Closing the Voice Gap:
Evidence from a Hospital System's Empowerment Program

by

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ABSTRACT

This dissertation explores how empowerment programs within organizations can effectively close workers' voice gap, or the difference between workers' desired and actual influence over organizational decision-making. By drawing on a 17-month ethnographic study of a hospital system's empowerment program, I examined the interactional and cultural processes that guide the justification, sustainability, and efficacy of worker empowerment. Chapter 1 motivates and introduces the case of the hospital system's empowerment program. Chapter 2 focuses on Coastal Care's justifications for empowerment, specifically how leaders and managers described the program as valuable and appropriate for their organization. Chapter 3 explores how Coastal Care navigated and overcame the challenges that hindered continuous worker involvement in the program. I identified the importance of scaffolding, or various unscripted practices, which complemented the formal design of the empowerment program. The scaffolding provided informal opportunities for worker involvement in instances when the formal programming failed to do so, ultimately sustaining involvement in the program. Chapter 4 identifies a process and conditions necessary for closing the voice gap via the empowerment program. Although the program legitimated worker power over workplace change, effective empowerment relied on frontline managers actively crafting opportunities for workers to exercise influence. When managers made three moves (prioritizing workers' issues, centering diagnostic dialogues, and engaging with assigning tasks), they mobilized skeptical workers to address departmental processes. Managers variously deployed these strategies as a consequence of their history with the issue: when they were physically close to the issue and when they had not encountered previous failures in resolving it. This dissertation contributes to research on empowerment programs and organizational theories of worker voice and upward influence. I bridge these oft-siloed perspectives by identifying formal and informal practices that promote opportunities for worker influence over organizational decision-making.

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CHAPTER 1: INTRODUCTION

Worker discontent is bubbling. In the US, most workers experience a voice gap, or the perception that they do not have enough say about their organization's decision-making (Kochan et al. 2019; Kochan et al. 2023). On top of bread-and-butter issues like pay and benefits, many also seek having more influence over matters concerning ethics, such as safeguards against bullying and harassment, and their employer's commitment to social progress (Raeburn 2004; Briscoe & Gupta 2016; Chen & Treviño 2022). Many healthcare and social service workers face insufficient staffing coupled with escalating job demands, leading to the moral distress that they cannot effectively provide quality services (Corley, Hammond & Fraser 2010; Sainato 2022; Kallas 2023). Despite feelings of futility in addressing emotionally charged topics (Morrison & Milliken 2000; Milliken, Morrison, Hewlin 2003), workers are now advocating for change. Addressing workers' concerns is important because workers with a voice gap are more likely to leave their job and have worse psychological well-being (Diaz-Linhart et al. 2024; Sull, Sull & Zweig 2023; Detert 2023).

This dissertation asks how workers can influence their desired workplace changes, effectively closing the voice gap. More specifically, how does this happen inside of organizations? As leaders experiment with empowering their staff with empowerment programs – formal organizational practices that provide opportunities for workers to speak up and influence change – what role do such initiatives play in workers exercising influence? I begin by introducing the literature on worker voice and empowerment before raising three research questions that these literatures have not addressed. I then introduce and motivate the case of a hospital system's empowerment program as well-suited to address such questions.

Though the concept of voice gap is relatively young, early political economists of capitalism – Adam Smith, Karl Marx and John Stuart Mill – observed that employers and legislators often "stifled" worker influence over decisions (Kaufman 2020, pp. 20-21). Industrial managers viewed labor as merely a commodity in the production process. With the formation of trade unions, workers could negotiate directly with their employers and had protection from any retaliation (Webb & Webb 1897).

Research on voice surged in the latter half of the 20th century beginning with Hirschman's *Exit, Voice, and Loyalty* (1970). Hirschman suggested that the customer's voice can play a role in improving firm performance. If customers are dissatisfied with a firm's product, they can effectively "exit" the firm-customer relationship. However, dissatisfied customers can also exercise "voice" by articulating their concerns with the product. Without listening to customers' voices, firms miss out on the opportunity to improve. Finding ways to hear a customer's concern could be a low-cost solution for managers.

Today, scholars across organizational behavior, industrial relations, and human resource management seek to understand the organizational implications of voice, defined as the discretionary articulation of a suggestion or issue with the intent of organizational change (Van Dyne & LePine 1998; Budd 2004; Morrison 2011; 2023; Wilkinson, Barry & Morrison et al. 2020). *Suggestions* are often promotive, offering solutions for organizational challenges, while *issues* are prohibitive, drawing attention to undesirable behaviors or process breakdowns (Liang, Liang & Farh 2012). When workers speak up, either informally or through a formal channel, organizations and workers can leverage these ideas to realize improvements. Speaking up about patient safety (Singer & Vogus 2013) or about management practices that lead to emotional exhaustion (O'Brady & Doellgast 2021) has the potential to influence organizational change.

As opposed to most voice scholarship that explains how *suggestions* lead to implementation (Morrison 2023), the concept of voice gap focuses on how voicing *issues* can influence substantive change (**Table 1**). Instead, extant knowledge of the outcomes of voicing issues is limited to its effect on individuals' perceptions: voicing issues often has a negative impact on how others perceive the voicer (Chen & Treviño 2022) and can incite negative feelings for both the voicer and the recipient (Welsh et al., 2021; Sessions et al., 2020). This paucity of knowledge could be coming from the fact that many workers stay silent about challenging issues, fearing the potential backlash from speaking up informally (Milliken, Morrison & Hewlin 2003) or voicing via a formal mechanism (Brooks 2018).

----------Insert Table 1 about here----------

Even so, many organizations have been experimenting with empowerment programs, or formal organizational policies that provide opportunities for workers to speak up and influence change (Adler & Borys 1996; Appelbaum et al. 2000; Lee & Edmondson 2017). For example, healthcare organizations can adopt shared governance models, which empower frontline staff to refine clinical practices and improve patient care (Barden et al. 2011; Litwin & Eaton 2018). Yet, many raise doubts about how empowering these programs are (Grenier 1988; Hodson 1995; Vallas 2003; Vidal 2007). Higher-status members can resist distributed influence and discourage workers from raising their issues (Bradley & Hill 1987) and worker skepticism can discourage ongoing participation (Vallas 2003; Turco 2016).

This dissertation is oriented toward understanding the efficacy of empowerment programs to address workers' concerns and begin closing the voice gap. Given that much of our understanding of empowerment programs is limited to their impact on performance, I explore several questions related to a program's perceived and realized efficacy. This dissertation draws

from 17 months of ethnographic fieldwork at Coastal Care[1], a hospital system that implemented an empowerment program. The program provided workers with the opportunity to co-lead a department-level, voluntary problem-solving committee with their managers. The organization designed the program so workers could articulate persistent issues that "make it feel hard to come to work" and collaborate on improvements.

This dissertation does not use voice gap as a survey measure; rather, I explore several questions that emerged about the potential of empowerment to give workers more influence over organizational decision-making. For one, why do organizations value empowerment programs? US employers have historically resisted workers having more rights in the workplace (Fantasia 1988; Kochan et al. 2023), so we must understand how organizations come to justify empowerment programs. Additionally, how sustainable are empowerment programs? New efforts to involve workers in decision-making may fizzle out over time (Cotton 1993; Hackman & Wageman 1995), so we must understand how organizations can sustain ongoing worker participation. Relatedly, how can empowerment programs give workers effective influence in their workplace? Higher-status actors can co-opt these programs to achieve their own goals, rendering a new tool that may disempower workers. To close the voice gap, empowerment programs like Coastal Care's must enable workers to assert their own interests, to speak up and be heard by others, and to make effective decisions that improve their workplace experiences.

The case: Coastal Care's empowerment program

Coastal Care is a large, unionized hospital system on the East Coast that employs thousands of staff. It comprises several hospitals, clinics, and medical centers that provide healthcare services to their region. Most hospital operations occur on two campuses: North and South. Both campuses include inpatient wings, outpatient clinics, and pharmacies. North campus

[1] Coastal Care, campus names, department names, and individual names are all pseudonyms.

is larger as it includes their medical university and many of the offices for white-collar departments and senior leaders. Union offices are located near North campus. Most employees at Coastal Care are represented by a union. However, one union represents the majority of staff; specifically, they represent administrative staff and lower-status clinical staff, excluding physicians and registered nurses (RNs). This union has a collaborative relationship with management such that both parties are focused on improving the quality of care, investing in skill development, and creating a workplace culture that employees can be proud of.

One stated shared goal is "employee engagement," or workers feeling committed to giving quality care and empowered to improve work processes, yet third-party employee surveys found that Coastal Care's employee engagement was lower than the national healthcare average. This was surprising because Coastal Care invested in many engagement initiatives and union representatives encouraged their members to participate in those initiatives like continuous improvement training. The dissertation focuses on a newer initiative at Coastal Care: a department-level empowerment program for lower-status workers. I first detail the members of the organization involved in the program's implementation before describing the program design.

The case of Coastal Care's empowerment program involves several actors (**Figure 1**). Senior leaders are those who take positions at the director level and higher within the organization. Frontline managers are the employees who directly supervise staff and are responsible for the performance of specific functional areas called departments. Frontline workers are Coastal Care employees who either do administrative work (e.g. billing and scheduling) or who do clinical work at the title of RN or lower. These clinical frontline workers include roles like personal care assistants (PCAs), medical assistants (MAs), and front desk

administrators. Physicians are clinical professionals who have job responsibilities with various departments, but they report to a different hierarchy; notably, physicians do not report to frontline managers or the direct supervisor of frontline managers. Union representatives are dedicated staff that represent frontline workers in specific departments. The focal union representatives of this case are part of the collaborative union and represent frontline workers excluding RNs; RNs have their own union. Improvement employees work within the improvement department, which oversees system-wide technical and process-related innovations. Empowerment employees are white-collar staff who oversee the program's operations, like program coaching, training, and administrative duties. The empowerment employees' wages are jointly funded by management and labor, with these wages determined by the collective bargaining process.

----------Insert Figure 1 about here----------

Management and labor collaboratively developed this empowerment program by drawing inspiration from problem-solving committees at other hospitals. This empowerment program initiated voluntary problem-solving committees at the department level, which engaged various organizational actors. (**Table 2**). A worker and their frontline manager were co-leaders of their department's committee, and each committee had a dedicated coach who provided guidance for co-leaders. Co-leaders hosted voluntary committee meetings and invited department staff to participate as representatives of different department functions. Typically, committee members represent their respective job title, but in larger departments committee members also represent different sub-departments, like "pods" and "wings." Committee members could also include RNs and physicians. Empowerment employees encouraged the committee's senior leader to review committee activities in their regular meetings with frontline managers. They also encouraged

senior leaders to offer guidance when frontline managers struggled to lead. Empowerment employees also encouraged the union representative to meet regularly with the worker co-leader, especially when frontline workers expressed frustration about the committee. This meeting was preceded by a 2-hour long orientation session for new co-leaders, which provided training in problem-solving methods informed by the system's Lean Six Sigma training that approximately 90% of employees received.

----------Insert Table 2 about here----------

The stated intent of the program was to "change how it feels to come to work every day." In contrast to an existing ideas platform, where workers across the system are encouraged to submit ideas for their department and implement them, the labor-management leaders agreed that this empowerment program must address complex department-level issues – issues with unknown root causes – that are important for the staff. One coach asserted that the program was "not about reducing falls," but instead it offered workers and managers the opportunity to collaboratively address challenges that evoke strong negative sentiments in workers. Coaches also encouraged co-leaders to select issues that were important for the organization and occasionally work on issues important for managers. The committee selected one or two measurable projects to work on at a time and would track their progress with software customized for the empowerment program.

The ongoing activities of the empowerment program involved several kinds of meetings (**Table 3**). Committee meetings would occur once or twice a month, typically at the start of the day before a department was open to patients or during lunchtime. Importantly, time spent in meetings still counted for a frontline worker's hours and frontline workers were still guaranteed regular breaks during the day. Committee co-leaders could also schedule prep meetings during

weeks without committee meetings to spend time with their coach discussing the progress of different projects. These prep meetings were not mandatory for committees, but halfway through my fieldwork the coaches started to strongly encourage co-leaders to initiate prep meetings. The coach also hosted a quarterly meeting with the committee's co-leaders, the senior leader, and the union representative to co-evaluate their committee operations. The empowerment employees hosted a monthly peer-support meeting where co-leaders across the system could learn about other committees' projects and review leadership skills. Finally, the empowerment employees maintained a bi-monthly steering committee meeting with designated attendees that represented senior leadership, the improvement department, human resources, and the union. The steering committee review the overall progress of committees, identify new departments for the program, discuss hospital operations and initiatives, and strategize various ways to publicize the program within the system.

----------Insert Table 3 about here----------

This empowerment program existed among several other programs within the system that provided formal opportunities for employee voice, in addition to formal grievance procedures. Every other year the system contracted a third-party firm to administer an "employee engagement" survey to understand how employees felt about topics like their safety climate or management practices. Also, the improvement department maintained a digital platform where departments could contribute ideas and track their implementation; these ideas were often "quick fixes," but improvement employees also utilized this tool to track their own system-wide initiatives. In in-patient units, RNs had access to unit-based councils (Church, Baker & Berry 2008) where RNs, frontline managers, and nurse educators could discuss and experiment with evidence-based nursing practices. The focal empowerment program is distinct in that it is

targeted at empowering lower-status workers to initiate and address department-level issues that require more work than a "quick fix."

Data collection

I conducted a 17-month ethnographic field study (March 2022-July 2023) of Coastal Care's empowerment program. Data collection encompassed multiple sources, but the primary data for analysis was obtained by observing committee meetings. I limited my observations to committees that met two selection criteria: committees where the manager was seen as competent by senior leaders and where the manager was highly receptive to the program. By doing so, I effectively controled for manager attributes that scholars have found lead to worker-informed change, so any variation would be explained by different factors.

In the spring of 2022, I began observing the introduction of the program in four clinical departments. These departments' committees provided insights into the program activities and perceptions, in particular the importance of frontline interactions and dialogues. After eight months of observation, I expanded my count to eight departments to include matched cases by department type. This included two administrative departments to understand if my findings were only relevant for clinical departments. This expansion facilitated a richer understanding of how the program operated across various contexts and how various actors interpreted the program. **Table 4** details the eight departments and **Figure 2** outlines the timeline of my frontline committee observations.

----------Insert Table 4 about here----------

----------Insert Figure 2 about here----------

Complementary data includes observing program infrastructure meetings (i.e. steering committee meetings, co-learning events, committee orientations, coach team meetings, and

program-related presentations), shadowing of various roles (i.e. frontline workers, frontline managers, coaches, and union representatives), informal interviews with various roles (i.e. frontline workers, frontline managers, coaches, union representatives, senior leaders, steering committee members, and former staff), post-meeting follow-up conversations with committee members, and archived program-related documents (i.e. presentations, training materials, flyers, visuals from committee meetings, and digital communications).

Ethnographic research proved uniquely suitable for investigating this setting. Even with these investments in empowering workers and opportunities for influence, it was puzzling why workers still felt disempowered and intriguing to explore how this program might empower them. Perhaps this disempowerment could have been driven by workers staying silent for fear of backlash, which workers even experience with formal opportunities to speak up (Brooks 2018). However, I observed that workers were *not* silent about their frustrations, often complaining openly in front of their managers. Complaining was common, but making change was not. Ethnographic studies afford the opportunity to explore such puzzles (Katz 2001).

Organization of the dissertation

I discuss my analysis in three chapters that correspond to the empowerment program's justification, sustainability, and efficacy. Chapter 2 focuses on Coastal Care's justifications for empowerment, specifically why leaders and managers described the program as valuable and appropriate for their organization. Chapter 3 explores how Coastal Care navigated and overcame the challenges that hindered continuous worker involvement in the program. I identified the importance of scaffolding, or various unscripted practices, that complemented the formal design of the empowerment program. The scaffolding provided informal opportunities for worker involvement in instances when the formal programming failed to do so. Chapter 4 focuses on

frontline managers' moves that ensured workers could achieve their desired workplace changes. I identified a process and conditions necessary for closing the voice gap via the empowerment program. Although the program legitimated worker power over workplace change, effective empowerment relied on frontline managers actively crafting opportunities for workers to exercise influence. When managers made three moves (prioritizing workers' issues, centering diagnostic dialogues, and engaging with assigning tasks), they mobilized skeptical workers to address departmental processes. Managers variously deployed these strategies as a consequence of their history with the issue: when they were physically close to the issue and when they had not encountered previous failures in resolving it.

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Figures and tables

FIGURE 1. Organizational structure of actors involved in the case

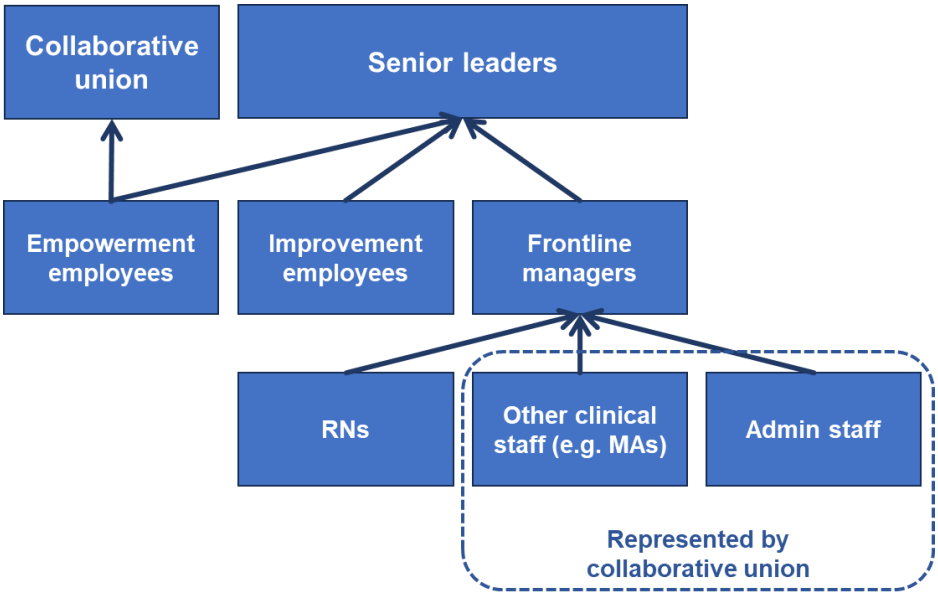

FIGURE 2. Timeline of committee meeting observations by month

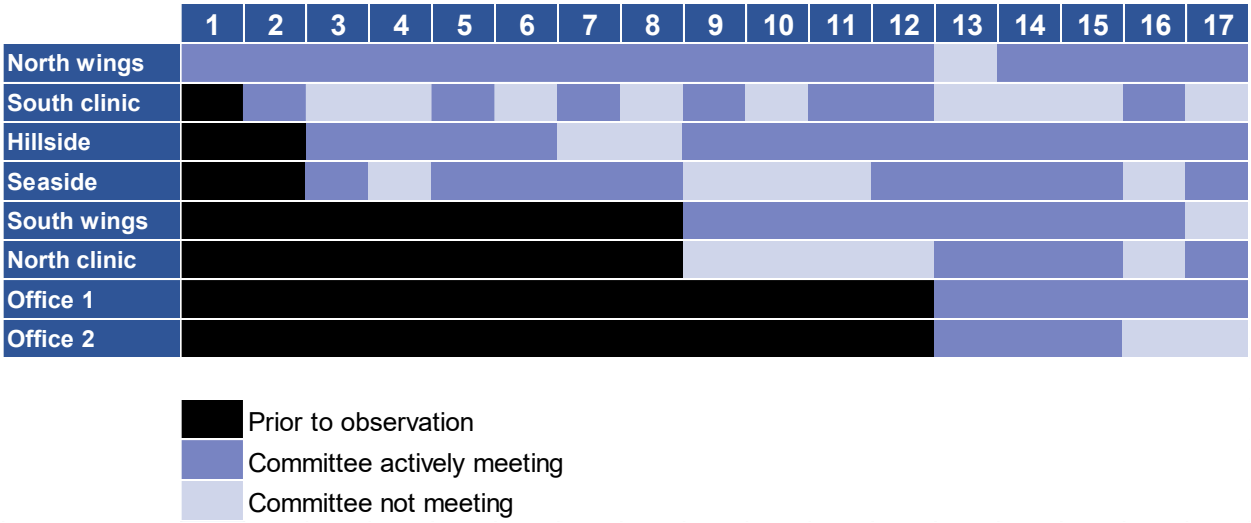

TABLE 1. Voice concepts relating to issues and influence

Concept	Definition	Issues	Influence
Voice gap	"the difference between how much say they expect to have at work versus how much they actually have" (Kochan et. al. 2019)	**Yes**	**Yes**
Prohibitive voice	"expressions of concern about work practices, incidents, or employee behavior that are harmful to their organization" (Liang, Liang & Farh 2012)	**Yes**	No
Voice instrumentality	"pertains to the influence of the individual's voice behavior on the outcome of a decision" (Avery & Quiñones 2002)	No	**Yes**
Voice enactment	"the extent voice is incorporated into the team's approach to the task" (Farh et al. 2020)	No	**Yes**
Voice cultivation	"practices that members engaged in to resurrect ideas that had initially been shot down, breathing new life into them and helping them endure over time to reach implementation" (Satterstrom, Kerrissey & DiBenigno 2021)	No	**Yes**

TABLE 2. Program-related actors, roles, and responsibilities

	Organizational actors	Program-related role	Responsibilities
Department-level committee	**Frontline workers**	Committee co-leader Voluntary committee members	Lead meetings and projects Attend meetings and participate in projects
	Frontline manager	Committee co-leader	Lead meetings and projects
	RNs, Physicians	Voluntary committee members	Attend meetings and participate in projects
	Empowerment employees	Coaches	Train and support co-leaders
	Union representative	Committee support	Support frontline workers
	Senior leader	Committee support	Support frontline manager
Program steering committee	**Empowerment employees**	Steering committee leads	Manage meeting agenda, lead meetings
	Senior leaders	Steering committee attendees	Represent interests of management
	Union representatives	Steering committee attendees	Represent interests of labor
	Improvement employees	Steering committee attendees	Provide updates and support for information systems

TABLE 3. Program-related meetings

Meetings	Potential attendees	Meeting activities	Meeting frequency
Committee	Co-leaders, coach, committee members, union rep, senior leader	Identify and discuss projects	1-2x per month
Prep	Co-leaders, coach, union rep, senior leader	Discuss projects and prepare for next committee meeting	0-2x per month
Co-evaluation	Co-leaders, coach, union rep, senior leader	Discuss the progress and efficacy of the committee	1x per quarter
Peer support	Empowerment employees, co-leaders (multiple committees)	Learn about other committees' projects and leadership skills	1x per month
Steering committee	Empowerment employees, senior leaders, union representatives, improvement employees	Discuss the progress, efficacy, and strategy of the program	2x per month

TABLE 4. Observed departments with empowerment committees

	North Clinic	South Clinic	Hillside	Seaside	North Wings	South Wings	Office 1	Office 2
Type	Outpatient	Outpatient	Outpatient	Outpatient	Inpatient	Inpatient	Non-clinical	Non-clinical
Location	Medical school	Other campus	Rural area	Rural area	Medical school	Other campus	Medical school	Remote work
Staff count	*x*	*x*	*5x*	*5x*	*> 5x*	*> 5x*	*x*	*2x*

CHAPTER 2: JUSTIFYING EMPOWERMENT

This chapter explores how members of Coastal Care justified the new empowerment program as valuable for the organization. The existing literature has argued that empowerment programs are part of a high-performance work system, so a new program could be useful to improve performance in tandem with other practices. However, this explanation lacks specificity, making claims of an integrated set of practices, rather than understanding why a particular program or practice is valuable for the organization. I argue that we should take a broader look at how organizational members describe an empowerment program's potential outcomes and how they understand employees as legitimate actors in organizational decisions. I examine various accounts made by senior leaders and frontline managers that justify the empowerment program and frontline employees' involvement. As expected, an important justification is that the program's practices can leverage workers' technical skills to achieve organizational "improvement." Importantly, though, members of this organization also develop accounts that reflect other organizational values – "partnership" and "respect" – aligning with their descriptions of the empowerment program as appropriate for their organization. This analysis uncovers multiple, complementary justifications for how frontline workers fit into organizational decision-making.

Justifying empowerment programs as improvement oriented

Contemporary employers often maintain a hierarchical structure to centralize authority and decision-making. Those atop the hierarchy have the formal and informal rights to speak and make decisions within the organization. However, many organizations have been experimenting with distributed authority, empowering workers to design internal processes (Osterman 1994; Appelbaum et al. 2000; Lee & Edmondson 2017). For example, self-managing teams give

workers the authority to coordinate and flexibly adapt their work processes on the line (Adler, Goldoftas, & Levine 1999; Batt 2000).

Extant knowledge understands empowerment programs as part of a high-performance work system (Kochan & Osterman 1994; Appelbaum et al., 2000). Leaders make the strategic choice to "bundle" empowerment programs with other human resources practices like job training (Osterman 1994; MacDuffie 1995; Pil & MacDuffie 1996; Youndt et al. 1996). These practices leverage high-skilled workers' expertise to improve work processes and make informed judgements on the line without waiting for approval. Similarly, implementing empowerment can be costly, so leaders must see their human resources practices as a strategic resource (Godard 2004; Arthur, Herdman, & Yang 2016; Kirkpatrick & Hoque 2022). This includes a collaborative relationship between labor and management (Kochan, Katz & McKersie 1986; Gill 2009), though organizations have also implemented programs like quality circles to prevent union organizing (Grenier 1988).

Organizations value high-performance work systems as they navigate their market segments and other factors external to the organization. In rapidly changing markets or industries with intense competition, many organizations seek ways to empower employees to make quicker decisions, respond to shifting market demands, and drive innovation (MacDuffie 1995; Huselid 1995; Appelbaum et al. 2000; Osterman 1994). Organizations that uphold Fordist ideals like top-down standardization avoid worker empowerment, even when peer firms have demonstrated efficiency gains (Vidal 2017). While scholarship on high-performance work systems has largely focused on the manufacturing industry (MacDuffie 1995; Adler, Goldoftas, & Levine 1999; Appelbaum et al. 2000; Rubinstein & Kochan 2001; Doeringer, Lorenz, & Terkla 2003), these practices have been proliferating in service sectors (Kaufman 2003; Kochan et al. 2011; Gittel

2016). Should a service organization pursue high-value customers, flexible frontline decision-making can effectively address the complex and unpredictable demands of these customers (Batt 2000).

Organizations may value high-performance work systems as a means to improve performance, but why do they value a *specific* program or practice to achieve this? Understanding this value of a particular program is important because early adopters of a program may be the only ones to realize any gains (Westphal, Gulati, & Shortel 1997) and new programs may have a mixed effect on performance by diminishing the efficacy of existing organizational practices (Givan, Avgar & Liu 2010; Litwin & Eaton 2018). Empowerment, and related concepts like high-involvement or high-performance work systems, is polysemic and not a bounded set of practices (Wilkinson 1998; Tolbert 2022). Scholars draw from a wide array of concepts and measurement (Huselid 1995; Youndt et al. 2016; Shin & Conrad 2016; Wood 2020); even worse, a recent review of HR systems finds that many scholars do not specify what practices they measure (Boon, Den Hartog, & Lepak 2019). Contemporary organizations may consider individual initiatives, but extant research explores practices in general rather than a specific one (Boxall et al. 2019).

I argue that we should take a broader look at how organizational members describe the goals of an empowerment program and how they understand employees as legitimate actors in organizational decisions. To do so, I examine senior leaders' and frontline managers' accounts justifying the empowerment program and frontline employees' involvement in the program. As would be expected based on the previous literature, an important account is the desire to leverage workers' technical skills to improve performance. Importantly, though, members of this organization also develop accounts aligned with their organizational values of partnership and

respect. Rather than only describing workers as knowledgeable of operations, leaders also recognized that workers have knowledge of the relevant interests related to decision-making (i.e. partnership) as well as knowledge of behavioral norms when addressing superiors (i.e. respect). In the following section I draw from the Sociology of Critique (Boltanski & Thévenot 2006), which explains how abstract organizational values like improvement, partnership and respect provide discrete grammatical structures for justifying who is qualified to do certain activities (i.e. workers involved in an empowerment program).

Drawing from organizational values for justifications

Organizations draw from various values, or what the Sociology of Critique refers to as worlds of worth, to justify their actions to others (Boltanski & Thévenot 2006; Lafaye & Thévenot 2017; Thévenot, Moody, Lafaye 2000). One's description of a valuable action relates to general social domains – for example domestic, civic, industrial domains of life – that connect common principles with a grammar of justifiable claims. The grammatical structure is such that:

> "…[the value] can be described via categories defining subjects (the *list of subjects*), objects (the *list of objects and arrangements*), qualifiers (*state of worthiness*), and relations designated by verbs (*natural relations* among beings). The qualification of these relations makes it possible to distinguish between circumstantial actions, which cannot bring accidentally juxtaposed beings into mutual engagement, and coherent actions based on a higher common principle" (Boltanski & Thévenot 2006, pg 140).

For example, domestic value justifies well-mannered and selfless behavior that sustains a hierarchy. Within one family, the parents (*subjects*) maintain (*natural relations*) the household finances (*objects*). Family members understand that parents are distinguished from their children who must defer on financial decisions. At the same time, parents protect their children from complicated decisions and dedicate a significant portion of the finances for any of the children's financial needs. The parents can reveal their financial standing and teach their children how to

properly allocate money as a rite of passage, but ultimately the parents are the only ones qualified to maintain the finances.

While these values draw from recognizable domains of social life, like a family, actors can apply domestic grammar to justify actions unrelated to their family. Drawing from the domestic value, a manager can justify their exclusive control over budgets and investment decisions as being the natural responsibility of a leader. Employees can have opinions, but criticizing the manager's choices is inappropriate. At the same time, a well-mannered employee could oversee petty cash, which sets the example that good behavior is rewarded. The various members of the organization are qualified to do specific actions because they are knowledgeable of the customs, as opposed to other values that might justify expertise or fairness. Within healthcare, a manager can justify a tenured nurse as the appropriate clinician to draw blood given their expert knowledge (*industrial*), but other staff may assert that a medical assistant would be better suited as they would be more considerate of the patient's feelings (*domestic).*

At Coastal Care, members across roles recognize multiple values when justifying organizational practices in general: improvement, partnership, and respect. These align with the industrial, civic, and domestic values, respectively. The industrial value justifies those with technical knowledge to control tools and resources because these actions maintain useful functions and lead to a predictable future outcome. The civic value allows members of a group to represent the needs and desires of their group to unify all subjects of the broader polity. The domestic upholds understanding of mutual respect.

Coastal Care's management justifies their new empowerment program because workers are qualified subjects of the program by their multiple values. As operational experts, workers have another opportunity to modify processes to improve performance. As stakeholders in

operational decisions, workers can represent their peer's interests in the deliberations of the empowerment committee. As actors familiar with norms of respectful behavior, workers are expected to speak up in a well-behaved manner; reciprocally, the program is a sign of trust and respect from senior leaders. Coastal Care justified the empowerment program as a way to uphold these values of improvement, partnership, and respect.

Data and methodology

My abductive analysis consisted of reading and iteratively reviewing my field notes, writing memos, and tracking justifications and actions related to the empowerment program. Analysis occurred in overlapping phases. In one, I tracked explicit explanations of the program's philosophy and mechanisms. I also used data from unstructured interviews and meeting notes to examine how actors interpreted the program, compared it to other workplace initiatives, and interpreted how others might interpret the program. Informants often explained the program as a way to improve performance, train frontline workers to lead change initiatives, and have workers feel better about work by engaging in changes. I remained curious about how they interpreted this specific program as valuable, given that other policies and initiatives were in place that could achieve the same outcomes.

In another phase, I sought to understand the broader organization values. To do so, I analyzed how actors validated or challenged their own and others' work-related actions. This led me to find many accounts that seemed to violate the value of improvement. Specifically, members of the organization articulated that one sacrificing their own time and effort was a worthy action, even if it was not optimal for performance. As I categorized these accounts into two values – one seemingly related to performance improvements and another to norms of respectful behavior – I recognized that these values only partially explained a recurring theme:

the problem of missing voices in meetings. I returned to these accounts to understand why meeting attendants lamented someone's absence and, in many cases, cancelled meetings if a specific individual or position could not attend. One's absence was undesirable because that a position's expertise was missing. Additionally, actors resisted discussing certain topics or making decisions without a higher-status position out of respect. However, by returning to these cases, I also recognized that many valued another's attendance in meetings for consensus decision-making. Different roles were not only technical or hierarchical, but also represented different points of view. A conversation would be unbalanced if relevant actors were not there to collaborate on decisions. This revealed a third value seemingly related to partnership and multi-party participation.

From these two phases, I developed a typology of Coastal Care's three values (**Table 1**) and drew from *On Justification*'s dimensions of values to do so (Boltanski & Thévenot 2006), such that each value is composed of qualifiers, subjects, relations, and objects. As the literature on empowerment programs suggested, Coastal Care members valued "improvement," but they also valued "partnership" and "respect." Accounts of the program's appropriateness for the organization were connected to one of these values. Senior leaders and frontline managers at Coastal Care justified the empowerment program and qualified workers as legitimate participants in the program in one of three ways: workers were skilled professionals who could optimize tools and operations, stakeholders who could engage multiple perspectives, and familiar positions who could recognize others' identities and obligations.

----------Insert Table 1 about here----------

I present the abductively produced typology in the next section and, in the discussion, describe an exception case that highlighted the importance of all three values supporting each other, rather than only the value of improvement.

Justifying empowerment at Coastal Care

The value of "improvement"

Coastal Care leaders and staff value the idea of continuously making "improvements." The hospital system draws from Total Quality Management (TQM), a management philosophy that encourages organizations to focus on the quality of their product and continuous learning from patients and staff alike. TQM is popular across many hospital systems, where regulatory requirements and accreditation standards often encourage hospitals to adopt TQM practices (Westphal, Gulati, & Shortel 1997; Ruef & Scott 1998). At Coastal Care, staff at all levels are not merely employees but agents of progress, dedicated to enhancing operational efficiency and quality of care. For example, staff in the oncology department heard complaints from patients of color that the variety of wigs did not include all hair types. Staff initiated a capital request for more wigs, creating a more inclusive environment for patients undergoing chemotherapy. This dedication to improvement also extends beyond medical practice, with administrative staff constantly seeking ways to streamline processes, such as implementing digital solutions for cross-department communication to reduce delays in patient transfers between departments.

Coastal Care also created many organizational processes that align with the improvement value. Within the last decade, the organization created an improvement department staffed with white-collar professionals trained in TQM principles and demonstrated experience with transforming organizational structures and practices. Some of the improvement employees also implemented and monitor the use of a system-wide digital platform where employees at all levels

– from senior directors to personal care assistants – can input ideas and track their implementation. To enable skillful use of the platform, employees have access to training in Lean, a method of making organizational improvements that focuses on reducing wasted time and identifying process issues. A supermajority of employees has taken this training.

Improvements not only affect patient care, but also how frontline managers and staff experience their day-to-day work. A process breakdown like a cumbersome hiring process can delay a new employee's start-date, maintaining higher work demands for the department with the open position. In one community hospital, a medical assistant and her frontline manager were lamenting the hiring process in a meeting with their senior leader, an improvement employee, and their program coach:

> Medical assistant: We have two open spots[…] Well actually three, excuse me. We have another MA that needs to be hired and [another] leaves Friday after her retirement. Lucky dog [they all laugh]. And we're still trying to fill a position from [eight months ago…]
> Frontline manager: We made an offer for one of our positions and it's still sitting in reference check. And when I questioned that last week, [HR] told me that her references were just being entered in now and it's still sitting in reference check. If this was somebody that we were dying to have, this process all by itself could have lost that candidate for us.
> Improvement employee: But that's process failure.
> Frontline manager: So I know they're working hard in that department to make some improvements and our old HR person was far more responsive. But I need some action. I see all the time jobs posted on LinkedIn and on Facebook for [Coastal Care] and I've never seen one of our positions posted. Not once.
> Improvement employee: And that's where the squeaky wheel gets the grease, right? If they don't know they have a problem, they don't know they have a problem.
> Medical assistant: So we're electing [the frontline manager] to be our squeaky wheel. [they both laugh]
> Frontline manager: What else is new, [medical assistant]? It's always me. [continues laughing] No, I'll do it. I don't have any problem with it. It's just I know that the person we had was relatively new and I was trying to be a good sport and let her get adjusted and comfortable with her position.

The frontline manager and worker are like customers for HR such that their frustrations with the faulty job-posting process are critical information for HR professionals to use. HR as experts of

hiring processes are the ones to improve the process. At the same time, the frontline manager recognizes that their HR person is new and may not be ready or knowledgeable enough to take on any improvements. Improvements require process experts to tinker and adjust their given operations.

At the time of this study, a surge in patient "census", or the number of patients in the in-patient departments, as well as staffing shortages, highlighted the value of improvement. The CEO sent an email to the entire hospital system entitled "A Critical Tipping Point," where he detailed all the strains on operations and described the system's various initiatives, many punctuated with an explanation of what each initiative was "improving." The communication also emphasized who the experts were: operations and clinical leaders. The efforts to improve system-wide operations required operations expertise to make optimal investments for the frontlines. Medical expertise could identify opportunities to safely progress patients to discharge. These efforts required joint expertise to determine what processes could be expedited. Leaving these initiatives to leaders relied on frontline experts doing the most with what they have.

The organization saw value in the program to enable frontline staff to identify department-level issues and address them. Frontline staff are qualified as experts within their departments. In hospital communications, in program training, and in program meetings, leaders and coaches emphasized this point. In a program meeting, one senior leader noted:

> "For everyone that hasn't heard the spiel for how I view [the program], these are the not too big, not too little. These are those activities just in the middle, that Goldilocks principle, [at the] departmental level that if we do enough of these based upon those caregivers that are at the [frontlines], they can really impact positively the organization. So that's why I'm part of it. We talk about a [program] team or [program] activity, they're working on numerous projects in my mind. And as a project practitioner for 30 years, it warms my heart because these are some of the– We can get too far away or not get so close. To me this is the just- right, the Goldilocks components of what we're doing for our organization's project management."

At Coastal Care, employees can leverage the digital platform for addressing smaller issues like small capital requests. For larger issues, like developing a system-wide, standardized strategy for expedited discharge, operations and medical leaders have the visibility and capacity to make improvements. The empowerment program creates an organizational structure where staff as frontline experts of daily routines can adjust departmental or cross-department processes for improved performance.

The value of "partnership"

Coastal Care leaders, staff, and union representatives also recognize value in "partnership" such that organizational decisions require a balancing of multiple interests. Organizational actors seek out different perspectives and frequently orient themselves toward the idea of "consensus." Including relevant stakeholders in organizational learning justifies decisions. It is one's different perspective that qualifies their engagement, allowing for a broader understanding of issues and enhancing the legitimacy of decisions.

Many members of Coastal Care, at all levels, refer to partnership as a valued end. Most of the staff have union representation and the largest union touts its collaborative relationship with management. The hospital system's senior leaders publicly assert that "there is no business case for adversarial labor relations." Union representatives assert and admire that the current hospital leadership has a "genuine interest" in hearing the voices of frontline workers. Even unrepresented staff like white-collar professionals seek out the perspectives of frontline workers as it pertains to their own work. In one meeting, an employee asked if anyone knew what happened with a contract ratification vote that had been administered recently. Another reported that the contract was ratified with a supermajority, but the employee immediately asked why the minority of union members voted "no." This employee was curious if any worker dissatisfaction

was relevant for the current meeting and dropped the issue when they learned the minority vote was related to wages.

Coastal Care also creates task forces to include various stakeholders, including lower-status staff, in strategic initiatives. As the hospital struggled with a staffing crisis, the president launched a task force to engage with the local immigrant community and requested a specific PCA to partner with him. They organized events to hear from immigrant employees and immigrant community members to learn how to hire and retain immigrant workers. Another task force brought together all ambulatory departments to collaborate on and implement new practices. In this case, each department had its own interests, so this task force could include different perspectives on the same issue. One initiative I observed focused on checking-in patients, an issue where front desk administrators in remote clinics strongly disagreed with the clinics on larger campuses. The task force served as an important touchpoint for different departments' representatives to raise their own concerns.

Partnership informs decision-making, even as organizational members lament how slow and frustrating this is. Meetings are frequently cancelled if one stakeholder cannot attend; if other meeting participants maintain the meeting, they still hold off on decision-making. In an informal interview with an improvement employee to discuss the empowerment program:

> I then ask how [the program is] the same as or different from other projects she has, and she begins telling me about [a newer project]. Her tone changes from warm and polite to something more hasty, desperate, and intimate[…] She says it's a lot of personality management and a huge struggle to get various stakeholders to stay engaged all the time. They all want to have a say but are not always making themselves available at important moments to make decisions. She says her project management style is usually all about dates and managing schedules, but now it seems to be about more than just that. "I want to help them just, for lack of a better word, adopt this thing." […I]t reminds her of the Tootsie Pop commercials. "We keep licking a lollipop and then switch out for another lollipop and we never get to the center[…] At the end of the day, I don't care what they decided. It's my job to just make sure they decide something."

As a project manager, she prioritizes timely project implementation, but she recognizes that shared decision-making is paramount. Partnership is especially a hindrance in the summer and the winter when time off and family responsibilities increase. Many recurring meetings are postponed during these times of year. Even if collaboration delays improvements, members of Coastal Care, at all levels, justify those delays as necessary given their commitment to partnership.

For white-collar employees, the recognition of partnership is evident in their embrace of diverse perspectives when embarking on new projects. Even if it means rescheduling meetings to accommodate conflicting schedules, they prioritize inclusivity to ensure that all voices are heard and considered in decision-making processes. This dedication to fostering an environment where differing opinions are valued seems to reflect a strong norm of partnership driving innovation and achieving collective success.

While the program enabled frontline staff to make improvements, members of Coastal Care also justified the program because it expanded partnership over decision-making over oft-overlooked department issues. Senior leaders identified pairs of managers and frontline staff to be co-leaders of their committees because they represented different interests. Frontline managers are incentivized to improve department metrics and frontline workers want to reduce the daily stresses and conflict. The program brings these two perspectives together who can also engage other relevant perspectives within the department.

Labor and management both recognize the program as a vehicle to enhance partnership on the frontlines, which is reflected in the orientation materials for program co-leaders, materials that are mutually endorsed by union representatives and leaders. One cornerstone of the program is interest-based problem-solving, which encourages multiple parties to withhold making specific

demands and instead state their interests – "what is important to you and why you care." The orientation leader used an example of flexible scheduling: a demand is "I want to work from home," but an interest is "my commute is making it hard for me to spend time with my kids." The program trains co-leaders to facilitate collaborative discussions where stakeholders can present multiple interests.

Another cornerstone of the program is consensus, in line with other decision-making mechanisms. The orientation leader notes:

> "Consensus probably sounds like a headache. We have this very specific way of making consensus, by asking these three questions:
> 1. Has everyone been heard?
> 2. Can everyone live with this decision, even if it wasn't your first or second choice?
> 3. Will everyone actively support this decision outside this room?"

The empowerment program creates an organizational structure where frontline managers and staff engage each other as partners. Rather than merely being a tool for experts to apply their skills, this specific program is collaborative so that changes reflect the interests of different perspectives.

The value of "respect"

Organizational members also advocate for an environment of "respect" across the hospital system. Respect encourages a certain amount of familiarity with others as well as a recognition of where individuals and roles sit within a hierarchy. Whereas some may conceive hierarchy as purely top-down, "respect" constitutes proper conduct up, down and across hierarchical positions. Lower-status positions display good manners – or withhold poor manners – in front of higher-status positions, but higher-status positions model and praise those good manners. The lower-status reflects the image of the higher-status. Even if there are stricter

criteria of good manners for those lower, “respect” also means those higher must limit poor manners.

For example, complaining about other roles or other departments is not discouraged at Coastal Care. Physicians can complain about medical assistants and vice versa. Frontline managers will openly complain about other departments and even encourage their staff to publicly complain. However, there are criteria for when complaining becomes bad behavior. For example, in shared spaces like meetings, managers discourage “naming names.” Complaining is acceptable so long as it does not become personal. Even if there is shared understanding that complaints about physicians reflect the behavior of one specific physician, names are not disclosed. In one meeting where a team discussed a project’s ongoing failure, the frontline manager decided to mention the name of the medical assistant who was resisting a new process. Before and after disclosing the name, she apologized and emphasized that this was bad behavior.

Another criterion for an appropriate complaint relates to who is in the room. The norms of complaining are asymmetric such that higher-status members can complain openly about lower-status members, but lower-status members refrain from complaining about higher-status members in front of them. Physicians openly complained about lower-status members like medical assistants, whether or not medical assistants are in the room; however, when medical assistants complained about physicians or “Coastal Care” – metonymy for senior leaders – they only did so when these higher-status roles were not present.

Respect depends on familiarity, so introducing two people or two departments involves recognition of each role’s position. The introducer models the respectful way to interact with each other. This is delicate when introducing a hierarchical pair. When one senior leader joined the steering committee of the empowerment program, the committee was in the early stages of

planning an event. As a champion of the program, this senior leader encouraged making the program more visible because it set a good example of employee engagement. This event was an opportunity to do so.

> Senior leader: Do we need approval?
> Program employee 1: [acknowledging the question] Yeah.
> Program employee 2: That's a good question.
> [everyone starts laughing and talking over each other]
> Program employee 1: HR people? Health and safety people? Who needs to bless this?
> Senior leader: I have a one-on-one with [the president] this Friday, so I could give him an update and see. You want me to just go right to the top here?
> Program employee 1: Uh, yeah. Yeah! Why not? [laughs]
> Program employee 2: Yes, please.
> Program employee 1: If this is a dumb idea we should know that now. [laughs] Maybe not dumb idea. If this is an idea whose time has not yet come–
> Senior leader: I do think it's a great idea, so I won't be presenting it as "[the program employee] just said." [laughs]
> [… at the end of the meeting]
> Program employee 1: And then, [senior leader], you're gonna go to the top and see if this idea has legs.
> Senior leader: Yeah, I'll go.
> Program employee 1: And if you don't get a clear yes or no, I think that's fine. We can keep playing with this idea and develop it more in order to get a clearer yes or no.

Rather than seeking the technical knowledge or perspective of other leaders, the senior leader encouraged the committee to seek a "blessing." This action displays respect for higher-status actors and gives the committee the opportunity for leaders to give recognition of the program as an exemplar.

Furthermore, being considerate is not merely about showing deference to higher-status staff but also about valuing and recognizing the feelings and experiences of those in lower-status roles. One senior leader's willingness to engage directly with PCAs to understand their experiences, particularly in response to complaints from a nurse, exemplified a commitment to empathy and understanding that transcends a deferential notion of hierarchy. One informant noted that:

> "They have a lot of respect for [the new senior leader]. When [the senior leader] went to [the floor], there was an issue between PCAs and the nurses. And when I first heard about it, she said, "yeah, [a clinician] came to me about some behavior that went on at a staff meeting," but it made it sound like it was [PCAs] that were in the wrong, so [the senior leader] went and talked to all of them and talked to the nurse and found out what the real story was. It's automatically the PCAs who are in the wrong to begin with. You know what I mean? It's automatically assumed it's the PCAs when, in fact, it was the nurse. The PCAs were calling out the nurse on how she was treating PCAs and how she was behaving, and she didn't like it. She started yelling and swearing at the PCAs, but it got back to upper management that it was the PCAs who was yelling and swearing at the nurse. But [the senior leader] got a lot of respect because she went, she talked to every single one of 'em and that means a lot to them."

By actively listening to and addressing the concerns of lower-status staff, leaders demonstrate a genuine commitment to fostering a culture of respect and inclusivity that benefits all members of the hospital community.

For the organization, this empowerment program reinforced reciprocity. This program could diminish what many referred to as a "command and control culture." When I asked leaders and frontline managers about the new program many qualified it as respectful, as exemplified by one frontline manager:

> "I'm glad they can be heard. It's stuff I hear on a daily basis. It's nothing new, but at least they feel like they have a stepping stool to being heard. I think that's good. Do I think we will get anywhere with this? I'm not quite sure because it's complicated and there's a lot of pieces to this[…First we have] to get the [staff's] respect from us to know that we're there to help. Prior to me coming on to [Coastal], it had a history of senior leadership who were not what they are now. They listened to everybody but didn't do anything. Now the staff believe "why bring it up to managers because we've done it before and no one does anything?" We have a whole new group but [staff] still have that same mindset from back 10 years or so or whatever. We have to get their respect back so we can move forward."

This manager noted that, even if the program cannot "get anywhere," the program can demonstrate to staff that leaders not only receive their complaints but can give back by taking even a small action.

Discussion and conclusion

Scholars often understand empowerment program as part of a bundle of human resource practices that can achieve organizational improvements. However, I find that senior leaders and frontline managers at Coastal Care value not only improvements but also partnership and respect, which inform multiple ways in which they justify the program as valuable for their organization. One notable, poignant exception illuminated why justifying empowerment depended on multiple values, rather than improvement alone (Katz 2002). Leaders and empowerment employees expressed excitement about working with a new champion of the program because this champion had strong training and demonstrated experience in process improvement methods. However, as they took a more active role in the program, various actors expressed hesitancy about the new champion's engagement. While they were technically skilled, they also exhibited behavior that seemed to violate the values of partnership and respect. For example, the new champion would only advocate for concerns workers raised. An empowerment employee reminded them not to take a side because their specific role in the program structure was to balance both sides. Others expected this champion to play a role of representing the program, rather than the interests of labor. The three values were seen as reinforcing, so someone who was extolling the improvement rationale but not demonstrating commitment to partnership or respect was seen as problematic.

This chapter contributes to the scholarship on empowerment programs by drawing attention to not only the organization's strategic goals but also their organization-wide values. My ethnographic research of a single organization found that multiple, complementary values drive how members of an organization justify workers as valuable participants in decision-making. However, this explanation does not address the efficacy of empowerment programs. The

following chapter explores how Coastal Care was able to sustain worker involvement in the empowerment program.

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Figures and tables

TABLE 1. Coastal Care's values

	"Improvement"	"Partnership"	"Respect"
Qualifiers What makes an action appropriate?	**technical**	**collaborative**	**considerate**
Subjects How do others qualify an actor? What makes an actor legitimate? Who has knowledge or awareness?	**skilled professionals** *staff, experts, leaders, managers*	**stakeholders** *titles, departments, leaders, members*	**familiar positions** *superiors, subordinates, peers, friends*
Relations What is a recognizable action? What are the habits and rituals?	**optimize** *acquire, make, use, update, test, review, lead, account for, document, standardize, measure, build on, specify*	**engage** *organize, facilitate, join, participate in, communicate, represent, hear, take, align, influence, endorse, vote on, bargain*	**recognize** *offer, give, reject, reveal, defer, remember, share, thank, "brag about," compliment, protect, introduce, train, consult, advocate for, joke about, apologize for, complain about*
Objects What does an actor achieve? What objects are valued? Who is the recipient? What do others attend to?	**tools, operations** *technology, training, ideas, changes, slides, diagrams, reports, calendar, projects, process, issues, staffing, causes, task, outcomes*	**multiple perspectives** *committees, meetings, surveys, "sides", attendance, decisions, contracts*	**identities, obligations** *one's time, informal communication, food, responsibilities, gestures, eye contact, nicknames, money, feelings, preferences, pictures, stories, history, ages, health, names, space, exemplars, the patient, appearance*

Note: Words listed in small italics are specific examples from the data. Each value has its own qualifier and general grammar of subjects-relations-objects. For example, stakeholders can engage multiple perspectivies because it is collaborative.

CHAPTER 3: SCAFFOLDING EMPOWERMENT

This chapter addresses how organizations maintain empowerment programs, focusing particularly on how organizations navigate and potentially overcome the challenges that hinder continuous involvement. Coastal Care's formal practices proved necessary to sustain worker involvement, as the literature suggests; however, they were insufficient on their own. Observing the ways in which participants decided to stay involved or withdraw from the program revealed a set of informal practices I refer to as *scaffolding* (Orlikowski 2006) that complemented the formal design. As participants vacillated between contributing to or withdrawing from this voluntary program, various actors enacted scaffolding with practices like avoiding measurement, co-opting non-program meetings and episodic guilting of workers. While this scaffolding at times seemed to contradict the program's goals, these practices were necessary for keeping workers engaged when the formalized practices did not. This chapter reviews the challenges inherent to empowerment programs and how scaffolding – a phenomenon not previously discussed in the literature on empowerment – can sustain program involvement.

The challenges and capacity for sustaining empowerment

Organizations have adopted and experimented with various initiatives for decades, but many programs fizzle out (Lawler & Mohrman 1985; Hill 1991; Cole 1998; Chi, Freeman, & Kleiner 2011) and firms may cycle through various fads with little impact (Abrahamson & Eisenman 2008). Empowerment programs may motivate employees initially, but inadequate structures can lead to disengagement (Cotton 1993; Vallas 2003; Philip & Arrowsmith 2021). Poorly designed programs do not provide clear expectations and leadership skills for workers, so efforts to empower them may revert to the norm of centralized decision-making (Kochan et al., 2011; Dobrajska, Billinger & Karim, 2015; Turco, 2016). Moreover, with efficiency gains as a

common justification for adoption, unactualized improvements can undermine frontline momentum and leader endorsement (Katz, Kochan, & Gobeille; Shin & Konrad 2017).

To sustain empowerment programs, organizations must maintain worker involvement in organizational changes. Even with leader endorsement, an organization confronts three tensions within empowerment initiatives, which can lead to workers withdrawing if left unaddressed (Boxall & Huo 2022). First, involvement is an improvement-oriented resource, but also demanding for workers, intensifying expectations of their work effort (Boxall & Macky 2014; Neirotti 2020). Second, involvement is a collaborative activity for decision-making across roles, but also can draw attention to existing conflicting interests (Kochan & Rubinstein 2001). Lastly, involvement is a communal behavior, affording staff opportunities to give each other directives, but this can confront existing hierarchical relations; workers fear backlash from higher-status actors who perceive any challenges to their authority (Wilkinson et al. 1992; Harley 1999).

I elaborate on each of these tensions. First, empowerment can leverage workers' expertise and experiences to flexibly adapt work processes, but doing so can become an added work demand (Boxall & Macky 2014; Shipton et al. 2024). Involving workers in decision-making or managing frontline process improvements can intensify job demands by increasing expectations, responsibilities, and accountability for workers. These practices also place pressure on employees to develop new skills quickly and manage their time effectively. Ongoing involvement can make processes more efficient and reduce frontline conflicts (Appelbaum et al. 2000; Shin & Konrad 2017), but achieving these gains requires proactive engagement from workers who may experience this as an additional burden.

Empowerment can also enable collaboration across interdependent roles, improving the quality of decision-making and timing of important information (Gittell, Seidner & Wimbush

2010). However, the second challenge is that bringing different perspectives and interests together can lead to disagreements and amplify conflict regarding both the process and outcomes of decisions (Vallas 2003; Turco 2016). Dissent and conflict avoidance can then undermine the collaborative potential of empowerment programs.

A less explored tension is that empowerment initiatives may require establishing new norms that may seem to challenge established status hierarchies. Leaders encourage lower-status actors to make decisions, which can contradict traditional top-down interactions on the frontlines and in meetings (Wilkinson et al. 1992). Many workers are accustomed to withholding their ideas and complaints to prevent potentially negative reactions (Morrison & Miliken 2000; Milliken, Morrison, Hewlin 2003). Fear can constrain their motivation to speak up publicly. Higher-status professionals and managers must also listen to workers' ideas and decisions so they can be incorporated into changing policies or practices, even though this may feel like a threat to one's ego (Fast, Burris, & Bartel 2014). An empowerment program offers opportunities for workers to critique work processes and potentially the behavior of higher-status roles, though there is no appetite for throwing out the status hierarchy entirely.

These tensions were present in the empowerment program I observed and required efforts to address them. The literature suggested that program-specific and human resources practices have proved effective at navigating these challenges. Effective formal programs focus on areas relevant to workers' abilities, provide workers with necessary information and opportunities to make change, and reward their contributions (Lawler 1986; Purcell et al. 2003). Many organizations also customize initiatives to suit their organizational context (Adler, Goldoftas & Levine 1999; Vidal 2017). Well-specified programs limit ambiguity and enable staff to leverage the initiative's potential (Adler & Borys 1996). For example, what drew many leaders to adopt

quality circles was the perception that the initiative was easy to implement; minimal attention to designing effective quality circles was a contributor to the program's decline in the US (Cotton 1993). They fizzled precisely because they were not prepared to deal with these tensions. Other organizational structures like cross-functional roles and incentives as well as training complement new empowerment programs. These structures can maintain trust, limiting resistance to ongoing worker empowerment (Adler, Goldoftas & Levine 1999; Gittell, Seidner & Wimbush 2010; Kochan et al. 2011).

However, the focus on formal structures has come at the cost of overlooking informal mechanisms of sustaining empowerment. Organizational change and policy efficacy is often contingent on micro-level processes of social interactions and unscripted practices (Kellogg 2009; Gray & Silbey 2014; Huising 2015; DiBenigno 2020; Chown 2021). Research on empowerment suggests that formal and informal processes are separate but potentially complementary parts of a human resource bundle (Marchington & Suter 2013; Mowbray, Wilkinson & Tse 2022) or that formality and informality are trade-offs (Litwin & Eaton 2018).

Drawing from my ethnographic research in the Coastal Care hospital system, I found that informal practices – unscripted interactions between program-related actors – were *scaffolding* for the empowerment program (Orlikowski 2006). Much like scaffolding in construction projects, these scaffolding practices facilitated activities that would be impractical if actors only drew from the formal program policies and goals. This scaffolding addressed instances when participants withdrew from the program as they grappled with the challenges of empowerment and when the formal program could not address these three tensions: involvement as improvement-oriented but demanding, collaborative but conflicting, and communal but

hierarchical. In the following sections, I will review my analytical procedures and the emergent finding of complementary scaffolding.

Data and methodology

The outcome of interest is program involvement. I attended to this because, even though the program structure was well-defined, there were many failed attempts at maintaining involvement. I operationalized involvement by drawing from informants' accounts of program involvement. These accounts ranged from intensive actions (i.e. facilitating meetings or coordinating changes outside of meetings) to more passive behaviors like reading project-related emails or attending meetings without speaking. While I initially looked past this passive behavior, they became important cases to include because informants valued these behaviors and the absence of these behaviors sometimes led to others' disengagement.

Analysis occurred in two phases. First, I drew attention to several poignant moments from my fieldwork, which are illuminating cases for ethnographic work (Katz 2002). For example, one PCA I regularly shadowed frequently expressed frustration about the program because her manager would only describe the program as the PCA's "thing." Without shared leadership, the PCA by herself was not able to get others to attend. She would spend the designated meeting time alone with me, expressing her frustrations. She knew what issues the department wanted to work on but did not have the knowledge to solve these problems by herself. I began interpreting this as a duty she both prized and resented. With poignant cases, I can observe informants contend with contradictions in their lives and probe for richer understanding. Along with other cases, I developed an initial typology that I revised in the second phase.

In the second phase, I drew from the dimensions of social action (Ewick & Silbey 2003) to clarify the different interpretations of involvement. Social action has the dimensions of normativity, constraints, capacity, and time/space. I relied on this analytical framework, attending to how informants characterized program involvement, how they accounted for and qualified specific instances of involvement, and how they accounted for and justified withdrawal. I also drew from my fieldnotes and archival data to connect my observations with their accounts. For example, with the case of the PCA, it was ambiguous to the rest of the department what the program was. In a quarterly meeting between program employees and the committee's co-leaders (i.e., the PCA and her manager), they realized they needed to conduct an orientation for the department, which clarified how different department members could stay involved.

I connected my typology back to my analysis of Coastal Care's justifications by identifying how actors interpreted instances of involvement in three different ways: as improvement-oriented, collaborative, or communal (**Table 1**). For one, members of Coastal Care interpreted program involvement as improvement oriented. Workers could bring their technical expertise to meetings, identify appropriate issues, and contribute their knowledge to problem-solving conversations. Also, involvement was a collaborative activity such that decision-making was driven by consensus across different interests. This could facilitate shared responsibility for decisions and, ultimately, limit future dissent from decisions. Finally, involvement was a communal action, setting an example for others to see that participating in the program was a valued end in and of itself. This could reinforce commitment to the program and potentially establish psychological safety.

----------Insert Table 1 about here----------

As identified in the existing literature, Coastal Care's formal empowerment program, along with human resource practices like training and collective bargaining, were necessary to maintain involvement, but these practices could not always address withdrawal. The three types of involvement were occasionally challenged by other factors. Involvement could lead to intensification of work, incite conflicting perspectives, or confront existing hierarchical relations. When formalized structures were unable to overcome these challenges, members of Coastal Care were able to maintain ongoing worker involvement by developing scaffolding, or unscripted practices, that complemented the formal program. The following section presents evidence of the three types of worker involvement, their related challenges, and the formal and scaffolding practices that sustain each type of involvement. The discussion section explores boundary conditions and counterfactuals.

Scaffolding involvement at Coastal Care

Improvement-oriented involvement and its challenges

The empowerment program is a vehicle for organizational improvements. It is distinct from other improvement initiatives because frontline managers and lower-status frontline staff can be involved in identifying persistent department-level problems and applying their role-specific knowledge to implement solutions. For example, committees have worked on issues like delayed lab orders, as opposed to just making small capital requests like they can with other initiatives. Program staff train the committee co-leaders to steer their committees to select problems that are "measurable" so that they can demonstrate the impact of their projects and, ultimately, the value of the program. In orientations, the program staff would assert that "not every project is gonna be a full win." "Occasionally a team will hit a homerun. We encourage you to hit singles."

However, frontline managers and workers may not have access to the tools, data, or knowledge to diagnose or address persistent issues. For example, with the rise of telehealth during the COVID-19 lockdowns, many patients would avoid or forget to complete paperwork or pay co-pays. Some committees developed projects to address these issues, but the data was not easy to collect or report on. In a quarterly review meeting between the program employees and one committee's co-leaders, the medical assistant complained about tracking patient contracts. There was no automated report or auto-communication to patients if they had not signed their contract, so the medical assistant would print out a list every day and highlight the patients to contact for contract signing. The coach empathized: "I wish we could ask the robots in [the system] to count for us. For now, it's you and the highlighter."

Collecting and tracking data became an additional task for workers in their already busy day. In committee meetings, workers complained about adding an extra step to their work routines, which could even slow down processes like checking-in patients. As some workers stopped collecting data, this kind of involvement fell into the hands of the most motivated staff. One manager said that the two workers who did much of the work described it "like PTSD from high school where you're the only one in the group project that's doing the work and everyone else kind of just sits back and lets you drive." Furthermore, when others saw how much work these few workers put into tracking success, they continued to justify their own withdrawal. Tracking a project's objective progress became a Sisyphean effort.

Additionally, frontline managers and staff withdrew when faced with competing demands or ambiguity about program duties. Patient demand surged in the winter season of 2022-2023, so senior leaders encouraged frontline managers and staff to cancel all "non-essential meetings." In general this included program committee meetings, though senior leaders in the program's

steering committee endorsed ongoing committee meetings if the committee was working on project that addressed patient flow. Many committees, even some with flow-related projects, chose to pause their meetings.

These factors – limited resources, competing demands, and ambiguity about program duties – constrain committees from creating and measuring change. Staff perceived working on improvements as effortful and time-consuming, requiring employees to balance their regular duties with the demands of committee duties. These factors intensified the effort to stay involved and workers could justify withdrawing their involvement.

Formalizing and scaffolding improvement-oriented involvement

Various formalized practices prevented improvement-oriented involvement from waning. The program staff and materials clarified the boundaries of what committees worked on and dedicated coaches discouraged committees from taking on unwieldy projects. The coach also developed a committee charter with the co-leaders so they could co-determine the appropriate cadence and goals of meetings. Consistent meetings with the necessary process experts in the room prevented what coaches called "déjà vu meetings," or meetings where attendees spent significant time recalling the status of projects. As the hospital system observed patient flow return to pre-winter levels, coaches encouraged the co-leaders to recommence the regular meetings. Co-leaders also leveraged the program-specific digital platform to input meeting notes, projects, and sub-project fields like tasks, project contributors, and project measures. This platform was accessible for all employees such that one could access their committee's digital inputs.

Measurable improvement is a stated goal of the program and even a required field in the program's digital platform; however, committees often did not collect data to demonstrate

improvements. Given the effort required for measuring projects, many committees avoided tracking improvements and some frontline managers actively discouraged their committees from collecting this data. Instead, managers and workers left projects unmeasured, relying on their subjective perceptions of outcomes. Co-leaders went by "feel" and qualified outcomes with indicators that sounded quantitative but did not have any supporting metrics. They reported to coaches and senior leaders that they were "hearing fewer complaints" or "saving time." A manager could describe her own observations as ways to suggest measurable improvements. For example, in a meeting related to tracking patient documents, the manager reported:

> "I have seen it get better as far as you guys remembering to check the box and fix things out there. I think it started out really well and then we slipped a little bit and now it's gotten better again. So just remember to check it. Even if you just check it once a day, beginning of the day, end of day. I don't care."

One manager even described measurement as a "waste of time" for committee members. These outcomes remained unmeasured, which reduced the burden of participating in the committee.

This did not go unnoticed by the program staff, who regularly discussed this in their meetings:

> "I think the biggest reason that it's been hard to get [committees] to report out measurable improvements is because they're mostly not measuring stuff. And I think that's on us. I think it's because they don't build the measurement in the beginning. They sort of figure out 'Let's figure out how to improve this thing.' And they start working on it, and then they complete that project and we come swooping in, from their perspective, and say, 'Okay, how do you know? How do you measure it?' And they just never incorporated, so the measurement plan is a highly optional part of the [program] right now. And I don't know if a hard stop is the answer, but we could certainly pick it up somehow."

Projects often addressed important issues that were not directly related to key department metrics, which the coaches were aware of and sympathized with. Program staff continued to encourage committee co-leaders to define measures, explicitly reminding co-leaders about

training documents on selecting measurable projects but avoided pushing too hard for fear of "giving [committees] too much work."

In addition to unmeasured outcomes, some frontline managers and program employees arranged for flexible coverage of frontline and committee duties. Some frontline managers would shift frontline responsibilities so specific committee members would have the time to attend meetings. Even though program employees were sensitive to overworking frontline managers, several managers covered frontline duties. They checked in patients during some meetings to ensure their staff was involved. Flexible coverage also extended to coaches. The program structure aimed for committee co-leaders to be self-sufficient, but coaches often took notes and maintained project details in a committee's portion of the digital platform to limit the work involved.

Formalization was insufficient in sustaining improvement-oriented involvement when workers perceived the program as intensification. Instead, program staff, frontline managers, and frontline workers complemented the formal with informal practices – even with practices like unmeasured outcomes that seemed to go against the goals of the program – to prevent withdrawal.

Collaborative involvement and its challenges

Those at Coastal Care also saw worker involvement as an opportunity for collaboration across roles. I review the challenges to collaboration as they appeared in this context and then how it was worked around. The program operates at the departmental level and program coaches orient committee members to select issues "that cause the most conflict" for projects. Addressing issues with multiple root causes must engage various roles, but with the shared goal of making the department's work more efficient and less stressful. Committee members vote on projects

and align on next steps, with meeting facilitators asking explicitly for disagreement to ensure all perspectives have been articulated. Bringing opposing perspectives into the room was not only about bringing different process experts together, but also about collaborative decision-making that could effectively ward off future dissent to the committee's decisions.

However, bringing different perspectives into a room also heightened conflict between departments, roles, or individuals. Those with relevant perspectives avoided getting involved when there were competing priorities, when they perceived imbalance of interests, or when they perceived involvement as mandatory. Competing priorities drew different roles to attend to issues they interpreted as most important. This constraint often arose with projects that involved physicians or other departments. Some committees referred to it like it was "cat herding" because those actors could focus on their own priorities and did not report to the frontline managers:

> Union representative: There's always been resistance to doing [committee meetings] during lunch.
> Frontline manager: I'm totally open to whatever we think will work. We tried to keep it simple with lunch and I know it's hard because the team covers two campuses, multiple areas, and so much comes up because they're covering inpatient and outpatient. 80/20 rule, if we can get even half the team to show up, then it's not just falling on the shoulders of the workers.
> Worker: What I'd like to do is nail people down on Tuesday and figure out how frequent we can do this. I wanna get the rest of the group engaged. I wanna hear what they have to say. I don't wanna make a decision without hearing from the rest of the group.
> Program employee 1: That's the point of the [program]. Not to tell them what to do, but to hear from everyone.
> Union representative: When I would attend, [the worker] and I would meet the day before and send text messages asking people to come.
> Worker: I feel nefarious. How can I grab these people?
> Union representative: I think that's a thing you can say. "Is this something we want to do?" Hear what folks say so that everyone doesn't feel like it's just more work.
> Program employee 2: You can also share with staff that there are a lot of different ways to do this. The old system was either complain to your coworker or share with your manager and hope that they do something about it. But nothing happens when we wait for a manager to find the time to deal with individual problems. That's what the [program] is for. To get more players in the field.

Competing priorities also included family responsibilities. In one committee, the worker co-leader took extended time off for family duties. In her absence, the committee stalled on projects, as noted by the worker's representative in a committee email:

> "I am afraid that changes are being made only by management and [the worker co-leader] isn't involved in the conversation. She is back now and ready to roll!! […T]he point of [the program] is a partnership between Management and Labor- Us and [the worker] -to work together to make things better. I know that we have tossed ideas around as a group but no set decisions to my knowledge of the changes except for [one project] to a degree (which I am not sure if that is being followed totally or not). All of this to say [the worker] is back and wants to and needs to be more directly involved in the changes and the implementation of the changes."

Getting multiple perspectives involved was challenging not only because it required increased effort but also because different roles had different priorities that drew them in different directions.

Once the relevant perspectives were in a meeting together, facilitating the conversation needed to strike a balance across the various groups. One committee that the program employees often used as a success story suddenly saw reduced attendance of front desk administrators. These workers expressed to their union representative that meetings and projects were only oriented toward clinical roles' issues. Even though their committee was working on a project the admins were passionate about, this perceived imbalance led to their withdrawal.

Also, one of the program's goals was decision-making derived from voluntary consensus, so workers became frustrated and withdrew attendance when they perceived the program as mandatory. With one committee, the co-leaders explicitly made the meetings mandatory, on top of regular staff meetings, to encourage broad participation. Upon doing so, attendance dropped off. Even though the committee gained two new attendees, other regular committee members refused to attend the meetings. Several informants described consensus-

driven meetings like they were occasionally a form of monitoring. Workers did not always want to talk about their perspective and potentially be held responsible for decisions that they felt forced to be part of.

There was one frontline manager of a highly regarded committee who jokingly attributed the committee's success to the fact that staff thought their first program meeting was mandatory. Prior to her time in this department, she had managed another department with a committee that struggled to meet consistently. I asked what she thought would happen if that committee thought it was mandatory:

> "I think it would have made more bodies show up, but I think there would have been more negativity and like the peanut gallery in the background of the room like 'This is stupid, why are we doing this?' The [program] is very much focused on consensus. Can you live with this decision once we walk out of this room? Are you all going to support it? I don't think we would have had that if we had made it mandatory."

Mandatory attendance upfront may temporarily draw attention to the program, but perceived mandates could hinder the open dialogue that many value at Coastal Care.

Formalizing and scaffolding collaborative involvement

Various formalized practices were helpful in addressing the challenges reviewed above. For one, the program charter was a living document where co-leaders and their coach could revise meeting times and committee members. Coaches also trained co-leaders in interest-based problem-solving, which encourages multiple parties to withhold making specific demands and instead state their interests – "what is important to you and why you care." This provided a framework for committee dialogues to steer away from making demands and instead focusing on addressing desires and preferences. Additionally, Coastal Care positioned many roles to be cross-functional in their work. Frontline managers could summarize multiple perspectives, different interests could have overlapping incentives, and many had connections with other roles or

departments if they recognized that meetings should include a missing point of view. These formal structures were effective at bringing in other perspectives when they could not attend.

However, the formal structures could not address all cases of withdrawal driven by conflicting perspectives, so people in various roles – frontline managers, senior leaders, and union representatives – developed informal practices to address this withdrawal. For example, each committee's charter listed the committee members and which area of the department they represented. However, some members refused to attend when they perceived that another perspective dominated the discussions. When people in specific roles did not attend, managers, leaders, and representatives would speak on their behalf, flexibly representing others' interests. Managers and leaders drew from prior conversations with other departments, physicians, or absent frontline workers. They did so, even without explicit requests for one's ideas to be represented in one's absence. This effectively kept their perspective involved in root cause analyses such that the absent representative partially informed decision-making.

In other cases of withdrawal from meetings, senior leaders and frontline managers co-opted other meetings to get specific individuals or roles to express their concerns or to give their "blessing" on decisions. In staff meetings, team meetings, or one-on-one meetings, leaders and managers asserted that the committee needed one's engagement on a project. This was most commonly due to physicians avoiding committee meetings when invited, which proved to be an issue when the committee implemented projects that involved physicians. In one committee's meeting, the co-leaders and their coach engaged their senior leader on the issue of physician avoidance:

> Coach: [*to senior leader*] Any other words of wisdom on what these guys could do to pull more providers in?
> Senior leader: While I have the ear of your medical director today [*laughs*], I'm gonna see what I can do to influence her.

> Frontline manager: Even if she has suggestions for who we can volunteer [*pauses*] or voluntell.
> Senior leader: Yeah, you have to voluntell some people at this point or threaten them that if they don't volunteer, they're gonna be voluntold [*all laugh*]. Let's see if that will help.

"Voluntell" means telling another that they are volunteering for an activity, like responding to a project's potential intervention. So as not to suggest a mandate, senior leaders or frontline managers would evoke voluntelling as a joke rather than an explicit demand. After this senior leader's meeting with the medical director, she reported that the medical director would start maintaining the committee meeting invitation, which legitimated the committee in the eyes of the physicians. At least one physician attended as a representative in future meetings, often along with the medical director.

The training on interest-based problem solving discouraged making specific demands so that decisions are collaborative. However, frontline managers bartered with staff or other departments when those actors refused to make decisions or avoided meetings. When managers thought that the committee had no other options, they asserted project-related needs and asked for what the other actor wanted in response. This was effective when engaging with a distal department that had no prior exposure to the program. For one project, a committee wanted representation from contracted support roles that did non-clinical scut work like cleaning up after a patient ate. After non-response from the contracted team, the manager asserted that the committee would take on a project that contractors thought would make their job easier. The contractors began attending meetings and participating in their project, even though they ultimately did not request to initiate a project.

In another committee, no meeting attendees took on the task of reviewing pending pharmaceutical authorizations for which they had just voted "yes." The manager expressed

frustration and asked medical assistants and front desk administrators what it would take for someone to say yes. “I’m willing to try anything as long as it’s not illegal and it’s good for patients.” Ultimately, a medical assistant agreed to do the task, so long as she could wear whatever she wanted to work that week. These practices of flexible representation, co-opting meetings, and bartering were important ways to scaffold involvement.

Communal involvement and its challenges

On top of improving outcomes and warding off dissent, Coastal Care members interpreted involvement as a communal activity. Attending meetings, raising new ideas, disagreeing, and leading change projects were not only functional and collaborative, but were also good behaviors to model for others. One senior leader told a committee that “even the naysayer who challenges the team totally is adding value because we don't wanna get into a group think: ‘yes, yes, yes.’ Just follow the lemming over the cliff.” When one department onboarded a few new hires, the frontline manager prompted committee members: “If you hear rumbles, encourage them to speak up.” Senior leaders, frontline managers, and program employees honored this behavior like when one personal care assistant attended her first meeting:

> Personal care assistant: [interrupts conversation] I don’t know if I can bring this up here, but the cabinet doors are broken. [apologetic tone] I wasn’t going to bring it up here.
> Senior leader: I’m glad you did.
> Frontline manager: They’re not broken hinges. They can just come off.
> Coach: So, who can take the next step?
> Frontline manager: We can have an engineer go to [the floor].
> Senior leader: Thank you for bringing it up. Sometimes we just get so used to living with things like that.

Because many employees felt unheard for years, Coastal Care wanted the empowerment program to facilitate speaking up as a shared practice.

However, making changes in a hierarchical environment revealed a tension between being respectful while also being directive, assertive, or critical of others' behaviors. Frontline managers and workers disengaged from the program when there was a risk of backlash or disrespect. On top of the many demands staff faced, fear was a persistent constraint. One frontline manager was approached to establish a committee in her department, but in a private conversation she expressed fear of committee meetings becoming "nuclear" with lower-status and higher-status roles accusing each other of bad behavior. In other committees, higher-status roles occasionally withdrew participation because they not only had little time to do project-related work but also did not want to show up to meetings without updates.

This tension within an established hierarchy also extends to informal hierarchies, like when a small number of workers are seen as informal leaders within their group.

> Union representative: The ones that I think don't wanna come are the ones that have the tribal bureaucracy amongst themselves. Where [she recalls a few names…] there's a hierarchy or tribal challenges amongst them where [some of them] won't come if Elise is there because of the stature that Elise has over them and that's not something that I can fix[…T]hat's why [some] stopped coming, was because Elise comes and Elise really speaks up.
> Interviewer: And that's in conflict with them speaking up?
> Union representative: Yeah. It's in conflict with them, period. Just her being there is in conflict with them. And it doesn't matter if she's the best PCA in the institution. Not that she is, but she's a good PCA [laughs]. It doesn't matter. It's because of her stature within her own community[…]
> Union representative: They just don't know how to stop talking. Especially Franny. If you were in the hospital, you would want them taking care of you [laughs]. You know, they're really good. It's just that she just talk talk talk talk talks.
> Interviewer: What would be a good way for getting there to be more of a shared dialogue?
> Union representative: I don't know 'cause I don't wanna stifle any of 'em. They've been kicked around for so long. I call it the abused dog syndrome, where they don't wanna speak up. Elise historically wouldn't speak up. "Oh, no, no, no. I just come in. I just do my job." And I think that this [program] has empowered her a bit.
> Interviewer: Which is good?
> Union representative: Yeah. It's good. I want that to happen to all of them [laughs], as long as it doesn't empower 'em so much it gets in trouble [laughs].
> Interviewer: How would it get them in trouble?

> Union representative: Oh, by speaking up in the wrong way. [The committee's worker co-leader] can say 'these are our patients, not just your patient or my patients. These are our patients.' If a nurse asks you to do something 'I can do that, but I have to take care of my assignment first.' She has a way of saying things that are negative to nurses, but it's not taken in a wrong way. Whereas some people [pauses] decline the invitation, we'll say, and get themselves into trouble and end up in a HR meeting because it comes across the wrong way. So it's all a matter of tone and mannerisms and context.

Many encourage speaking up to higher-status actors, but formal and informal hierarchies can make lower-status workers reluctant to get involved in the program.

Formalizing and scaffolding communal involvement

In some cases, the program structure and the union contract were effective at sustaining involvement in the program. Documentation was a basic feature of the program, and lower-status workers would thank the committee for writing things down. It affirmed workers that their concerns or ideas were important enough to document. Additionally, the program developed a self-evaluation tool that they reviewed with co-leaders every three months. This tool had a strong emphasis on training and celebrating success. Program employees encouraged co-leaders and frontline workers to attend optional workplace training on leadership skills. Program employees also developed cross-committee events. One monthly event offered opportunities for committee co-leaders to review leadership skills and present their project successes to each other. Another event was an annual fair for co-leaders to present their projects to the broader hospital system, including senior leaders. These program practices complemented the union contract, which fostered psychological safety. Program employees and union representatives encouraged workers to speak up and the union contract ensured that no complaints or stories would affect their employment status.

However, these formal practices were insufficient in addressing withdrawal of communal involvement. Instead, frontline line managers, union representatives, and program employees

employed several informal practices that complemented the formal structures. For example, training materials on constructive dialogues were not always effective. Sometimes workers monologued, raised irrelevant narratives, or used accusatory language in meetings. Frontline managers informally trained workers on how to speak up in a well-mannered way. Frontline managers who openly discouraged this behavior would have informal conversations with workers outside of meetings. When planning for the committee meeting with the contracted support, the frontline manager reminded workers about using constructive language and actively listening for new information.

When workers were persistently silent in meetings, managers and union representatives guilted workers into speaking up by saying things like "speak now or forever hold your peace" or "what you permit, you promote." Because these calls to action came from a trusted relationship, this language was effective. Guilting was also used when workers were uncomfortable with leadership responsibilities like facilitating meetings or actively engaging their coworkers. In one committee's prep meeting, the manager and the program employees guilted the medical assistant to facilitate a meeting, but with the promise of support:

> Program employee 1: If you were able to facilitate at least a part of the meeting, maybe just like one of the agenda items, I think that'd be great. I hear you talking a lot, like I can identify your voice off screen and go like, "Oh, good, I'm so glad she said that." But I wonder is there a way that you could kind of step into a place where you're facilitating the meeting at least some of the time?
> Medical assistant: I can try [laughs]
> Program employee 1: The rest of us will help you[…]
> Frontline manager: We'll have you public speaking in no time. We ripped off the band-aid at the [program event]. When we were taking turns and I was like doing one of these. [gestures with index finger for someone to come] I'm like, "No, one of you gets to talk now. It's not my turn anymore." So we were kind of like pushing her out of the nest a little bit, but you did great.
> Program employee 2: Yeah, that's true. And sometimes people do just need to be pushed into it a little to know that they can do it.
> Frontline manager: And we're in a safe space. [softens her tone] No judgment.

> Program employee 1: And all of us can step in if you get stuck[…S]o maybe at the next [committee] meeting, which is next Friday, you could at least take a chunk of it or kick off the meeting or close the meeting. You don't need to feel like you need to run a 45 minute conversation. It's just a piece.
> Medical assistant: Perfect.

In another committee, the frontline manager put pressure on the committee members to get the rest of their colleagues involved as a one-time, exhaustive effort.

> "We need to get people to log into [the digital platform] because believe it or not Big Brother is watching and it's not every week that I don't get a push from somebody. It says [she mimics a nagging voice and everyone laughs] 'no one from [your department is] involved in [the platform].' And I said we have 1000 other things to do here. [everyone laughs] And it's tough for me when I have to tell the clinical staff that y'all have to start doing [some new process] and then for me to say, "Oh by the way, you gotta do this too." So we have two things: we need to try to get everybody to log in [the platform] and we need to give them an idea card for them to put an idea up on my corkboard[…T]his is how they want me to game the system."

To encourage a communal practice of speaking up, these managers drew from their own behaviors – public speaking at an event and advocating for staff, respectively – to guilt committee members into increasing their efforts.

Also, the program was designed to bring many roles into the same space for problem-solving. This could meet the goal of identifying improvements and making collaborative decisions but could also draw attention to exemplars of speaking up. Receptivity to speaking up in a shared space demonstrated that this behavior was safe and valued. However, these shared spaces also brought hierarchical roles into contact, whether it comprised formal status distinctions like RNs and PCAs or informal hierarchies with Elise's stature among PCAs. In some of these cases, frontline managers and union representatives strategically used separate spaces to encourage workers to speak up. Katherine Kellogg refers to these as relational spaces (2009), or spaces that are exclusive but still inclusive and psychologically safe for lower-status actors. For the manager who was worried about "nuclear" meetings, the program employees

agreed to start the committee as an initiative for the lowest-status staff first. For the committee with Elise, the co-leaders and the union representative created several separated spaces they referred to as a "roadshow" where different subgroups of workers engaged with their committee's projects.

While these separate spaces were deviations from the program, the program itself did have prep meetings as a formal space for co-leaders to meet with their coach, union representative, and senior leader. In many instances, this becomes a psychologically safe space for co-leaders to express their own challenges with the program without the fear of offending or shaming their committee. The manager of one committee used the prep meeting to discuss an instance of being reported by a worker. She endorsed this behavior and considered it an important issue to respond to:

> "I will say that this is a safe space for me to talk. The last time I addressed a behavior issue, and let me say that I think I was calm, professional, and I talked about the lack of teamwork that was being displayed in this department. Somebody in [one group] put in an ethics complaint. So somebody took their little tag here [holds up a card on her lanyard], which I am happy that they know how to use, and put an ethics complaint in about me and what I talked about at that meeting. So you can imagine that I'm a little gun shy to address behavioral issues, but I can't let them go. But I wanna address it as a clinic issue with regards to behavior. Just point me towards HR if you want me to go in that direction and we'll move on. But this is a standards of respect issue."

The co-leaders, union representative, and coach spent the rest of the meeting brainstorming. They ultimately determined that this was a topic to bring to their committee as a part of broader discussion regarding standards of respect. In conjunction with formal structures, these informal practices of informal training, episodic guilting, and separate spaces were important tools to scaffold communal involvement in the empowerment program.

Discussion

Coastal Care designed the empowerment program to facilitate worker involvement in making organizational improvements via collaborative decision-making, reinforcing a norm of speaking up about process breakdowns and undesirable behaviors. Program-related actors were able to maintain involvement with informal scaffolding that complemented formal structures. Some of these informal practices seemed to contradict the program's goals but were utilized to achieve the major goal of ongoing involvement. However, my observations suggested that an important boundary condition is that relationships at Coastal Care were trusting. Absent a foundation of trust, one could imagine senior leaders rebuking practices like avoiding measurement, co-opting meetings, and episodic guilting.

On the other hand, counterfactual cases revealed that scaffolding could not always address involvement when staff faced competing demands. In cases related to improvement-oriented or collaborative involvement, flexible coverage and co-opting meetings were effective at navigating competing demands. Staff could make time for meetings and stay involved in projects during other meetings. However, scaffolding like separate spaces and episodic guilting were not effective at encouraging involvement as a communal behavior when workers withdrew due to competing demands. Workers were concerned about leaving their coworkers "high and dry" by attending meetings when demands were high in their department. In these cases, the committee's coach met with the union representative and co-leaders to discuss projects and to determine if the committee needed changes like selecting a different meeting cadence or new committee members. They withheld actions like episodic guilting to limit shaming or overwhelming workers.

At the same time, competing demands also strained the involvement of higher-status actors. The program was designed so that involvement was reciprocated across all roles regardless of status. When frontline managers or program staff were overburdened and could not take on their own committee-related work, they discouraged meetings. They were concerned about disappointing workers when they could not do their committee work. In some cases, this happened repeatedly and fueled workers' frustrations with the program. Coaches and union representatives shifted their focus to repairing strained relations. They took a formal approach with committee involvement by pausing the committee and putting in a concerted effort to relaunch when relations were repaired.

Conclusion

This chapter highlights the potential complementarity of formal and informal practices to sustain an empowerment program. As organizations seek to maintain involvement, participants face several tensions: involvement becomes a resource for improvements, but also an increased demand; involvement becomes collaboration, but also incites conflict between different participants; and involvement becomes a communal practice of taking and giving directives but cannot challenge the hierarchy of roles. Coastal Care clarified program mechanics and leaders publicly endorsed them, but sustainability relied on additional informal practices that scaffolded involvement when workers withdrew. By recognizing the interplay between formal and informal mechanisms, this chapter explores how these practices, even those that seem to contradict the program's goals, can ensure that organizations sustain worker empowerment programs.

However, this does not explain if empowerment programs can achieve results beyond continuity. The following chapter addresses how and under what conditions ongoing

involvement in Coastal Care's empowerment program can address workers' issues such that workers can achieve their desired workplace improvements.

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Figures and tables

TABLE 1. Types and dimensions of program involvement

	Improvement-oriented	Collaborative	Communal
Challenge	intensification	conflicting perspectives	hierarchical relations
Normative How is involvement justified? What are the exemplars of involvement? How do others respond to involvement?	Involvement optimizes organizational processes.	Involvement wards off dissent.	Involvement reinforces ongoing commitment.
Constraint What circumstances impede or discourage involvement? Is involvement withheld? When does involvement evoke negative emotions?	Limited resources, competing demands, ambiguity	Competing demands, perceived imbalance interests, perceived mandates	Competing demands, perceived risk
Capacity What processes encourage involvement? What tools, skills, and relationships do they use?	*Formal* Clear expectations, digital platform, expertise *Scaffoling* Unmeasurable outcomes, flexible coverage	*Formal* Committee charter, cross-functional expertise *Scaffolding* Flexible representation, bartering	*Formal* Documentation, leadership skills, union contract *Scaffolding* Informal training
Time/Space Where does involvement happen? When does involvement happen? Is involvement ongoing?	*Formal* Scheduled and patterned interaction, shared space	*Formal* Shared space *Scaffolding* Co-opting meetings	*Formal* Shared space *Scaffolding* Episodic guilting, separate spaces

CHAPTER 4: CRAFTING EMPOWERMENT

This chapter focuses on how organizations can effectively empower workers to speak up, to set change agendas, and to make decisions. Despite organizational efforts to develop empowerment programs for workers, both higher-status members and workers themselves may resist the assigned influence that workers have been offered for organizational change. Additionally, while scholarship has identified processes and conditions for workers' upward influence on some issues of concern to them, less is known about how workers might affect change on what I call emotionally-fraught issues that seem unlikely to change. My research identifies a process and necessary conditions for effective formal empowerment. This program trained workers to lead problem-solving committees in their departments and test small changes that address their issues. Although the program legitimated active worker participation, I demonstrate that empowerment relied on managers actively crafting opportunities for workers to exercise influence. Managers made three moves (prioritizing workers' issues, centering diagnostic dialogues, and engaging with assigning tasks) in order to support and mobilize skeptical workers to address departmental issues. Managers variously deployed these strategies as a consequence of their history with the issue: when they are physically close to the issue and when they have not encountered previous failures in resolving it.

Worker empowerment and influence in organizations

Worker empowerment constitutes lower-status actors exercising influence over organizational decision-making (Bowen & Lawler, 1995; Wilkinson, 1998; Lincoln et al., 2002; Seibert, Wang, & Courtright, 2011). Organizations typically centralize decision-making among higher-status actors, limiting what frontline workers can do (Kanter, 1977, 1984). However, organizations can facilitate worker empowerment by formalizing opportunities for workers to

exercise power. These opportunities grant workers the rights to certain actions, like the right to make decisions (Freeland & Zuckerman, 2016; Turco, 2016). With the formal right to decision-making, workers can realize their desired outcomes like getting information-systems employees to customize the functionality of digital technology (Kellogg 2022; Myers 2024). Importantly, this notion of empowerment is distinct from psychological empowerment, which focuses on an individual's feelings and perceptions (Conger & Kanungo, 1988; Spreitzer, 2008).

Worker empowerment is effective when members of an organization actively shift their agendas and solution-seeking to reflect workers' concerns. However, ethnographies of worker empowerment identified how higher-status actors and even workers themselves reject this redistribution of authority (Grenier, 1988; Smith, 2002; Vallas, 2003; Vidal, 2007), rendering ineffective any rights granted to workers. Higher-status actors like managers and high-skill professionals can feel threatened and undermine worker-led decision-making. For example, in quality circles managers narrowed the scope of the committee to small issues (Bradley & Hill, 1987) and program officers shut down worker-raised issues (Grenier, 1988). Additionally, expanded rights to do something means expanded responsibilities and accountability (Freeland & Zuckerman, 2006; Turco, 2016). Workers may fear backlash or being perceived as difficult (Ahmed 2021) and skeptical workers can limit participation (Hodson, 1995; Vallas, 2003; Vidal, 2007). Empowerment hinges on the reception from higher-status actors and workers.

Understanding how and when empowerment is effective requires examination of organizational members' responses to and utilization of redistributed authority. Specifically, as organizations implement an empowerment program, or a set of formal organizational policies that provide opportunities for workers to speak up and influence change (Adler & Borys, 1996; Appelbaum et al., 2000; Lee & Edmondson, 2017), when and how do workers exercise power,

ultimately making organizational changes, via the rights extended by an empowerment program? Programs vary in terms of what rights they extend to workers, so exploring this question requires careful attention to a program's specific rights: agenda-rights give workers the power to set the domain of a conversation and debate, voice-rights give workers the power to speak openly from their perspective, and decision-rights give workers the power to determine who does what (**Table 1**).

----------Insert Table 1 about here----------

Empowerment programs extend broad voice-rights to workers. However, non-routine listening (Rowe, 1987; Dutton and Ashford, 1993; Detert & Treviño, 2010; Liang et al., 2012; Marchington & Suter, 2013) and idea collection (Nembhard & Tucker, 2011; Satterstrom, Kerrissey & DiBenigno, 2021; Yang & DiBenigno, 2023; Jung, 2023) do not give workers the opportunity to make decisions, reserving the final say for higher-status actors. Sanctioned groups (Katz et el., 1983; Lawler, 1986; Hill, 1991; Barker, 1993; Batt, 1999; Appelbaum et al., 2000; Smith, 2002; Vallas, 2003; Lee & Edmondson, 2017; Litwin & Eaton, 2018; Seegars, 2021) and grievance procedures (Slichter et al.1960; Freeman & Medoff, 1984; Frege, 2002; Budd & Colvin, 2008; Avgar, 2021) do extend decision rights to workers.

The focus of this analysis is sanctioned groups. Many sanctioned groups – like quality circles (Lawler & Mohrman, 1985; Grenier, 1988; Appelbaum & Batt, 1994), self-managed teams (Barker, 1993; Vallas, 2003; Lee & Edmondson, 2017), and shared governance (Barden et al., 2011; Litwin & Eaton, 2018; Kellogg, 2022) – are unique in that leaders extend agendas rights to a narrow domain, like a work unit, and decision-making is collaborative among the various participants. This affords workers a concrete, familiar domain for manageable improvements such that workers can make decisions based on their own day-to-day work experience (Kanter

1977; 1984; Wilkinson, 1988; Hackman & Wageman, 1995; Adler, Goldoftas & Levine, 1999). With clear roles and responsibilities as well as program-specific budgets, sanctioned group programs can prevent reverting to the norm of centralized decision-making (Pfeffer, 2013; Dobrajska, Billinger & Karim, 2015) and prevent confusion about who is accountable for what.

Scholars have found that various organizational features complement the rights extended via sanctioned groups. Extensive training ensures that workers attain the right skills to identify and address issues (Osterman, 1994; MacDuffie, 1995) and job security can foster commitment to the organization and improvement-oriented change (Kalleberg & Moody, 1994; Smith, 2002). In unionized organizations, collaborative labor-management relations ensure that union representatives encourage worker participation (Drago, 1988; Kochan & Rubinstein, 2000; Budd, 2004; Kochan et al., 2011) rather than raising the concern that more worker involvement undermines the union (Kochan, Katz & McKersie, 1986; Verma, 1989).

However, scholars have primarily focused on empowerment programs' effects on outcomes like organizational performance and job satisfaction (MacDuffie, 1995; Pohler & Luchak, 2014; Litwin & Eaton, 2018), so there is a limited understanding of how sanctioned groups can effectively empower workers to influence their desired workplaces changes.

In Coastal Care, I found that frontline managers actively encouraged ongoing worker participation instead of resisting the empowerment program. This is in line with recent scholarship that suggests frontline managers can play a crucial role in new workplace practices by encouraging workers to participate (Townsend & Mowbray, 2020; Kilroy, Dundon & Townsend, 2023), but scholars have still not addressed how manager involvement in programs like sanctioned groups can lead to worker-initiated change. To understand what role frontline managers play, I draw from the literature on upward voice and influence in organizations, which

explores how voicing ideas to higher-status actors like managers can lead to change. Bringing the literatures on empowerment programs and employee voice together also addresses the ongoing call for a broader research agenda that includes formal pathways or structures for upward voice and influence (Morrison, 2011; 2023; Budd, Gollan & Wilkinson, 2010; Detert et al., 2013; Mowbray, Wilkinson & Tse, 2014; Wilkinson, Barry, & Morrison, 2020).

The voice process and the conditions for change

Employee voice has been defined within the organizational behavior literature as the discretionary articulation of an issue or idea with the intent of organizational change (Van Dyne & LePine, 1998; Morrison, 2011; 2023). An employee targets a recipient, often a higher-status actor like their manager (Detert & Burris, 2007; Detert et al., 2013; Mowbray, Wilkinson & Tse, 2015). This behavior can occur formally, by speaking up in settings where one's voice is explicitly encouraged, or informally. With this definition, voice is an observable behavior, rather than the presence of a voice channel like a union grievance procedure (Morrison, 2023), though voice channels can provide opportunities for voice behavior (e.g., articulating an idea).

This research tradition suggests that, after an employee articulates their idea, implementation depends on who the recipient is and how the idea is framed. Certain targets are better suited to implement ideas. This can depend on attitudinal factors, like managers are more likely to act on issues when they exhibit openness or perceive themselves as efficacious (Detert & Burris, 2007; Burris, 2012; Fast, Burris, & Bartel, 2014; Burris et al., 2023). Managers who are more open to change are likely to implement new ideas, as opposed to those who perceive a new idea as a threat to their authority and ego (Fast, Burris & Bartel 2014). Employees can also target competent and well-resourced managers, those with the right skills and tools to make change (Fast, Burris & Bartel 2014; Burris et al., 2023). Yet, even if an employee targets a

capable recipient, they must also present the idea in such a way that it will be perceived as appropriate for the organizational context (Ashford et al., 1998; Dutton & Ashford, 1993; Dutton et al., 2001; Howard-Grenville, 2007; Lauche & Erez, 2023). Managers are responsive to ideas they perceive as "quality," like those that are seen as feasible or performance oriented (Brykman & Raver, 2021). Employees can also strategically time their ideas, like when some leaders were more open to new ideas in the early months of the COVID-19 pandemic (Yang & DiBenigno, 2023). Colleagues and managers can support an employee by amplifying or repeatedly supporting that idea over time (Satterstrom, Kerrissey & DiBenigno, 2020; Satterstrom et al., 2024).

However, these explanations often downplay the complex process of change, casting a manager as the judge, jury, and executioner of an idea. This is important to foreground, especially because workers not only articulate easy-to-implement *suggestions*, but also speak up about *concerns* (Liang, Liang & Farh 2012). When a worker describes their concern, this issue often derives from processes that intensify work or persistently incite negative feelings and involve multiple actors (Milliken, Morrison, Hewlin 2003; Ahmed 2021; Meyers 2024). For example, consider an ongoing conflict between different groups over limited medical technology in a hospital. In Coastal Care, this was the case with glucometers in one inpatient hospital. An employee can raise the idea of buying new glucometers and the manager can decide to use some of the budget or not. However, more equipment may not resolve the issue if another group continues hoarding the technology. To make change, multiple actors must recognize, discuss, and act on the issue. The manager, personal care assistants, and facilities staff across multiple groups had to be involved in some capacity so that the root causes were addressed. A receptive and

capable manager must go beyond the role of recipient and proactively facilitate how multiple actors respond to a concern.

In my setting, the conditions were favorable for change – the organization implemented an empowerment program complemented by other policies, receptive and capable managers actively participated, and workers' concerns were seen as important to address – yet there was still variation in which issues were addressed and whether changes were successfully implemented. Change depended on specific moves made by managers that uphold the rights extended to workers via the empowerment program, a process I call *crafting empowerment*. Workers needed managerial support to claim power from this program. This crafting process included prioritizing workers' issues to assert their right to set agendas, fostering diagnostic dialogues to uphold their right to voice, and engaging in task assignments to uphold their right to make decisions. Ongoing involvement from multiple roles remained pivotal, but the translation of their ideas into meaningful change hinged on their manager's execution of all three of these moves.

Furthermore, the manager's personal history with a given issue significantly influenced their response. When a manager was physically distant from the issue's context, their approach tended to emphasize workers' autonomy in problem-solving. Conversely, when a manager had experienced past failures in addressing a particular issue, a sense of futility arose, potentially impeding their willingness to promote change. Managers who were physically proximate to the issue and unburdened by prior failures were likely to successfully enact all three empowering moves, effectively facilitating workers' agency in driving change.

In the following section I outline the analytical procedures. In my findings, I begin by describing the types of issues that workers raise and the variation in issues that lead to change. I

then outline the necessary moves managers made, illustrated with a case, and detail the necessary conditions, illuminated by three matched cases.

Data and methodology

The outcome of interest is changes made that address worker-articulated issues. This was of empirical importance, given the program's mission of improving working conditions, but also of theoretical importance. With power understood as the contingent outcome of achieving what one desires (Wrong, 1970; Ewick & Silbey, 2003), empowerment exists when workers can influence others and bring their experiences at work closer to their hopes. I identified change with two indicators: alterations in practices and workers' expressed satisfaction with those changes. I observed these change efforts unfold in meetings, where managers and workers discussed practice changes or failures in making changes. I triangulated with frontline observations and follow-up conversations. Additionally, satisfaction and dissatisfaction with change efforts were discussed in meetings and follow-up conversations. I often found that workers expressed satisfaction with changes, even if they were moderate or partial solutions.

The focal unit of analysis is emotionally-fraught issues that workers raise. Emotionally fraught refers to issues that consistently trigger negative emotional responses in workers. For example, ongoing receipt of incorrect or soiled instruments aroused frustration, disgust, and anger for workers. Across the eight committees, workers raised 28 emotionally-fraught issues. I focus on emotionally-fraught issues to avoid deductively classifying issues as either worker- or employer-interests. These emotionally-fraught issues, even issues like disrespect and job intensity, were described and framed as important to the organization because they could impact patient care.

I excluded manager-raised issues not only because of my focus on worker-raised issues

but also because manager-raised issues were often in response to top-down initiatives. Some examples of manager-raised issues include increasing electronic patient check-in or reducing call wait times. Others have explained how workers contribute to manager-defined issues (Satterstrom, Kerrissey & DiBenigno, 2021; Kellogg, 2022). Instead, I observed how workers contributed to solving issues that are salient and emotionally charged, which are often issues where the status quo seems inevitable (Detert, Burris, & Harrison, 2010), and I explored the conditions that led to change across these worker-raised issues. Additionally, other stakeholders – frontline managers, program employees, and union representatives – repeatedly encouraged workers to organize meetings' agendas around emotionally-fraught issues, or those issues that make it "feel hard to come to work."

Employing abductive analysis (Timmermans & Tavory, 2012; 2022), I engaged in an iterative process, alternating between raw data and existing theory. Over time, I categorized the data, connected categories with themes, and developed interpretations. Subsequent data collection and new prompts for informants presented opportunities to refute and refine interpretations (Katz 2001). Developing theory involved two phases. For one, I identified the importance of managers' actions. It seemed as though their activities outside of meetings drove change, but I was also surprised to see that, in productive committee meetings, the manager talked a lot and took most of the next steps. This led me to identify three important steps: how a manager 1) endorsed issues; 2) centered the meeting's dialogue; and 3) engaged with assignments. I connected the data to organizational theory about rights, outlining how the manager was upholding workers' agenda-setting rights, voice rights, and decision-rights, respectively.

In the other phase, I identified conditions for managers' moves. At first, it seemed as

though it depended on the managers' characteristics. However, with theoretical sampling, I added additional cases, providing more matched cases (i.e., South Wing for the existing North Wing case and North Clinic for the existing South Clinic case) and two new matched administrative departments (**Table 2**). Comparing across all eight committees, I found variation across seemingly similar managers involved in similar projects. Additionally, many poignant moments forced me to reinterpret prior observations, for example, one thick-skinned manager breaking down in tears. Such poignant moments are a unique benefit with ethnographic data. Instead of only documenting accounts of action, such moments illuminate how people thrive or crumble when facing invisible social forces (Katz, 2002). Identifying and interpreting these poignant moments helped me identify that, despite my early interpretations, managers did not support or derail projects wholesale. Instead, managers had their own personal histories with each issue, which impacted whether they proactively supported workers as they addressed issues.

----------Insert Table 2 about here----------

In the following section, I present my issue typology and review how change varies across and within issue types and committees. Then I describe how managers craft empowerment for their workers with three moves. I present one case to demonstrate how this process unfolds. Finally, I explain the two conditions under which managers make these moves. I support this explanation by illustrating how these conditions influenced the response of three different committees' managers to the issue of delayed lab orders for patient appointments.

Crafting empowerment at Coastal Care

Variation in change across emotionally-fraught issues

One reason that some changes may occur while others do not is differences in the issue itself or in the responsiveness of particular managers. To understand if change was driven by the

type of issue or by a committee's manager, I sought to compare positive and negative cases of change across issues and departments.

To compare the types of issues, I began by inductively exploring what makes issues essentially similar. Issues represented a topic that has multiple undesirable factors. For example, one issue could be that physicians do not always follow evidence-based practices for hand hygiene. This issue may be composed of multiple factors, like lack of knowledge about best practices and broken disinfectant dispensers. I determined that similar issues would have similar kinds of undesirable factors, or what I refer to as root causes, so I first categorized root causes.

I identified root causes from narrative accounts made by committee participants. Across these 28 issues, root causes fit within one of 5 categories:

- Routines involve the definition of work responsibilities.
- Insufficient resources involve the availability and capability of tools workers have access to.
- Accountability involves whether well-documented routines are enacted (e.g., a front desk admin following the appropriate steps to check-in a patient).
- Personnel involves staffing levels and how staff treat each other.
- Inter-departmental process breakdowns involve the quality of communication between the committee's department and another (e.g., a clinic coordinating the exchange of medical instruments with a sterile processing department).

With this example of hand hygiene, lack of knowledge about best practices is a root cause related to routines. Without clear documentation of best practices, physicians do not practice proper hygiene. Additionally, having broken dispensers is a root cause related to insufficient resources.

I then created an issue typology based on issues that have similar sets of root causes, which led to six issue types (**Table 3**). This typology ensured that I was comparing outcomes (i.e. changes made) across issues that would require similar kinds of interventions. All issues had a root cause related to routines, but vary by what other root causes factor in:

- Insufficient tools involved routines and tools.
- Training only involved routines.

- Internal processes involved routines and accountability.
- External coordination issues involved routines, accountability, and inter-departmental process breakdowns.
- Job intensity involved routines, accountability, and personnel, specifically short staffing.
- Disrespect involved routines, accountability, and personnel, specifically rude behavior.

The hand hygiene example would be an issue related to insufficient tools.

----------Insert Table 3 about here----------

Across issue types (**Table 3**) and departments (**Table 4**) there was variation in which issues led to change, but there was also variation within issue types and departments. Additionally, all departments took on issues that involved more than just root causes of routines and insufficient resources (i.e. accountability, personnel, and/or interdepartmental). Among such issues, change still varied within departments.

---------- Insert Table 4 about here ----------

I identified that the actions of a department's manager played a pivotal role in driving change (**Table 5**). Specifically, when managers made three moves, changes occurred, and workers felt that they had influenced change. These three moves were prioritizing the issue, centering a diagnostic dialogue, and engaging with task assignments. When managers made these moves, workers were able to influence the changes they wanted to see. Such actions upheld workers' organizational rights (agenda-setting rights, voice rights, and decision-rights, respectively), effectively crafting worker empowerment.

---------- Insert Table 5 about here ----------

Managers' moves for crafting empowerment

Before illustrating these moves more concretely with a case, I trace the three critical moves in broad terms, derived from my analysis. One move a manager made was prioritizing the

emotionally-fraught issue that workers raised. Workers raised these issues in their committee's first meeting; after the coach explained what the committee was, they then explicitly asked workers to discuss the issues that "make it hard to come to work." Workers wrote issues on post-it notes, and the coach put them on the board, grouping together post-it notes with similar comments. The committee voted on issues and, in many cases, reached near-unanimousness about what issue would "feel" best to address first. When prioritizing the issue, the manager publicly endorsed the issue as a project for the committee's agenda. The manager also communicated the issue in department-wide emails and recognized the issue during subsequent meetings.

Beyond publicly recognizing the issue as important for ongoing discussion, the manager also prioritized the issue by encouraging committee meetings tied to the empowerment program. Committee meetings provided workers with the time and space to focus on their issues. Other department meetings like staff meetings focused on leader-defined initiatives like implementing a new technology or improving specific patient quality metrics. When the manager encouraged meeting attendance, this legitimized collective time and attention on the issues workers raised in committee meetings.

Another necessary manager move was centering a diagnostic dialogue. William Isaacs (1999) conceptualizes an issue like a circle. Each person, role, shift, or work pod can have their own perspective at different points along the perimeter. Centering a dialogue brings each person to the middle of the circle to look out and see all perspectives on the issue. This process is necessary so that no one specific voice or perspective is de facto prioritized. The manager explicitly acknowledged that there were always different stories for the same issue. This broadening of the issue beyond one's individual scope made it possible to identify the multiple

root causes of the issue, rather than only one's own.

To bring everyone to the metaphorical center of the issue, the manager asked for concrete stories or examples of the issue. Workers presented their own specific experiences with the issue. In one department, workers complained about how a patient might contact their department multiple times about the same topic. The manager encouraged different roles to provide their own recent examples of this issue. A front desk admin described documenting a patient call in their record only to find that another worker had already documented the same conversation with the patient. A nurse explained that a medical assistant frantically contacted her demanding that she speak to that patient over the phone immediately. Different roles were able to learn about others' perspectives. The diagnostic dialogue was a delicate balance between encouraging multiple people to speak and making sure everyone was listening. When managers centered a dialogue, workers saw firsthand that identifying root causes required more than just their personal diagnosis of the issue.

During diagnostic dialogues, I was surprised to see that managers who successfully centered dialogues also spoke a lot in meetings. Beyond prompting for examples or narratives, managers also articulated perspectives of any absent roles and discouraged monologues or non-sequiturs. Also, managers used a shared visual, like taking notes on a whiteboard or reviewing documents, to guide the discussion. These visuals were effective at maintaining collective focus and cultivating a shared understanding. Rather than silencing workers, managers spent time synthesizing multiple perspectives and ensuring that all committee members could agree on what the issue's root causes were.

The third necessary move was engaging with task assignments. After the committee aligned on one or more root causes, they needed to decide on next steps. Identifying appropriate

task assignments was not always straightforward and sometimes workers suggested attitudinal changes instead of process improvements. “[That role] should just respect us” was a common suggestion. By actively engaging in decision-making, managers guided the committee toward meaningful assignments. The manager also facilitated voting on assignments. Rather than one worker or just the manager making decisions, the manager administering a vote led to a shared decision.

Engaging with assignments often meant that managers took on assignments themselves. Though coaches encouraged workers to take on any work between meetings, many assignments involved tasks that only managers could do or that only managers could do successfully (**Table 6**). Consider the assignment of facilitating offline conversations with another department. With one issue, the worker co-leader attempted emailing another department’s manager multiple times, always cc’ing her manager. This assignment was only successful when her manager responded and requested a quick meeting between the three of them.

----------Insert Table 6 about here----------

Successful case: Hillside’s issue of “wet signatures”

Hillside, a rural family health hospital, received many patient forms that were external to the hospital system. Patients brought in worker’s comp forms or field trip papers that required a physician’s “wet signature,” or a signature on a physical paper. Hillside guaranteed that the patient’s form would get a wet signature within 14 days. However, there were many instances when the form was not ready or even lost. One medical assistant said she found a form in a physician’s office dated several years prior. In the first committee meeting, workers insisted that this was the most frustrating issue.

Following that first meeting, the manager prioritized the issue by communicating the

project in staff meetings and by beginning committee meetings by asking about the missing wet signatures issue. In a private conversation with me, the manager stated that this issue, while important for patient care, was not the most important one for her. This was not a metric that the hospital tracked. She was surprised it was so important for her staff, but she was happy that the committee uncovered this worker-priority. On top of public endorsement, the manager was a strong advocate for meeting attendance. Before meetings she walked around the clinic to remind staff about the meeting. At the start of the meetings, she announced on the speaker system that the meeting was starting.

Two months after changes had been implemented, the manager and the union representative discussed the waning attendance of front desk admin. The union representative noted that the front desk admin felt like the changes were not working and resented the committee's focus on other issues. The manager requested that the union representative encourage one of the admins to attend the next meeting so this issue could be raised to the rest of the committee. In the next meeting, the committee agreed to relaunch the wet signatures project. By prioritizing the workers' issue, this manager proactively upheld their right to set departmental agendas.

As for centering the dialogue, the manager encouraged all committee members to speak up because this issue involved every role and every work pod in Hillside. In the early stages of the project, the manager facilitated conversations such that the committee could create a diagram of their "ideal process." Committee members also told different stories about delayed or missing forms, examples of process breakdowns that the manager called "undesirable diagnostic events" (UDEs). The manager included these UDEs on the diagram in bright pink and encouraged the committee to identify different process changes for each UDE. Over several months committee

members and their colleagues tested different solutions to reach this ideal process and brought anecdotes about failed solutions back to committee meetings. The manager encouraged discussion about failed tests so the committee could continue learning and eventually resolve this issue. This iterative process proved important months later, after the manager and union representative noticed the waning attendance of front desk admin. In a meeting, one front desk admin revealed that few Hillside workers followed the new process and the front desk admins bore the brunt of patient displays of anger. By centering the diagnostic dialogue, this manager actively upheld their right to voice ongoing concerns related to this issue.

In meetings, the committee also had to assign the next steps. With root causes related to routines and accountability, the committee made many decisions about task assignments. Given the delicacy around accountability, the manager took on many of these assignments, like redefining job responsibilities, having one-on-one conversations, and reviewing process changes in staff meetings. Beyond taking on assignments, the manager played an important role in guiding the committee's decision-making regarding an accountability root cause. After the project's renewal with front desk admin attendance, committee members complained that one worker explicitly refused to follow the new process. This was particularly challenging given that this worker was the lead of her work pod. The manager recommended making a specific "forms lead" for that work pod. She encouraged workers to make other suggestions or to raise concerns about this role. After discussion, the committee agreed this was an appropriate assignment.

My analysis suggested that the empowerment crafting process, involving all three moves, was necessary for the workers' issue to reach resolution in this case, and in others I analyzed. The manager played an active role in maintaining attention on the issue. Rather than responding to just one worker's complaint or idea, she ensured that multiple committee members identified

root causes and that the committee assigned tasks that addressed these root causes. Workers retained the right to set the department's agenda to include the wet signatures issue, the right to voice about prior or ongoing process breakdowns, and the right to make decisions that influenced work processes and responsibilities.

Conditions for change: the manager's history with the issue

While most committees affected change on at least one issue, managers varied in the moves they made across issues and that variation predicted which issues were addressed via changes. Importantly, even managers who successfully made all three moves for one issue did not make these moves for all worker-raised issues. The conditions that facilitated change hinged on the manager's history with the specific issue at hand. When a manager's physical proximity to the issue aligned with their active engagement, they were inclined to take decisive action in support of workers' influence. In contrast, when a manager remained physically distant from the issue, they encouraged workers to independently resolve concerns. Additionally, instances where a manager previously grappled with an issue and found resolution elusive bred a sense of futility, which deterred them from initiating change and inadvertently conveyed this apprehension to their workers.

One issue – delayed lab orders – illuminated these conditions because three different committees recognized this as an issue, but only one committee's manager enacted all three moves, leading to change. Workers across these three different committees described the lab order process frustrating and stressful. When patients showed up for a lab appointment, the lab order were frequently missing or incorrect. Other times, a patient showed up for a regular visit, which required the patient to have labs administered before the visit, but the patient did not get their labs. Patients displayed anger or chastised workers when they had to wait for the correct

order or reschedule the appointment. In all three committees, workers and managers diagnosed the issue as related to routines and accountability.

In the case of the committee that addressed this issue, the manager effectively executed all three steps: prioritizing, centering, and engaging. In this case, the manager made sure staff knew about the project on an ongoing basis and encouraged broad attendance of the committee meetings. As it pertains to the diagnostic dialogue, in the first meeting where this issue was on the agenda, one worker brought in her own list of seven process breakdowns and her seven respective suggestions for improvements. The manager asked the worker to hold off on disseminating the document so that the entire committee could explain their perspectives, rather than letting one dominate and frame the entire discussion. This action, which could look like silencing a worker, was important for facilitating a diagnostic dialogue. The committee identified multiple root causes (unclear expectations, missing information, higher-status practices, lateral-role practices) and addressed these through multiple assignments across several roles (front desk admin, medical assistants, nurses, physicians, and the manager) that agreed to act. The worker with her own list was still able to present her diagnoses and suggestions, but not to the detriment of a dialogue with multiple contributions.

For the second department, the manager only prioritized the issue. When workers initially raised the delayed lab orders issue, the manager publicly endorsed this as a project for the committee to address. She also encouraged staff to attend the committee meeting, which she set at a time on their slowest day. However, the manager rarely attended the committee meetings, encouraging her personal care assistant to run the meetings and keep track of progress. Without the manager present, workers only complained about the issue and struggled to identify next steps. Over time, these meetings became a time and place to complain about the program itself as

they did not see progress on this issue. While at times they identified assignments that the manager could help with, they waited for the manager to attend meetings so they could all agree on the next step. “I just want some support,” the personal care assistant would say. Without the manager in attendance over several months, the workers stopped discussing the issue.

This manager oversaw multiple departments and spent little time on the frontlines of this committee’s department. Workers joked that other departments could not function as well as theirs and playfully expressed surprise when they saw the manager show up. Because of the manager’s physical distance from the action of the lab orders breakdown, she saw the issue as “their thing.” In a meeting with the coach, manager, and two frontline workers in attendance, the coach asked how they felt about co-leading the committee.

> Manager: With [the personal care assistant] being the lead, that will also get buy-in from staff. She is talking more with people about [the program]. We are trying to import what people are saying. It’s been really helpful to get people to chime in with [the personal care assistant’s] lead.
> Coach: I want it to be clear that both of you are involved, not just [the personal care assistant]. I’ll [say co-leadership is] a squishy maybe.

Even with ongoing encouragement from the coach, the manager believed process improvement was in the hands of the staff.

In the third department, the manager did not make any of the necessary moves for change. Even though workers expressed that the lab orders issue was the most important, the manager included other topics on the meeting’s agenda and avoided public discussion. When the coach tried to encourage a discussion about delayed lab orders, the manager had a disdainful facial expression and made sarcastic comments about the lab. She also withheld posting about the issue on the committee’s project board. She was proud of the committee and invested in a physical board that she strategically placed near the break area. She posted about other projects, but not delayed lab orders. Also, though she regularly attended meetings, she had to miss one and the

coach again encouraged workers to discuss the issue:

> Coach: Does this seem like something you'd want the [committee] to work on?
> Worker co-leader: Well, I'll have to talk to [the manager] about it. [She] would tell you herself we've been banging our heads against a brick wall with this one.
> Coach: Some [committees] have approached this issue with some success, like with cheat sheets or—
> Co-leader: Well, we did that […]
> Coach: What can we do in the next month to learn about this?
> Co-leader: Have people double check their work [they all laugh…]
> Coach: Make a list of the most common wrong orders. I'm assigning that to you, [co-leader], and maybe we can look at that next month.

In the next several meetings, the issue did not make it back on the agenda. Months later, the coach facilitated a brainstorming session to get more issues raised. The issue re-emerged, but the manager diverted attention to another.

This manager had tried to fix the lab orders process in the past but failed. For this reason, the issue was a particularly sensitive issue for the manager. This became evident during a conversation about the system-wide employee engagement survey. She and I reviewed employee feedback about her and at one point she started to cry. Despite receiving higher scores than the average manager, she focused on the only negative comment a worker wrote in the free-response section. It just said "communication." The manager immediately noted that she could guess who wrote this down and she knew it was about delayed lab orders. Even if she misinterpreted the comment, her reaction highlighted how difficult it was to approach the issue of lab orders.

These matched cases illuminated that variation in change depended on the intersection of these two dimensions: manager's physical proximity and a manager's prior failures with the issue. When a manager was physically close to the issue, they had a sense of responsibility to be involved in change. When a manager had not failed at solving the issue in the past, they likely did not have discomfort related to addressing the issue. These conditions made it possible for a manager to play an active role in the change process, effectively crafting empowerment for

workers and upholding their new organizational rights.

Discussion and conclusion

This chapter explores how and when an empowerment program can enable workers to exercise power. By tracking how change occurred across emotionally-fraught issues, I developed a model of crafting empowerment, suggesting that an organization cannot merely give workers the tools for power, but rather higher-status actors must help workers leverage opportunities to have influence over change. All workers had access to the same program and the same problem-solving training as well as support from a union representative, empowerment coach, and a receptive manager. Yet only when a manager had a specific history with the specific issue did they take the necessary actions to uphold worker influence. By examining formal programming and the process of encouraging multiple workers to influence change, I discovered that these policies could empower managers to coordinate problem-solving by amplifying workers' priorities, narratives, and suggestions.

Future research on empowerment programs can explore their efficacy across different contexts, like organizations, program types, and the composition of participants (Lee & Edmondson 2017). Complementary factors like labor-management partnerships are rare, as are large investments in process improvement training, but, absent these factors, could trusting and supportive frontline relations play a sufficient role? Programs vary in myriad ways, including the rights extended, the types of issues workers raise (e.g., corporation-wide strategies vs. department-level performance), or the types of participants. For example, employee resource groups encourage underrepresented groups to engage on issues like diversity and inclusion. Given the significant role of higher-status actors like managers in my findings, scholars can explore whether proactive involvement of those from more privileged groups enables or

constrains diversity and inclusion initiatives.

This chapter makes multiple contributions to our understanding of worker empowerment and upward influence. First, prior studies suggest that under certain conditions – supportive organizational structures and receptive frontline managers – workers can influence change. However, even with these conditions, I find variation in the program's efficacy. My findings suggest that, in addition to these conditions, the manager's history with an issue plays a key role in worker empowerment. Prior studies suggest that managers are either defensive or receptive to workers raising issues (Fast, Burris & Bartel, 2014). Instead, I find that a manager's attitude toward voice is context dependent. With prior failure, managers can experience their own futility; even competent, generally supportive managers can divert attention from a concern that they share with workers when they have previously tried to solve that issue and failed. Additionally, managers distant from the frontlines can absolve themselves from taking specific steps to address certain issues, overlooking their own connection to any root causes. One critical intervention of this research is to explore the context-contingent process of redistributing power (i.e., of actively shifting agendas and solution-seeking to reflect workers' priorities), rather than categorizing managers or other organizational members as open to voice, or not.

Additionally, I explored empowerment as a process, rather than just a program, illuminating mechanisms and frontline outcomes. Workers needed managerial support to claim their power, so frontline managers must proactively craft what happens within an empowerment program. This research contributes a process-oriented model of empowerment that bridges the oft-siloed research streams related to voice and organizational change (Morrison, 2011; 2023; Budd, Gollan & Wilkinson, 2010; Detert et al., 2013; Mowbray, Wilkinson & Tse, 2014; Wilkinson, Barry, & Morrison, 2020).

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Figures and tables

TABLE 1. Variation in rights by program type

	Rights loaned by program		
Program type	**Agenda**	**Voice**	**Decision**
Sanctioned groups	**Narrow**	**Broad**	**Collaborated**
Grievance procedures	**Narrow**	**Broad**	**Mediated**
Non-routine listening	**Narrow**	**Broad**	No
Idea collection	No	**Broad**	No

TABLE 2. Observed departments with empowerment committees

	North Clinic	South Clinic	Hillside	Seaside	North Wings	South Wings	Office 1	Office 2
Type	Outpatient	Outpatient	Outpatient	Outpatient	Inpatient	Inpatient	Non-clinical	Non-clinical
Location	Medical school	Other campus	Rural area	Rural area	Medical school	Other campus	Medical school	Remote work
Staff count	*x*	*x*	*5x*	*5x*	*> 5x*	*> 5x*	*x*	*2x*

TABLE 3. Issue types, respective root causes, and counts of change

	Insufficient Tools	Training	Internal processes	External coordination	Job intensity	Disrespect	TOTALS
Issue count	**2**	**4**	**8**	**7**	**3**	**4**	**28 issues**
Issues w/ change outcome	**2**	**4**	**5**	**5**	**1**	**2**	**19 issues**
Root causes (counts by issue type)							
Routines	**2**	**4**	**8**	**7**	**3**	**4**	**28 issues**
Unclear expectations	*2*	*2*	*2*	*5*	*2*	*4*	*17*
Missing information		*3*	*7*	*4*	*1*		*15*
EHR default settings		*2*	*6*	*3*			*11*
Insufficient resources	**2**		**1**	**2**			**5 issues**
Accountability			**8**	**2**	**3**	**4**	**17 issues**
Higher-status practices			*6*	*2*	*1*	*3*	*12*
Lateral-role practices			*4*		*2*	*1*	*7*
Individual practices			*5*	*1*			*6*
Personnel			**1**	**2**	**3**	**4**	**10 issues**
Short staffing			*1*	*2*	*3*	*3*	*9*
Rude behavior						*4*	*4*
Cross-dept processes				**7**			**7 issues**

TABLE 4. Variation in change by department

	Change Ratio	
Department	**All Issues**	**Issues** excl. Insufficient Tools and Training
North Clinic	*0/3*	*0/3*
South Clinic	*0/1*	*0/1*
Hillside Hospital	*5/6*	*5/6*
Seaside Hospital	*3/4*	*2/3*
North Inpatient Wings	*3/5*	*2/4*
South Inpatient Wings	*4/4*	*3/3*
Admin Office 1	*4/4*	*1/1*
Admin Office 2	*0/1*	*0/1*

TABLE 5. Issues grouped by type with the manager's moves and history with the issue

		Manager's moves			Manager's history w/ issue	
Issue	**Change**	**Prioritizing**	**Centering**	**Engaging**	**Prior failure**	**Physical distance**
Insufficient Tools 1	Yes	Yes	Yes	Yes		
Insufficient Tools 2	Yes	Yes	Yes	Yes		
Training 1	Yes	Yes	Yes	Yes		
Training 2	Yes	Yes	Yes	Yes		
Training 3	Yes	Yes	Yes	Yes		
Training 4	Yes	Yes	Yes	Yes		
Internal processes 1	Yes	Yes	Yes	Yes		
Internal processes 2	Yes	Yes	Yes	Yes		
Internal processes 3	Yes	Yes	Yes	Yes		
Internal processes 4	Yes	Yes	Yes	Yes		
Internal processes 5	Yes	Yes	Yes	Yes		
Internal processes 6		Yes		Yes		Yes
Internal processes 7		Yes				Yes
Internal processes 8					Yes	
External coordination 1	Yes	Yes	Yes	Yes		
External coordination 2	Yes	Yes	Yes	Yes		
External coordination 3	Yes	Yes	Yes	Yes		
External coordination 4	Yes	Yes	Yes	Yes		
External coordination 5	Yes	Yes	Yes	Yes		
External coordination 6		Yes				Yes
External coordination 7						Yes
Job intensity 1	Yes	Yes	Yes	Yes		
Job intensity 2					Yes	
Job intensity 3		Yes	Yes		Yes	
Disrespect 1	Yes	Yes	Yes	Yes		
Disrespect 2	Yes	Yes	Yes	Yes		
Disrespect 3						Yes
Disrespect 4		Yes			Yes	

TABLE 6. Root causes, respective task assignments, and task takers

Root cause	Task Assignment	For Whom
Routines		
Unclear expectations	Communicating defined responsibilities	Managers, workers
	Producing a physical document for the frontlines	Managers, workers
	Approving new standards	Managers
	Running surveys on preferences or expectations	Managers
	Shadowing	Workers
	Scheduling coverage when shadowing	Managers
Missing information	Informational conversations/surveys	Managers, workers
	Adding information on existing documents	Managers, workers
	Approving new standards	Managers
EHR default settings	Communicating with IS	Managers, workers
	Developing a dotphrase	Managers, workers
	Producing cheat sheets	Managers, workers
Accountability		
Higher-status practices	Discussing in staff meetings	Managers
	Surveying higher-status employees	Managers
	Documenting process delays	Workers
Lateral-roles practices	Discussing in staff meetings	Managers
	Surveying employees	Managers
	Documenting process delays	Workers
Individual practices	One-on-one meeting	Managers
	Redefining responsibilities	Managers
Personnel		
Understaffed	Taking on frontline scut work	Managers
	Shifting coverage/responsibilities	Managers
Rude behavior	One-on-one meeting	Managers
	Surveying workers	Managers
Insufficient resources	Obtaining equipment	Managers
Cross-department	Inviting external departments	Managers
	Facilitating offline conversations	Managers, workers
	Escalating to senior leaders	Managers
	Documenting shared standards	Managers, workers
	Documenting process delays	Workers

CHAPTER 5: CONCLUDING COMMENTS

This chapter briefly summarizes the contributions of the dissertation and the implications for the field of industrial relations. I focus on the field of industrial relations given its rich tradition of examining worker empowerment and high-involvement work systems.

As workers in the US continue to seek more influence over workplace decisions, it is more important than ever to understand how they can effectively exercise power and achieve their desired changes. This dissertation, which focused on a hospital system's empowerment program complemented by human resource practices, demonstrates the importance of strategic interactions on the frontlines, which legitimate and coordinate worker-informed change. At Coastal Care, frontline managers made critical moves that led to addressing worker issues, effectively closing the voice gap. Program scaffolding and manager-led crafting ensured that workers were able to continuously participate in the program and inform frontline changes.

Industrial relations scholars recognize that frontline managers can play a role in the employment relationship but have yet to identify how and to what effect. My findings demonstrate how managers can enact employment relations practices in workplaces through scaffolding and crafting, moving beyond formal policies alone. Given industrial relations' emphasis on structures determining organizational activities, interests, and outcomes, my findings raise questions for the field.

Are employment relations merely a byproduct of a firm's environment? Industrial relations scholars assert that organizational and employment outcomes are determined by labor's and management's strategic responses to external factors like market dynamics. For example, these scholars note that frontline managers did not introduce quality of working life (QWL) programs until the late 1970s and early 1980s when staying competitive in the global markets

was becoming more dependent on product quality. Managers relied on QWL to involve skilled workers more in product-related decisions (Kochan, Katz and McKersie, 1986). However, I challenge this model by identifying the role of frontline interactions in shaping how members of the organization justify and implement the program. Managers at Coastal Care not only described worker involvement as a means to improvements, as one would expect given the focus on quality care in US healthcare, but also as a meaningful outcome unto itself. Implementing the program demonstrated respect for workers, a value unrelated to external forces. There is fertile ground for deeper understanding of how internal dynamics like frontline interactions can shape strategic choices.

The pluralist tradition of industrial relations characterizes workers' and management's interests as depending on the actor's relation to production. At times these interests can conflict and overlap. However, within-manager variation in crafting empowerment problematizes how scholars can understand an actor's interests. Is it not in a manager's interest to engage knowledgeable and motivated workers in addressing a process breakdown like delayed lab orders? Doing so has the potential to improve productivity and patient satisfaction, key managerial goals at Coastal Care. Yet some managers who made specific moves, empowering workers to address an emotionally fraught issue, did not make the same moves on other issues. Their practices depended on their own experience, not always based on productivity-oriented interests. Their interest in solving certain issues was an effect of the frontline interactions, not the other way around. This presents an opportunity to further explore how various actors come to understand their interests and to what effect, rather than assuming they are entirely determined by one's relation to production outcomes.

Additionally, how can scholars incorporate managers' and workers' experiences into their normative analyses of employment practices? Industrial relations scholars evaluate practices based on how they balance efficiency, equity, and voice (Budd 2004), but whose criteria are they using to assess these outcomes? At an abstract level, one might describe Coastal Care's empowerment program as an exemplar of employment relations because it is in the spirit of improved performance, respectful treatment of workers, and direct participation in decision-making; the dissertation finding of three justifications for the program at Coastal Care might even suggest the same. Yet, even in departments with receptive managers, I found variation in how workers and managers assessed the program along these dimensions. At times, workers felt their voices were not heard. Managers occasionally noted disrespectful behavior in meetings. This variation raises questions on how to appropriately evaluate the ethics of certain practices and bring in interpretations from research subjects.

These new questions for industrial relations highlight the value of this dissertation's data and methodology. Common data for industrial relations research are administrative data, survey data, semi-structured interviews, and comparative case studies. Instead, I collected multiple types of qualitative data – observations, informal interviews, and archiving documents – which I analyzed abductively to understand how different members of the organization interpret the program and whether it fits with their idea of a good workplace. Experiencing the everyday place of work with workers and their managers, I found many instances that challenge key assumptions of industrial relations – deterministic external factors, production-related interests, and the ethics of empowerment –suggesting that scholars can revitalize the field by revisiting long-standing assumptions with dialogue across inductive and deductive methods.

While this dissertation raises new questions, it does not provide a universal model for industrial relations. The research design has limitations. Specifically, the analysis is focused on one hospital system, one empowerment program, and a subset of departments. Limiting this research to one hospital system, I cannot explain variation across different organizations, industries, political environments, or economic conditions. Shifts in organizational leadership, strategy, and design could impact the efficacy of an empowerment program. Limiting this research to one empowerment program, rather than the work system, I cannot understand whether the program is systematically integrated. Some scholars might say I only focused on the frontline work environment, rather than all "levels" of the employment relationship (Kochan, Katz & McKersie, 1986; Piore & Safford 2006). While I observed many instances of committee projects informing other initiatives and vice versa, it remains an open question whether new programs are incorporated into organization-level strategy, decision-making, and outcomes. Finally, by focusing on a subset of departments, I cannot explore any risks involved with diffusing and sustaining this program across the entire organization. My selection strategy was to focus on favorable departments so I could identify any variation under existing explanatory conditions. Whether this program is institutionalized depends on how other parts of the organization respond to the program design and any frontline successes attributed to various program committees. Importantly, I encourage future research that addresses these questions by using multiple methods so that inductive and deductive analysis can inform a richer understanding of employment practices.

Holistically, this dissertation analyzes how empowerment programs within organizations can effectively close workers' voice gap, or the difference between workers' desired and actual influence over organizational decision-making. By drawing on a 17-month field study of a

hospital system's empowerment program, I identified interactional and cultural processes that guide how members of the organization justify, sustain, and ultimately achieve worker empowerment. By revisiting classic industrial relations questions with underutilized methods, I raise new questions that encourage future scholars to guide their theory building with the interpretations and experiences of workers and managers.

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