for leadership positions,

lack of visibility, and limited philanthropic capacity as key barriers to board appointments as perceived by nonnurse board members. “If you give a bigger donation, you get more talk time.”<sup>24(p24)</sup> Cracking the old boys’ network is characterized by outdated perceptions of nurses’ capacity for leadership and philanthropy.

Other studies focused on barriers and power struggles within the patriarchal boardroom. “I have attended many board meetings where...suddenly something has been decided without having been discussed.”<sup>21(p119)</sup> “Many board decisions take place...after the third scotch.”<sup>19(p68)</sup> Another participant

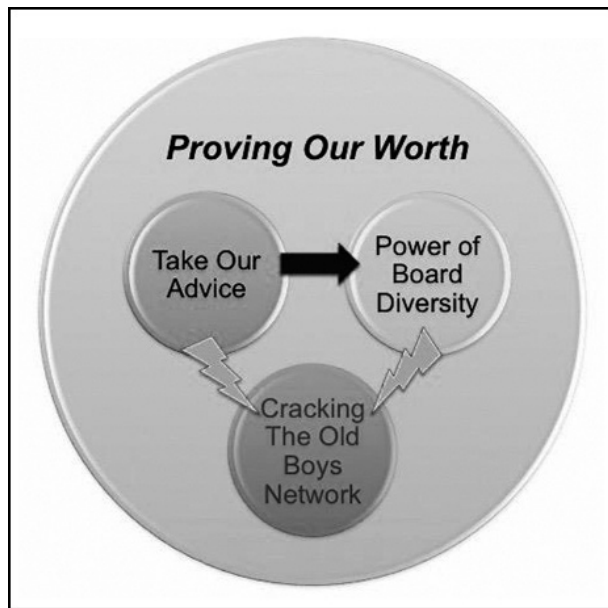


Figure 2. Proving our worth: the central issue of nurses and women on governing boards. Relationships are demonstrated via thunderbolts and an arrow. The straight arrow indicates a collegial relationship without tension. Thunderbolts indicate relationships with power-based tension.

added, “Any woman that enters the board is treated with a good dose of suspicion.”<sup>25(p273)</sup> Power struggles also manifest in sexualized behavior and stereotyping. “It’s been challenging earning respect and being treated as an equal member...”<sup>20(p94)</sup> In describing behavior during board retreats, 1 participant states, “If you go to bed at 11:30 PM you are considered to be the...unpleasant old maid, but if you don’t you will get the questions with sexual over- and undertones.”<sup>19(p68)</sup>

Some studies noted the practice of tokenism on boards, particularly where quotas were mandated. Tokenism reflects negatively on female board members, burdening token members, and reducing female influence on boards.<sup>21,24,25</sup> Participants were strongly against board quotas because they minimize competency-based board appointments. “Quotas undermine these women who worked very hard to get where they are now.”<sup>25(p275)</sup> Tokenism in the patriarchal boardroom is a silencing mechanism that limits board equality for women or nurses.

To be fair, not all board experiences of nurses and women are negative. One participant reflected, “...I think they listen to me carefully...I am included in everything...I’m very definitely part of the organization...”<sup>19(p70)</sup> “Hats off to the person who brought me (a nurse) onto the board. There was this acceptance and awareness that nursing plays a key role...that created a great opportunity.”<sup>24(p23)</sup> Although some boards benefit from inclusive membership practices, the old boys’ network leads many nurses and women to develop strategies and solutions for cracking or confronting patriarchal board norms.

### Take Our Advice

Take our advice is the overarching theme that guides nurses and women in pursuit of board appointments. It is the collective toolbox of solutions and strategies that support the case for the power of board diversity and confront the old boys’ network. Financial acumen and professional preparation were recurring concepts. Both are important for understanding board responsibilities and essential for participating in board discussions.<sup>19-23,25</sup>

Participants emphasized the importance of networking, creating alliances, and formal mentorship. Mason et al<sup>23</sup> recommended that nurses seek board mentors for “...grooming the expectation.”<sup>(p898)</sup> Groysberg and Bell<sup>20</sup> recommended developing “...a pipeline of future...board members through director advocacy, mentorship, and training.”<sup>(p97)</sup> Mason et al<sup>23</sup> and Bilimoria and Huse<sup>19</sup> suggested developing a personal plan for self-promotion to increase visibility with board leaders. Groysberg and Bell<sup>20</sup> and Mason et al<sup>23</sup> recommended formal processes and infrastructure for board promotion. “Somebody has to start talking to the decision makers...It would be great if you [had] some way of saying ‘here’s a hundred nurses who qualify to be board members...”<sup>23(p898)</sup> “You demonstrate your value by rolling up your sleeves and just getting it done and then saying, ‘oh, by the way, I happen to be a nurse.’”<sup>24(p24)</sup> Collectively, the strategies and solutions themed take our advice offer a unified approach toward securing and managing board appointments for nurses and women (Table 3).

**Table 3. Take Our Advice: Strategies for Securing and Managing Board Appointments**

Strategy	Description
1. Preparation	Prepare for board service and for board meetings.
2. Network	Network broadly among professionals from a range of sectors.
3. Create alliances	Create and develop relationships of affinity within groups.
4. Seek formal mentorship	Seek mentorship for professional development and advancement.

Adapted from research findings, results, and conclusions.<sup>19-23,25</sup>



## Proving Our Worth

Proving our worth, the central issue for securing and managing board appointments for nurses and women on boards, provides a deeper understanding than could be detected from each study in isolation. This central issue is the paramount synthesis of the overarching themes that not only defines board challenges for nurses and women but also provides insight into solutions and strategies for change. Regardless of the knowledge, skills, and expertise for board service, nurses and women are constantly in the position of proving their worth for board service and often must prove themselves worthier than their counterparts.

As Figure 2 illustrates, take our advice informs or guides the overarching theme of power of diversity. The arrow indicates a supportive relationship between take our advice and power of diversity. Preparing for board service, developing alliances and a personal plan, seeking mentors, and self-promotion support and leverage the power of board diversity. The struggles between these 2 themes and cracking the old boys' network are symbolized by lightening rods as nurses and women attempt to relate within traditional patriarchal board dynamics. The lightening rods characterize power-based tension between traditional patriarchal boards and nurses and women who seek equality within boards. The points of the lightening rods indicate the mechanisms necessary to penetrate the old boys' network.

The power-based tensions demonstrated in Figure 2 are revealed in the quotes of the overarching theme, cracking the old boys' network. Power imbalances and marginalization of women and nurses on boards erode the effectiveness of boards and impair organizational outcomes.<sup>26</sup> The energy expended by nurses and women to prove themselves worthy as equal and valuable board members detracts from the potential for achieving outcomes based on shared interests and goals.

## Discussion

Nurses and women are making their case or proving their worth for board participation. Mastal et al<sup>13</sup> shaped the case for parity in the boardroom and the affirmation of nurses' worth for board service by describing nurses' value to healthcare board quality and safety discussions. Conclusions from Zaichkowsky,<sup>15</sup> Mathisen et al,<sup>16</sup> and Walton et al<sup>14</sup> also shape the case for the power of diversity.

Power struggles are exemplified through the overarching theme of cracking the old boys' network. Dunn<sup>17</sup> concludes that women's appointments to boards are limited to women with insider knowledge. McDonald and Westphal<sup>8</sup> conclude that women and

minorities are denied access to boards based on limited mentoring. They also addressed the importance of mentorship as a facilitator to board appointments that was uncovered in the overarching theme titled take our advice.

## Implications for Practice

According to Paterson,<sup>27</sup> the powerful interpretations from metasyntheses are useful for generalizations. Proving our worth, the central issue about nurses and women on boards, has the potential for generalization. This metasynthesis identifies issues that are useful for advancing social discourse toward boardroom parity. The results are useful for raising awareness about boardroom challenges and potential facilitators for nurses and women. Table 3 describes strategies for securing and managing board appointments. Through dialogue and reflective action, nurses, women, and board members can begin breaking down barriers to embrace a more egalitarian approach to board governance.

## Suggestions for Further Research

There is a need for more qualitative studies using rigorous methodology focusing on nurses and board governance. For example, the central issue, proving our worth, can be developed and tested as a theory supportive of nurse board appointments. Finally, research to test potential facilitators to board appointments can be useful for increasing engagement of nurses and women on governing boards.

## Strengths and Limitations

The consistency of outcomes across the qualitative studies contributes to the main strength of this metasynthesis. These consistencies reduced risks to credibility associated with interpretive judgments and development of key metaphors,<sup>18</sup> leading to a concise and cogent outcome. Trustworthiness was addressed through confirmation of the procedures, interpretations, findings, and metasynthesis conclusions with another researcher at multiple points throughout the research process. Although committed to unbiased research conduct, it is possible the researchers' preconceptions influenced the outcome of this metasynthesis.<sup>18</sup> The low number of studies available for this metasynthesis reduced the thick descriptions and reduces transferability of the results. Differing governing practices in countries represented in the qualitative studies limit confidence in the results. Governance issues of women in corporate business settings may not mirror the governance issues of nurses in healthcare settings even though both represent gender equality issues.

## Conclusion

Boardroom parity for nurses and women is an important social agenda with implications for strategic decision making in healthcare and business. The central issue, “proving our worth,” derives from the overarching themes (power of board diversity, take our advice, and cracking the old boys’ network) that were developed after reciprocal translation of key metaphors from qualitative and mixed methods studies. The results provide a deeper understanding about

nurses and women on boards than could be understood by reading the studies in isolation. This metasynthesis is useful for supporting social discourse and change in healthcare and business governance to include nurses and women as equal participants on governing boards.

## Acknowledgments

The authors acknowledge support from Cheryl T. Beck, DNSc, CNM, FAAN, School of Nursing, University of Connecticut.

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## CHAPTER IV

### The Rationale for Nurses on Boards: A Mixed Methods Study

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## Abstract

**Background:** Inclusion of nurses on boards (NOB) to enhance healthcare transformation is recommended; however, the engagement of NOB is persistently low with no research based rationale for NOB.

**Purpose:** To articulate the rationale for NOB in the voices of nurses who serve and begin a program of research.

**Method:** An explanatory sequential mixed methods design was utilized with priority on the quantitative strand (Delphi method). The qualitative strand was accomplished with focus groups.

**Results:** Twenty-nine NOB participants (Delphi phase) and nine NOB participants (focus groups) agreed the rationale for NOB is embedded in 26 specific knowledge, skills, and perspectives that nurses contribute for boardroom discussions and policymaking.

**Discussion:** Extant literature supports the rationale for NOB to influence organizational direction and policy supportive of healthcare transformation.

**Conclusion:** Board leadership is a mechanism by which nurses can act upon the professional obligation to support social justice within the metaparadigm of nursing. Further research is recommended.

**Keywords:** nurses on boards; mixed methods research; healthcare governance; feminism

## CHAPTER IV

### THE RATIONALE FOR NURSES ON BOARDS: A MIXED METHODS STUDY

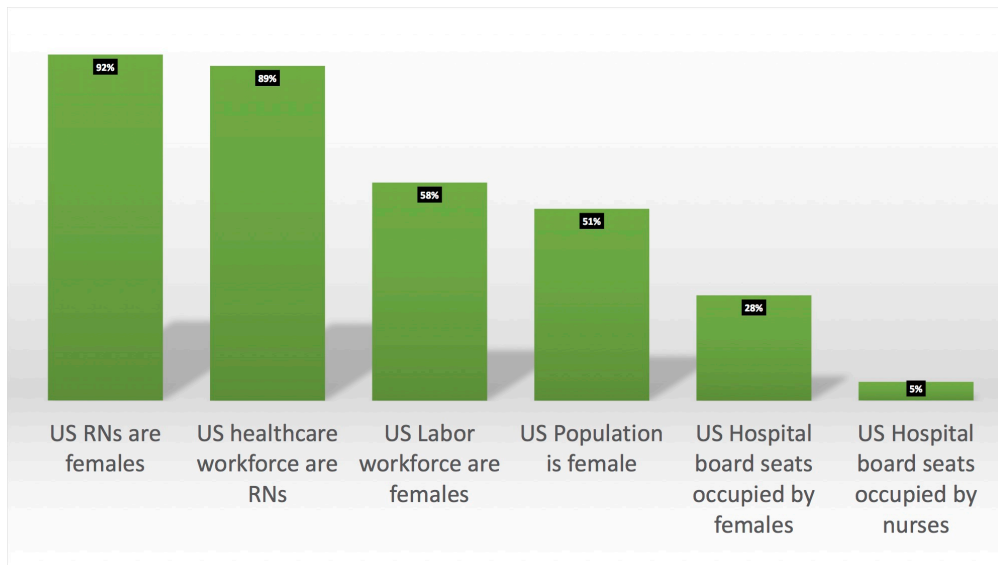
Healthcare governing boards are responsible for setting organizational strategies and guiding performance oversight carried out through the fiduciary duties of care, loyalty, and obedience. The ability of healthcare organizations to provide quality, safe, accessible, equitable, and cost-effective care to people and populations is affected by the decisions of their governing boards (The Governance Institute, 2016). Mounting complexities in healthcare delivery organizations and the overarching need for healthcare transformation highlight the imperative for highly qualified individuals to lead at the governance level. However, studies demonstrate healthcare board composition rarely reflects the full range of diverse, expert stakeholders for advancing healthcare (Prybil, 2016). Critical among the missing stakeholders are nurse leaders.

Only 5% of hospital board members are nurses. Eighty nine percent of the United States (US) healthcare workforce is comprised of registered nurses and 11% are active physicians (Budden, Mouton, Harper, Brunell & Smiley, 2016; Kaiser Family Foundation, 2017). The national healthcare workforce is composed mainly of nurses (American Hospital Association [AHA], 2014), 92% of whom are females (Budden, et al., 2016). However, females only occupy 28% of US hospital board seats (AHA, 2014) even though females comprise 51% of the US population and 58% of the US labor workforce (US Department of Labor Statistics, 2010).

Figure 1.

Figure 1

*Background Data about Nurses and Females in the United States*



(American Hospital Association, 2014; Budden, J., Moulton, P., Harper, K., Brunell, M. L. & Smiley, R., 2016; Kaiser Family Foundation, 2017; US Bureau of Labor Statistics, 2010)

Sigma Theta Tau International, the American Nurses Association, the American Academy of Nursing, the Nurses on Boards Coalition, the AHA, and other professional organizations advocate the appointment of qualified nurses to boards of directors (AHA, 2014; Nurses on Boards Coalition, 2017). However, the persistent low engagement of nurses on boards (NOB) fails to meet the obligation for comprehensive knowledge-based governance decision-making on behalf of people served by healthcare organizations (AHA, 2014). The low appointment rate of NOB reflects status quo board practices and limits opportunities for healthcare organizations to leverage the valuable expertise of nurses to advance policies supportive of just and equitable healthcare. Without input from nurses as voting members on healthcare boards of directors, decisions are made in the absence of key knowledge experts with consequences impacting the health of patients and communities served.

Although key organizations advocate the critical role for nurses on healthcare boards, a dearth of research exists about NOB (Sundean, Polifroni, Libal & McGrath, 2017). A fundamental deficiency of the extant research is the absence of a research generated rationale for NOB. The purpose of this study was to articulate the rationale for NOB in the voices of nurses who serve and to set a foundation for a systematized program of research about NOB

supportive of improved healthcare governance practices and policies to aid healthcare transformation. The explanatory sequential mixed methods study answered the following research questions:

1. What is the specific rationale for NOB as identified by an expert panel of NOB?
2. What are the perspectives of a secondary sample of NOB about the rationale for NOB identified by the expert panel?
3. How do the opinions of the expert panel of NOB compare with the perspectives of the secondary sample of NOB regarding the rationale for NOB?

### **Literature Review**

In an integrative review about NOB, evidence from 11 studies demonstrated recommendations moving from passive observation about NOB with no action steps to change status quo governance to a clear call for action to modernize governance practices inclusive of NOB (Sundean et al., 2017). The studies also call nurses to actively seek board roles and continue building the program of research about NOB (Khoury, Blizzard, Moore & Hassmiller, 2011; Mason, Keepnews, Holmberg & Murray, 2013; Sundean, 2015; Sundean & McGrath, 2016; Walton, Lake, Mullinex & Mooney, 2015). Among findings, non-nurse board leaders' perceptions marginalize nurses' voices for governance roles (Khoury et al., 2011; Mason et al., 2013). Marginalizing perceptions include beliefs that nurses lack leadership characteristics, philanthropic capacity, and decision-making power for board service. Additionally, findings showed non-nurse board leaders believe nurses are indifferent to board leadership, preferring only direct patient care (Khoury, et al., 2011; Mason, et al., 2013). First-hand experiences of nurses (and women) serving on boards expose the disparaging issues encountered. Nurses (and women) share experiences of marginalization on boards espousing traditional norms (Sundean, 2015; Sundean & McGrath, 2016; Walton et al., 2015). A single study suggests at least one nurse on a hospital board is associated with more effective board practices and better

overall organizational outcomes. However, this finding must be regarded with caution since it was from a single study that did not control for confounding factors (Szekendi et al., 2015).

In a similar review, Prybil (2016) examined factors about healthcare governance practices and reports clinician engagement on hospital and hospital system boards (inclusive of nurses and physicians) remains low despite AHA recommendations to include these two critical groups of professionals. Prybil recommends board leaders with NOB share their perspectives about the contributions of nurses at the board level. Like Sundean et al. (2017), Prybil advocates active appointments of NOB, encourages nurses to prepare for board service, and promotes research inquiry about NOB (Prybil, 2016).

In a study about nursing leadership, Peltzer et al. (2015) reported only 15% of a sample of Kansas nurses aspire toward governance leadership. The same sample cited lack of time and support as barriers for general leadership goals inclusive of governance leadership. Recommendations include intentional leadership development opportunities.

In a recent auto-ethnographic case study, McBride (2017) portrays her experiences on a hospital system board. Her contributions highlight expertise in quality and safety, and focus on systems management as contributing factors to her influence on the board. McBride recommends nurses continue to describe their board experiences to inspire other nurses toward board leadership. Non-nurse board leaders are urged to engage nurses as valuable board members (McBride, 2017). Characterizing board experiences also provides a pathway for better understanding skills and competencies nurses need for effective board leadership.

While the extant research raises awareness about NOB, the studies neither coalesce to build a coordinated and systematized trajectory of research about this phenomenon nor do they make a compelling case for NOB based on healthcare outcomes or nurses' specific governance contributions (Prybil, 2016; Sundean et al., 2017). Finally, no studies explicitly articulate the rationale for NOB.

## **Worldview and Philosophical Foundation**

A pragmatic worldview was adopted for the study because it accommodates multiple paradigms as a persuasive lens for examining research phenomena, acknowledges the role of the researcher in the research, and effectively balances deductive and inductive research approaches simultaneously (Creswell & Plano Clark, 2011; Florczak, 2014). The study was underpinned by feminist philosophy to amplify nurses' leadership voices and experiences in the context of healthcare governance. Addressing inequalities associated with power imbalances leading to discrimination, marginalization, and missed opportunities, feminism emphasizes action for social change to confront dominant social norms and status quo practices (Lorber, 2012; Sprague, 2005).

Sprague (2005) suggests feminist research can incorporate quantitative and qualitative approaches when addressing issues of power imbalances and inequalities. Sundean and Polifroni (2016) suggest feminism is an appropriate philosophical framework for understanding the phenomenon of NOB, contributes to knowledge about contemporary nursing leadership roles, and supports nurses' professional contract with society. The feminist framework supports the current study approach by actively engaging nurses to articulate the rationale for NOB rather than respond to a rationale imposed by others.

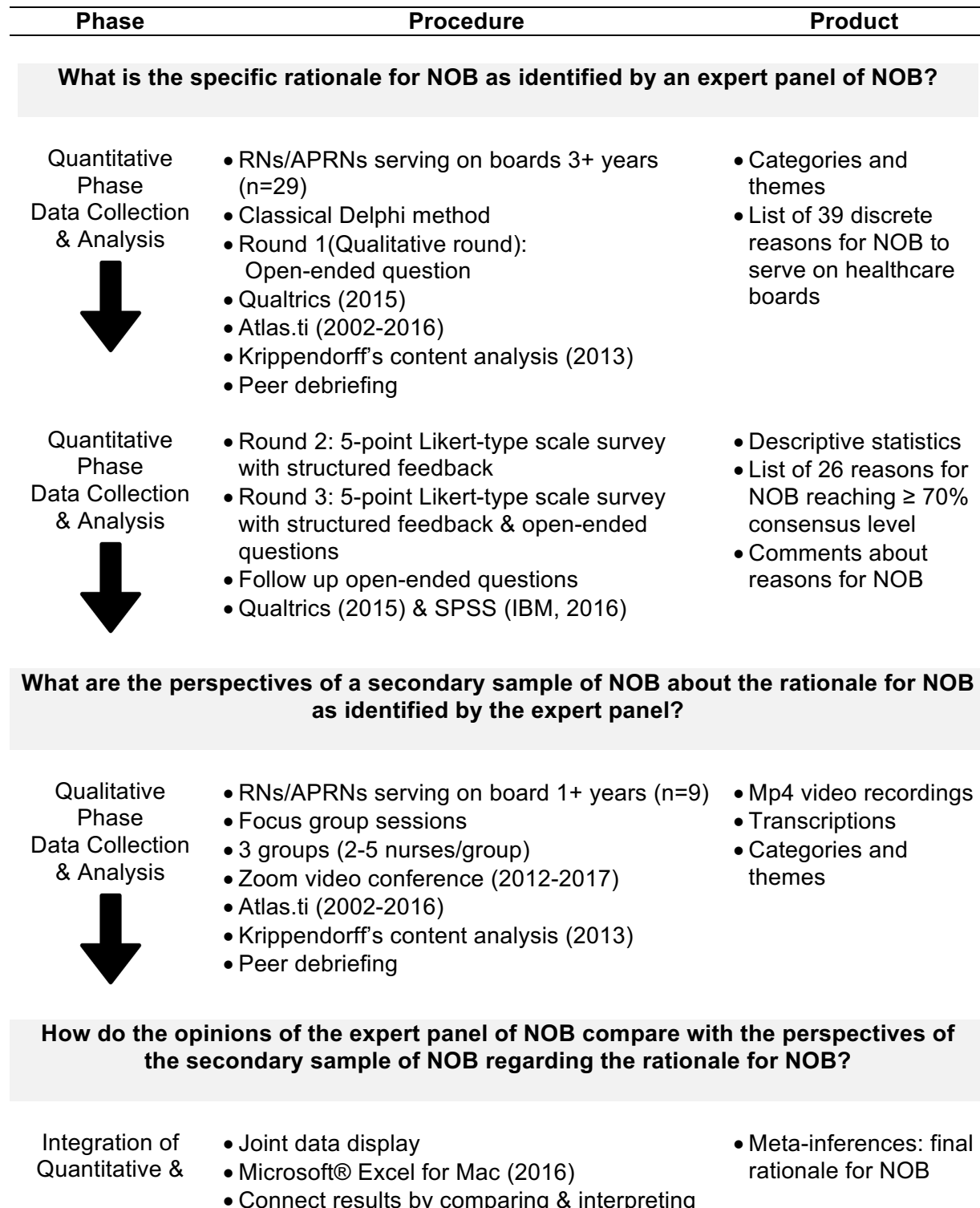
## **Method**

### **Research Design**

The study utilized the explanatory sequential mixed methods design with priority on the quantitative strand: QUAN → qual (Morse & Niehaus, 2009). The study began with a quantitative strand followed by a smaller qualitative strand to more fully explain and enrich the quantitative findings. Findings from both strands were integrated and connected to derive meta-inferences used to answer the research questions (Creswell & Plano-Clark, 2011). The study was approved by the Institutional Review Board at the University of Connecticut. Figure 2.

Figure 2

*Procedural Flow Diagram*





Qualitative results	• Prepare manuscript for publication	• Manuscript for publication
<b>Sample</b>		

Sample sizes for Delphi method studies range from 2-500 according to Keeney, Hasson, and McKenna (2011). Based on feasibility for recruitment, the target sample size for the Delphi strand of this study was 30 and included 20% over-enrollment to account for potential participant attrition. Convenience sampling with additional snowball sampling was used to recruit the expert panel for the quantitative Delphi strand. Names and email addresses for the Delphi sample group were procured from the American Nurses Foundation and the investigator's familiarity with nurses serving on boards. Registered nurses (RNs) and Advanced Practice RNs (APRNs) with  $\geq$  three years' experience and voting rights on nonprofit hospital or healthcare boards were included as the expert panel in the Delphi strand. Katz and McIntosh (2014) suggest  $\geq$  three years' board leadership experience for board leadership effectiveness. To contribute to heterogeneity of the data for the study, a separate participant group for the qualitative strand (focus groups) was recruited via convenience sampling from the investigator's familiarity of nurses serving on boards. Kruger and Casey (2015) suggest sample sizes of 4-7 participants per focus group for video conference sessions. Because the supplemental component of the explanatory sequential mixed methods design is not meant to stand alone and data are not collected to reach saturation, Creswell and Plano Clark (2011) suggest a smaller sample for the qualitative strand. Twenty-nine potential participants were recruited for the qualitative strand with a target sample size of 15-21 to account for attrition. Inclusion criteria for the qualitative strand consisted of RNs and APRNs with  $\geq$  one year experience on nonprofit hospital or healthcare boards. Recruitment for the qualitative strand occurred upon conclusion of the quantitative strand. Nurses serving on only nursing association boards were excluded from both participant groups.

The different participant groups for each strand of the study supported the feminist and pragmatic frameworks of the study. Including two separate groups of nurses in the study

contributed to sample and data heterogeneity, and demonstrated the researcher's commitment to thought diversity about the topic. Recruitment, consent, and enrollment of both participant groups occurred with reminders online via Qualtrics (2015). Upon enrollment, participants for both strands completed a demographic survey via Qualtrics (2015). Demographic data were analyzed in Microsoft Excel (2016).

## **Procedures**

### **Quantitative Data Collection and Analysis**

The quantitative strand was conducted using the classical Delphi consensus method because it is useful when little is known about a phenomenon and it is a recognized method for mixed methods studies (Asselin & Harper, 2014; Bloor, Sampson, Blaker & Dahlgren, 2015; Keeney, Hasson & McKenna, 2011). The panel of experts participated in three rounds of Delphi surveys via Qualtrics (2015) to identify key reasons for NOB in the voices of nurses who serve (Keeney, Hasson & McKenna, 2011). The first round, an open-ended qualitative round, generated reasons for nurses to have a seat on healthcare boards. Data were analyzed in Atlas.ti (2002-2016) and reasons for NOB were clustered into categories and themes using Krippendorff's method of content analysis. Krippendorff's method includes selecting units of analysis from data, recording or coding data through an iterative process, and reducing similar codes to develop categories and themes (Krippendorff, 2013). Categories were developed into Likert-type surveys implemented in two successive survey rounds to develop consensus agreement.

The Likert-type surveys consisted of five-point scales with end-point anchors (Strongly disagree-Strongly agree). Analysis of the Likert-type surveys in rounds two and three determined consensus agreement. Participants were given controlled feedback in round three consisting of each participant's previous responses along with median group responses for consideration in consensus building (Keeney, Hasson & McKenna, 2011). Controlled feedback

was also provided in a final survey to capture comments about final consensus items or reasons for NOB.

Descriptive statistics were developed and analyzed from data in the consensus building rounds using Statistical Package for the Social Sciences (International Business Systems, 2016). Items reaching  $\geq 70\%$  consensus (combined responses of 'agree' or 'strongly agree') were removed from further consensus-building rounds. In round three, participants were given an opportunity to make comments on items that reached consensus in round two. Items that did not reach consensus in round two comprised the consensus building portion of the third Delphi round and was administered with controlled feedback. Analysis proceeded the same as for round two. Following the third round, participants were given an opportunity to comment on the last items to reach consensus agreement. The consensus items were ranked by mean scores (Keeney, Hasson & McKenna, 2011) to generate the final list of reasons for NOB which were presented for validation in the qualitative strand, the focus group sessions.

### **Qualitative Data Collection and Analysis**

The qualitative strand of the explanatory sequential design is the supplemental, explanatory component. The supplemental component is not meant to stand alone and data were not collected to reach saturation. Rather, data are collected to explain, validate, or complete the findings of the quantitative strand (Creswell & Plano Clark, 2011).

Data for the qualitative round were collected in three focus group sessions conducted via Zoom video conference platform (Zoom, 2012-2017). Kruger and Casey (2015), and Galloway (2011) acknowledge the utility of technology aided focus group sessions and specifically recognize authenticity of participants in video conference focus group sessions. Participants were randomly assigned to two focus group sessions; however, the final focus group schedule was adjusted to accommodate participants' needs resulting in three sessions. Participants were notified of the focus group schedule and specific instructions for accessing Zoom (2012-2017) with reminders via Qualtrics (2015). Sessions lasted an average of 63.19 minutes with group

sizes consisting of 2-5 participants. During each focus group session, the reasons for NOB generated from the Delphi strand were shared with participants who were invited by the investigator to provide comments, perspectives, and ideas for revisions. Reasons for NOB were shared first in four separate PowerPoint slides (Microsoft® PowerPoint for Mac, 2017) associated with the four themes from the Delphi study. Themes were not disclosed to participants. Ample time was given to review each slide and to comment on the content. After the slides were shared, the full list of reasons for NOB were shared with continuation of the questioning route and group conversation. Each focus group session was recorded in mp4 format, entered in Atlas.ti (2002-2016), and analyzed using Krippendorff's method of content analysis to develop themes (Krippendorff, 2013).

### **Mixing of Quantitative and Qualitative Data**

Consistent with mixed methods methodology, findings from both strands were arranged in a joint data display, analyzed, and connected to arrive at more comprehensive findings and meta-inferences (Gutterman, Fettes & Creswell, 2015). Integration of the data allowed for comparisons between the two strands. Meta-inferences are characteristic of mixed methods studies leading to synthesized results uncommon in separate quantitative or qualitative studies (Creswell & Plano Clark, 2011; Teddlie & Tashakkorie, 2009).

Analysis of the joint data display illuminated similarities and dissimilarities of results between the quantitative and qualitative strands. Congruities between the two strands validated those reasons for NOB. Incongruities between the two strands were considered along with consensus levels and means from the quantitative strand, and transcripts from the qualitative strand. Final judgments and interpretations were made via peer debriefing. Results of data connection and analysis resulted in the final rationale for NOB.

### **Validity**

Threats to validity associated with mixed methods research and Delphi methods studies are well established (Creswell & Plano Clark, 2011; Keeney, Hasson & McKenna, 2011; Leech,

Dellinger, Brannagan & Tanaka, 2010). Strategies to address trustworthiness of the results included collection of robust data with thick descriptions, a comprehensive audit trail of evidence to justify decisions, use of controlled feedback in the Delphi surveys, peer debriefing, and use of a systematic content analysis method (Keeney, Hasson & McKenna, 2011; Krippendorff, 2013; Lincoln & Guba, 1985; Morse, 2015). Frequent, timely communications and the pre-set Delphi consensus level aimed to maintain participant engagement and to reduce spurious results (Kruger & Casey, 2015).

Careful recruitment of study participants ensured accurate reflection of focal content (Keeney, Hasson & McKenna, 2011). Heterogeneity with two separate sample groups for the quantitative and qualitative strands supported trustworthiness of the data. Because the study was underpinned by pragmatism and feminism, the goal was not to uncover universal truth but rather to lend voice to the participants. Similarly, the results of the study are not intended for generalization/transfer to the entire population of nurses but rather to illuminate the perceptions of the participants about the rationale for NOB (Creswell & Plano Clark, 2011; Sprague, 2005).

## Results

### Quantitative Strand Results: Delphi Phase

A nationally distributed sample of 29 nurse board leaders participated in the Delphi strand. Participants were primarily females ages 60 and above with 41 or more years as a nurse, and doctorate prepared. Half of the participants were working full time in nursing, in an academic environment, and identified their roles primarily as nurse executives or nurse faculty. Seventy five percent reported current board service. Tables 1 and 2.

Table 1

#### *Recruitment and Participation*

Variables	Delphi Survey	Focus Groups
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Total recruited (n):	109 (1 email undeliverable)	29
Total responses (n):	46 (45 interested in participating)	12
Response rate:	.43	.41
Ineligible to participate (n):	9	1
Enrolled (n):	36	11
Participants (n):	29 (rounds 1 & 2), 28 (round 3)	9
Participation rate:	.81 (rounds 1 & 2), .78 (round 3)	.82

Table 2

*Sample Demographics*

Variables		Delphi Survey				Focus Groups	
		Delphi Rounds 1 & 2 (n=29)		Delphi Round 3 (n=28)		(n=9)	
		n	%	N	%	N	%
<b>Gender</b>							
	Female:	28	.97	27	.96	1.00	1.00
	Male:	1	.31	1	.04	0.00	.00
<b>Age Range</b>							
	40-49 years:	2	.07	2	.07	4	.44
	50-59 years:	1	.03	1	.04	4	.44
	60-69 years:	17	.59	17	.61	1	.11
	70+ years:	9	.31	8	.29	0	.00
<b>US Region of Residence*</b>		(n=28)		(n=27)			
	Northeast:	9	.32	8	.30	8	.89
	South:	9	.32	9	.33	0	.00
	Midwest:	5	.18	5	.19	0	.00
	West:	5	.18	5	.19	1	.11
<b>Highest Education</b>							
	Master's degree:	5	.17	5	.18	4	.44
	Doctorate degree including						
	Juris Doctorate:	24	.83	23	.82	5	.56
<b>Nursing Tenure</b>							
	11-20 years:	1	.03	1	.04	0	.00
	21-30 years:	3	.10	3	.11	4	.44
	31-40 years:	3	.10	3	.11	4	.44
	41-50 years:	16	.55	16	.57	1	.11
	50+ years:	6	.01	5	.18	0	.00
<b>Employment Status</b>							
	Full time (Nurse or APRN):	16	.55	15	.54	5	.56
	Part time (Nurse or APRN):	2	.07	2	.07	1	.11
	Outside nursing (full/part time):	3	.10	3	.11	3	.33
	Retired:	8	.28	8	.29	0	.00
<b>Primary Work Setting**</b>							
	Academic environment:	17	.59	16	.57	2	.22
	Clinical environment including school	3	.10	3	.11	4	.44
	health services:						
	Policy/Planning/Regulatory/Licensing	1	.03	1	.04	1	.11
	Agency:						
	Other:	8	.08	8	.29	2	.22

Other work environments include nonprofit organizations, professional organizations, insurance environments, consulting.

**Role/Title\*\* (multiple entries)**

APRN:	1	.03	1	.03	1	.07
Consultant:	6	.15	6	.16	2	.14
Nurse executive:	11	.28	10	.27	4	.27
Nurse faculty:	15	.38	15	.38	4	.27
Nurse manager:	0	.00	0	.00	0	.00
Nurse researcher:	2	.05	2	.05	1	.07
Other Health related:	3	.08	3	.08	3	.21
Other non-health related:	1	.03	1	.03	0	.00

Other role/titles include staff nurse, health equity educator, VP, CEO, Executive VP.

**Currently Serving on a Board**

Yes:	22	.76	21	.75	8	.89
No:	7	.24	7	.25	1	.11

**Cumulative Years of Board Service**

	(n=28)		(n=27)			
1-2 years:	n/a		n/a		1	.11
3-5 years:	7	.25	7	.26	1	.11
6-8 years:	6	.21	6	.22	3	.33
9-11 years:	2	.07	2	.07	2	.22
12-14 years:	5	.18	4	.15	2	.22
15+ years:	8	.29	8	.30	0	.00

**Board Organization Types (multiple entries)**

	(n=27)		(n=26)			
Hospital or hospital system:	14	.40	13	.39	1	.10
Healthcare foundation:	4	.11	4	.12	2	.20
Other:	17	.49	16	.48	7	.70

Other board organization types include government commissions, long term care organizations, accreditation organizations, education organizations, public private partnerships.

**Board Committees\*\* (multiple entries)**

	(n=26)		(n=25)		(n=8)	
Audit:	3	.04	3	.04	0	.00
Community benefit:	5	.06	5	.06	0	.00
Development/fundraising:	2	.03	2	.03	2	.14
Executive:	13	.17	13	.17	3	.21
Finance:	6	.08	6	.08	0	.00
Governance:	11	.14	11	.14	1	.07
Government relations:	1	.01	1	.01	0	.00
Nominations/membership:	3	.04	3	.04	0	.00
Quality improvement/safety:	13	.17	13	.17	1	.07
Strategic planning:	13	.17	12	.16	3	.21
Other:	8	.10	8	.10	4	.29

Other board committees include compensation, physician relations and medical appointments, awards/scholarship, human resources, academic/education/training, interdisciplinary membership, advocacy, diversity/cultural competency.

\*US regions from: [http://www.census.gov/econ/census/help/geography/regions\\_and\\_divisions.html](http://www.census.gov/econ/census/help/geography/regions_and_divisions.html)

\*\*Primary work setting, Role/title, and Board committee designations mirror those used by Budden et al. (2016).

Participants in the first Delphi round responded to the open-ended question, “Considering your experience as a nurse board leader, what do you believe are the specific reasons that nurses should have a reserved seat on healthcare boards?” Analysis revealed 39 discrete reasons for NOB. Over two successive rounds, participants developed  $\geq 70\%$  consensus for 26 of 39 reasons for NOB. Thirteen items did not reach consensus agreement. The rationale for NOB generated from the expert panel is embedded within four themes: 1. knowledge; 2. skills; 3. perspectives; and 4. benefits and opportunities. Dendograms were used to display the pathway of analysis from quotations to categories and themes (Krippendorff, 2013). Tables 3 and 4; Appendix, Figure B1. Along with the 26 consensus items, participants also provided free text comments about the results.

Table 3

*Delphi Consensus Items Ranked by Means*

<b>Consensus Items (n=26)</b>		<b>Theme</b>	<b>Round/ Consensus Level</b>	<b>Mean</b>
The reason for nurses to have a seat on healthcare boards is:				
1.	Because nurses are knowledgeable about healthcare quality and safety issues.	K	R2/100%	4.97
2.	Because nurses are knowledgeable about patient/family needs across the care continuum.	K	R2/97%	4.90
3.	Because nurses understand community health needs.	K	R2/97%	4.69
4.	Because nurses bring a holistic perspective to patient care and healthcare.	P	R2/93%	4.66
5.	Because nurses are skilled patient advocates.	S	R2/97%	4.62
6.	Because nurses offer research and evidence-based practice knowledge for boardroom discussions.	K	R2/90%	4.62
7.	Because nurses are knowledgeable about health equity.	K	R2/90%	4.59
8.	Because nurses are knowledgeable about complex healthcare delivery systems.	K	R2/93%	4.55
9.	Because nurses are patient-centric.	P	R2/93%	4.52
10.	To provide nurses with opportunities to influence health policy.	B&O	R2/86%	4.52
11.	Because nurses provide a unique perspective.	P	R2/83%	4.34
12.	Because nurses are knowledgeable about human resources issues.	K	R2/90%	4.31
13.	Because nurses are skilled team collaborators.	S	R2/90%	4.31
14.	Because nurses are skilled problem solvers.	S	R2/83%	4.28
15.	Because nurses understand healthcare finances and the links to organizational and patient outcomes.	K	R2/79%	4.28



16.	Because nurses are knowledgeable about healthcare regulatory standards.	K	R2/76%	4.17
17.	Because nurses are skilled leaders.	S	R2/79%	4.14
18.	Because nurses represent the largest portion of the healthcare workforce.	B&O	R2/72%	4.14
19.	Because it places nurses on par with other healthcare providers.	B&O	R2/72%	4.14
20.	Because nurses are skilled team builders.	S	R2/76%	4.10
21.	Because nurses have strong communications skills.	S	R2/72%	4.07
22.	Because nurses are skilled change agents.	S	R3/79%	4.04
23.	Because consumers have trust and confidence in nurses.	B&O	R3/75%	4.04
24.	To role model governance leadership and decision-making for other nurses and students.	B&O	R2/76%	4.03
25.	Because nurses understand competing agendas.	K	R2/72%	3.86
26.	Because nurses have effective innovative thinking skills.	S	R3/71%	3.86

Themes: K=Knowledge, S=Skills, P=Perspectives, B&O=Benefits and Opportunities  
Consensus agreement reached in either Round 2 (R2) or Round 3 (R3).

Table 4

*Non-Consensus Items*

Non-Consensus Items		Consensus Level
The reason for nurses to have a seat on healthcare boards is:		
1.	Because nurses have strong strategic thinking skills.	61%
2.	To increase professional recognition for nurses.	54%
3.	To improve nurses' understanding about organizational issues in healthcare.	50%
4.	To provide nurses with opportunities to interact and collaborate with an interdisciplinary group.	43%
5.	Because nurses are compassionate.	36%
6.	Because nurses are empathetic.	36%
7.	To advocate for nurses and the nursing profession.	32%
8.	Because nurses are objective leaders.	32%
9.	To provide nurses with the opportunity for career development.	29%
10.	Because nurses have a business perspective.	25%
11.	Because most nurses are female and therefore, provide a specific gender perspective.	25%
12.	Because nurses are skilled policy leaders.	22%
13.	Because nurses are altruistic.	14%

The phrase *reserved seat*, used in the opening question, was challenged by one participant and prompted concern over the influence of the modifier in generating reasons for NOB. In consideration of this concern and because the intent of the question was to focus on

reasons for NOB and not reasons for a *reserved seat* for NOB, the decision was made to eliminate the word *reserved* from further Delphi rounds and to omit its use in the focus group sessions. To address the concern about the word *reserved*, one item was added to round two of Delphi survey with an invitation to comment on the concept. Eighty six percent of participants agreed or strongly agreed that “Nurses should not have a *reserved seat* on healthcare boards unless they are specifically prepared and qualified for the board role.” Quotes from two participants capture the sentiments of the sample group: “I have experience with this concept of a ‘reserved seat’ on a non-profit board. Unless filled by an exceptional nurse leader, it can actually be a ‘token’ nod toward nursing.” Another participant summarizes the issue like this:

Just having a reserved seat which must be filled whether or not there is a well-qualified person to do so may not serve the organization and its mission well. The last thing you want is a ‘poor performing’ nurse at the policy development level as it may ‘taint’ the attitude of leaders in terms of the adequacy of future nurse board members.

### **Knowledge**

The reasons for NOB clustered in ten categories in the knowledge theme. Participants built consensus agreement about nurses’ knowledge about patient, family, and community health needs, healthcare organizations and systems, and research and evidence-based practice. Table 5.

Table 5

#### *Delphi Consensus Themes and Categories*

<b>Themes</b>
Categories
<b>Knowledge</b>
healthcare quality and safety
patient/family needs across the care continuum
community health needs
research and evidence-based practice
health equity
complex healthcare delivery systems
human resources
healthcare finances and links to organizational and patient outcomes
healthcare regulatory standards
competing agendas
<b>Skills</b>

---

patient advocacy  
team collaboration  
problem solving  
Leadership  
team building  
Communications  
change agency  
innovative thinking

#### **Perspectives**

holistic patient care  
patient-centric  
unique perspective

#### **Benefits & Opportunities**

opportunities to influence health policy  
nurses represent the largest portion of the healthcare workforce  
parity with other healthcare providers  
trust and confidence from consumers  
role model governance leadership and decision-making for other nurses and students

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Commenting on nurses' knowledge about complex healthcare delivery systems (93% consensus), one participant noted:

This is a point of excellence for nurses, especially for seasoned nurses. Input from clinical nurses working on the front line, nurse educators and researchers, and nurse supervisors and administrators, especially those who have risen to administrative levels over entire facilities with multi-disciplinary staff under them, have tremendous knowledge to bear on improving health care systems.

Responding to nurses' knowledge about healthcare quality and safety issues (100% consensus), this comment surfaced, "Nurses are at the center of care delivery; thus quality and safety are their central concerns. Many quality professionals are registered nurses, building upon years of pragmatic and applied learning."

#### **Skills**

Consensus was reached about nursing skills relevant for governance decision-making clustering in eight categories. The categories included patient advocacy; team building and collaboration; problem solving; communication; leadership; innovative thinking; and change agency. On patient advocacy (97% consensus), one participant wrote, "Nurses are the strongest patient advocates of all professions. If only we could advocate as well for ourselves."

On being skilled problem solvers (83% consensus), one nurse responded, “(A) generalization. Some nurses are excellent. Others not so much.”

### **Perspectives**

The expert panel identified perspectives as critical for healthcare governance decision-making. The perspectives of nurses relative for board leadership clustered in three categories: unique perspective; holistic patient care; and patient-centrism. About nurses’ holistic approach to patient care (93% consensus), one participant stated, “I think we talk about this as if all nurses do it. I think the time pressures and workloads detract from our ability to meet this practical ideal.” Commenting on nurses’ unique perspective (83% consensus), one participant voiced, “Thought consensus should be higher. Nurses provide a VERY unique perspective. Should be 100%.” Another participant noted, “Not a good argument (for board positions) unless you explain what ‘unique’ means.”

### **Benefits and Opportunities**

Consensus agreement reasons for NOB in the theme titled benefits and opportunities clustered in five categories: opportunities to influence health policy; nurses represent the largest portion of the healthcare workforce; parity with other healthcare providers; trust and confidence from consumers; and the opportunity to role model governance leadership and decision-making for other nurses and students. This category tapped a visceral sense of the position participants expect to occupy to fulfill their professional obligations. On the opportunity to influence health policy as a board member (86% consensus), one participant stated, “You cannot shape the bigger picture if you are not at the table.” However, not all comments in this category reflected support. A succinct comment about nurse board representation offering parity with other healthcare providers (72% consensus) was this: “This strikes me as whiny – and less compelling. The idea of ‘par’ is self-serving.”

### ***What is the specific rationale for NOB as identified by an expert panel of NOB?***

The specific rationale for NOB is based on nurses’ knowledge about patient, family,

community health needs, and health equity, in addition to organizational knowledge about complex healthcare organizations and systems. Nurses' understandings of the associations between finances, organizational and patient outcomes, human resources issues, regulatory standards, competing agendas and research and evidence-based practice provide key knowledge for boardroom governance decisions. Nurses' leadership skills specific to patient advocacy, teamwork, problem solving, communications, and change agency also position them as strong board members. Nurses' unique and holistic perspectives specific to patient-centric healthcare position them as valuable healthcare board members. With strong consumer trust and confidence, representing of the largest portion of the healthcare workforce, board appointments for nurses place them on par with other healthcare providers. Board service presents nurses with opportunities to influence health policy and role model governance leadership and decision-making for other nurses and students.

### **Qualitative Strand Results: Focus Group Sessions**

Nine nurse board leaders participated in the qualitative strand (focus groups), slightly under the minimum targeted sample size of 12. Participants were mainly representative of the northeast US, females ages of 40-69 years, with 21-40 years' professional nursing experience, and education at the masters and doctoral levels. Half of the participants reported working full time in nursing and 33% reported working outside nursing. Participants working in nursing reported working primarily in clinical settings. Work roles were primarily executive or administrative roles. The majority reported current board service and 77% reported six or more years' cumulative board service. Table 2.

#### ***What are the perspectives of a secondary sample of NOB about the rationale for NOB as identified by the expert panel?***

Focus group participants offered positive and negative endorsements for the consensus reasons for NOB generated from the Delphi strand. Positive endorsements signaled agreement with reasons for NOB. Negative endorsements signaled disagreement. With exception of the

reasons for NOB listed in the benefits and opportunities category, the focus group participants generally agreed with the consensus reasons for NOB from the Delphi strand.

Positive endorsement themes generated from the focus group session included 1. agreement; 2. depends on the nurse; 3. generic board leader description. One negative endorsement theme was titled disagreement. Participants also offered suggestions for revisions to the Delphi consensus items. Finally, participants offered general advice and suggestions about serving on boards, provided insights into board service expectations and encouragement to nurses considering board service. Table 6.

Table 6

*Focus Group Revision Suggestions and Advice*

REVISION SUGGESTIONS	
<b>Benefits &amp; Opportunities category:</b>	
1.	Add professional growth opportunity
2.	Add interdisciplinary relationship building
3.	Add opportunity for professional representation/voice
4.	Add contribution to social good
5.	Add contributes to board diversity, including gender diversity
6.	Add opportunity to broadly influence the healthcare industry
7.	Remove 'for other students and nurses' from role model governance leadership...
<b>Knowledge category:</b>	
1.	Add 'and cultural sensitivity' to health equity item
2.	Revise to convey nurses understand the delivery and service of healthcare
3.	Revise language: Nurses' education, practice and experience are likely to give them knowledge
<b>Perspectives category:</b>	
1.	Add 'and values the human experience' to the holistic patient care item
2.	Add contributes broad perspectives
<b>Skills category:</b>	
1.	Add strategic thinking skills
2.	Revise language: Nurses' experiences, capabilities and skills inform their abilities to contribute to boards
<b>General:</b> Remove 'because' and add more active words (i.e. Provide, offer, contribute, bring, 'potentially contribute,' 'are likely to contribute')	
ADVICE	
1.	Understand finances.
2.	Think broadly and strategically.
3.	Understand governance fiduciary and leadership responsibilities.
4.	Board leadership is different from management and other leadership roles.
5.	Understand organizational mission & vision.
6.	The board is responsible for ensuring the success of the organization.
7.	Fully engage and be enthusiastic about governance.

- 
8. Be adaptable to changing situations and circumstances.
  9. Individual characteristics must match the board needs at that time.
  10. Building a board is like building a team with specific characteristics.
  11. Nurses need to build confidence to serve on boards.
  12. The list of reasons for NOB can be used to encourage and inspire nurses to serve.
  13. Nurses should mentor each other for board roles.
  14. Board service builds expertise where nurses can have impact.
- 

Focus group participants commented the reasons for NOB should not be attributed to the entire profession of nurses pro forma, adding that qualifications for board service depend on individual experiences, education, and specific capabilities of each nurse. Furthermore, the focus group participants also agreed that consensus items and themes could identify characteristics of any board-ready individual regardless of profession. For example, one participant noted,

If you know why you are joining a board or would like to agree to participate on a board, these are the skills you look for in yourself and see what you are comfortable with and you can contribute to that board.

Consensus reasons for NOB in the Delphi knowledge theme were the most frequently affirmed by the focus group participants. The Delphi perspectives category followed with general positive endorsements, closely followed by the skills category. The Delphi benefits and opportunities theme and specific categories received the most negative endorsements by the focus group participants. For example, a negative endorsement was stated this way, “I don’t think the reason for being on a healthcare board is because consumers have trust and confidence in us.” Another participant commented, “...to role model governance leadership and decision making for other nurses and students – why is that important to the board? It’s good for other nurses.”

In contrast, a positive endorsement example read this way,

I think the reason I was brought in on the board to serve was because of the thought that nurses have a unique perspective. ...Nursing knowledge, nursing practice: if you want that on a healthcare board, then you would bring a nurse on. But the other things...other professions have those. But they don’t have the unique nursing perspective.

Suggestions to revise consensus items included changes, deletions, and additions. For example, participants suggested rephrasing the language in the consensus items by focusing on what nurses can contribute to boards rather than who they are. Another example was the suggestion to add language about nurses valuing the human experience to the holistic perspective item. Table 6.

### **Mixing of Quantitative and Qualitative Results**

Analysis of the joint data display from both strands led to a more refined and comprehensive understanding of the rationale for NOB. Table B2. Through an iterative comparative process, the Delphi reasons for NOB, consensus levels, and focus group endorsements (positive and negative) were considered in this phase of analysis to further inform interpretations and judgments. Consideration was also given to whether consensus agreement was attained in round two (early in the consensus-building process) or round three (later in the consensus-building process). Revision suggestions and references to the non-consensus items also augmented this phase of analysis. Tables 3, 4, 6.

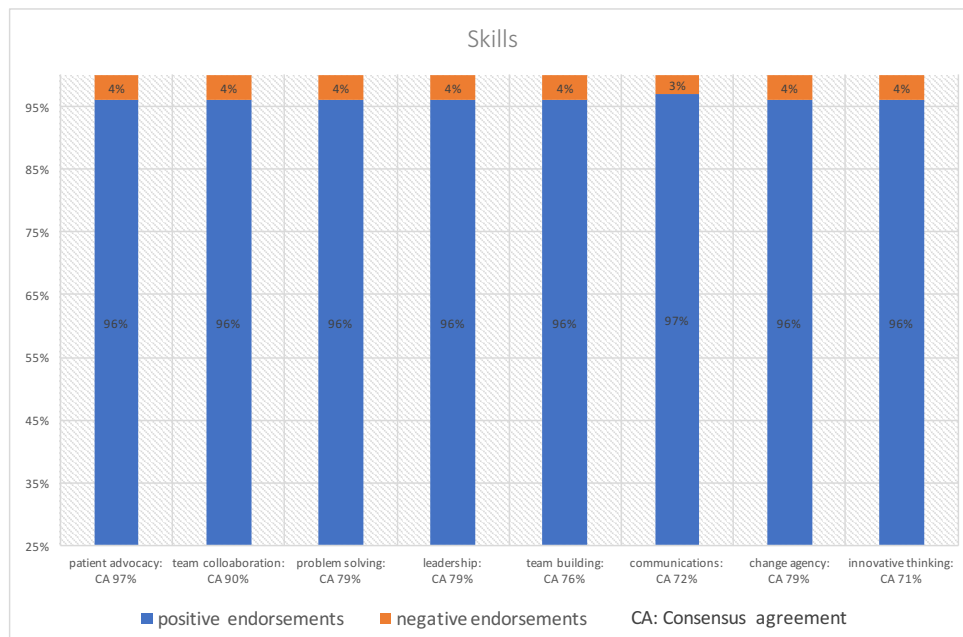
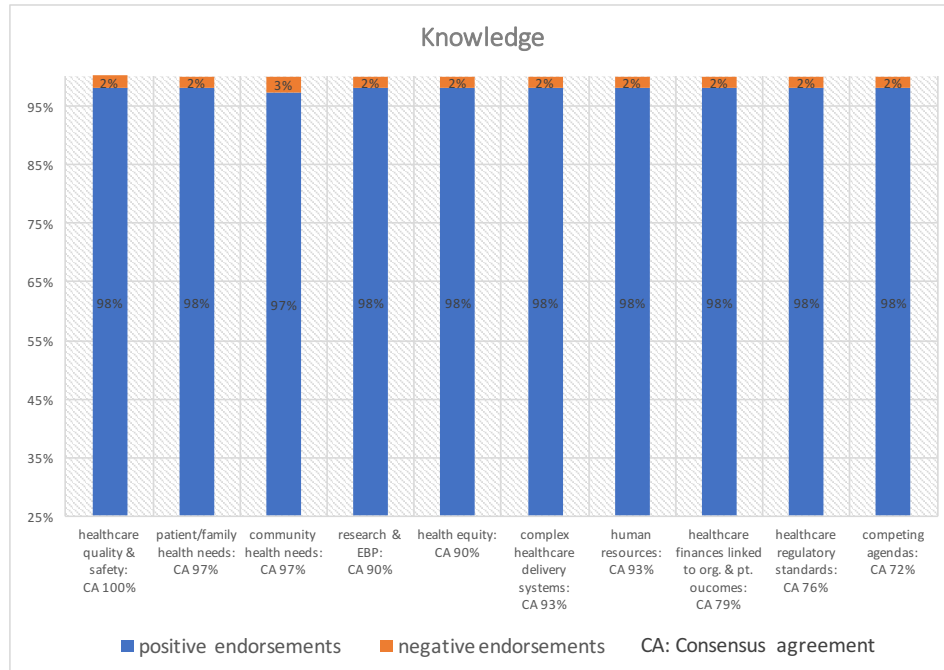
#### ***How do the opinions of the expert panel of NOB compare with the perspectives of the secondary sample of NOB regarding the rationale for NOB?***

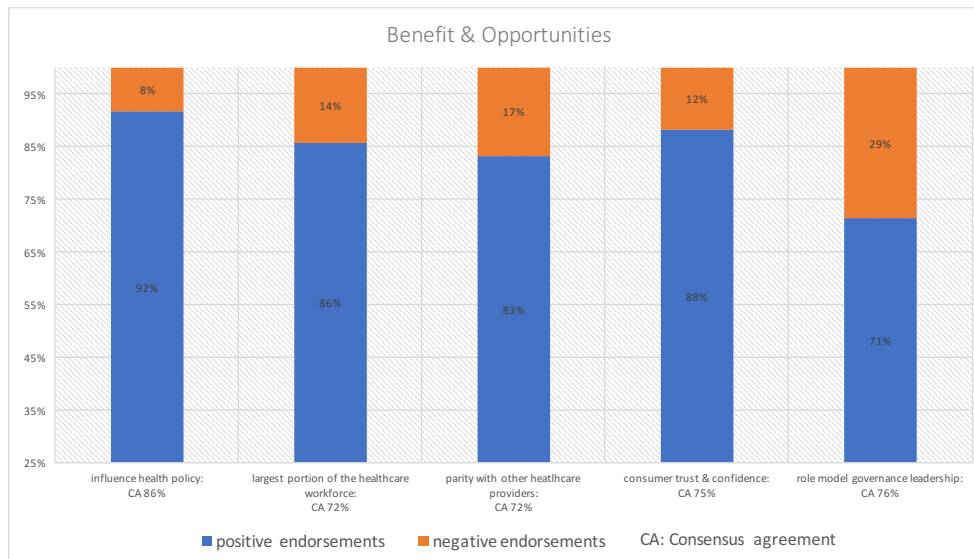
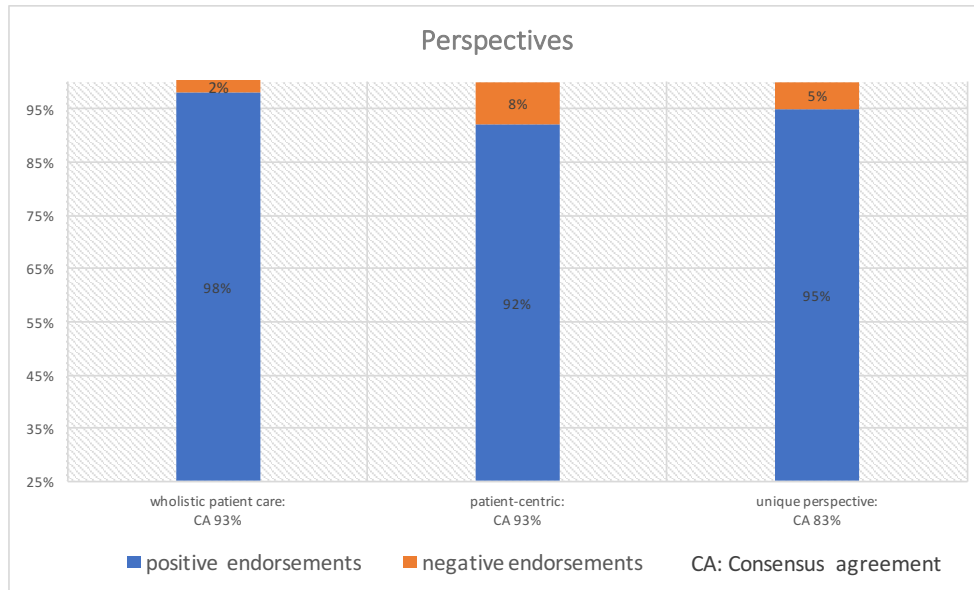
Comparisons between the opinions of participants in the quantitative and qualitative phases were generally congruent except for opinions about items in the benefits and opportunities category as mentioned in the qualitative results section. Although multiple negative endorsements focused on the items for role modeling governance leadership, parity, and the size of the nursing workforce, judgment to keep the items rested on the strong levels of consensus achieved in the second round of Delphi phase. Similarly, negative endorsements for nurses' unique and patient-centric perspectives resulted in the judgment to keep the items based on high Delphi consensus levels achieved in the second round. Figure 3.



Figure 3

*Joint Data Display Charts: Focus Group Endorsements by Delphi Themes/Categories*





Suggestions from the focus group participants to add reasons for NOB were considered in combination with consensus and non-consensus items. Four items that did not reach consensus after the third Delphi round were suggested for addition to the list of reasons for NOB in the qualitative phase. The concepts were strategic thinking skills (61% consensus), opportunities for interdisciplinary relationship building (43% consensus), and contributing (female) gender perspective (25% consensus). Because  $\geq 70\%$  consensus agreement was not

achieved by the third Delphi round, the suggested items were not added. Revision suggestions were incorporated into the final rationale for NOB.

After connecting the data from both strands of the study, the final rationale for NOB reads:

Nurses are positioned to contribute value to healthcare boards based on their education, professional experiences, and knowledge of the delivery and service of healthcare. With knowledge and understanding about patient, family, and community health needs, health equity and cultural sensitivity, healthcare quality, safety, and regulations in combination with research and evidence-based practice knowledge, nurses can enhance boardroom discussions and decision-making resulting in improved healthcare quality and outcomes. Nurses are likely to understand complex healthcare delivery systems and competing agendas, organizational finances and links to patient outcomes and human resources issues, thus strengthening governance decisions about organizational operations. Nurses contribute leadership skills specific to patient advocacy, team building and collaboration, problem solving, innovative thinking, communications and change agency that are relevant for effective healthcare governance processes and for achieving organizational mission. Nurses offer unique perspectives as they value holistic and patient-centered care. These perspectives keep the human experience at the center of board discussions to ensure stakeholder health needs are met by the organization. With strong consumer confidence and trust as the largest portion of the healthcare workforce, nurses' knowledge, skills, and perspectives position them to role model governance leadership and decision-making, and place them on par with other healthcare providers, adding professional and thought diversity to board member composition. With broad perspectives and understanding of the human experience in health, board appointments for nurses position them to give voice to stakeholders for social good and to influence health policies. Not all nurses are interested in or ready for board service, but boards can be confident that engaged nurses will contribute similar governance characteristics as other board members,

and will contribute valuable, critical, and unique characteristics of the nursing profession at the governance table.

### **Additional Question**

A single additional question was asked of participants in both strands: “What do you wish you knew or were prepared for before you began board service?” Analyzed data clustered in three themes: 1. board orientation and development; 2. board politics and culture; and 3. knowledge deficits. Participants reported needing appropriate board orientation inclusive of education about governance principles, acceptable boardroom communications methods, conflict management, and expectations for time, philanthropy, and social engagements. Disrespectful board behavior inclusive of gendered behaviors were encountered by participants. Examples include interruptions, aggressive communication styles, and the sense of needing to behave like “...one of the guys.” Both groups reported not being prepared for the healthcare knowledge deficits of many board members. Similarly, participants reported personal knowledge deficits regarding finances, strategy, quality, and safety issues at the board level. Finally, peer mentoring was reported as a need to facilitate the transition into board service.

### **Discussion**

Results from this study are validated and enriched by recent literature about NOB. The knowledge, skills, and perspectives as thematic reasons for NOB are reiterated by nurse leaders, industry organizations, researchers, and other advocates of NOB (AHA, 2014; Benson & Hassmiller, 2016; McBride, 2016; Szekendi et al., 2015; The Governance Institute, 2016). McBride (2016) describes personal accomplishments as a nurse and health system board chairperson, citing deep understanding about patient care, quality, safety, systems, and finances contributing to organizational policies and success. This personal account aligns with the characteristics and contributions identified in this study. A former health system CEO and a former nurse board member describe the firsthand account of the benefits of NOB referring to unique clinical perspectives, knowledge, and experiences that were otherwise missing on the

board. The nurse's knowledge, skills, and perspectives complemented the board composition leading to enhanced board effectiveness and organizational outcomes (Hachten & Mershon, 2017).

Salmon describes the nurse educator's role in preparing nurses for successful board leadership inclusive of education opportunities outside the typical nursing curriculum. The editorial echoes participants' comments from this study and offers a reminder that clinical knowledge and skills do not transfer laterally to the boardroom. Intentional governance preparation is often a necessary step to the boardroom (Salmon, 2016). Vestal makes similar points describing leadership differences between executive roles and board governance roles, and emphasizes the place for NOB in the changing healthcare environment (Vestal, 2015).

Consensus agreement was achieved about nurses' understanding of healthcare finances, and several focus group participants emphasized the importance of understanding organizational finances. However, participants from both phases of the study also reported having inadequate financial preparation for governance. Similarly, while communications skills were strongly endorsed by participants as a reason for NOB, participants also reported they were not prepared for the formality of governance communications processes. Curran (2016) and Rambur (2015) explicitly outline requirements for understanding organizational finances and formal governance communications processes.

Acker (1990) describes patriarchal norms and status quo that dominate structures and processes in many organizations forcing those in less dominant positions, like women and nurses, to lower hierarchical levels. McMillan (2016) describes this loss of power as a mechanism for silencing nurses. Acker (1990) goes on to argue that disturbances in the status quo of traditional patriarchal norms disrupt organizational structures. The concept of nurses on boards, albeit predominantly women, within the traditional male boardroom setting is disruptive to dominant norms and disruptive to status quo board practices, and may explain the reluctance to engage NOB (Acker, 1990; McMillan, 2016).

However, gender inequality as an issue relating to NOB did not gain consensus agreement in this study. Gender inequality rarely emerged in either strand of the study. However, in the few instances where gender was discussed, it was described as a problematic issue of disrespectful behavior in the boardroom that nurses were not prepared for and as a blatant boardroom disparity based on current statistics. Sundean and McGrath (2016) acknowledged this issue at length for nurses and women on boards. Prybil (2016) suggests the low board appointment rate for nurses is related to gender and occupational inequalities. Considering the call to diversify healthcare board composition (AHA, 2014), it is surprising that gender equality did not gain consensus in this study. It is possible the female nurse board leader participants have grown accustomed to their often token positions on boards and no longer appreciate the ongoing gender inequalities that exist in board practices. Another explanation is the reluctance of women to acknowledge gender inequality in multi-gender environments to allay concerns about professional dismissal or exclusion, and to support the need to assimilate into a male-dominated professional environment (Superson, 2011). Further investigation is suggested to better understand this finding.

Nurses' strategic thinking skills did not gain consensus in the Delphi phase (consensus agreement 61% after the third round). Although focus group participants suggested adding this concept to the rationale for NOB, the suggestion was made in only three instances. During peer debriefing, it was decided insufficient evidence existed to include the concept in the rationale for NOB based on the low consensus level and low volume of endorsements by focus group participants. Demographic evaluation showed that participation on strategic planning committees was one of the top three most frequently reported board committee for all study participants (Delphi participants 17% and Focus Group participants 29%). It is interesting that participants reported a high frequency of participation on strategic planning committees but did not endorse strategic thinking skills as a reason for NOB. Further investigation is warranted to understand this discrepancy.

Surprising also were the negative endorsements from focus group participants in the benefits and opportunities category. Although it is possible study participants responded to the specific language about the categorical reasons for NOB, they were divided about professional promotion of these reasons for NOB. Promotion of the profession, different from professional-centrism, is necessary to gain equal partnership in board leadership and healthcare transformation. Leveraging consumer support, emphasizing the critical mass of the nursing workforce, expecting boardroom parity, and role modeling board leadership for others in the profession are all ways of enacting political social agency to disrupt status quo governance practices consistent with sociopolitical ways of knowing and acting (Acker, 1990; Chinn & Kramer, 2011; McMillan, 2015; White, 1995). Within the context of the nursing profession's aim for social justice, giving full voice to the power of nursing for board leadership strengthens nurses' professional and political position. On a broader level, nurse board leadership is squarely situated within the metaparadigm of nursing (Fawcett, 2005): nurse board leaders care for human beings by influencing and transforming organizations to optimize health and healthcare. Stepping boldly and with confidence into the power and voice of the profession is necessary to achieve nurses' collective goals on behalf of stakeholders. As one participant commented about nurses' patient advocacy skills, "...If only we could advocate as well for ourselves."

Recognizing the opportunity to influence health policy through board leadership (86% consensus) is also consistent with sociopolitical ways of knowing (White, 1995) and demonstrates the commitment of the nursing profession to "...uphold its social pact with society at every level of the healthcare continuum including governance." (Sundean & Polifroni, 2016, p. 397). Although this reason for NOB reached high agreement consensus, it should be noted that the concept of nurses being skilled policy leaders did not reach consensus. Influence over the direction of policies in support of health and healthcare for people, communities, and populations is a fundamental role for the nursing profession (Nickitas, Middaugh & Aries, 2016;

Russell & Fawcett, 2005). Enacting influence for health policy through board leadership is commensurate with the goals of healthcare governance and the aims of the nursing profession. Discrepancies in consensus about nurses' influence over health policies and nurses' policy skills may relate to language biases presented to participants and represents an opportunity for further investigation.

### **Implications for Nursing**

The articulated rationale for NOB from this study reflects the experiences and beliefs of participants, nurses who serve on healthcare boards. Although results from this study are not generalizable/transferable to the entire population of nurses in the United States, extant literature supports the rationale for NOB and nurses' rightful place in board leadership to influence organizational direction and policy in support of health and healthcare for those served by healthcare organizations. Practice implications include proactive actions for nurses to engage in steps toward board leadership through intentional board service preparation, seeking board mentors, and self-promotion for board appointments. As much a call to action for nurses, this study is also a call to board leaders to engage nurses as valuable board leaders in healthcare transformation. Increasing the appointments of nurses to boards will not only meet the demands for board composition diversity, it will also leverage the knowledge, skills, and perspectives of nurses critical for healthcare governance decision-making. Intentional preparation for board service and peer mentorship can facilitate board appointments and the transition to board leadership.

Education implications from this study include the opportunity to introduce concepts of board governance and leadership in nursing education programs and continuing education. Although board service will not be an aspiration for all nurses, all nurses should be educated about this aspect of nursing leadership as it relates to core nursing concepts and professional obligations. Furthermore, education about nurses' roles in board governance provides an understanding of nurses' broadening sphere of influence over health and healthcare.



Recommendations for further research include expansion of this study with a larger sample to better understand the rationale for NOB and to test specific outcomes of this study. For example, studies examining the role of nurse board leaders in shaping health policies relate to the value of NOB and healthcare transformation. Studies testing the outcomes of board preparation interventions inclusive of mentoring will lead to best practices supportive of board leadership roles for nurses. Continuing examination of the experiences of nurse board leaders and board leaders who engage nurses as voting members will uncover further essential themes about changing status quo practices in governance leadership and measures of effective nurse board leadership. Continued examination of boardroom gender inequalities is also warranted. Finally, studies examining the relationships between NOB and healthcare outcomes are suggested.

### **Strengths and Limitations**

A strength of this study includes engagement of nurses serving on boards to articulate the rationale for NOB. This approach is consistent with the feminist framework adopted for the study. The rationale for NOB, was developed within a rigorous research design inclusive of two separate sample groups adding credibility to the results. With prioritization on the quantitative strand of the study, the nationally distributed sample group for the Delphi phase strengthened the study. Use of video conferencing for the focus group sessions was a unique strength of the study, adopting current technology to enhance engagement of participants and data analysis. Use of peer debriefing and a comprehensive audit trail contributed to the rigor of the study.

Limitations of the study include the small sample size and opinion-based design that precludes generalization/transferability of the results. Demographic questions did not capture race/ethnicity of participants. This omission posed a missed opportunity to fully describe the participant groups and is inconsistent with the inclusive tenets of feminism. Similarly, the recruitment strategy did not focus on balancing race/ethnicity in the sample groups may have led to biased results. Biases were potentially introduced at multiple points in the study including

qualitative data analysis, wording of reasons for NOB used in both phases of the study, and the ways consensus items were presented to the focus group participants. Even though mitigation attempts were made by the investigator, it is possible Delphi participants emphasized the phrase '*reserved seat*' in the first round leading to biased study results. Attempts were made to control researcher bias through a comprehensive audit trail, reflections, and peer debriefing; however, biases may have been introduced.

### **Conclusion**

This mixed methods study articulates the rationale for NOB in the voices of nurses who serve. The results identify nurses' unique and valuable knowledge, skills, and perspectives that contribute to healthcare board deliberations and decision-making in support of health and healthcare for stakeholders served by healthcare organizations. As the largest portion of the healthcare workforce, engagement of NOB leverages the profession's high consumer trust to work alongside other healthcare professionals and board members to govern healthcare organizations and influence health policies. Making the case for NOB, study results support the need to disrupt status quo board practices in favor of more diverse board membership inclusive of nurses to advance healthcare governance practices and healthcare transformation.

Board leadership is a mechanism by which nurses can act upon their obligations to support social justice within the metaparadigm of nursing. Nurses engaged on boards can leverage professional power to partner with other professionals to accomplish the need for healthcare reform. In so doing, NOB contribute to professional advancement and transformation. Although not all nurses will serve on boards, the rationale for NOB makes a compelling case for board leadership as a ubiquitous role for nurses along the continuum of nursing care for people, communities, and populations.

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## **CHAPTER V**

### **Conclusion**

## CHAPTER V

### CONCLUSION

The purpose of this dissertation was to explore issues relating to nurses on healthcare governing boards within a feminist framework, to increase the understanding about the value of nurses on boards through the voices of nurse board leaders, and to set a foundation for a trajectory of research about NOB. The first manuscript (Chapter II) explored the concept of NOB through the lens of feminist philosophy urging nurses to "...act through emancipated empowerment for board appointments." (Sundean & Polifroni, 2016, p. 399). This manuscript calls nurses to take their rightful places on governing boards to fulfill their professional obligations. A call to action for nurses, this manuscript also sets the tone for exploring the issue of NOB as one that has been affected by gender and occupational inequality, and status quo board practices. Recommendations include a practical guide for nurses to engage on boards and a call for theory development about NOB.

The second manuscript (Chapter III) explores nurses and women on boards to better understand the central issue within the context of a metasynthesis. *Proving our worth* is the central issue of the analysis from seven qualitative studies with an international sample. Nurses and women on boards must prove their worth, thus reducing energy focused on advancing governance priorities and goals to serve stakeholder/shareholder needs (Sundean & McGrath, 2016). This finding aligns with the feminist lens described by Sundean & Polifroni (2016), highlighting status quo governance practices and marginalization. Sundean and McGrath (2016) also described themes about the importance of board diversity for effective governance and advice from nurses and women board leaders. The advice corroborates with the practical guide for nurses seeking board appointments offered by Sundean and Polifroni (2016) and includes self-promotion, mentorship, creating alliances, and board preparation. Sundean and McGrath (2016) recommend exploring facilitators to board appointments that can be applied as mechanisms for increasing board appointments.

*The Rationale for Nurses on Healthcare Governing Boards: A Mixed Methods Study*, the third manuscript in the dissertation (Chapter IV), is an original study. Whereas much governance literature expresses the need for nurses on boards from opinion leaders in healthcare, this research manuscript describes the value proposition for nurses on boards through the voices of nurses who serve on healthcare boards. Building on the call to action from Sundean and Polifroni (2016), this study adopted the feminist framework to empower nurses to express the rationale for NOB based on their personal experiences. The rationale for NOB, developed by a consensus model Delphi survey and validated by supplemental focus group sessions with nurse board leaders, describes the value nurses offer for healthcare board governance. Nurses' value to boards is defined within their professional knowledge, perspectives, and skills. Recommendations include expanding upon the study and developing interventions to prepare nurses for board service.

Guided by the tenets of feminist philosophy, this dissertation offers a thoughtful journey to re-conceptualize NOB through the experiences and perspectives of nurses who serve on boards. Sundean and McGrath (2016) describe marginalization of nurses and women serving on boards governed by male norms. The experiences for nurses and women on boards conflict with feminist lines of reasoning, triggering activation of strategies for change to achieve more just board practices. These strategies include emphasizing the power of gender, occupational, and thought diversity, and offering advice for success to potential nurse and women board members. Consistent with ideas offered by Diprose (2000) and Superson (2011), findings demonstrated unrest with prevailing patriarchal board norms and an urgent need to develop strategies for change.

The mixed methods study articulating the rationale for NOB further espoused feminist philosophy by conceptualizing the value proposition for NOB in the voices of nurses who serve. As feminist scholarship, the results of this study elicit the power of nurses serving on boards via their experiences as contributing board members within traditional patriarchal board settings.

Participants readily described the rationale for including nurses as voting board members and the professional power they contribute to board processes. The willingness to re-conceptualize board norms inclusive of nurses is consistent with feminist philosophy (Diprose, 2000; Sprague, 2005; Superson, 2011). Furthermore, the rationale for NOB leverages the voices of nurses who serve to disrupt prevailing patriarchal board norms and status quo board practices that conflict with feminist reasoning about inclusive and equitable organizational structures and processes (Acker, 1990; Diprose, 2000; McMillan, 2016; Superson, 2011).

However, the same study participants were reluctant to describe the rationale for NOB within the context of gender inequality. This is a surprising discrepancy given the low engagement of nurses on healthcare boards (AHA, 2014), the low engagement of women on healthcare boards (AHA, 2014), the marginalizing perceptions of (mostly male) board leaders about nurses on boards (Khoury, et al., 2011; Mason, et al., 2013), and the marginalizing experiences of nurses and women on boards described by Sundean and McGrath (2016). This finding is contrary to feminist philosophical lines of reasoning that support and promote disclosure of conflicting and marginalizing experiences (Diprose, 2000; Superson, 2011). Study participants' reluctance to acknowledge gendered boardroom experiences may signal a protective mechanism for nurses who wish to prevent professional dismissal or exclusion by male board leaders. Similarly, female nurse leaders who are accustomed to board leadership positions may be unappreciative of the ongoing challenges of traditional board norms relating to gender inequalities. Assimilation of female nurse board leaders into the patriarchal norms of boards is concerning and does not advance the feminist agenda for inclusiveness, equality and social justice.

Intemann, Lee, McCartney, Roshanravan, and Schriempf (2010) warn against the insidious lure of complacency within marginalized groups in patriarchal societies and the risks of jeopardizing feminist advancements for social equality based on short term advancements for small groups of people within larger marginalized groups. Recent national attacks against

women's reproductive rights serve as striking examples of the fragile sustainability of social justice. Threats to healthcare access also highlight the need for ongoing vigilant feminist action and inquiry into societal oppression and marginalization.

The risks of complacency can be applied to NOB as the reluctance of female nurse board leaders to fully acknowledge gender inequality in the boardroom and the role for gender as a leverage point to advocate for NOB. Nurse board leaders, a very small group of nurses nationally, cannot risk complacency as a norm when the majority of nurses are not invited to serve on boards (Intemann et al., 2010). The root of this complacency remains unexamined; however, the resulting self-silencing of study participants about gender inequality in the boardroom reduces the use of voice as a mechanism for knowledge as power (Buresh & Gordon, 2013; Intemann, et al., 2010; McMillan, 2016; Sundean & Polifroni, 2016). Furthermore, silencing of nurse board leaders' voices places the urgent movement to expand nurse leadership in the boardroom at risk. For nurses in board roles, it is critical to remain cognizant of and active in the movement to support board appointments for other nurses and other women (Sundean & McGrath, 2016). With only 5% of nurses occupying hospital board seats nationally (AHA, 2014), complacency and silence about ongoing marginalization and inequalities perpetuate prevailing norms of healthcare board governance practices and fail to advance the feminist agenda for board diversity, inclusivity, and equality.

At a time when healthcare transformation requires collaboration between knowledge leaders from groups most engaged in the daily work of patient care to establish and evaluate healthcare organizational direction, nurses are alarmingly absent from governance membership. Persistent absence of nurses in healthcare boardrooms and perpetuation of conventional board culture and norms create barriers for advanced board practices and improvements in healthcare organizations (Khoury, Blizzard, Moore & Hassmiller, 2011; Mason, Keepnews, Holmberg & Murray, 2013; Prybil, 2016; Sundean & McGrath, 2016; Sundean & Polifroni, 2016; Sundean, Polifroni, Libal & McGrath, 2017). The absence and dismissal of nursing knowledge as power in

the boardroom (McMillan, 2016; Sundean & Polifroni, 2016) limits advancement of healthcare, restricts nurses from fulfilling their social justice contract with society, and stalls the evolution of the nursing profession (Russell & Fawcett, 2005; Sundean & Polifroni, 2016).

The sociopolitical obligation of the nursing profession to apply knowledge as power on behalf of patients, populations, and communities is fundamental within the metaparadigm of nursing (Fawcett, 2005; White, 1995). This obligation extends to the governance setting where overarching organizational decisions are made that affect the quality, quantity, timeliness, policies, and inclusivity of healthcare. Status quo governance practices dismiss the unique contributions of nurses in board discussions, thus neglecting the healthcare needs of communities in favor of protecting status quo governance (Acker, 1990; McMillan, 2016).

Beginning with a philosophical foundation, moving to a description of the central issue of NOB and women on boards, and progressing to describing the rationale for NOB in the voices of nurses who serve, this dissertation demonstrates nurses' sociopolitical agency to expand upon its leadership roles and to advance healthcare in support of people, populations, and communities. Where status quo governance and marginalization have been the norm, the premise and outcomes of this dissertation confront such limiting narratives in place of knowledge as power to advance healthcare and to advance the leadership influence of the nursing profession.

Academic implications of this dissertation include educational opportunities to prepare nurses for the sociopolitical obligations embedded in the profession as they relate to board service. While it is important to prepare entry level nursing students for safe patient care, the larger picture of nurses' roles in influencing the direction of healthcare delivery within organizations and nationally cannot be overstated. Specific to NOB, opportunities in pre-licensure education include introduction to concepts of board governance and governance policy as domains of the nursing profession. At the graduate levels, nursing education must focus on governance and policy leadership roles in addition to advanced practice, research,

philosophy, and theory. Educational opportunities that connect patient care and outcomes to board governance practices and decisions will broaden practicing nurses' understanding of and appreciation for the interplay between patient care and governance/policy.

Setting expectations for expanded professional roles such as board leadership should begin in the educational setting. It is every nurse's obligation to be informed and to understand the influence of the profession within organizational governance and health policy work. Education supportive of empowered board leadership roles advances nurses' spheres of influence over healthcare at a very early stage. Along with the concept of lifelong learning for nurses, educators can impress upon nursing students at all levels the work of advocacy for marginalized groups including nurses is never done, and is therefore, also a lifelong process (Intemann, Lee, McCartney, Roshanravan & Schriempf, 2010).

Similarly, it is every nurse's obligation to support the advancement of the profession as a mechanism for advancing health and healthcare. Board leadership as a ubiquitous role for practicing nurses is a relevant implication from this dissertation. Expectations for nurses' empowered roles in healthcare transformation are supported by the Institute of Medicine report, *The Future of Nursing: Leading Change, Advancing Health* (2010). With these expectations come responsibilities to be informed, prepared, and to accept leadership roles of influence.

In a recent study with a sample of 971 registered nurses, only 15% reported aspirations toward board leadership (Peltzer et al., 2015). No target number exists for how many nurses should aspire toward board roles; however, nurses must be educated to understand the importance of board leadership roles as one mechanism for fulfilling the social justice obligations to society and to support the evolution of the nursing profession. While nurses occupy only 5% of hospital board seats (AHA, 2014) with no target percentage as a benchmark, it is reasonable to conclude that a critical mass of nurses is needed in boardrooms to influence the direction of healthcare and policies. Practicing nurses should play a role in advocating for healthcare board appointments and policies that support such appointments.

Traditional board practices have yet to fully embrace the value of NOB; however, that should not deter nurses from preparing for and seeking board positions. Confronting status quo board practices will initiate changes necessary for true innovation leading to advancements in healthcare transformation. The manuscripts in this dissertation serve as much to confront status quo board practices as to call nurses to action to prepare and promote themselves for board service. Although governance oversight organizations like the Center for Healthcare Governance (AHA, 2014) emphasize the importance of board composition diversity, the history of healthcare boards does not demonstrate the propensity to embrace such change. Nurses who wait to be invited onto boards may be met with disappointment. Proactive steps toward preparation, self-promotion, mentorship, and promotion of nurse colleagues for board positions will favor emerging nurse board leaders and will pave the way toward inclusive board practices.

Building on the foundation of research in this dissertation, next steps will include the following studies:

1. Exploration of nurses' experiences on boards in relation to the findings of the mixed methods study. Specific examples of nurses' board contributions will expand upon findings from the mixed methods study and delineate the ways nurses influence healthcare governance. Outcomes from this study can be used to develop measures of effective nurse board leadership.
2. Exploration of non-nurse board leaders' experiences with NOB. Experiences will be compared to the results of the mixed methods study in this dissertation to identify congruencies and incongruences. This study will be useful for identifying gaps between board leaders' and nurses' values and expectations regarding nurses' contributions to governing boards. Aligning values and expectations could lead to changes in board practices and increases in nurse board appointments.
3. Further development of a board competency instrument (Sundean, 2016) that can be used as a mechanism for preparing nurses for board service. Development of a valid



- and reliable board competency instrument can be used to support a controlled intervention study to test nurse board readiness and intent to self-promote for board appointments.
4. Exploration of nurse board leaders' influence over health policy. This study will identify the types and levels of policies NOB are most likely to influence and will more tightly connect nurse board leadership with policy outcomes.
  5. Exploration of NOB's experiences of gender inequality in healthcare boardrooms will further delineate this phenomenon within the context of feminist inquiry. Research to explore the reluctance of nurses to discuss gender inequalities in the boardroom may uncover essential concerns that can be useful for theory development and ongoing inquiry into traditional board practices.
  6. Longitudinal exploration of nurses' experiences on boards to validate findings from the metasynthesis. This study will identify trends in board practices over time specific to traditional norms and shifts toward more modernized board practices inclusive of board member diversity.

Important to each of these studies, is the need to examine the role of race/ethnicity for NOB. Although this critical variable was omitted in the mixed methods study described in Chapter IV and discussed as a limitation of the study, the role of race/ethnicity may expose further inequities for NOB. Furthermore, feminism and feminist researchers emphasize inclusivity and social equity as critical components of research methodology (Sprague, 2005).

This chapter provides a synthesis of the three scholarly works (manuscripts) and makes recommendations for practice, education, and further research about NOB. Drawing on feminist philosophical tenets, nurse board leadership is a mechanism for leveraging professional power for healthcare transformation, meeting social justice obligations, disrupting status quo board practices, and advancing leadership roles for nurses. Nurse board leadership is situated within

the metaparadigm of nursing: NOB care for human beings by contributing to governance decisions and policies that create healthier environments where health can be optimized for all.

Healthcare is a complex system at the crossroads of humanity, technology, science, and business, and therefore, requires a diversified matrix of directors to govern the many facets that contribute to high quality healthcare. The composition of board directors that includes diverse, comprehensive expertise and thought leadership is best suited to achieve quality outcomes. The evidence in this dissertation make a compelling case for NOB as crucial players in the well-balanced healthcare board and as critical contributors to healthcare transformation through governance leadership. An emerging nursing leadership role, NOB are urged to disrupt status quo healthcare governance practices in favor of newer structures and processes that promote equal participation opportunities, foster collaborative and creative knowledge sharing for the transformation of healthcare, and support the advancement of the nursing profession. Board leadership practices inclusive of nurses acknowledge the rich professional repertoire nurses offer to healthcare governance in pursuit of processes and policies supportive of healthcare transformation.

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## Appendix A

Figure A1

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## Appendix B

### Sample Analysis Tables

Table B1

#### Sample Dendogram (Delphi Perspectives)

Quotations	Themes	Category
Nurses provide the most specific, comprehensive view of patients' care across settings.	<b>Holistic Patient Care</b> Mean 4.66 Consensus 93%	<b>Perspectives</b>
Holistic view from admission to post-discharge of patient needs		
Nurses are educated to view the patient and system holistically and can "see the forest for the trees"		
Nurses bring a holistic view of health		
As a provider who approaches healthcare and outcomes from a broad, wholistic approach to patient and family care and inclusiveness of the patient/family in care planning;		
Nurses bring a different perspective to healthcare boards, as a nurse our primary purpose is patient care, holistic care.		
Nurses not only have inpatient experience but probably outpatient, end of life care, and see the patient as a whole.	<b>Patient-centric Perspective</b> Mean 4.52 Consensus 93%	
Overall, Nurses have the advantage of a more complete view of the patient, family and community issues related to healthcare.		
Nurses represent not only a nurse's and nursing perspective, but that of our patients as we are above all, strong patient advocates.		
My final point is based on my experience on boards for healthcare that it is still true at many table physicians are considered the customer and not the client/patient and I have made it my mission to bring the actual client to the room when actions are being considered		
Nurses bring a patient perspective to their board role		
Nurses are patient-centric in their problem-solving		
The unique perspective that nurses bring about issues at the point of care for both providers, patients, and families.	<b>Unique Nursing Perspective</b> Mean 4.34 Consensus 83%	
Nurses have their own unique perspective on our health care system		
The nursing perspective is closely related to the patients experience of health care		
practical perspective on health care delivery		
Provision of a particular perspective as a nurse		
Assisting the board to make the best decisions from a wider perspective		
nurses worldview		
Nurses represent not only a nurse's and nursing perspective, but that of our patients as we are above all, strong patient advocates.		
Nurses provide a unique perspective within health care and nurse specifically nurse leaders should be positioned to give voice to that perspective.		
Since nurses make up the majority of the health care work force, nurses' perspectives should be heard		
To provide practice and perspective diversity in decision making, building of effective teams and strategic planning		
Nurses bring a different perspective to healthcare boards, as a nurse our primary purpose is patient care, holistic care.		
Nurses have their own unique perspective on our health care system as well as represent professional nursing's views and policies.		

Table B2

*Sample Section Joint Data Display*

Delphi Consensus Categories and Items	Delphi Consensus Level	Focus Group Themes			
		Positive endorsements			Negative endorsements
		Agreement	Depends on the nurse	Generic board leader description	Disagreement
The reasons nurses should have a seat on healthcare boards is:					
Benefits and Opportunities					
To provide nurses with opportunities to influence health policy.	86%	•••••••• •••••••• ••	•••••••• •••••••• ••	••••••••	••••
Because nurses represent the largest portion of the healthcare workforce.	72%	••••••~•• ••	••••••~•• ••••••~•• ••	••••••~••	••••••~••
Because it places nurses on par with other healthcare providers.	72%	••••••~• •	••••••~• ••••••~• ••	••••••~•	••••••~•
Because consumers have trust and confidence in nurses.	75%	••••••~•• •••	••••••~• ••••••~• ••	••••••~•	••••~•
To role model governance leadership and decision-making skills for other nurses and students.	76%	••••••~• •	••••••~• ••••••~• ••	••••••~•	••••~• ••••~•

“•” denotes endorsements from focus group participants within the stated themes.

Positive endorsements occur in the themes titled Agreement, Depends on the nurse, and Generic board leader description.

Negative endorsements occur in the theme titled Disagreement.