How commitment and involvement influence the development of strategic consensus in health care organizations: the multidisciplinary approach

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Aim The aim of this study was to describe how clinician and non-clinician managers achieved consensus of strategy in hospitals. This was the first empirical study undertaken that investigated the impact of organizational commitment on the strategic involvement–strategic consensus relationship.

Background Clinicians and non-clinician managers hold a pivotal role in health care management from the strategic perspective. The importance of multidisciplinary collaboration is recognized, yet how strategic consensus is achieved amongst health service managers, has not been previously researched.

Key issues The focus of the professional is often on local concerns rather on the broader organizational strategy. This orientation has led to the charge by health service management that clinicians are not interested in, or do not seek to be involved in strategy development. As half of the clinician group in this study were registered nurses and midwives it is important, for multidisciplinary and interdisciplinary collaboration and for strategic development that this group has an awareness of the importance of strategic involvement and organizational commitment in the attainment of strategic consensus.

Conclusion A descriptive study was undertaken and quantitative data were generated through the survey method. The aims of the study were articulated through hypotheses. Almost 400 middle manager heads of department, working in acute care not-for-profit health service organizations, in the Republic of Ireland, responded. Findings indicated that a stronger relationship existed between consensus and commitment than between involvement and commitment. In addition, when present in the organization, involvement and commitment together were better predictors of consensus than each of those factors on its own, but significantly commitment had a greater impact in predicting consensus than involvement had.

Keywords: clinicians, commitment, consensus, involvement, non-clinicians, nurses

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Literature review
The role of the clinician or non-clinician head of department is a key role in health service delivery (Carney 2004a). Currie (1999) identifies the positive influence of middle managers in the business planning process. Harrison and Miller (1999) argue that clinicians, including nurse managers, are embracing new
roles that are strategic, but that there is no agreement yet in relation to the requirement for clinicians at head of department or clinical directorate level to be involved in strategic development. Still, there appears to be an assumption that these roles are of strategic importance (Cowling & Newman 1994, Dawson et al. 1995). Clinicians are now being faced with complex and competing pressures (Dopson 1996, Schein 1997, Drenkard & Cohen 2004). Management of these pressures requires a greater level of strategic involvement than was required in the past (Drucker 1988, Wells 1999, Carney 2004b,c).

The importance of strategy making is noted in the literature. Floyd and Wooldridge (1992b) found that few middle managers articulate the same goals of superiors, and that those who disagree with strategic initiatives block the implementation of strategy. Dopson et al. (1992), in their study of the changing role of the middle manager in Britain found resistance to change by middle managers in public sector organizations, such as the National Health Service (NHS), and related this to their distinctive sense of professional identity. Professional clinicians seek to control their own work to their own standards (Freidson 1976), while at the same time resisting taking instruction from their administrative superiors who are asserting the aims of the employing organization (Ong 1998). It is recognized in the current health care structure that there is a potential for redistribution of power within organizations and a resultant shift in power and control from the clinician towards the managerial components (Shortell et al. 1988, Carney 2006c). Professional clinicians can influence the management of the organization by having an impact on the policy formulation process if permitted (Carney 2004a, 2005), and should be involved in exercising an upward influence through strategic planning and formulation of strategy (Floyd & Wooldridge 1996, 1997, Dutton et al. 1997, Currie & Proctor 2005, Rouleau 2005). Strategic planning is an on-going decision-making process, the purpose of which is to specify the ideals, goals and objectives required by the organization in the future.

Dess (1987) demonstrates that strategic consensus is achieved through the sharing of strategic information and through direct exposure to strategic priorities. Health service organizations are staffed by a combination of clinicians and non-clinicians, therefore of importance to professionals is the manner in which strategic consensus is achieved. Nurses, who form the largest group of health service clinicians, have attracted considerable management attention during the past decade and have developed their own ways of reinterpretting management's intentions (Carney 2002, Bolton 2004). Of importance is the service to society that the members of a profession provide, and the public acceptance that follows this service (Miller et al. 1993), a perception based upon a sense of 'professional excellence' (Bowen & Ford 2002, Douglas and Ryman 2003). Consequently, the focus of the professional is often on local concerns rather than the broader organizational strategy (Mintzberg & Quinn 1992, Harrison & Miller 1999). This orientation has led to the charge by health service management that clinicians are not interested in, or do not seek to be involved in strategy development (Wells 1995a, Carney 2004a,b). Furthermore, the non-clinician manager provides some services that have a long-term focus such as financial or capital management that are often perceived to be at variance with those services provided by clinicians that have a short-term focus, thus resulting in conflicting interpretations regarding each other’s roles (Fitzgerald 1996, Exworthy & Halford 1999, Carney 2004b). Even though clinician managers are also concerned with those areas, their focus is on the immediate nature of health care delivery. Bolton (2004) in a longitudinal study carried out in a large NHS Trust hospital in Britain, which charted the changes that occurred in the nursing work process over the 6-year period to 2000 argues that the control of health care professional work is now firmly in the hands of hospital management. Therefore, reaching an understanding of each other’s role in achieving consensus on organizational strategy is an important goal for clinicians and non-clinicians (Carney 2004c).

Authors have highlighted the importance of consensus in strategic decision-making, and of strategy development as a consensus-building process (Nielsen 1981, Hrebinia & Joyce 1984). There is a lack of empirical research relating to the extent of senior management strategic consensus (Dess & Origer 1987), and little evidence to suggest that this differs with middle management. In an individual capacity strategic consensus is defined ‘as agreement amongst top, middle and operating level managers on the fundamental priorities of the organization’ (Floyd & Wooldridge 1992b: 28). Wooldridge and Floyd (1990) define consensus ‘as the product of middle management commitment to, and understanding of, strategy’ (p. 235), resulting in the combination of collective heart and mind in managers who are acting in consort with a common set of strategic priorities. Dess (1987), in his study on consensus in strategy formulation undertaken in American hospitals, found that strategic consensus is achieved through the sharing of strategic information and through direct
exposure to strategic priorities, and also that the relevance of involvement in strategy formulation to the achievement of consensus is not well understood (Dess & Origer 1987, Floyd & Wooldridge 1992b). Carney (2002) found that strategic consensus occurs when managers are involved in, and are committed to strategy development and when the organizations culture and structure are favourable. However, it is also recognized that strategic consensus may not always occur due to the fast moving pace of organizational change (Collins 1998), presence of multiple cultures (Thorne 2000, Carney 2006c) and the fact that organizations are often the sites of multiple and converging forms of conflict in relation to how the organization should be managed (Willmott 1987) and how patient services should be delivered (Carney 2006c). In a research study related to 50 000 responses made to the authors’ website (http://www.orgdna.com). Neilson et al. (2005) write of the passive-aggressive organizations that suffer from a ‘cluster of pathologies’ (p. 83) whereby employees work at ‘cross-purposes’ to one another in a seemingly congenial atmosphere where consensus of strategy appears to have been achieved, yet these agreed-upon plans and strategies are not implemented as employees are paying lip-service and putting in just enough effort to appear compliant.

The role of commitment in the achievement of strategic consensus is not known. The concept of organizational commitment is complex and encompasses many dimensions. Corser (1998) asserts that commitment is employees’ encompassing a complex sense of loyalty that involves a strong belief in the goals of the organization and congruence with the value system of the organization. Carney (2006b) identified commitment as a willingness to serve the organization through continued membership. Commitment to the organization influences individual levels of commitment in various ways (Randall and Cote 1991, Cote 1991, Cohen 1993, 2000), and it could therefore be argued that employee commitment and, by extension, middle manager commitment to the organization implies commitment to key organizational strategies.

The psychological approach to organizational commitment is defined as employees having a psychological identification with the goals and beliefs of the organization, and a willingness to concentrate efforts towards helping the organization to achieve its goals (Porter et al. 1974, Mowday 1978, Mowday et al. 1979). This process results in identification with the organization’s objectives to the extent that individual and organizational goals are closely aligned (Guth & Macmillan 1986). Research conducted by Porter et al. (1974) was based on a series of studies involving 2563 employees working in nine divergent organizations. Commitment is portrayed as the internalization of the values of the organization, i.e. a willingness to concentrate efforts towards helping the organization to achieve its goals and a desire to remain as a member of the organization. Carney (2002) identified that even when professional and organizational commitment is at variance and resulting in conflict, commitment predicted strategic involvement. Mowday et al. (1979) noted that this represents more than passive loyalty to the organization and that this loyalty develops over a period of time and remains stable over time. An extension of this thinking is the commitment model that incorporates high commitment, high involvement and high performance (Lawler et al. 1995, Porter O’Grady & Malloch 2002).

Organizational factors play a major role in affecting the behaviour and attitudes of employees (Cohen 1993, Taylor et al. 1996). Organizational systems and structures that align organizational goals with those of the middle manager will build commitment into strategy (Floyd & Wooldridge 1992a), and for this to occur, middle managers must commit to and understand strategy (Wooldridge & Floyd 1990). A number of authors classify commitment as an attitudinal or behavioural concept (Bateman & Strasser 1984, Putti et al. 1990) that results in positive behavioural benefits to the organization in terms of commitment. Ogilvie (1986) says this is an all-encompassing attitude that results from a sense of support, and acknowledgement of one’s efforts on behalf of the organization. Strategic commitment by middle managers is not evident in the literature, apart from reference to this form of commitment by Floyd and Wooldridge (1992a). In their case study research, undertaken in manufacturing and financial sector industries, Floyd and Wooldridge (1992a) found that poor implementation of strategy resulted from poor middle management understanding and commitment to organizational strategy. Guth and Macmillan’s (1986) study, which involved examining 330 written reports, found that middle managers were motivated more by perceived self-interest than by organizational interest, and stated that organizational and middle manager objectives should be aligned in order to achieve commitment to strategy implementation. It may be assumed that strategic policy will positively influence organizational commitment (Putti et al. 1990).

Summary of study design

The aim of the study was to explore the extent to which a relationship exists between strategic involvement and
strategic consensus and to determine the influence of organizational commitment on this relationship. A descriptive study was used to achieve the study aims. Quantitative data were generated through a questionnaire.

Sample
A total frame of 860 clinicians and non-clinicians, working in positions as head of department, in 60 of the 65 acute care not-for-profit hospitals in the Republic of Ireland, was used.

Data collection
The total population was surveyed via a questionnaire. Ethical principles relating to confidentiality and anonymity were followed. The overall response rate was 50%; however, due to non-completion for various reasons, the valid response rate was 42% (n = 352), comprising 66% (n = 234) professional clinicians and 34% (n = 118) non-clinicians. Of the 66% professional clinician respondents, just over 50% (n = 120) were nurse or midwife managers. Data analysis commenced in September 2001 and was completed in May 2002.

Research instrument: survey scales
A four-part self-reported data questionnaire was designed to measure the two hypotheses posed. Two new measurement scales (Organisational Consensus and Biographical) and two existing scales (Organisational Commitment and Strategic Involvement) were used. Apart from the Biographical scale, each item in each of the other three scales was scored on a 5-point scale, ranging from 0 (strongly disagree) to 5 (strongly agree). Cronbach’s alpha, supporting the scales’ internal consistency and content validity are, for Strategic Consensus = 0.96, Organisational Commitment = 0.93 and Strategic Involvement = 0.90 (Table 1).

New Instruments: Strategic Consensus Scale development
The 20-item ‘Strategic Consensus’ Scale was used to measure strategic consensus. The scale was adapted, in format only, from Floyd and Wooldridge’s (1996) ‘The Strategic Consensus Questionnaire’ (Resource A) that was based on Porter’s 1980 theory of competitive strategy (Porter 1996). ‘The Strategic Consensus Questionnaire’ was designed by Floyd and Wooldridge (1996) to assess the relative importance of reducing costs and increasing differentiation in the organization’s competitive strategy. These areas were not the focus of the present study; therefore a scale related to 5-key strategic areas: strategic planning, operational, financial, new initiatives and human resource management, identified from strategic management literature, was designed to measure strategic consensus. Scale items related to focusing staff on meeting organizational goals and reaching agreement on strategy in these five strategic areas. Items also related to the reaching of consensus in decision-making on service delivery and to the 5-key strategic areas. The mean value for strategic consensus was 3.98.

The Biographical scale was developed by the author to measure respondent data. This scale included biographical and demographic data.

Research instrument: existing survey scales – Strategic Involvement and Organisational Commitment Scales
The 20-item Likert-type instrument scale devised by Floyd and Wooldridge (1996), and distributed to 259 middle managers in 25 mainly for-profit organizations, was used to explore if middle managers perceived that they were involved in the development of strategy in their organizations. Items on this scale addressed a number of factors, including the frequency with which middle managers perceived that they were involved in operational and human resource planning, evaluated the merits of new operational proposals generated in the department, translated the organizational goals into objectives for other staff and evaluated the merits of new proposals concerning budgetary management. Additionally, items addressed communication of information to higher-level managers, searching for new opportunities and bringing them to the attention of higher-level managers, communicating and selling top-management initiatives to subordinates and encouraging multidisciplinary problem-solving teams. On the
0–5 response scale, the mean value for Strategic Involvement was 3.35 (Table 2).

The 15-item ‘Organisational Commitment’ Scale was used to measure organizational commitment. The scale items assessed respondents’ willingness to help the organization be successful, loyalty to and pride in the organization, desire to remain with the organization and similarity of personal and organizational values. Following a review of the relevant literature, the researcher decided to use an unabridged version of the ‘Organisational Commitment’ Questionnaire (OCQ; Mowday et al. 1979). The OCQ was based on a series of studies, carried out by Mowday et al. (1979), involving 2563 employees in nine divergent organizations. This 15-item scale was considered to be the most suitable instrument to measure organizational commitment in the context of this study. Analysis undertaken to measure reliability was thus performed on the individual items of the scale supported alpha 0.8798 (N = 306, number of items = 15), supporting the measurement scales’ internal consistency (Cronbach 1951). Convergent validity for this measure of organizational commitment was assumed due to the fact that a wide range of studies (approximately 352) utilized the OCQ measurement instrument in the past 20 years (Mowday et al. 1982).

### Data analysis

All quantitative data from the study instruments were coded, entered, verified and analysed using SPSS, Version 11. Inferential analyses were undertaken. Univariate and multivariate assumptions were tested for violations, and parametric and non-parametric statistical analyses were utilized. Normality was determined through the utilization of histograms, measures of Kurtosis and the Kolmogorov–Smirnov test for normality. Hypotheses were tested using Pearson correlation coefficients to determine relationships between variables, and correlation analyses were performed on the principal measurement scales. Recoding of data was undertaken prior to regression analysis. Significance was established at the 0.05 level of probability. Statistical regression analyses models were developed in order to answer the hypotheses posed.

### Research findings

#### Sample characteristics

Just over half were in the 31–45 age group (n = 191) and only 3% were in the <30 age group. Slightly more than one-third consisted of males (n = 123) and the remainder (n = 223) females. Just over 60% were clinicians (n = 234) and 34% (n = 118) were non-clinicians. Of the professional clinician group 50% (n = 110) were nurse and midwife managers. Eight of every 10 respondents (n = 257) were educated to degree level and beyond.

The first hypothesis tested was ‘that there is a positive relationship between strategic involvement and strategic consensus’. The hypothesis was supported as findings reported that involvement accounted for 18% of the variance in consensus, indicating that involvement was making a moderate contribution to the prediction of consensus (R² = 0.179, F(7, 281) = 8.74, P = 0.000), and that the regression model was statistically significant.

The second hypothesis tested was ‘that the strength of the association between strategic involvement and strategic consensus is influenced by organizational commitment’. Statistical analyses were undertaken in three steps through multiple regression analysis. In Step 1, involvement and consensus were entered into the regression model. Findings indicated that for every unit rise in involvement, consensus increased by 0.37 of a unit (scale: 0–5, β = 0.371, P = 0.01), suggesting that involvement predicted consensus.

In Step 2, involvement and commitment were entered in combination into the regression equation with consensus. The correlation of involvement with consensus (r = 0.379, P < 0.01), and commitment with consensus was significant (r = 0.407, P < 0.01), suggesting that involvement and commitment significantly related to consensus. The regression equation of involvement and commitment with consensus was R² = 0.231, F(2, 348) = 52.20, P = 0.0005, indicating that involvement and commitment explained 23% of the variance in strategic consensus.

The correlation of commitment with consensus was also significant (r = 0.407, P < 0.01), suggesting that commitment was significantly related to consensus. For every unit rise in commitment, consensus increased by 0.46 of a unit (scale: 0–5, β = 0.461, P = 0.0001).

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**Table 2**

Mean, standard deviation and sample size: Strategic Involvement, Organisational Commitment and Strategic Consensus

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean scores ranged from 0 to 5</th>
<th>Standard deviation</th>
<th>Sample size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Involvement</td>
<td>3.35</td>
<td>0.60</td>
<td>352</td>
</tr>
<tr>
<td>Organisational Commitment</td>
<td>3.55</td>
<td>0.72</td>
<td>351</td>
</tr>
<tr>
<td>Strategic Consensus</td>
<td>3.98</td>
<td>0.82</td>
<td>352</td>
</tr>
</tbody>
</table>
The regression equation, $R^2 = 0.165$, $F(1, 349) = 69.165$, $P = 0.000$, indicated that commitment accounted for 17% of the variance in consensus.

In summary, the total regression equation demonstrated that involvement and commitment, when both were present, were better predictors of consensus than if involvement or commitment were present as single entities. The regression model further indicated that commitment ($\beta = 0.461$, $P = 0.0001$) was the variable having the greatest impact in predicting the variance in consensus followed by involvement ($\beta = 0.371$, $P = 0.0001$). When allowing for commitment, the effect of involvement on consensus was less. Commitment did affect the relationship between involvement and consensus, and when one adjusted for commitment or kept it constant, the pure effect of involvement on consensus was reduced. Commitment had a significant direct effect on consensus ($\beta = 0.461$) and therefore commitment on its own had a higher effect on consensus than commitment going through involvement.

Regression analyses indicated that commitment made a unique contribution to the prediction of consensus, and commitment and involvement in combination, were making a moderate contribution to the prediction of consensus. The hypothesis was supported as findings indicated that the regression model was statistically significant (Tables 3 and 4). The response rate was a satisfactory 42% and justification for the non-response rate from certain respondents was previously provided to the researcher. Nevertheless, the non-response rate would be important to investigate in future studies undertaken in the health service context. Additionally, measurement contamination is often a cause for concern and this factor always requires scrutiny.

### Discussion

Findings demonstrated that clinicians and non-clinicians managers achieved consensus in relation to the strategies developed in their organizations. Nine of 10 respondents ($n = 281$) agreed on the importance of focusing staff on meeting organizational goals, eight of 10 ($n = 272$) indicated that ensuring budgetary controls was important, and the same number ($n = 272$) agreed that encouraging the development of new programmes was moderately to very important. Findings support Floyd and Wooldridge (1996), in indicating that a high level of strategic awareness and consensus, allied to strategic operational knowledge, exists amongst clinician and non-clinician heads of department. Findings also support the Quality and Fairness Health Strategy (Department of Health 2001) that health care must be delivered through inter-professional partnerships and consensus, and that turf wars and old hierarchical thinking in relation to the professions must disappear, for the benefit of the patient.

Still, factors influencing strategic consensus vary. Notably, Ashmos et al. (1998) suggest that two different perspectives may be obtained through the participation of clinicians and non-clinicians in strategic matters, and that difficulties will arise in strategy development if consensus is not reached amongst senior and middle managers. Dooley and Fryxell (1999), in their study of 86 decision-making teams, undertaken in American hospitals, found that consensus building was an important factor in the strategic decision process, and that this was influenced by loyalty to the team and to the organization. Dess and Origer (1987) say that there is a requirement for the integration of strategic consensus when formulating strategy. Authors have highlighted difficulties in the achievement of strategic consensus and have suggested that as health care is delivered in a turbulent and constantly changing environment (Edwards & Hale 1999) this has resulted in less consensus on the organizations’ strategic direction.

### Table 3

<table>
<thead>
<tr>
<th>Model 2</th>
<th>Unstandardized coefficients</th>
<th>Standard error</th>
<th>Standardized coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Involvement</td>
<td>0.517</td>
<td>0.230</td>
<td>0.379</td>
</tr>
<tr>
<td>Strategic Involvement</td>
<td>0.371</td>
<td>0.068</td>
<td>0.272</td>
</tr>
<tr>
<td>Organisational Commitment</td>
<td>0.355</td>
<td>0.057</td>
<td>0.314</td>
</tr>
<tr>
<td>Organisational Commitment</td>
<td>0.461</td>
<td>0.055</td>
<td>0.407</td>
</tr>
</tbody>
</table>

**Predictors:** strategic involvement; dependent variable: strategic consensus.

**Predictors:** strategic involvement, organizational commitment; dependent variable: strategic consensus.

**Predictors:** organizational commitment; dependent variable: strategic consensus.

### Table 4

<table>
<thead>
<tr>
<th>Model</th>
<th>$R$</th>
<th>$R^2$</th>
<th>Adjusted $R^2$</th>
<th>Standard error</th>
<th>F-value</th>
<th>Sig. change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0.379</td>
<td>0.144</td>
<td>0.148</td>
<td>0.758</td>
<td>58.710</td>
<td>0.000</td>
</tr>
<tr>
<td>2</td>
<td>0.480</td>
<td>0.231</td>
<td>0.226</td>
<td>0.719</td>
<td>52.19</td>
<td>0.000</td>
</tr>
<tr>
<td>3</td>
<td>0.407</td>
<td>0.165</td>
<td>0.163</td>
<td>0.748</td>
<td>69.17</td>
<td>0.000</td>
</tr>
</tbody>
</table>

Predictors: (1) strategic involvement, (2) strategic involvement and organizational commitment, (3) organizational commitment; dependent variable: strategic consensus.
(Wells 1999). This view supports Floyd and Wooldridge (1992b) who report difficulties in managing strategic consensus in a turbulent environment, where priorities are constantly shifting.

The present study was the first empirical study to investigate the impact of organizational commitment on the strategic involvement–strategic consensus relationship. Findings indicated that a stronger relationship existed between consensus and commitment than between involvement and commitment. In addition, when present in the organization, involvement and commitment together were better predictors of consensus than each of those factors on its own, but significantly, commitment had a greater impact in predicting consensus than involvement had. These are important findings as research up to now has focused on these three areas as discrete concepts and researchers have not identified if relationships existed. The importance of the effect of organizational commitment on strategic consensus is an important area for further research and it is important to develop new ways of thinking about and measuring strategic consensus and to identify other factors that may impact on strategic consensus.

Authors have suggested that employees display feelings of loyalty, affection and belongingness (Jaros et al. 1993, Carney 2006b), and emotional attachment to the organization (Allen & Meyer 1990, Gruen et al. 2000), or that they bond with the organization (Iverson & Buttsigie 1999, Gruen et al. 2000). This personal commitment appears to lead to work commitment (Mottaz 1988, Putti et al. 1990, Carney 2006b), and to increased levels of cooperative behaviour amongst employees (Gruen et al. 2000), that would indicate that for strategic involvement to occur there should also be commitment to the organization. It is possible that the measures of organizational commitment, strategic involvement and strategic consensus used in this present study could have produced spurious interrelationships because these constructs tap the affective domain. However, Cronbach’s alpha for the measurement scales was satisfactory. Also, the relationships existing amongst the three major variables used in the study may be more complicated than regression analysis or path analyses are capable of determining. Nevertheless, the measurement scales and statistical analyses undertaken appeared to be robust, resulting in statistically significant findings.

Research has indicated that strategy is formulated by consensus building amongst senior management (Dess 1987), but also that up to 1990 research had not focused on the middle manager. Previous research has suggested that organizational commitment appeared to influence strategic involvement (Porter et al. 1974, Wood & de Menezes 1998). Guth and Macmillan (1986) aligned commitment with a sense of identification with the organizational objectives that in response led to strategic involvement in the development of strategic goals and objectives (Wooldridge & Floyd 1990). Floyd and Wooldridge (1992b) related organizational commitment to middle managers’ level of consensus in the achievement of specific organizational objectives, and argue that the strategic context in which the organization operates will influence strategic consensus. Corser (1998) links this commitment to employees’ having a high level of involvement in work-based activities that results in a sense of support and acknowledgement by top managers of their efforts on behalf of the organization (Ogilvie 1986). Willingness and goodwill result from employees perceiving that support for their ideas and well-being exists in the organization (Carney 2002, 2004b, 2005a, 2006a, 2006b). This form of support produces a reciprocal sense of obligation to support the organizational goals and united vision for the organizations’ future direction and purpose and as a result leads to organizational commitment (Eisenberger et al. 1990, Shore & Tetrick 1991), and confers benefits in terms of employees having a psychological identification with the organizational goals and beliefs (Mowday et al. 1979). Carney (2004b) also found that further justification for the influence of commitment on involvement and consensus is indicated by comments made by middle managers who expressed a willingness to put in a great deal of effort beyond that normally expected in order to help the organization be successful, to tell friends that the organization was a great place to work and that they really cared about the fate of the organization.

Findings from this study indicated that involvement and commitment together were better predictors of consensus than each of those concepts on its own, and also that commitment had a greater impact in predicting consensus than involvement had. Findings indicated that six in 10 \( (n = 214) \) demonstrated commitment by moderately strongly agreeing that they told their friends that the organization was a great place to work in and a similar number \( (n = 213) \) agreed that they were extremely glad that they had chosen to work for the organization over others they had considered at the time they joined. Seven in 10 \( (n = 249) \) were proud to tell others that they were part of the organization and slightly less \( (n = 213) \) agreed that the decision to work for their organization was a good one. As other authors have pointed out that employees bring a set of expectations to their role, and how they perceive these
expectations to have been met or exceeded will determine their commitment level to the organization (Putti et al. 1990, Morrison and Robinson 1997, Chang 1999, Carney 2004b, 2006a), these findings that respondents were positive in their attitude to the organization, are important for organizational human resources management. It is recognized that professional commitment and organizational commitment may often be at variance particularly amongst professional clinicians where commitment to the profession and commitment to the organization may conflict (Scoble 1991, Corser 1998). However, this research does not support this perspective. Rather, findings supported the importance of organizational commitment and the critical impact of commitment on the relationship between involvement and consensus. This finding has important implications for the management of not-for-profit organizations, and highlights the necessity for middle manager commitment to their organizations. It was further demonstrated that middle managers had strategic involvement and strategic consensus, and that in order to nurture, promote and grow this relationship commitment to the organization is a critical success factor. However, the dynamic nature of the health service environment may be a unique one, consequently it would be important to undertake this research in a for-profit setting, and establish if findings are similar, and also to determine if the relationships explored in this study change as a result of changing environments.

Brodwin and Bourgeois (1984) in their study of management practices, undertaken in 19 organizations, found that ‘collaborative’ and ‘cultural’ patterns served to utilize consensus building amongst the organizations’ hierarchical levels. Hewison and Stanton (2002) argue that such change is taking place and that ‘policy emphasis has shifted towards collaborative and co-operative approaches to the provision of health care’ (p. 349). However, Long (2004), in respect of nurses working in the United States, notes that more nurses must be educationally prepared as problem solvers in order to meet the management challenges of complex health care environments. In a recent research undertaken in the United States, Lopopolo et al. (2004) highlight how the administration, management and professional skills of one group of clinicians – physical therapists are not known and have put forward the ‘extensive knowledge’ components required for multi-disciplinary collaboration (p. 145). Additionally, Kupperschmidt (2004) discusses new models of health care delivery that incorporate partnership, equity and ownership. Meehan (2003) recommends trustworthy collaboration between clinicians in the delivery of patient care. It was demonstrated in this study that commitment to the organization combines positive elements that assist in the promotion of strategic consensus.

Conclusion

This study highlights the importance of heads of department achieving strategic consensus and of the strong influence of organizational commitment on the attainment of strategic consensus. Additionally, the importance of strategic involvement on this relationship was identified. Factors such as organizational goals and strategies, the environment and the strategic context in which the organization operates influence strategic consensus. Therefore, agreement amongst all categories of managers on the fundamental priorities of the organization will enhance strategic goal achievement and result in consensus on the organizational goals. Findings bode well for future health professional clinician and non-clinician manager collaboration. Nurse managers are ideally positioned to influence employee commitment to the organization and thereby to encourage strategic consensus amongst clinician and non-clinician colleagues.

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References


Carney M. (2006b) Positive and Negative outcomes from values and beliefs held by health care clinician and non-clinician managers. Journal of Advanced Nursing 54 (1), 111–120.


