1990-05-01

The Nurse Manager: An Ethnography of Hospital-Based First-Line Nurse Managers Practicing in an Expanded Role

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THE NURSE MANAGER: AN ETHNOGRAPHY OF HOSPITAL BASED FIRST-LINE NURSE MANAGERS PRACTICING IN AN EXPANDED ROLE

by

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A dissertation presented to the
FACULTY OF THE PHILIP Y. HAHN SCHOOL OF NURSING
UNIVERSITY OF SAN DIEGO

In partial fulfillment of the
requirement for the degree
DOCTOR OF NURSING SCIENCE

May 1990

Abstract

The behaviors, beliefs and values that characterize everyday practice of first-line nurse managers in their expanded role in two acute care hospitals were analyzed. Ethnographic field research techniques were used including nine months of observation and in-depth interviews with practicing nurse managers.

After reviewing historical events that shaped the role of the nurse manager, the role was then placed within the economic, social and health care context of the 1970's and 80's. Research and anecdotal descriptions of the manager role of the past twenty years were also explored.

Research was conducted in two voluntary acute care, multi-service hospitals. One manager was observed intensively for two months to develop a semi-structured open-ended interview guide. The guide was then used to conduct extensive ethnographic interviews with 16 inpatient managers. In addition, six nurse administrators were interviewed, institutional documents examined and a variety of techniques used to triangulate observations and theories that emerged and to examine issues of validity and reliability.

Managers described their role as four processes: 1) social control, establishing, monitoring and maintaining standards; 2) resourcing, the provision of emotional support, goods and services; 3) translating/ interpreting/negotiating among unit-based or related constituencies; and, 4) facilitating change. Administrators concurred with the managers' descriptions emphasizing social control.

Managers described themselves as desiring control/power to make beneficial changes; being stimulated by a changing work environment and deriving satisfaction from staff development. They identified essential skills for role enactment as communication/ interpersonal expertise, clinical knowledge, flexibility, a strong ego and political savvy.

The study then examined how managers analyze the complexity of change, alter their management strategies accordingly, create a working culture that is maximally adaptable to an unstable health care environment and how they enact specific changes. They identified ways to enhance success and avoid or respond to failure, knowledge that they had acquired primarily experientially.

Finally, the study examined the common culture of nursing management within the context of its historical roots, particularly the necessity for a bicultural identity that incorporates beliefs and values of both manager/employee and professional clinician/nurse. Structured mentoring is explored as a bridging strategy to enhance enculturation and skill acquisition.

DEDICATION

This dissertation is dedicated to Samantha whose prayers every night for two years ended with, "and please help my mother with her research."

ACKNOWLEDGEMENTS

Many people, particularly faculty and nursing colleagues, have generously contributed their time and talents to the completion of this dissertation.

I am particularly indebted to my dissertation committee whose intellectual guidance and tireless, good humored, support kept me focused and moving forward. June Lowenberg served both as committee chair and as a mentor. Her guidance through the intricacies and pitfalls of developing an ethnography was essential to the completion of this project. Janet Harrison provided an expert administrative perspective and critique of this project, and also served as my advisor throughout my doctoral program. Judith Liu provided critical insights about methods and theory throughout all phases of this project, and gave structural and editorial support during the final manuscript preparation as well.

Additionally I wish to thank faculty, administrative colleagues and friends who shared their ideas, critiques and support at various points in this project. Many of these individuals filled multiple roles simultaneously; Mary Louise Braney, Colette Carson, Mary Anne Hautman, Francis Hanckel, Michael Jhin, John Oden and Rita Snyder-Halpern.

However, without the expert and timely technical support of Sharon Warren Robertson this whole project would

have collapsed of its own weight. For her professionalism I am truly grateful.

My parents Edna and Warren Everson, brother Eric and sister Sharon were a constant source of love and belief in my ability to complete this project. My sister also helped by being ever available for child care which greatly eased the logistics of my doctoral program.

My husband Jon and daughter Samantha provided love and support that kept me goal-directed. They are even more pleased than I am that this is completed.

Most of all I thank the nursing managers and administrators of "Harbor View" and "Valley Central" hospitals. Their experiences, insights, and perspectives are the essence of this research. They allowed me access to their work. Although they were extremely busy, my requests for interviews and observations were graciously received and many managers went well beyond my initial requests offering extended resources and information. For those managers and administrators who critiqued my ideas and various drafts of this document validating or offering additional insights, I am especially grateful. The better I have come to understand the enormous complexity of their roles, the more my respect grows for them and the work they do.

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CHAPTER I

INTRODUCTION

The quality of patient care in acute care hospitals depends critically on the first-line nurse manager, a position with significant responsibilities that is poorly understood and little studied. Such nurses work at the crossroads of the care delivery system and must coordinate and integrate a myriad of diverse, often conflicting needs and priorities within their clinical domain. Acute care hospitals have recently empowered and expanded the position of the nurse manager. Thus, even preliminary understanding has been superseded by role changes and must be re-examined and extended.

By better understanding nurse managers, we can more effectively develop, select and support these nurses and further appreciate their position as an uneasy interface of so many expectations. Because so little is empirically known, this investigation will begin at a descriptive level identifying the behavior, values and beliefs of practicing nurse managers.

To understand the role, it is first necessary to appreciate both the historical and current context within which nurse managers function. Next I will present and

explore their perceptions in depth and begin formulation of some theories of behavior as practice patterns of nursing management. Finally, potential paths for collateral or subsequent study will be identified.

Let us begin with context. The practice settings of nurse managers are in turmoil, driven by costs, technology, changing values and new bureaucracies.

The cost of inpatient hospital health care exceeds what consumers are willing to pay either privately or through taxes. But without funds, how can adequate health care be provided as the right of every citizen?

Advances in medical technology challenge the nurse manager to assist staff, not only with the acquisition of new technical skills, but also with complex compelling ethical questions: What is life? What criteria define a viable life? Under what circumstances should the continuation or cessation of life be an individual's prerogative? How will the new technologies and health care resources be allocated and by whom?

Health care personnel are experiencing changes in values, behaviors and expectations. These changes are pronounced among hospital-based nurses, who are increasingly insistent on the recognition of their professional status and role in this complex environment (Baird, 1987; Porter-O'Grady, 1987; Poulin, 1984b). A shortage of nurses

emphasizes these changes, and the closing of nursing schools because of low enrollment is a strong indicator that the situation will not improve in the near future (Aiken & Mullinix, 1987).

Thus, hospitals are rapidly changing both in structure and complexity and will continue to do so, driven by increasing technology and a variety of economic, social and ethical issues (Coddington, Palmquist & Trollinger, 1985; Gilmore & Peter, 1987; Silva, 1984). The impact on the nurse manager is substantial.

The traditional bureaucratic hierarchy used to manage departments of nursing has become ineffective (Althaus, Hardyck, Pierce & Rogers, 1981; Fine, 1977). Executive nurse administrators are experimenting with a variety of organizational models that are designed to recognize the professional aspirations of hospital-based nurses and the new trends in health care. Often these changes increase the authority, accountability and span of control of the first-line nurse manager.

This new expanded and empowered position has various names: patient care coordinator, unit manager, unit director, and in some cases the head nurse title has been retained. It is the intent of this study to explore this new phenomenon from the perspective of current role incumbents.

This group has not been well studied. Nursing research on administrative personnel has focused primarily on the characteristics and functions of academic or service based executive leadership roles or administration as a functional specialty (Harrison & Roth, 1987; Poulin, 1984a; Ulrich, 1987; Zimmerman & Yeaworth, 1986). Studies concerned with various aspects of first-line nurse management have been limited primarily to surveys of job descriptions to determine common role expectations or investigations of the effect of the manager's leadership style on staff nurses' job satisfaction or their ability to practice. But, there is no information about the everyday culture or the phenomenon of "first-line nursing management." These nurses are being given increasing explicit responsibility for the management of substantial human and economic resources in highly complex and unstable settings, yet little is empirically known about how they perform their role or the critical components of their role. Thus, selection and development of new managers is often an intuitive process, rather than one which is empirically grounded.

This approach to manager selection and development has proven suboptimal. The literature is replete with articles by both managers and administrators describing high levels of stress, dissatisfaction and ultimately turnover among managers. The lack of empirical knowledge of the phenomenon

of first-line nursing management is adding to the human resource and economic burden of an already troubled health care setting.

Problem Statement, Purpose, Aims, and Assumptions

Problem Statement

First-line nurse managers interact with virtually all hospital constituencies and have become vitally important in modern health care organizations, yet their role is not well understood. Rather than testing theory from other disciplines for applicability to this critical nursing role, an understanding of the phenomenon of first-line nursing management will be developed from the perspective of the role incumbents, grounding nursing theory in the experience of practicing nurse managers.

Purpose and Aim

This descriptive study will identify, describe and analyze the behaviors, beliefs and values that characterize the everyday practice of first-line managers in their expanded role. Specifically, the study has four aims.

First: to identify and describe the belief systems and values that nurse managers hold about the management of their patient care areas; how they organize their units, allocate authority and responsibility among their staff; and

how they interpret events, set priorities and make decisions.

Second: to identify and describe nurse managers' role behaviors, patterns of social interaction and normative and/or ritual behavior, or what they actually do on a day-to-day basis.

Third: to identify and describe shared knowledge language and interpretations of the subculture of nurse managers from the perspective of the subculture members.

Four: to formulate beginning theories of first-line nursing management derived from the perspective and experiences of practicing managers.

Assumptions

In developing this research, it was assumed that the problem could be suitably approached using ethnographic methods and further that major, long term factors influence the phenomenon of first-line nursing management as it exists today.

The first group of implicit assumptions concerns an ethnographic methodology that presumes social groups develop a common culture that shapes their everyday lives and creates an interpretive framework through which the "facts" of daily events are given meaning. This study seeks to develop an ethnographic description that "identifies the subjective meanings" that are attributed to events rather

than the "objective characteristics" of events themselves (Emerson, 1983, p. 23). Thus, the data presented in this study describe but do not evaluate the nurse managers' world view. Their behaviors, beliefs, attitudes and values manifest this world view and are the basis of understanding this phenomenon.

An ethnographic methodology itself assumes a symbolic interaction world view (Denzin, 1970). Symbolic interactionists consider a "situation has meaning only through people's interpretations of it" (Bogdan & Taylor, 1975, p. 14). Because many factors influence "a participant's perspective," such as status, age, sex, and so forth, people in similar positions in the same organization often hold "shared perspectives." To understand the meaning of these perspectives, a researcher seeks to "take the role of the other" and observe behaviors in context (Chenitz, 1986, p. 46).

Ethnomethodologists believe that human behavior is an attempt to make the world explicable through the development of "abstract rules and common sense understandings" (Bogdan & Taylor, 1975, p. 15). Like symbolic interactionists, the ethnomethodologists attempt to suspend their personal understanding of events in order to understand the culture they are observing.

By examining meanings and interpretations of events

shared by nurse managers, it becomes possible to understand and describe their behaviors, values and beliefs, or reality as they experience it. By using an ethnographic method, I sought understanding of the first-line nursing managers' reality as the basis to construct nursing theories concerning the process of nursing management.

The second group of significant assumptions comes from a review of the literature, augmented by experience. I believe three characteristics rooted in the early history of nursing shape the current subculture of nursing management. First, nurses are primarily employees of institutions. Second, the nursing profession is predominantly female. Third, the majority of hospital-based nursing activity is in response to physician orders, thus placing nurses in a subordinate relationship.

Nurse managers are employees of institutions which prescribe and proscribe specific activities and relationships to superiors and subordinates. Although the institution views patients and families as a collective task to be processed efficiently and expeditiously, nurses have professional values and view patients and families as unique individuals with needs and rights that have a higher priority than the organizational efficiency. Thus, by definition, nurse managers must enact a role that is laden with conflicting loyalties and values.

Nursing's value of caring and medicine's goal of curing can be equally disparate. Furthermore, because medicine is a predominately male profession and nursing a female profession, transactions between the two groups are further complicated by socially determined gender expectations and behavior. It is my belief that nurse managers who have a reputation for competence among their colleagues and superiors, have developed behaviors and beliefs that accommodate conflicting values and expectations.

Finally, it is my assumption that nurses who function in an expanded role are potentially pivotal in terms of organizational power and that politically sophisticated constructive use of that power is critical to the well-being of professional nursing practice and ultimately patient care. How and for what purposes nurse managers exert their power is an important question for this study.

The purpose of this study has been to develop a description of the subculture of first-line nursing management. It is my belief that understanding the process of nursing management from the perspective of practicing managers is an essential prerequisite to the development of nursing theory about this phenomenon. Nursing is a practice profession; therefore, its empirically based scientific theories must be grounded in the experiences of its practitioners (Chenitz & Swanson, 1986; Dickoff, James &

Wiedenbach, 1968).

Methodology

Ethnographic research techniques were chosen as the methodology for developing a description of the subculture of first-line nursing management from the perspective of practicing managers.

The data for this study were gathered in two inpatient acute care hospitals in Southern California using ethnographic observation and interviewing techniques. I began in Harbor View Hospital by observing one experienced, enculturated nurse manager as she conducted the day-to-day activities of her job. Based upon observations and interviews with her and with her peers, I developed an informal open-ended interview guide designed to elicit their beliefs, behaviors and values about the phenomenon of nursing management. Using the guide, I then conducted intensive interviews with all five inpatient nurse managers in Harbor View. The guide was revised as data was collected and new or more productive areas of inquiry emerged.

Using the guide developed in Harbor View, I then interviewed the inpatient nurse managers in a second hospital, Valley Central, who were functioning in a similar role(s). As the study progressed, I analyzed the data,

allowing "classes and their links" or "categories" to emerge (Schatzman & Strauss, 1973, p. 110). As this process continued and evolved throughout data gathering and analysis, it provided focus and direction for the study (Glaser, 1978). The details and rationale for this methodology and how the study evolved are fully elaborated in Chapter Three.

Implications

It is essential for the delivery of cost-effective, high quality patient care that first-line managers are developed and selected who can be effective, satisfied and stable in their role. Empirically establishing the parameters of the role, the nuances of its enactment and the competencies necessary for a manager to be effective and satisfied are critical to that goal. As will become apparent in the literature review, much of what has been published about the role has been based upon speculations about the activities and tasks a nurse manager performs and the tasks the hospital needs to have accomplished. For example, some research has been based upon institutional job descriptions assuming a 1:1 correlation between what is written in a formal job description and what is actually happening.

This study is more direct, being designed to describe the informal day-to-day realities of the nurse functioning in the expanded first-line management role. This lays the foundation for the development of nursing theory grounded in the experiences and reality of nurse managers. Such theory provides a base for both future research and experiential testing.

Although nurse manager is a unique human services management position, some commonalities with other first-line manager position can be identified. For example, when Marciniszyn (1971) applied the borrowed theory of decentralized decision-making, she found the response of the first-line manager in nursing to be similar to those of first-line managers in industry where the theory originated (Dearden, 1960). Chapter 7 explores the management practice patterns identified in this study for their applicability and utility for similar positions in other contexts.

Structure of the Dissertation

The body of this dissertation has been divided into seven chapters. It begins with the review of the literature and the methodology, includes the two chapters on data analysis and concludes with a discussion of the findings and their implications.

Chapter 2, a review of the literature, is presented in three parts. The first traces the evolution of the nurse managers' role placing it in a historical context. Part two places the role in its contemporary context and examines new hospital based organizational models of management practice. The third section of the chapter reviews the available research over the past twenty years as it relates specifically to the first-line nursing management role.

Chapter 3 details the methodology used to conduct the research. It begins by characterizing the study setting, participants and specific data gathering techniques. The methodology as originally conceived is then presented, followed by modifications that were made as the research progressed and their rationale.

Chapter 4 begins the data analysis with the description of the role of the nurse manager from the perspective of formal institutional documents, nurse manager participants and administrative nursing supervisors. The analysis continues with the description of some of the commonly held professional work history and personal characteristics of the nurse managers, and concludes with an account of the skills managers identified as necessary for the enactment of their role.

Chapter 5, the second data analysis chapter, takes one aspect of the manager's role, the facilitation of change,

and details the process and techniques managers utilized to actually negotiate change. The analysis describes how managers evaluate the impact of potential change and prepare their staff; how they assist them in understanding the change and its resultant expectation for new behaviors and values; and ultimately how managers intervene when staff are unable to accommodate new expectations.

Chapter 6 discusses the practice patterns of first-line nursing management constructed from the data analysis and compares them to the study assumptions. Factors identified as influencing the practice patterns of managers that were not analyzed during the study are briefly explored.

The final chapter evaluates the study findings and their potential implications for the selection and development of nurse managers. Criteria are developed to explore the application of nurse manager practice patterns to non-nursing management and directions for future research are identified.

Summary

Nursing management is in a period of transition, particularly the role of first-line nurse managers. As the role gains importance it becomes increasingly critical to understand the everyday reality of the phenomenon. This

understanding will improve not only the support to current role incumbents but will also enhance the likelihood that future managers will be more effectively selected and prepared to assume the accountability and meet the responsibilities required in this pivotal position.

CHAPTER 2

REVIEW OF THE LITERATURE

The literature review begins with an analysis of historical events that shaped the formation of the role of the nursing manager and their continuing influence through the middle of the twentieth century. Next the role of the first-line nurse manager within the economic, social and health care context of the 1970's and 1980's is examined. Finally, the research of the past twenty years is reviewed as well as the role as it is presented anecdotally in the nursing literature.

Historical Context

This research began with the assumption that certain aspects of contemporary nursing management are rooted in the nineteenth century and that understanding the role's antecedents is essential to understanding the contemporary phenomenon. These will be briefly traced and examined in light of the beliefs, behaviors and values of the study participants. The roots are: the majority of nurses work as employees in institutions; most nurses are women; and, nurses seem to work in subordination to physicians (Strauss, 1966).

Events Prior to the 1900's

Although nursing had flourished throughout recorded history as a set of skills and attitudes handed down from generation to generation, it first developed a formal hierarchy in western Europe, where the Catholic Church and the military assumed responsibility for the sick poor and wounded soldiers (Strauss, 1966). By the eighteenth century in Catholic European countries and in their New World settlements, religious orders managed most hospitals, leaving clear imprints on nursing. A hallmark of the Order of St. John for example was "strict obedience" to authority (Jensen, 1943, p. 104), and the Sisters of Charity established strong traditions of selfless charity.

As part of the Protestant Reformation, Catholic convents and monasteries were dismantled and religious orders were banned, including those who cared for the sick poor. These groups were not replaced in any thorough or systematic way, thereby disrupting the delivery of institutional based health care in countries like Britain, and retarding the development of hospitals in her New World colonies (Palmer, 1983).

Although both Protestant and Catholic hospitals were developed primarily to care for the poor, Catholic nurses (nuns) were respected and delivered efficient care learned under an apprenticeship system. In contrast, most nursing

in Protestant hospitals, particularly in Britain, was so haphazard it was a popular subject for social satirists such as Charles Dickens (Jensen, 1943).

The sharp contrast between organized and haphazard nursing care became apparent during the Crimean War. The appalling conditions surrounding the care of British soldiers created a situation that allowed the dramatic, scientific and well publicized intervention of Florence Nightingale, which changed the course of nursing (Palmer, 1983). Nursing now became a "collectively organized, institutional resource, in close association with physicians thus giving them control and jurisdiction over nursing activities" (Reeder & Mauksch, 1979, p. 209).

From the beginnings, the organizational hierarchies of the religious and military systems were directed by men who defined the scope of nursing duties. The occupational hierarchy was directed by women, particularly in the Catholic nursing model.

The managerial hierarchy of religious orders and the military gave rise to the "matron" who functioned as an institutional resource and as chief of nursing (Palmer, 1983). Thus nursing emerged from the nineteenth century as an institutionally based profession, socialized to obey both an institutional hierarchy dominated by men (physicians) and a professional hierarchy of women.

Although nursing was not exclusively a woman's domain, the predominance of women has influenced the profession's development. Two major reasons for this predominance were that nursing was one of the few careers open to women, and that the care and nurturing tasks assumed by nurses were and still are closely associated with religious and social concepts of a woman's or a mother's role. "Innate characteristics" of the sex or "their natural gifts" were the basis upon which women and nurses were allowed some measure of authority in early hospitals:

> Prominent businessmen are not experts in housekeeping, nor is it possible for men to equal women in this department, not only because they have not had the experience, but because nature does not give them the gift. Admitting that men can supervise the housekeeping and nursing in a hospital and can secure their being economically done, and to the eyes of an inspector well done, still, as a rule, institutions so governed will be wanting in one of the most desirable and essential particulars, namely, that gentle and refining moral influence which is seldom found outside of the house kept in order by a woman. (Walker, 1877, p. 77).

These essential women were often "dismissed with thanks by the hospital director as soon as their work was running smoothly with value proven" (Dock, 1912, p. 116). Although this was not universally true, particularly in smaller institutions, "on the whole, the steady general tendency has been for men to take control out of women's hands" (Dock, 1912, p. 117).

Women as nurses were similarly valued and then relegated to lesser positions of organizational influence as the institution grew in size and prestige. Typically, the late nineteenth century nurse executives were directly responsible to the Board for all aspects of the functioning of the hospital, including hiring, firing, managing all staff, buying and maintaining all capital and operational equipment and supplies, as well as, providing for the care and feeding of all patients and staff. As nursing schools were added, the Chief Nurse Executive (CNE) chose students for admission and supervised their education. As one historian described it, this was "a truly terrible list of duties" (Burdett, 1893, p. 871).

But by 1900 Chief Nurse Executives typically reported to the Board indirectly and had lost substantial autonomy. This loss was due in part to the fact that in western cultures nursing's relationship to medicine is fundamentally driven by the higher value ascribed to curing rather than caring, and that these activities are linked to male and female roles. By the turn of the century, as curing became possible, hospitals ceased to be centers for caring and became centers for curing (C. Smith, 1983). Whereas the rich had been able to avoid hospitals by providing care in their own homes, curing was a much more specialized resource that led to democratization of hospitals.

As hospitals became mainstream, so did their structure. Hospitals were staffed primarily by students, with a skeletal nursing administrative structure of graduate nurses responsible for supervising a unit or floor where they had multiple roles and lines of accountability (Goldmark, 1923). Under the nursing hierarchy graduate nurses taught and supervised students who gave the care, provided direct care themselves and managed all aspects of the physical environment. Under the direction of the physician they carried out or monitored various aspects of the curative process.

Hospital based nursing's status, and ultimately the role of the head nurse was now defined with multiple roles, levels and lines of accountability.

Nursing Management: 1900 to 1940

Although nursing, medicine and hospitals changed dramatically between 1900 and 1940, the role of the nurse manager, once established, did not. The scope of responsibilities and the nature of the relationship with the physician in the institution remained fairly stable. The nurse manager had become a teacher of students, a manager of unit based personnel, head housekeeper and direct care-giver to patients.

As medical treatment of patients in hospitals became more complex, it became necessary for hospitals to hire more

graduate nurses rather than depend exclusively on students for care. Students were also requiring greater clinical supervision than before. This occurred at a time when unregulated schools of nursing were producing a surfeit of nurses who could not find work as private duty nurses (Kalisch & Kalisch, 1986). The needs of the hospital for greater stability and expertise from its nursing staff, and the need of the nurses for work served to further institutionalize nursing as a profession and develop a managerial bureaucracy within the profession and hospital.

The nursing administrative hierarchy began to expand with the addition of nurse supervisors. Hospital administrators were advised to add this role if "departments were too large [for the manager] to attend to all of the detail" (MacEachern, 1935, p. 394).

> The supervisor is responsible to the Director of Nursing for the management of her section. This includes requisition and maintenance of supplies, care of physical equipment, complete nursing care of the patient, and where there is a school of nursing she devotes time to the practical side of education. (MacEachern, 1935, p. 393)

Thus, the roles and lines of accountability that emerged at the turn of the century became more clearly established. The nurse manager was now designated administrative representative of the institution, clinical expert and physician surrogate.

In her organizational or administrative role, the

nurse manager supervised and/or carried out all of the unit based housekeeping and dietary activities or the hotel functions (Goldmark, 1923). This included cleaning beds, refrigerators, sterilizing and repackaging equipment, preparing special diets, setting up and supervising trays, etc. (Goldmark, 1923). She communicated and enforced hospital policies and procedures and supervised staff, most of whom were students.

Floor nurses were eventually relieved of responsibility for hotel functions when hospitals hired ward helpers in response to the Goldmark report (1923). However, nurse managers were not. As representatives of the institution they continued to supervise the staff who provided these hotel functions and were accountable for them (Barrett, 1949; Waylen, 1938).

In her clinical role, the nurse manager both delivered patient care and taught student nurses in formal classes and at the bedside. These students delivered two-thirds of the hours of actual care until after World War II.

As hospitals increasingly became centers for curing, the predominance of physicians increased. Nurse managers' clinical role expanded to represent the physician's growing clinical authority to staff. As medical and scientific advances occurred, physicians began to delegate what had been the province of medical practice to nurses. By the

1940's, nurses were doing more for patients than physicians themselves had done a half a century before (Brown, 1948). The nurse manager was both the teacher of these new skills and the physician's key contact on the ward; she was his eyes, ears and clinical judgment in his absence (Shyrock, 1959).

World War II Through 1970

During the first half of the century nursing management evolved through steady incremental steps. But from the 1940's to the present, change has been more rapid, driven in part by periods of staffing crisis which did not abate when the war ended. The working conditions of nurses had not changed, but women were increasingly unwilling to tolerate them. In response, hospitals and nurses developed new categories of workers such as nurses aides, medical technicians, licensed practical nurses and ultimately associate degree nurses (Brown, 1948).

Hospitals grew rapidly in size and complexity. Skeletal bureaucracies at the beginning of the 1900's mushroomed after World War II in response to new clinical services, external regulations and funding, and the diversity of services offered by large city hospitals. By 1955 the nurse manager was spending approximately thirty percent of her time on clerical functions (Barrett, 1963). Although she had less responsibility for hotel functions,

her duties as organizational manager required her to report, record, regulate and coordinate all activities of staff, patients, physicians and numerous personnel from other departments that passed through her unit (Mauksch, 1966).

By the 1960's the nurse manager role as clinical expert and teacher of students had also changed. Schools were now supplying their own clinical instructors, thus splitting the nurse managers' clinical roles into service and education creating two distinct groups which, over time, developed discrepant values. Early research on this issue found that these value discrepancies were problematic both for new staff and for patients (Ondrack, 1975; K. Smith, 1965). Nurse managers valued behaviors that expedited the task at hand, while educators were more focused on individuality and creativity. Anderson (1964) suggests that the managers' values were the result of the increasing emphasis on the bureaucratic aspects of her role.

Nurse managers did not give up their role as educators and socializers, however, but redirected it to a myriad of new staff entering the unit. Problems of attrition, turnover and maldistribution of nurses that occurred at the close of World War II were chronic by the end of the 1960's (Ginzberg, 1967). Staffing shortages and the addition of new categories of personnel to remediate this problem gave rise to a new model of nursing practice, team nursing

(Anderson, 1964).

As team nursing developed on the unit, it replicated within the patient care area the stratified bureaucratic administrative structure of the general hospital. Team nursing was designed to make care more efficient and effective and to assist the nurse manager in supervising large numbers of staff that changed every eight hours as a consequence of the elimination of split shift assignments (Lambertson, 1953). However, the model seemed to further alienate nursing administrators from their increasingly dissatisfied care-giving staff (Bloom & Alexander, 1982).

Within the team model of practice, managers gave less direct care than was the case under the functional model (Hagen & Wolff, 1961). Hospitals hired and rewarded managers who emphasized the bureaucratic functions of their role. Yet, staff valued "leaders" who were "exemplars of clinical practice" (Anderson, 1964, p. 243).

Hospital-based nurses had become highly competent technically, were acquiring basic and advanced degrees in universities, but had stopped talking to their administrative colleagues and had turned to unions to improve their position in hospitals (Kalisch & Kalisch, 1986).

In sharp contrast, the nurse manager's relationship to the physician did not change dramatically during the

post-war period. Even with team nursing the nurse manager retained her position as the physician surrogate. Many doctors continued citing concerns begun at the turn of the century about over-educated nurses (American College of Surgeons, 1947; Dock, 1912; Reeder & Mauksch, 1979). Despite the gains made by the women's movement in the rest of the society, the doctor-nurse patterns of communication continued untouched by outside influences (Hughes, 1988). However, nursing's continued progress toward professionalization began to create instability in these relationships and in the hospital generally.

Contemporary Context: New Organizational Models

The expanded role of the nurse manager is in large measure an outgrowth of the social and health care changes that have occurred over the past twenty years. These changes will be explored briefly to develop the context before examining the literature about the expanded role of the nursing manager.

Changes in the 1970's and 1980's

The steady incremental change that was the hallmark of health care and nursing prior to the 1960's accelerated dramatically in the 1970's and 1980's. Nursing education

was moving from hospitals to universities, aided in part by federal grants for education (Litman & Robins, 1984). An increase in the number of masters and doctorally prepared nurses, revision of Nurse Practice Acts, and rapid development of nursing theories all supported the movement of nursing from a traditional and technical model to a more professional model of practice (Kalisch & Kalisch, 1986; Meleis, 1985). Simultaneously hospitals, particularly teaching and research centers, were rapidly increasing in size and complexity and were becoming the third largest industry in the U.S. (Litman & Robins, 1984).

These changes overwhelmed the centralized and hierarchically organized nursing service administrations (Fine, 1977). Nursing administration was plagued by inflexibility, loss of initiative, poor communication and dissatisfaction; resulting in collective bargaining at the lower levels of the hierarchy and inattention to long range planning and organizational development in the upper levels of administration (Marciniszyn, 1971).

Industry and government had experienced similar problems prior to World War II and had addressed them by decentralizing decision-making. Such decentralization meant a pattern of delegation of authority and responsibility for decision-making to the lowest acceptable level in the management structure (Greenwood, 1974). Under most

circumstances this included a major reduction in the administrative hierarchy.

New Organizational Models

Inspired by the successes reported in industry, several nursing administrators applied decentralized decision-making techniques to hospital nursing departments. The results were both constructive and problematic.

The positive aspects included improved communication, creativity and innovative decisions that improved patient care (Cox, 1980; Probst & McGuire-Nogs, 1980; Rotowsky, 1978; Simmons, 1980). The most widely documented example was a county hospital which focused operational authority in the hands of the nurse manager (Althaus, et al, 1981). Only one of the early studies reported problems. The negative aspects involved loss of coordination among various divisions, competition among divisions for resources, and a general inability to view the needs of the institution beyond their own units (Marciniszyn, 1971). Both positive and negative aspects of these changes are similar to findings reported in industry (Dearden, 1960; Likert, 1953).

In 1982 Congress passed legislation for the prospective payment system, including diagnostically related groups or DRG's (Baird, 1987). This federal cost containment initiative added financial pressures to sociological pressures for improving the management of

resources. Many hospitals have responded by decentralizing decision-making and reducing administrative overhead.

The nursing literature of the 1980's is replete with strategies to manage cost containment and the resulting effects on staff (Fanning & Lovett, 1985; Salmond, 1985; Wellington, 1986). Many of the strategies have included some form of decentralized decision-making with a decrease in the number of upper level administrators and an expanded role for the nurse manager.

The reported outcomes have continued to vary. Proponents cite the achievements of cost containment, job satisfaction and patient care goals (Althaus, et al, 1982; Fanning & Lovett, 1985; Spitzer, 1986). However, Wellington (1986) points to problems in coordination, the lack of nurse managers capable of performing an expanded manager role and the limited number of staff nurses prepared to assume the authority and accountability autonomous professional practice demands.

Decentralization is one of the more visible and popular alternatives to traditional bureaucratic structures, but it is by no means the only alternative: participative management, contracting, self-governance and numerous other structures are being evaluated. Each form of management is attempting to respond to the desire for autonomous professional practice expressed by many

nurses (Hinshaw, Smeltzer & Altwood, 1987; Porter-O'Grady, 1987; York & Fecteau, 1987). Each model requires the delegation of decision-making authority and responsibility to lower points in the organizational structure, which in most cases involves empowering and expanding the role of the first-line nurse manager (Althaus, et al, 1981; Fine, 1977; Hodges, Knapp & Cooper, 1987; Marciniszyn, 1971).

The authority and accountability of these new management roles typically includes: (1) fiscal accountability for personnel and operational budgets of several million dollars; (2) authority to hire, evaluate, determine salaries, establish staffing patterns and schedules, and conduct disciplinary action for 30-100 staff; and, (3) accountability for professional practice including standards of care, development of staff and quality assurance of patient care (Beaman, 1986). Because individual clinical areas are now functionally more independent, nurse managers are the primary influence establishing the working culture of the unit, its values and priorities (Schein, 1986).

Although the role of the nurse manager in acute care hospitals is pivotal for the delivery of high quality patient care, little is known about the everyday practice of these first-line managers who, like the CNEs of the 1800's, find themselves facing a terrible list of duties.

Current Research

In 1977 Stevens wrote "it is accurate to claim a paucity of substantive research in nursing administration at the present time..." (p. 9). By 1986 the editorial staff of The Journal of Nursing Administration (JONA) pointed out that there were only eleven published research studies concerning head nurses, most of which possessed methodological flaws that "limited the findings and utility", thus they could be judged to have accomplished little more than problem identification ("Stress Among" 1986, p. 6). Five additional studies have since been published.

The literature is rich with opinion and anecdotal observations about the role of the nurse manager, yet the empirical data, particularly that focused on the expanded role of the nurse manager, is minimal. Therefore, this review will include all published research on nurse managers.

For convenience, the research is reviewed in categories of behavior, beliefs, values, of nurse managers in the expanded role and career development. The majority of the research deals with the first category: nurse manager behavior. No research was identified in the second category

of beliefs, and only one study on values was found.

Nurse Manager Behaviors

Research about nurse managers' behaviors considers three types of behaviors: role task behaviors often delineated in organizational job descriptions; role enactment behaviors over which a nurse manager has discretionary control; and, role response behaviors or role induced stress (Stevens, 1983).

Role Task Behaviors

An early study by Jones and Jones (1979) used observation and interviewing to determine that nurse manager activities can be successfully analyzed using Mintzberg's (1973) managerial categories. Although these conclusions are reiterated throughout the literature, the study design in itself does not support a more generalized conclusion. They found that the nursing manager role has a significant managerial component which most nurses are academically unprepared to fulfill; and that many professional nurses are unwilling to accept management tasks as legitimate aspects of the role.

Barker and Ganti (1980) studied the activities of nurse managers and their assistants using a self-logging technique. Like the Jones and Jones (1979) study, this study cannot be generalized and must be viewed as a program evaluation in light of the methodological limitations.

Barker and Ganti (1980) found managers spending 39% of their time in direct patient care and 39% on patient care management issues although the role was described as managerial. The disparity between written job expectations and actual practice was not explained although they speculate that a lack of preparation and value for the managerial role may have contributed.

Two broader, more recent studies to identify nurse manager role tasks were conducted by Beaman (1986) who surveyed all Los Angeles county hospitals and Hodges and Knapp and Cooper (1987) who questioned 288 CNEs randomly selected from the American Organization of Nurse Executives (AONE).

Beaman (1986) found that 50% of the responding hospitals identified 31 similar nurse manager role tasks and that 16 of the tasks were related to those defined by Barker and Ganti (1980). She found no relationship between the types of tasks and the size of the hospital.

Hodges, Knapp and Cooper (1987) found that 76% of the CNEs reported that their departments of nursing were decentralized, but did not define this term. Fifty-eight percent of the CNE's ranked the manager position as the most important in achieving organizational goals. An analysis of functions found the role increasing in autonomy and responsibility compared to the traditional role in a

centralized organizational structure; 87% stated masters prepared head nurses would be more cost effective; and 95% reported they would hire such nurses if possible.

Both studies contribute a general understanding of the growing importance of the manager role, yet neither study queried nurse managers directly about what they actually do. Rather, they depended upon the CNE's perception of the ideal role incumbent or a written job description.

All of the four studies examining role behaviors agree that there are competencies required to perform the role identified in job descriptions that are not included in basic professional education. Although there is a growing consensus about what tasks are performed by first-line nurse managers theoretically, the beginning analysis of their actual behaviors indicate that theory and reality may not be congruent.

Role Enactment

How the head nurse actually performs role related tasks, role enactment, has been studied primarily as it impacts the nursing staff's perception of the manager's leadership ability and its effect on their job satisfaction and/or burnout. For example, four studies used a questionnaire which was designed to examine the relationship between two constructs of leadership style, consideration and structure. Consideration was defined as

behaviors that emphasize concern for group needs, while structure emphasizes achievement of organizational goals (Fleishman, 1969; Stogdill, 1963).

The first two studies (Johnson, 1976; Neely & Blood, 1986) examined what nursing staff considered effective leadership behavior, and found that staff felt both consideration and structure were necessary attributes for nurse manager leadership. The nurse managers themselves wanted high consideration and low structure from their immediate supervisors (Neely & Blood, 1986). K. Johnson (1976) reported that managers assessment of their own style did not agree with the assessments made by supervisors and staff, however, the latter two agreed with each other.

The second two studies examined job satisfaction and burnout as it related to the leadership behaviors of consideration and structure (Drennan & Whittenaure, 1987; Duxbury, Armstrong, Drew & Henly, 1984). Drennan and Whittenaure (1987) found no relationship between satisfaction and structure, but a positive relationship between satisfaction and consideration. Duxbury, et al (1984) also reported that structure was relevant only when the head nurse style was highly structured and linked with low consideration for staff.

In a descriptive study to determine staff nurses' perception of effective leader characteristics,

consideration was also identified as important (Campbell, 1986). Despite the small sample size and use of a questionnaire untested for psychometric properties, Campbell's (1986) findings were similar to those of Drennan and Whittenaure (1987) and Duxbury, et al (1986).

Several incidental findings were reported in a study by Alexander, Weisman and Chase (1982) examining the relationship between perceived autonomy, job satisfaction and work setting. To explore job related characteristics, a nurse manager scale was developed to examine "the staff nurse attitudes toward head nurse leadership style and responsiveness" (Alexander, et al, 1982, p. 49). Staff nurse perception of head nurse responsiveness and their perception of their own practice autonomy, and internal locus of control were all strongly and positively correlated across all types of inpatient clinical settings. The study methodology cannot determine a causative relationship among these variables, but it does suggest that the staff nurse perception of a high autonomy head nurse leadership style may significantly influence the staff's sense of personal efficacy.

A study by Niebuhr, Bedeian and Armenakis (1980) investigated the relationship between subordinate personality characteristics and perception of leadership behavior and found that the personality of a subordinate

strongly influenced how the subordinate perceived a supervisor's behavior. Therefore the authors suggest that aggregating data about subordinate perception of leader behavior may be a methodological flaw. If this is true, it could explain some of the weak correlations described in previous studies. Niebuhr, et al (1980) included five levels of personnel in one nursing department, but did not describe the categories of personnel and their relationship to each other. These omissions make study findings difficult to evaluate.

Although the manager's style of role enactment seems to clearly affect the nursing staff, which behaviors produce which effects is less clear. That a considerate leader positively influences subordinate's job satisfaction seems axiomatic, yet the correlation is not particularly strong. Early studies show the need for structure as well as consideration but more recent research shows structure as no longer influential. This may be a function of sample selection or changing trends in nursing or perhaps nursing leadership/followership behavior involves more than two constructs.

As part of a study on interns and residents, Strauss (1971) described briefly the dynamics of control and territoriality exhibited by a permanent head nurse toward the rotating house staff in a neonatal intensive care unit

(NICU). What nurse or doctor has not heard or told stories about "Attila the Hun" who "brought them up." Yet, little is known about the affect of nurse manager behaviors or how they choose to enact their role.

Nurse Managers' Role Induced Stress

Numerous articles and several studies concerning the stress experienced by nurse managers have been published over the last ten years ("Stress Among", 1986). The source of this stress is variously attributed to conflicting role expectations, environmental influences, and role transition (Adams, 1988; Dooley & Hauben, 1979; Flake, 1987; Thornton, 1982). Unfortunately, many of these publications do not include adequate information to determine if the position being described is the traditional or the new expanded manager role.

Conflicting role expectations of the two primary authority structures within hospitals constitute the main source of stress for nurse managers: role expectations of the institution as represented by the nursing supervisor, and medicine represented by the attending physician or chief of service (Adams, 1988; Flake, 1987; Thornton, 1982). Anderson (1964) supports the supervisor-head nurse relationship as a source of conflict. Yet, two recent studies found no significant conflict of role expectations between managers and either authority structure (Kennedy,

1984; Stahl, Querin, Rudy & Crawford, 1983).

Kennedy (1984) proposed that stress in role conflict and ambiguity between managers and physicians, in a large Army hospital, would be demonstrated by a differential perception about how nurse managers allocated their time, but the data did not bear out this hypothesis. Similarly, Stahl, et al (1983) failed to demonstrate significant differences between managers' activity and supervisor expectations in 12 Ohio hospitals.

In both studies the lack of discrepancy between the manager's behavior and that expected or perceived by the authority structure of physician or supervisor may be the result of strong bureaucratic role expectations of the manager. Adams (1988) suggests this is true in the military. Likewise, the Stahl, et al (1983) ratio of managers to supervisors, given as 2:1, would make the supervisor readily available to assure the manager role is enacted as the supervisor defines it. Both studies opine that conflict may not result from manager behavior versus bureaucratic expectation, but rather from role delineation and overlap.

Two additional studies specifically examined managers' stressors and analyzed potential causes (Gribbins & Marshall, 1984; Leatt & Schneck, 1980). An exploratory study of ten nurses with varying degrees of management

responsibility in one NICU identified stress in direct proportion to their inability to reconcile diverse values, expectations and priorities of various groups (Gribbins & Marshall, 1989). The head nurse in particular was described as occupying a pivotal position in a hospital organization where the multiple, conflicting world views and expectations converge and thus had the highest potential for job stress.

Leatt and Schneck (1980) examined sources and frequency of stress as related to various clinical areas. They found no relationship between either age and experience, and perception of stress, but did find education and area of specialty practice affected not only type but amount of stress perceived. Because of sampling distortions they drew no conclusions or generalizations about the exact relationship of education to stress perception. No generalizations about the relative stress levels within specialty areas was reported beyond the fact that each specialty area generates specific types and amounts of stress.

The role transition from staff nurse to manager is widely perceived as a significant stressor; however, no research has been published to document this (Boccuzzi, 1979; Dodwell & Lathlean, 1987; Dooley & Hauben, 1979; Flake, 1987; Thornton, 1982). There is also no research and few suggestions concerning stress reduction for nurse

managers, and only a few suggestions about coping by job sharing and improving communication skills (Gribbins & Marshall, 1984; Hyndman & Personius, 1983). Nursing management is unanimously perceived to be a critical and demanding job. However, empirical support for such opinions has not progressed beyond tentative problem identification ("Stress Among", 1986).

Nurse Manager Values

Only K. Smith (1964) addressed nurse manager values. Values were determined by content analysis of unit staff evaluations written by managers. Head nurse values were then compared to nurse educator values which had been determined by content analysis of the educator's evaluations of students. K. Smith (1965) found major differences existed between the values of educators and head nurses and suggests that these differences create a conflicted socialization process for new staff, and may ultimately be a source of schism in the nursing profession.

Although it is logical to assume that value discrepancies exist between these two groups, content analysis of hospital evaluations may more accurately reflect personnel department criteria than manager values. That value differences exist between educators and service administrators and create problems, has since been empirically supported by two additional researchers although

neither studied the values of nurse managers specifically (Kramer, 1974; Ulrich, 1986).

Educational Preparation and Selection

Concerns about selection and education of nurse managers has generated a variety of programs, articles and studies within the United States and in other countries. Although we must treat the studies done outside the U.S. with caution because three foreign studies indicate significant differences in role expectations and education among countries.

The literature unanimously opines that many nurse managers are inadequately prepared to meet the managerial demands of their role. One cause is that selection of a nurse manager often occurs for reasons other than the appropriate fit between the managerial requirements of the position and the capabilities of the job applicant (Bergman, Stockler, Shavit, Sharon, Feinberg & Danon, 1981; Price, Simmons & Poutz, 1987). Another problem is institutional reorganization expanding the nurse manager role, thus requiring the development of new skills of the role incumbents (Wellington, 1986). In either case, the outcome is the same: nurse managers often lack the managerial skills necessary for first-line management.

Traditionally, the manager has been expected to learn the necessary skills through experience, reading or under

the tutelage of the supervisor (Boccuzi, 1979; Hutchinson & Murphy, 1985). As the discrepancy between skills and capabilities has increased, many hospitals have developed in-house management courses or have sent managers to a myriad of continuing education courses (Kirk, 1987).

In the mid-1970's both Britain and Israel reorganized their national health services and expanded the role of the first-line nurse manager (Bergman, et al., 1981; Forrest, 1983). However, the findings in a national needs assessment in Israel (Bergman, et al, 1981), in Britain (Forrest, 1983), and in the United States (Kirk, 1987) are very different. British nurses felt relatively secure in the behavioral aspects of their role, while their American and Israeli counterparts did not. On the other hand, British and Israeli nurses felt a lack in their analytic skills which American head nurses did not.

Bergman, et al. (1981) and a later British study (Dodwell & Lathlean, 1987) recommended that national continuing education programs be established to upgrade the skill level of role incumbents. Both recommended these programs be university based because the role expectation had exceeded what can be taught in any basic nursing program.

Although studies specifically concerned with the necessary competencies for nurse managers have not occurred

in the United States, certainly the expectation is for managers to have advanced education (Department of Health and Human Services, 1988). The number of nursing administration programs awarding masters and doctoral degrees are rapidly increasing. Nursing leaders in education and administration state that where possible a master's degree in nursing administration is the desired academic preparation for the new nurse manager role (Hendricks, 1983; Hodges, et al, 1987; Poulin, 1984b).

The search for ways to select and prepare first-line managers has included non-traditional directions. Vocational behavioral theory has been explored on the assumption that successful managers as a group have personal attributes that enhance not only their ability but satisfaction in their role. Hansen and Charter (1983) explored this concept using the Holland Vocational Preference Inventory (1973) to distinguish personality profiles of management and non-management master's level nursing students. The two groups could be differentiated by personality variables but could not by using demographic or career data. Those with management interests were significantly more realistic, social, conventional, enterprising, artistic and acquiescent. Unfortunately, because the sample was drawn from a graduate student population with merely an interest in management, rather

than practicing managers, it is not possible to make inferences about managers based on these findings. However, this has been a productive approach for career counselling selection in numerous other occupations, and is being pursued in nursing (Hefferin & Kleinknecht, 1986).

The notion that clinical expertise is an essential component of the managerial role is highly contested, but has also not been explored empirically (Powers, 1984; Rotkovitch, 1983; Wallace & Cory, 1983). Del Bueno and Walker (1984) at Stanford, piloted a program to explore this issue experientially. BSN graduates with one year of clinical experience and interest in an administrative career were evaluated. Those who showed particular management aptitude as demonstrated through testing and personal interviews, were chosen for an adult learning/mentoring model of managerial skill development. Although the results of the project were inconclusive, because only one of two candidates finished the program, it raised important questions. What is the best model for developing first-line managers? How necessary is clinical competence versus expertise? Is there a way to determine who has potential for success and prepare them in other than academic programs?

Expanded Role of the Nurse Manager

Although there is little published empirical data about the new expanded role of the nurse manager, there are many descriptions of role responsibilities and some general consensus about the origins and purpose of the role. Most authors, however, have chosen one aspect of the new role responsibilities to cover in depth. If all these were combined, the new role would require an awesome range of competencies.

The new role is usually described as combining the roles of head nurse and supervisor to achieve cost containment, efficiency or enhanced professional practice (Johnston, 1983; McPhail, 1987; Powers, 1984). The new role is not easily categorized, being viewed by some as middle level, and by others as a first-line management position.

The scope of the role usually includes twenty-four hour a day accountability for patient care, administrative and personnel management (Connaughton, 1981; Hopkins, 1981). The literature is unclear about the degree of discretionary authority invested in the role, although articles written by role incumbents articulate an intense sense of accountability. Much of the literature about the expanded role addresses various aspects of leadership responsibility,

primarily in the area of personnel management. Managers have traditionally evaluated staff performance, but must now do so in a manner that promotes staff growth, motivates high performance and is cost effective (Stull, 1986). Nurse managers are charged with developing esprit de corp and a constructive growth promoting culture, while buffering staff from unnecessary external stress (Barrett, Gessner & Phelps, 1975; Connaughton, 1981; Smith & Minty, 1984). Managers must be prepared to recognize and counsel staff who are experiencing loss and grief behaviors (Clark, 1984), or perhaps are impaired through chemical dependency (Hutchinson, 1987), and provide ethical and legal leadership (Sredl, 1983). Of course, to accomplish these tasks effectively requires the development of expert interactional skills (Calabrese, 1982; Schmieding, 1987).

There is little written about the administrative aspects of management other than that the manager has the accountability to manage and budget, cost effectively. It is unclear whether this is due to lack of interest or to the fact that within this area the manager has little discretionary control.

Likewise, there is little written about the patient care aspects of this new role, other than an acknowledgement that the manager is responsible for assuring the quality of care delivered to patients. The

aspect of the role that is in contention is the degree to which the managers should achieve and maintain a position of clinical competence in the clinical specialty they manage (del Bueno & Walker, 1984; Powers, 1984; Rokovitch, 1983; Wallace & Cory, 1983).

Summary

This research was initiated based on the assumption that contemporary nursing management continues to be influenced by three historical antecedents: the majority of nurses work as employees of institutions; most nurses are women; and, nurses seem to work in subordination to physicians. These influences have been examined tracing the evolution of the role of the nursing manager and placing it in a historical and contemporary health care context. These influences will be reexamined in light of the research findings in Chapter 6.

Research concerning nursing management is sparse and often methodologically flawed. Some empirically based data has been gathered related to role behaviors and values, but it is unclear to what extent the findings can be generalized to include both the traditional and expanded role of the nurse manager.

Likewise, there are studies that have examined the

effect of the manager's leadership style on staff and the stress managers experience as a result of their role responsibilities. Yet, they too have not progressed beyond problem identification. The one aspect of the role that is most thoroughly understood is that it demands managerial competence that is beyond what can be obtained in any basic nursing program, and that therefore some form of additional education is required.

CHAPTER 3

METHODOLOGY

The goal of this descriptive study was to identify, describe and analyze the behaviors, beliefs and values that characterize the everyday practice of first-line nurse managers in their expanded role. A variety of ethnographic field research techniques were used. First, one nurse manager was extensively observed, for the purpose of developing an open-ended, semi-structured interview guide. Once enough data was gathered to structure the guide, intensive interviewing was conducted with four additional managers in the same hospital as the original informant and 12 other managers in a second hospital. The following discussion describes the choice and justification of the methodology, the settings and entree, participants, data gathering and analysis techniques, ethical considerations and study limitations.

Choice and Justification

Fawcett and Downs (1986, p. 9) state that "the choice of a research design depends upon the question asked and the

current state of theory development. If little is known about the phenomena to be investigated, descriptive theory generating research is needed." This aptly characterizes the current understanding of the nurse manager's role, because review of the literature uncovers minimal available empirical data. A descriptive "factor searching study" is required (Diers, 1979, p. 105). Therefore, the empirically based methodology of ethnography was chosen for the purpose of developing nursing theory describing the phenomenon of first-line nursing management which would be grounded in the experiences and perspectives of practicing managers.

Ethnography, participant observation, and field research are sociological and anthropological terms with broadly comparable meanings constituting "not a single method, but a type of research enterprise" (McCall & Simmons, 1969, p. 3). The goal of the method is an "analytic description of a complex social organization" (McCall & Simmons, 1969, p. 3) that identifies the group's way of life, their beliefs, behaviors, understandings, attitudes and values--"in sum, their social and cultural worlds" (Emerson, 1983, p. 19). The researcher develops an "intimate familiarity" with the social life of a group through "prolonged immersion" in the group's daily activities using two primary field research techniques: "bodily presence in the physical scenes of social life" and

"open-ended, semi-structured conversations" with group participants (Lofland, 1976, p. 8). I conducted ethnographic field research using both techniques to develop an understanding and description of the everyday life experiences of the nurse manager subculture from the perspective of the subculture participants. It is based on the phenomenological perspective that seeks understanding and is not concerned with a singular truth or fact as in the tradition of positivism (Bogdan & Taylor, 1975). By Leininger's (1985) definition, this study is a "mini-ethnography" or is a "small scale ethnography focused on a specific or narrow area of inquiry."

Setting and Entree

Two acute care hospitals in Southern California, Harbor View and Valley Central, were chosen as the sites for this ethnography. Each of these hospitals have nursing management structures that emphasize an empowered and expanded nurse manager role.

Research began in Harbor View Hospital where I have personal and professional contacts, both within and outside the department of nursing. I have served as a consultant to this hospital and have developed and conducted several projects. Despite these relationships, I had little or no

contact with most of the nursing managers and staff.

Harbor View Hospital is a multi-service medical center, one component of which is a 150 bed inpatient facility, designed to serve a specialty patient population. It is an independent hospital with academic affiliations and serves as a clinical teaching site for a variety of health care professions.

My primary contact during the research was the Associate Director of Nursing (ADN), who is the immediate supervisor for inpatient nurse managers. Her sponsorship in the system and that of the Vice President for Patient Services, facilitated my access not only to nurse managers individually but also to group meetings and individual supervision with managers. The clear and appropriate support from these nurse administrators significantly decreased the time needed to build the trust necessary to become privy to the "backstage realities" of Harbor View Hospital (Leininger, 1974, p. 49; Lofland & Lofland, 1984).

Prior to meeting with these administrators to request access, I prepared two documents: a summary of the research methodology, which I also used in applying for research privileges with the Institutional Review Board (IRB), and a preliminary questionnaire. The questionnaire was developed to clarify for the IRB the type of data I was seeking and to decrease anxiety that I would ask for information that would

be inappropriate or disruptive. During the interview I shared several of these questions with the CNE and ADN to show how I intended to approach managers. I had two goals for this preliminary session. The first was to gain their support for the project. The second was to clarify my position establishing boundaries for my role, particularly various aspects of confidentiality. These goals were met, and I was granted access pending IRB approval.

Selecting an institution where I have established a reputation as a "productive problem-solver" with some of the staff proved an occasional liability. Pollner and Emerson (1983, p. 239) warn that losing control of the normal "quid pro quo" of field research may disturb the field, and interfere with the research process. Equally problematic were the links I had with administrative leadership. Although these relationships facilitated access to the setting, they also required constant attention to avoid inhibiting the development of trust with managers. I had to repeatedly clarify with managers and administrators the boundaries of my role as a researcher. I had anticipated, and was not surprised, by attempts to engage me in evaluating staff and problem-solving personnel issues because I have professional expertise in these areas. What I was not prepared for was the intense internal struggle not to be drawn into such activities.

This struggle, although present, was less an issue at Valley Central Hospital. Valley Central is a full service medical center with 500 inpatient beds on its main campus. Like Harbor View, it is a non-profit hospital serving a broad spectrum of patients. The administrative structural differences in the two settings will be described in Chapter 4.

Entree into Valley Central was more complex, but my goals and approach were similar to those used in Harbor View. I met first with the Vice President for Patient Services, then presented the proposal to the Nursing Research Review Committee, the Associate Directors of Nursing and ultimately met individually with each of the inpatient nurse manager groups. At each of these meetings individuals were receptive to participation in the project and initial access was achieved without difficulty.

Because the contact with Valley Central involved only brief periods of observation and extensive individual interviews and not the intensive, prolonged and repeated contact that occurred with Harbor View managers, my struggle to maintain my role as a researcher was less acute.

In summary, the research settings were one medium sized and one large, tertiary acute care hospitals with nursing administrative structures that include an empowered expanded role for the first-line nurse managers. In each hospital

managers had primary, twenty-four hour administrative accountability for their units, and only one administrative line supervisor between themselves and the chief nurse executive. Harbor View Hospital was used for both intensive observation and interviewing; Valley View was used for interviewing and only brief observation.

Study Participants

Theoretical sampling was used as the primary method for participant selection, which required selecting study participants according to the theoretical needs of the research (Morse, 1986). My initial intent was to identify a sample comprised of experienced, thoroughly enculturated, effective first-line managers working in expanded roles.

Initially, I sought nurse managers with three or more years of first-line management practice; a somewhat arbitrary criterion because many believe thorough enculturation takes considerably longer (Spradley, 1979). However, the expanded first-line manager role is relatively recent, and the turnover in role is rapid. Because the three year criteria would have limited the sample to only nine potential informants I modified my criteria and used all 16 inpatient nurse managers in both study hospitals. However, the data was analyzed and reported by categorizing

informants as novice, experienced and veteran according to their years of experience in the role (see Appendix A). The differences in attitudes and behaviors among these groups are described in both Chapter 4 and 5.

The concept of "effectiveness" is difficult to define; however, for the purposes of this study, a manager was considered effective if the CNE and ADN would rehire the manager into their current role without any hesitation (Cameron, 1986). All 16 inpatient managers were deemed effective by this criteria.

As part of my initial interview with nursing administrators in each research setting, the criteria for effectiveness was described and they were requested to identify any of their inpatient managers who would be eliminated by this criteria. In order to maintain the confidentiality of this request I offered to interview all managers regardless of whether they would ultimately be included in the research. The administrators were supportive of this initial request and, in follow-up interviews, were explicit about their criteria for effectiveness and what they considered exceptional competence. These descriptions are presented in Chapter 4.

Although many CNE's are now requiring that nurse managers in expanded roles have master's degrees, preferably in nursing, specific academic degrees were not a criteria.

Demographic details of study participants are available in Appendix A.

This method of participant selection avoided those who were at odds with their immediate supervisors. Although such an individual might have made a significant contribution to an understanding of the subculture, they also represented a risk to the research. Unstable relationships in systems are politically precarious. It would have been too easy for me as an outsider to become embroiled in personal conflicts and thereby risk losing access to the institution as a research setting. I was particularly concerned about this potential at Harbor View where I had a prolonged observation period. Prescreening manager participants also assured that data was being collected from individuals who were considered effective or competent in their management practice. Data from 16 inpatient nurse managers in two hospitals cannot be considered representative of all first-line nurse managers or even first-line nurse managers in teaching hospitals in Southern California. However, prescreening avoided confounding the data by including observations of incompetent practice.

The field work began with the selection of one nurse manager in Harbor View Hospital. The CNE and the ADN were asked to suggest a first-line manager who they

considered an exemplar or prototype of the expert nurse manager. I requested that the nurse manager be experienced, successful and comfortable in her role, and viewed by her peers, colleagues, and subordinates as an expert manager. The manager selected was given an informed consent by the ADN and agreed to meet with me to discuss the research.

After our initial meeting and a tour of her clinical area, she readily agreed to participate, and I began an observation period that lasted for two months, approximately 15-20 hours a week. During this period of time I followed her wherever she went, ultimately achieving the label of "the Shadow." Observations included public settings such as staff meetings, clinical work at the bed side, management and committee meetings and private work in her office, staff counselling, her own peer review, meetings with her assistant managers and supervision time with ADN. Based on this period of observation I developed an interview guide that I used to validate my observations by conducting an intensive six hour interview with her.

After completing an initial observation period with the primary informant, I spent the next two months interviewing and observing four additional managers in Harbor View. At the end of this period, I restructured the open-ended interview guide, using the categories that had emerged, and then began intensive ethnographic interviewing at Valley

Central (Glaser & Strauss, 1967; Morse, 1986). I continued observations at Harbor View at a weekly group manager meeting for the next five months and one all day manager retreat, to monitor the reliability of my initial observations.

In Harbor View, I chose informants both by direct observation and by reputation. In Valley Central I was limited to the reputational method only (Gilbert & Kahl, 1982). The use of this method was on a much smaller scale than the studies where it was originally developed. However, it greatly assisted in clarifying cultural themes concerning values and beliefs even in this limited application.

I also conducted interviews with four associate directors of nursing and two vice presidents for patient services who were also nurses, to gain their perspective of the role and role incumbents.

Ultimately decisions about which participants to choose were based upon the criteria of appropriateness and adequacy (Morse, 1986). Appropriateness refers to "the degree in which the method of sampling fits the purpose of the study as determined by the research question" (Morse, 1986, p. 185). Adequacy refers to sufficiency and quality of the data.

Data Gathering and Analysis Techniques

The data gathering techniques for this project were participant observation and intensive open-ended and semi-structured interviewing. Initial observations began with the informant selected jointly with the CNE and ADN at Harbor View and involved observing and listening in all work situations that were part of the everyday life experiences of the manager as described previously. Observations continued until adequate data was available to develop the initial structure for an intensive interview guide.

It was my intent that the concerns, world view and language of the managers direct the development of the interview guide. Because I was asking nurse managers to teach me about their language with all its meanings, shared beliefs and values, I took care that I did not impose my questions or sense of what was important on them. However, as the data analysis progressed, I found that many of the questions from the guide developed to gain access to the research setting were so broad that they were appropriate in the semi-structured interview.

Once the guide was developed, I began interviewing other managers within Harbor View and reduced my observation time. As described earlier, I maintained one forum where I

continued to observe over time as a reliability test for the data. This also allowed me to maintain myself as a familiar presence making it easier to return to the setting and contact key informants for validity testing of my speculations and theories (Bloor, 1983).

Ultimately this proved to be an effective technique. I was able to validate my findings in person as I continued to collect data at Valley Central and by phone after I had left both settings. These validity checks included discussing theoretical models as they emerged with two administrators and two managers in each setting and requesting that two of the managers and one administrator read drafts of some chapters and comment. The confirming, and in one case excited, responses I received indicated that I had accurately presented at least some aspects of the culture of first-line nursing management.

In the end, data collection involved 16 inpatient nurse managers interviewed during two or three sessions each. Each interview lasted three to five hours and included at the least, one brief observation period of the clinical setting where the manager worked. Appendix B describes the process in greater detail and includes the interview guides.

In addition to the manager observation and interviews, six nurse administrators were interviewed in single sessions of one to two hours each. Documents were examined

concerning organizational structure, job descriptions, manager evaluations, evaluation practices and standards, minutes of nurse manager meetings and where available, needs assessments within individual units conducted by nurse managers. These documents and administrative interviews were used to triangulate data and validate findings that emerged from interviews and observations of nurse managers (Bloor, 1983).

Ethnographic field notes were compiled on a daily basis and at the end of each observation period or interview. Formal interviews were conducted using a tape recorder with the approval of each informant. A pocket Dictaphone or written notes were used to record observations in the field or when formal recording was inappropriate. Over 2500 pages of notes were typed and coded.

Data collection and analysis occurred simultaneously using Lofland's (1976) technique of disciplined abstraction and Glaser and Strauss' (1973) constant comparative analysis. This analysis involved immersion in the data for the purpose of developing an account and an explanation of the phenomena "from an understanding of the perspective of the actors" (Melia, 1982, p. 329).

Using these approaches I began and continued data analysis throughout the period of data collection using retroduction which Emerson (1983, p. 95) describes as

"moving back and forth between observations and theory, modifying original theoretical statements to fit the observation, and seeking observations relevant to the emerging theory."

For Lofland (1976, p. 66), the role of analyst begins with "an abstract sense of what the generic situation is and what the generic strategies are." The analyst then, "immerses himself in the concrete data" and "constructs an analysis of the situations and strategies" by intertwining concrete, empirical data and abstractions.

Glaser and Strauss (1973, p. 111) use a process called the constant comparative method that involves a search for patterns as "data is coded according to its properties." As new data is added, it is compared to previously developed categories and sets for the purpose of expanding, recording and ultimately "saturating the categories" with information until a "parsimonious set of integrated concepts is developed" (Hutchinson, 1986, p. 125). Theory thus generated is grounded in empirical data (Melia, 1982, p. 328).

Study Limitations

Limitations of this study are of two kinds: those general to all qualitative studies and those specific to

this study. An ethnography is designed to describe the social/cultural values, attitudes, behaviors, beliefs and common understandings to generate rather than to test, theory (Emerson, 1983; Frake, 1983; Glaser, 1978). Therefore findings cannot be rigorously generalized beyond the study population, nor can the study be precisely replicated (Bloor, 1983).

This study was an exploratory study of a critical phenomenon in nursing. Glaser and Strauss (1973) state that the validity of a study's theory rests upon whether or not categories are saturated. Germain (1986) suggests that a study should be examined to ascertain whether the number of informants and the observational settings are adequate.

Regarding saturation, I began this study looking at a wide range of issues and ultimately examined only one aspect of the first-line nursing management phenomenon. For the practice patterns that emerged from the data the categories were well saturated by completion of data collection. However, the data was so rich and complex, I was forced to abandon other lines of inquiry that may be essential to understanding the role. A discussion of these issues is presented in Chapter 6.

Representativeness of setting was discussed earlier; however, because six of the informants had been managers for only one year, a period some consider inadequate for

enculturation to take place, their participation may also be a limitation (Spradley, 1980).

Whether the insider/outsider dilemma was maintained in acceptable balance, may also be considered a limitation. I began this research as somewhat of an insider. Although I have not been a manager nor directly supervised managers, I have been an Associate Director of Nursing in a large acute care hospital. This gave me significant insight and shortened the learning curve on the nuances of nursing management, but it also enhanced the risk that I may have made unvalidated assumptions about meanings of language and behavior that are the foundation of the culture (Spradley, 1979).

During the prolonged participant observation contact with Harbor View it became increasingly difficult to avoid "going native" as the pressure to join the group as an active member increased over time. Yet, the data that emerged from Valley Central where I maintained a much stronger outsider status so paralleled that of Harbor View that the potential biases seems to have been controlled (J. Johnson, 1983; Spradley, 1979).

Finally, I may also have assumptions and biases about the role, of which I am unaware--those taken-for-granted meanings which may have colored my observations. For example, it is my opinion that nursing should retain

administrative control of its practice in hospitals and that managerially effective first-line nurse managers are essential to this end. However, I do not have any bias concerning a particular administrative structure that would allow this to happen.

The fact remains that I am a nurse strongly committed to the use of professional nurses in first-line management roles. This strong bias must be considered a study limitation, although my awareness of this buffered its impact.

Ethical Considerations

Spradley (1979) states that not only must the ethnographer be acutely aware of the concerns and interests of informants, but the protection of their welfare, dignity and privacy must be the primary consideration in any action or decision made by the ethnographer. Fortunately ethical considerations were not acute or complex in this study. The study questions and methodology posed no significant threat to informants. The study population were fully capable of informed consent, were not engaged in deviant or stigmatized activities, and in most cases informants were sophisticated about research procedures.

Three ethical safeguards were implemented in this

study: informed consent, confidentiality and the non-interventive status of the researcher.

A summary of the proposal was submitted to the University of San Diego Human Subjects Protection Committee (see Appendix C and D), as well as the IRB's of Harbor View and Valley Central Hospitals. Each IRB granted expedited reviews with a verbal informed consent. However, a formal written consent was given to each study participant who was involved in a formal interview and the ramifications of the study were discussed thoroughly with them (see Appendix C).

The greatest risk to informants in this study would have been a breach of confidentiality on my part. The confidential nature of my notes and observations were stated on all initial contacts and reiterated as necessary. All field notes were coded to ensure confidentiality. No verbal or written feedback concerning people or events was made available. However, a summary presentation of all the findings will be offered to the participants who are interested. All study participants were told of this plan for disseminating findings.

To maintain the confidentiality of the Directors of Nursing and Vice Presidents for Patient Services, their statements are not identified beyond calling them administrators. The confidentiality of the managers is maintained by the use of composite speakers. In addition,

names of places and events have been altered to assure confidentiality.

A slightly different issue was the non-interventive, particularly non-evaluative nature of my role as a participant observer. Because I have worked as a consultant in Harbor View, additional attention was required to clarify expectations and to assure that I did not assume the role of system or personnel analyst. If staff or administration had sensed that I was evaluating their performance, I would have been excluded from all but the most superficial "front stage realities." This did not occur.

Summary

This study was conducted using ethnographic field research techniques for the purpose of developing a description and preliminary theory of the phenomenon of first-line nursing management. The study took place in two acute care hospitals and included six inpatient nurse administrators and 16 managers.

Data was collected through observation and interviews with participants and the examination of pertinent institutional documents. The analysis and collection of data occurred simultaneously using the techniques of disciplined abstraction and constant comparative analysis.

Limitations include the inability to generalize or replicate the study, representativeness, and a narrow focus on selected aspects of a complex phenomenon. Biases of the researcher and the insider/outsider dilemma were also examined. Ethical considerations were not problematic.

CHAPTER 4

NURSE MANAGERS: WHO ARE THEY AND WHAT DO THEY DO?

Given the difficulty of describing the role, that is apparent in the literature and was confirmed by the managers in this study, I will present my findings from two contrasting perspectives. The first perspective, examines the formal organizational documents that describe and evaluate the role and the role incumbents. The second perspective describes the everyday experiences of the nurse managers from their perspective.

Therefore the chapter begins with analysis of written organizational documents concerning the role of the manager and managers' descriptions of what they actually do. Next the characteristics of nurse managers, their beliefs and values, and what they consider the skills essential to enact their role are identified. These characteristics and skills are compared to their day-to-day management practice to examine the fit between work experiences and necessary skills. The perspective of the nurse administrator supervising the manager is also included in light of the conflicting research findings about the supervisor's expectation for the manager's performance and

the manager's expectation.

As the research progressed three distinct groups emerged: the novice manager with less than a year-and-a-half experience; the experienced manager with up to 4 1/2 years experience; and the veteran manager with over 4 1/2 years experience. Composite speakers have been developed to represent each group both for the purpose of highlighting differing perspectives based on levels of experience and to assure confidentiality of manager participants. Demographic profiles and descriptions of these composite speakers appear in Appendix A.

The Role of the Nurse Manager: Formal Expectations and Day-to-Day Experiences

There have been several attempts to describe the tasks and functions of the first-line nurse manager using self-logging techniques (Barker and Ganti, 1980), analysis of job descriptions and reports of chief nurse executives (Beaman, 1986; Hodges, Knapp, Cooper, 1987). Although each study sheds some light on formal role expectations, none of the studies have asked nurse managers what they do on an everyday basis. Barker and Ganti (1980) did identify a significant difference between formal organizational expectations and how managers actually spent their time, a

discrepancy confirmed by many of the managers in this study. The following comment by Anne, a novice manager, is typical:

> I'm not sure anyone knows what we do, including us. I know that's not a very good commentary, but I think it's true of a lot of nursing. When I was trying to decide if I was going to take this job, I asked Helen [experienced nurse manager in the same hospital] to tell me about it...and she tried but it's not the same as doing it.

Formal Organizational Role Expectations

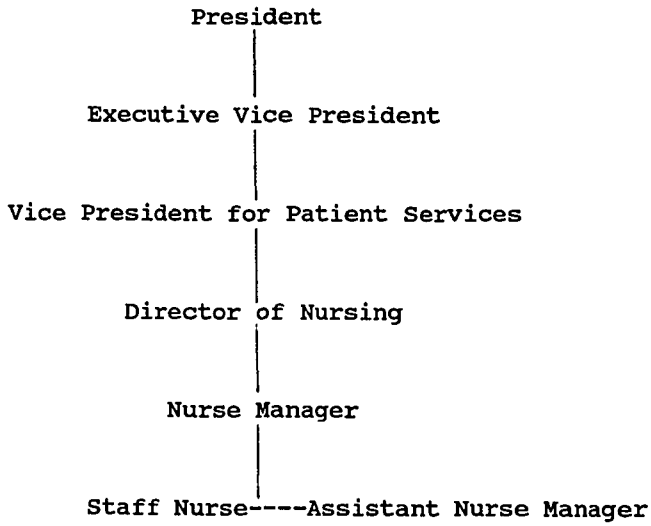
Although it is almost axiomatic that there is a difference between what is formally written about how work is accomplished in an organization and what actually occurs in everyday operations, the written descriptions of the nurse manager role represent how hospitals wish to present the role to the "outside" world. In Goffman's language this is "front stage reality" (Goffman, 1959).

Three sets of documents describe this "front stage reality": organizational charts, job descriptions and performance evaluations. Although only two hospitals participated in this study, their decentralized organizational structures allow four "division" groups of nurse managers. Therefore, their differences and similarities will be described by divisional group rather than by hospital.

Organizational Charts: Where the role of the manager fits in the organization

As described in the methodology chapter, Harbor View Hospital is a multi-service corporation that has as its primary function the care of specialty clients, including 150 acute care inpatient beds. The seven nurses who participated in the study from Harbor View were the five inpatient nurse managers, the Director of Nursing and the Vice President for Patient Services. For the purpose of confidentiality, Figure 1 describes their relationship to the organization and to each other only within the nursing hierarchy.

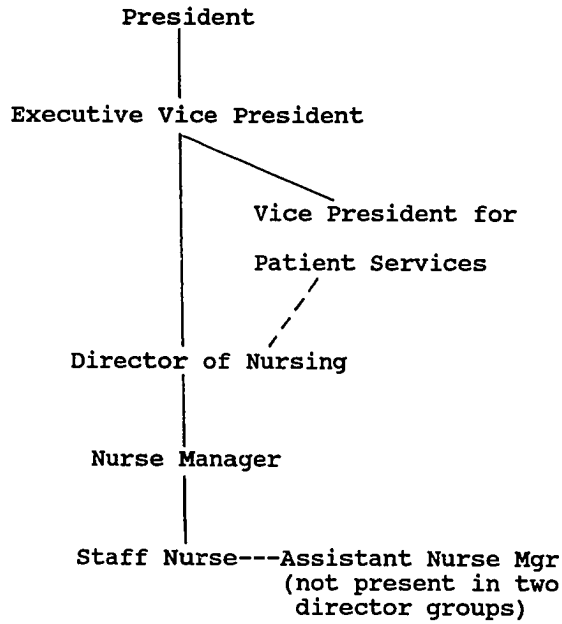
Figure 1. Organizational Chart of Harbor View Hospital



Valley Central is also a multi-service corporation whose primary function is a full range of adult and maternal-infant services including 500 inpatient acute care beds. The participants in the study were the Nurse Managers from the eleven inpatient units, the three Directors of Nursing accountable for the three divisions of inpatient services and the Vice President for Patient Services who functions as a consultant to the Directors of Nursing.

Valley Central is highly decentralized and allows the division directors of nursing the latitude to make autonomous structural organizational decisions. As Figure 2 illustrates, one of the divisions has assistant managers similar to Harbor View, while the second two do not. With the exception of the Nurse Manager, the titles of various positions in both hospitals have been modified for purposes of confidentiality and to demonstrate parallel relationships and highlight the differences between the two structures.

Figure 2. Organizational Chart of Valley Central Hospital



The similarities between the institutions, reflected in the organizational structure, are the result of organizational philosophies of decentralization. In both institutions the staff nurse reports directly to the manager and the manager to the nursing director. There are no intervening line supervisory positions. At Harbor View the Director of Nursing has a line relationship to the Vice President for Patient Services. In Valley Central this is a consulting relationship with direct administrative accountability to the Executive Vice President.

In Harbor View and in one division of Valley Central, nurse managers have designated administrative assistants. Although these assistant managers do not have line accountability for staff nurses, they do assist with clinical development and evaluation of staff and assume other managerial functions at the discretion of individual nurse managers. In some instances, there were nurse managers in both hospitals who were accountable for programs in addition to their patient units, such as acute care transport services or the intravenous therapy team, or there were individuals who managed multiple clinical units who had assistants providing managerial support for these activities. How the assistant's role functioned will be dealt with in

greater detail in Chapter 5.

Several of the managers had programs reporting directly to them without designated administrative assistants. In the divisions without assistant managers, senior clinical staff provide ad hoc management functions in the nurse managers' absence. Both institutions had formal clinical career tracks for nursing staff. All staff were expected to manage the care of individual patients and to participate to varying degrees in unit and division program development and management. However, in both hospitals the nurse managers were the first level of staff specifically designated as members of the hospital management. Assistant nurse managers were considered part of the clinical staff.

The ramifications of decentralization were described in Chapter 2 and will not be examined further beyond noting that both hospitals were experiencing the benefits of increased autonomy and difficulties of coordination identified in the literature, and were continuing to explore structural alternatives. However, the organizational charts illustrate the potential positional power of nurse managers in hospitals. They also underscore the level of accountability, authority and responsibility of the

role, particularly when one considers that each manager may be supervising as many as 120 staff, 40 inpatient beds or more and multi-million dollar budgets.

Formal Written Role Expectations

In both hospitals there are formal documents that delineate the functions and tasks of the nurse managers and formal tools and processes that evaluate their performance. Although I do not intend to analyze these documents and processes in detail, the categories of functions and tasks contained in the documents illustrate formal organizational expectations that can be compared with everyday experiences of managers and administrators.

The analysis begins with a general description of tasks and job expectations in four specific categories: human resource management, fiscal resource management, quality of care and leadership. Although the written language and degree of task specificity used in the job descriptions varied considerably among the four divisional nurse manager groups, there were many similarities. Both will be highlighted.

I will then describe the evaluation tools and processes of the two organizations which are philosophically and structurally different. The analysis seeks to describe in broad terms the

relationship between written expectations and evaluation.

Job descriptions

The philosophy of decentralized decision-making within one of the study hospitals allowed each director of nursing to develop different job descriptions. Thus one from each administrator's group will be examined.

The most significant common denominator among all four groups was that the nurse manager job was the first level in the nursing organization that had "twenty-four hour per day accountability" for discrete "clinical area(s) and their attendant programs." Formal responsibilities were focused primarily on these areas and programs and involve human resource management, financial resource management, quality of clinical care and leadership.

Human resource management for all managers included "the hiring, developing and motivating of staff within the assigned clinical area." It also included "monitoring productivity/performance, disciplining and terminating staff when necessary." One description specifically called for "promoting staff satisfaction through appropriate communication", "problem solving, program development" and "staff development." The other descriptions expressed these

concerns only tangentially through statements such as "creates an environment that facilitates professional growth and development."

The management of financial resources involved "developing" and "maintaining" program/unit budgets within "approved budgetary guidelines," as well as "projecting clinical trends and their resultant fiscal needs." The maintenance component of these responsibilities involves "controlling area/program," "salaries, supplies and equipment" within the boundaries of defined administrative guidelines or "justifying and gaining approval for budget modifications." The projective part of the task included "yearly construction of capital and operating budgets" and may involve "developing preliminary budgets for new programs."

Quality of care is a very broad category that includes assuring that patient care is delivered "at or above standards established by hospital policy inclusive of the formal internal and external regulating bodies." I was surprised to discover that only two of the four descriptions mentioned nursing practice as such. By implication this makes the nursing manager accountable for all aspects of patient care delivered within the manager's assigned areas.

A second aspect of quality included the manager's responsibility for "monitoring" the care delivered to patients and taking "remedial" action to "assure" standards are achieved. In two of the descriptions they are also responsible for developing new "policies, systems, programs and standards" that enhance "the quality of patient care." Two of the job descriptions stated that the manager was to "apply theory and research." In one case to enhance management, in another to enhance clinical practice.

The final category, leadership, defines the managers' relationship to the institution at large, the "community" and their responsibility for their own "professional development." In all the descriptions there is either a statement concerning the manager's responsibility for "communication" and either by statement or implication "collaboration" with other members of the organization.

The manager's leadership role in the institution is one of "coordinating of services" that relate to patient care within the "assigned area" and "participation on task force/committees that have system-wide applications" as a representative of their assigned area's perspective. Formal responsibility for representing the institution's perspective to the staff

was limited tc the "communication of" or "insurance, documentation, implementation and compliance with approved programs and policies."

The manager's leadership duties to the "community" beyond the hospital also varied. In one case it was not mentioned, while the other three cases were expected to "promote good public relations for the organization" by "participating in community/professional organizations as a hospital representative as directed."

The final component of leadership, "professional growth," involved the manager's personal development. In all cases, managers were responsible for their own "personal and professional growth." Three of the descriptions were specific about how this occurred and included directives about conferences, inservices and professional organizations. The fourth stated more generally "maintaining professional affiliations that enhance professional growth."

Thus, the job descriptions under which the four groups of managers functioned vary considerably. At one extreme was a generic description that does not mention patient care or nursing specifically. At the other was a detailed description including specific behaviors and tasks pertinent only to one job in the

organization. It is noteworthy that the extremes of these documents occurred within the same institution.

Overriding these differences are general statements about formal institutional role expectations common to all the nurse managers in this study.

First, managers have responsibility in four categories of management: human resource management, fiscal management, quality of service delivered and leadership. Second, they are responsible for all aspects of obtaining and paying staff and assuring that staff deliver care to patients in a way that meets the standards designated by the hospital and/or external regulating bodies, or terminating staff from the organization if standards are not met. Third, managers must develop and maintain all aspects of unit-based budgets within the parameters set by the hospital or justify and obtain permission for variations. Fourth, they must relate to other managers and administrators within the hospital in a way that facilitates the work of their area/programs and the work and goals of the total organization, and in some cases the community at large. Finally, nurse managers are responsible for assuring that they obtain and/or maintain the skills necessary to accomplish these tasks. As Liz, one of the veteran managers, described the attainment of

knowledge to meet the role:

> Well, it's a professional model. I mean, you know, I'm ultimately responsible for myself, so I'll set an objective, ask people who I'm close to if it seems to make sense, and if there are resources they know of that I don't know of, about how I might develop that part of my self. Going to school helps. Going to seminars helps. I network with other people in other hospitals. ...it's just management. Management in hospitals is changing so fast there's just no other way to do it.

Evaluation

The yearly evaluation processes used in the two study hospitals were philosophically and structurally different. In Harbor View nurse managers were evaluated by a peer review committee established by a nurse manager. In Valley Central the evaluation used a series of organizational rating tools that were compiled by the director of nursing for that division. In both hospitals, the evaluation process was the formally designated method of monitoring nurse managers' performance using a merit incentive program to reward managers for compliance with organizational expectations.

Harbor View used a peer review process based upon the job description. The managers write an evaluation of their own performance in managing their various units and programs for the last year, including where appropriate, yearly goals and objectives. They

distributed these documents to an ad hoc committee of reviewers of their choice. The committee included a staff nurse from the manager's clinical areas and programs, staff development consultant, assistant unit managers, a physician (the unit medical director where appropriate), and a manager from one of the non-nursing hospital-wide programs. The meeting was chaired by the director of nursing who summarized the meeting, added her own perspective, determined the merit raise based on the peer review and her own criteria, and completed relevant personnel forms. Membership in the group may change on a yearly basis. According to Sara, an experienced manager whose peer review I attended:

> I might choose to have a manager or a doc based on the fact that we worked together on a specific project or developed a program together, but all this is a new way of doing things, so I'll just have to see how it works.

In the review I attended, the group met and spoke together without the manager present, reviewing documents the manager had submitted, and made comments where they had specific information to share. The documents included a detailed evaluation based on each area of the job description and several documents from the projects this particular manager had supervised. The manager being reviewed was then invited to join the

group, the committee reiterated their previous comments and suggested several changes they would like her to make in the coming year.

Two aspects of the process were surprising. First, when I reviewed the documents she had submitted in her evaluation, I was amazed that she was still standing because the work load of this particular manager was staggering. The second surprise was that the manager's written comments were primarily objective. For example:

> Increased consistency in recovering lost charges [from a specific program] from $350 to approximately $150 or less per week...

The review group, however, spoke of relationship building, collaborative behavior on projects or supportive behaviors with staff. As one committee member stated:

> She just keeps coming back to us setting expectations that we can work together to solve a problem...she keeps doing it until we get the message. We know we're not easy to work with and there are times last year I would have left us if I were her, but she didn't and we mostly got the message.

In Valley Central the evaluation process at the time of the research was a "criterion" based point system. The job description categories such as human resource management were assigned points and given specific standards. The managers were then assigned

points according to how well they had met the standard. The standards, and the points they are assigned, shift on a yearly basis depending on the focus of the hospital generally or the administrative group specifically. For example, one division might decide that their human resources management category needed emphasis and that area of the management performance appraisal form would read as follows:

Human Resource Management (20 points total)

- cost per unit of service (10 points)
  meet: at budget
  above: less than budget

- staffing patterns are designed to provide a ratio of 10%, 15%, part time staff to regular staff (10 points)
  meet: 10% PT staff
  above: 15-20% PT staff

Another group might choose to distribute the same points differently according to their own emphasis.

Although the numbers have been modified and the style is a combination of two divisions, the form and goals of the example are typical of all divisions within Valley Central.

Like Harbor View, Valley Central also gathered input from staff, physicians and patients. However, Valley Central gathered information through written surveys. The survey asked for the manager's constituents to answer questions indicating their level of satisfaction with the services the manager

delivered. Thus, this aspect of the survey was overtly subjective. For example, employees were asked to evaluate their perceptions of the manager's capacity or skill at "communicating effectively, creating a positive work climate, personnel supervision and employee management/administrative cohesion effectiveness." Physicians and patients were similarly surveyed.

The final tool was a leadership assessment tool that was completed by the nursing director for the manager's division. In some divisions the nurse manager also completed this tool as a self evaluation. As one administrator pointed out:

> The design of our program is to be as objective as possible and we try to do this by getting input from as many people as possible to the manager's performance. Asking for people's opinion about someone's performance is highly subjective, but our goal is to ask as widely as possible in hopes of making this a more objective process.

In Harbor View the evaluation was constructed and directed by the manager using face-to-face peer review process. Although the evaluation was based loosely on the job description, the manager chose the emphasis and might not address some of the written job expectations. The evaluation was process oriented, subjective and interactive.

The evaluation process in Valley Central was criterion based with specific standards. The categories of job description were addressed as outcome standards that were met, exceeded or failed. The quality of service was evaluated anonymously using patient satisfaction, employee satisfaction and physician satisfaction survey scores. Although the constituency satisfaction scores were acknowledged as subjective, the evaluation process was intended by the institution to be outcome oriented, objective and non-interactive with the exception of the director who met with the manager to present and discuss the evaluation.

The similarities among the four nurse manager groups in terms of formal role expectations are numerous. Job descriptions are delineated in terms of formal role expectations configured into four similar categories of responsibility. All managers have 24 hour accountability for the functioning of their areas; have the authority to make decisions concerning resource management within specific parameters; are responsible for the quality of the service delivered within their areas and programs; and have their performance measured against the criteria of satisfaction of the recipients of that service.

The differences among the groups occur in

organizational structures, in written expectations and in the process of evaluation. Structurally, two of the four manager's groups have designated assistant managers. The language of the job descriptions and their specificity vary greatly. At one extreme is a description that is primarily outcome focused with little mention of relationships. At the other extreme is a description that includes both. Finally, the evaluations in Harbor View are interactive with the manager controlling the process by committee selection and choice of emphasis. By contrast the evaluations at Valley Central are criterion based. Organizational expectations are represented as precise standards with perspectives of managers' constituency gathered through standardized surveys. There is no managerial control over what aspects of performance will be evaluated or who will do the evaluating.

The Manager's and Administrator's Perspective of Everyday Experiences

Liz, a sophisticated veteran manager summed up both the managers' and administrators' experiences of the managers' everyday role:

> It's like Prometheus [sic] rolling a boulder up the hill, just to keep control of what we have now on our units, much less the programs. Our volume is just outrageous so it's always feeling like you have just this much air [puts fingers beneath nose to

> indicate pre-drowning]. You just have to learn to be real smart about what you choose to do and what you choose not to do. Which pile of papers you look at, which you don't and who you can work with. Delegate. Delegate when you can...because you can't do it all. People are what you have to pay attention to, always! There are no people issues that can go. Sometimes a little creative negligence can go a long way in helping people think for themselves, but you can't forget about those issues or you'll have mutiny. ...in my opinion, the most important part of the job are the interpersonal parts. In my opinion, management is about relationships.

Unlike Liz, researchers have focused on the tasks and functions commonly found in organizational job descriptions. It is interesting to note that the performance appraisal process in both study hospitals treated the manager's role as involving relationships and tasks equally. But, as we shall see in the following discussion, the everyday experiences of nurse managers are much more focused on relationships.

The Managers' Description of Their Everyday Experiences

The managers' description of their role is revealing by their choice of language and metaphors and by what they identify as the most critical aspects of their role. Their perspectives will be presented by Anne who represents the novice category, Sara the experienced manager and Liz the veteran.

Managers describe their role: an overview

The nurse manager has a complex and intricate role that "you can never fully understand until you do it." We can seek a partial understanding by beginning with an overview of the role and then examining several of the more intricate processes.

In the initial stages of this study I asked managers how they would describe what they do to a young nurse interested in management. The responses to this query were a study in extremes. Anne, a new manager of a critical care unit, offered this general observation:

> Well I'd tell them that it's wonderful and it's awful. And, that it's exciting and it's tedious as hell. And basically any extreme you can think about you'll find. [She laughs] On any given day, if not in any given hour. ...and it's not glamorous and wonderful all the time, or maybe even any of the time. But that the rewards you get are good, they last and you need to value those...find them where you can and keep them. Take them home with you!

The following statements from a veteran and an experienced manager illustrate the concern with conflicting expectations. Liz describes the problem, Sara the attendant feelings:

> ...it's almost a paradox because our scope in management has increased so much... I have perforce needed to learn a whole lot more about budget and FTE commitments and interpretation of profit and loss statements, and so on in the last year than I've probably

> ever wanted to know in my whole life. So a lot of energy is directed that way, yet I have to be a lot more clinically involved because we don't have the clinical supports that we used to. So, it's really getting pulled in two directions...
>
> -and-
>
> I'll tell you what head nursing is...it's squeezed from the top and squeezed from the bottom--that's what it is! Sometimes I get pulled in so many directions I could scream!

They also describe the need to establish and maintain standards while retaining their role as emotional resource; building relationships and fostering growth and professional independence in staff. Although both new and long term managers told me they were aware that such tasks were part of their role responsibilities before they became managers, they were shocked to discover what it was like to accomplish such seemingly "straight forward" tasks. As Sara and Liz described their evolving awareness of their role:

> Sometimes I feel like I'm being a mother to all of these people. I take care of them, I nurture them, walking behind them, you know, pick up your shoes, get your TB test done, get your license renewed, don't forget your CPR... you <u>have</u> to do it! I <u>have</u> to say things like "if so and so hurt your feelings you need to tell her that she hurt your feelings and not to treat her like she doesn't exist any more"... You know this is a part of a role nobody ever tells you about. I have to teach them how to communicate, teach them how to develop a good work ethic, whether they have one or not and a lot of times they don't, but bringing it to their

> attention that they have to be more responsible for their sick time, for example.
>
> -and-
>
> I didn't do very well my first year. I didn't know how much I had to talk to people! I got terrible feedback on my interpersonal skills, that I didn't smile enough...that I, I don't know, that I needed to reach out to people. I didn't know, I didn't understand what big images other people carry of authority figures, that you really have to bend over backwards to diffuse all of that... I mean people don't just see me, they see their mother, their father, their priest, anybody in their former life or current life who's an authority figure. Whether it's real for me or not, it's an entirely different story so you really have to work hard in relationships because that's how the work gets done.

Gradually the role of the nurse manager emerged as a study in opposites and paradoxes. It is unpredictable and lacks routines. The manager must "constantly switch hats." Yet there is an opportunity for control that provides each manager with options to enact the role in their own unique style. The following descriptions are both from highly effective veteran managers who supervise acute care areas. However, each has chosen to enact the same role with very different styles.

> There is no normal day! There is no day you can come to work and you can say "this is gonna happen first, and then I'm gonna do this and then I'm gonna do that. It just doesn't happen that way." It's not like a staff nurse who comes in and she knows that she has feedings at 10 o'clock and at 1

> o'clock and at 4 o'clock and meds due at this time with things very structured. My day is very unstructured. It depends on what's going on and what the immediate needs are of the unit. Sure I have my to-do-list or things that I need to do at some point during the day, if I can get those done in the beginning of the day, great! If not, they've got to be done before I go home... If they can go another day, I let them go...There are certain things I try to do every day. I try [emphasis] to touch base with every staff nurse. To say hello to see how they're doing, to strike up a conversation, be visible, make sure that I know which patients are the sickest and what kinds of nursing care they demand, what problems are occurring with nursing care.

-and-

> In reality, my day is pretty much scheduled and booked Monday through Thursday and Friday is the day I can usually work in extra meetings with individuals or committees...So there's a lot of structure in that sense, however, if indeed I see something else has a greater priority I can cancel what I have scheduled. So in that sense, I have a tremendous amount of control! You can't cancel an hour of patient care, you know, and so there is indeed structure, but I think the individual control, is much greater.

For some of the managers the lack of external structure and the freedom can be a source of stress. Anne, a very new manager with responsibility for an active medical/surgical unit said:

> I'm not as structured as I'd like to be. It seems like I can never follow through on even that temporary mental structure... I mean this door is constantly, Anne, Anne, Anne, then the phone rings, then banging on the door and so I just can't quite seem to have the time to really get a lot done, which is why I like to work on weekends because I can

> come in here and there are no phones and there are no meetings and I can just work.

Liz, an ICU manager with more than six years experience, described the skills required for the role as the ability to be patient, to take the long view, and a willingness to commit to long hours.

> One of the things that you learn over time is that things have to move slowly...sometimes all head nursing is is putting out fires for long stretches of time. And, then it gets better and you have an opportunity to do some of the exciting things. Some of the programs and staff development that are really going to make a difference in the long run. One of the things I found with new managers coming in no matter what their education or previous experience has been...they all come with the assumption that you complete your work in an allotted period of time and you go home and it's over, it drives most people absolutely wild that you don't finish things very quickly in these kinds of jobs...

Liz was in the process of describing her typical day which usually runs about 11-12 hours.

> Yeah, those are long hours. It's not like anybody puts that structure on me...when you commit to doing a job that you have to do the best job you can do and I guess those hours, that it just seems like that's what the job requires. I've been in this role for seven years and that pattern hasn't changed.

As the managers' role emerged from their descriptions it became clear that this was not a role for the "faint of heart." It is a role with many coexisting contradictions; it has professional values focused on individual patient need; yet, it is

managerial with a high value on organizational goals for efficiency and the greater good of the group. It is structured, yet lacking in structure, allowing discretionary decision-making for the manager to enact a personal style. The role requires simultaneous attention to management, clinical and systems/political issues at multiple levels of organizational complexity. It is a role that demands patience, a long term perspective and a strong commitment of time and energy.

More importantly, these nurse managers describe themselves and their role using the language and metaphors of social process not the language of management tasks. The next section considers the more intricate categories of the manager's everyday experiences and we will see the emphasis on process continue.

Process categories of the nurse manager's role

Even first year managers who were openly concerned with mastering the tasks the role requires spoke in terms of process rather than tasks. As Liz expressed it:

> It's been my experience with new young managers that they can learn the tasks fairly easily. The tasks are really a minor part of the whole thing. The thing they really need and often don't come with are decent interpersonal skills...personnel issues are

> what you spend 80% of your time on. So if you don't have these skills you're really sunk!

The processes described by the managers fall into four major categories: social control, "resourcing," unit-based translating/interpreting/negotiating and ultimately, facilitating change.

Managers describe a wide variety of daily behaviors concerned with establishing, monitoring and maintaining standards. Conceptually, these processes can be clearly understood as the sociological construct of social control (Berger & Luckmann, 1966). The nurse manager is the organizational "therapist" to assure that "deviant behavior" of staff is modified so that the work of the unit/program can proceed in accordance with institutional norms (Berger and Luckmann, 1966, p. 113). In nursing terms these would be the standards of practice, in management terms performance standards; and, as Sara labeled both processes "mothering." A detailed example will be presented in Chapter 5 during the discussion about facilitation of change.

The process of social control occurred frequently in this study and typically involved establishing, monitoring, and maintaining standards; the terms used by managers and administrators.

The nurse manager seeks to create a work

environment that complies with overt standards, such as practice standards, fiscal standards and personnel standards, and covert standards of the organization and unit's culture. Managers recognize and accomplish this in a variety of ways.

The following vignette came from Sara, an experienced manager, who was developing an extensive training program, for already expert clinicians to manage patients in the recovery phase of extensive surgery. To be chosen as part of the new team was considered highly desirable by the senior staff on the unit, and because the manager had a covert goal of setting higher standards of professional behavior on the unit, she established an application process. Sara describes how several staff responded to the new standards:

> I told her that filling out the application in pencil and putting down as her qualifications "because she's good" simply wasn't acceptable. She was furious! And, went on and on about how doesn't doing ten years of doing really good work count for anything! She was really enraged to say the least! [P] was also excluded and was not happy about the situation. She went on vacation and had not had her interview before she left. By the time she got back she had missed the deadline, so I had to tell her that her application couldn't be accepted. She was really shocked.

Anne described setting expectations for her staff concerning how they would interact with patients and families.

> We've basically turned around some of the patient satisfaction problems we were having, but I spent a tremendous amount of time talking... I've really tried to be a role model, it was really great when I was doing two jobs, because I would say things like, "you know there's a lot of stress on me and what I'm doing and yet if you have an issue I'm willing to just sit and listen to you and I'm not telling you that I have 50 other things to do and that's all I really expect you to do with patients."

Nurse managers also monitor established standards either directly through a variety of tools, such as incident reports, fiscal reports, etcetera or indirectly through staff reports. Much of the direct monitoring happens informally as described by Sara:

> I was much happier when my office was close to the unit and I could work with my door open. You get so you can hear when things are out of control, some doc or a parent's voice starts to rise, the noise level of the floor increases or you can hear a baby crying and it goes on too long...

The indirect monitoring comes from a variety of sources: secretaries, physicians, or staff nurses themselves. As Anne, a novice, explained:

> My AUM's [Assistant Unit Managers] are really clinical and track what's going on because they are right there in the middle of it all. I certainly have my informants, not that I choose them, they choose to inform [she laughs]... I try to foster staff problem solving among themselves as long as it's not

> too stressed they can do it...but when the stress goes up they lose it!

Maintaining and monitoring standards are often interwoven and include such areas as team building through the hiring process. The following example was offered by Anne:

> I really do a lot of informal talking so I can get a feel, or at least try to get a feel, for what their value is about the patient... I don't not hire people because they don't have my philosophy but because they don't value the patient. I mean, it's not that easy anymore, I need staff and they need to come here so part of my interview process is really letting them know what my expectations are all about... I also pull in people who are appropriate from the floor to interview with me. So they hear it again and again and again...

In other instances, maintaining standards requires direct intervention on the part of the manager to insure institutional standards are met or to sustain a productive work environment by enforcing unit based cultural standards of behavior. Liz said:

> With insurance matters right now, there's a lot of complexity...sometimes patients get dumped, if you want to call it, on the organization that really could be provided the same level of service in the area they're coming from... and I have to muscle the doctor a little bit more. I don't expect the staff to have to handle physicians in these kinds of situations. I'll do it because I'm not the person that has to deal with those physicians on a daily basis, taking care of their patients...the physician can vent their anger on me instead.

The second major process is that of resourcing which managers describe as having two aspects: emotional support and providing goods and services. The emotional support aspect of "resourcing" includes unit-wide behaviors such as "being visible," "staying calm," and "conflict resolution" or it may be individually focused by supporting a staff member through personal and professional crises. Anne offered this description of her hiring process:

> It's really a high value that the staff had. It's something they asked for when I was interviewing for this job. They kept asking for visibility. They wanted to know that I was really involved. They want to know that what happens here matters to me. You know, they're a very competent independent staff. I mean, they manage issues that come up. So it's not really that I need to be pulled in to deal with issues. They just want me to be visible and around the unit, kind of to set the tone in some ways.

Liz offered the following example:

> Staff really gets angry with physicians... Recently a staff nurse who had just had an awful encounter with Doctor X in front of a family and was just mortified about what Doctor X had said. She was drawing blood and he was critical of the way she drew it and she felt like that really...impacted her credibility with the family. She came storming into my office really upset... I said "you can do this, let's talk about ways to present the issue to him, tell me what happened." She described the situation and I said, "well was what he said right?" And she said, "yeah well he was right." And, I said, "well then probably you needed to get the information, so you don't have a problem with what he told you, you just have a problem

> with the way or, you know, the situation he told you in." ..."we'll go talk to him and I'll be behind you." She said, "oh, I know you're always behind me, supporting me." I said "no, I'm going to be right behind you!" [laughing]. "So if it really gets out of control I'm going to be there" and, it was just great to watch because I know Doctor X well enough to know that if he thinks he's offended someone that really upsets him. And, so she did a nice job...

The second component of "resourcing" is the provision of goods and services. Providing goods ranges from ordering and ensuring that equipment and supplies are available and maintained, being sure shifts are covered with the appropriate mix of staff and if "holes" or emergencies occur actually providing hands-on patient care. Services encompass direct and indirect staff development and a variety of liaison relationships with social service, community referral services, dietary, etc. Like social control, this aspect of "resourcing" is described in the literature in terms of tasks; however, managers describe their activities in terms of process. The following examples are typical of how wide ranging and creative the nurse managers can be when "resourcing" goods and services. Liz described her frustration at this aspect of the role and a creative solution:

> One of the classic things I did is we bought a gurney... We had it like two days and it disappeared, couldn't find it anywhere. And, so I went through the whole system of asking

> the floor aides to look for it, the staff and nobody...here's like this $3,000 piece of equipment that I didn't keep 48 hours and it disappeared. So, finally what I did was put up a sign and I said that I would give a pizza to anyone who could find the gurney. It was found in 40 minutes after I put up the sign.

Occasionally resourcing means the manager does "hands-on care" as Liz described:

> There've been a couple of times in the last month and a half in which the department has become saturated, meaning all the rooms are filled, trauma codes are coming in, medical codes are occurring and the hallway is lined with patients, there's not enough staff to go around. Twice within, or three times within the last couple of months I've actually grabbed a lab coat, stethoscope, taken patients for a short period of time... Sometimes people go home in the middle of the night, acutely ill, and there's no one else and I've had to come in and work. I am by no means, the strongest clinician, but I can do it... I will do it before I will allow the staff to be overloaded with unrealistic patient workloads. I get nervous [laughs], you know? But, I'm safe. I think that's important... I sincerely believe that the staff still like to see their ultimate manager be able to do what is expected of them [staff nurses], to some degree I think they also more than anything like the feeling that their manager will pitch in to the trenches when needed.

It was not my intent to evaluate the staff's perception of the nurse manager role. However, I did have opportunities through direct observation, indirect comments by managers, review of a hospital-wide survey of staff satisfaction and four unit-based surveys of

staff nurses to gain some insight into their priorities for nurse managers. I conclude that the "resourcing" aspect of the manager's role is the behavior most valued by staff. This was confirmed by a recent editorial in American Journal of Nursing (Katzin, 1989), that asked staff nurses to identify what they most valued about their manager. The following is a quote by a manager who received high praise from her staff in a hospital-wide survey:

> Staff are my top priority and I'll drop whatever I'm doing to talk to them. I don't ever say to my staff... "I don't have time to talk to you right now, I have to finish this..." That might not be right, I probably should stick more to some other kinds of priorities, maybe what I'm working on is more important. I probably should stick to that and say, "no, I need to talk to you later", but I don't want to do that. I'm afraid that I'll lose that rapport that I have with them.

The third process in the nurse manager role is one of translation/interpretation/negotiation. The manager's role in the study hospitals is what Kotter (1978) and Zanzi (1989) describe as highly dependent. A dependent role requires the manager to rely on individuals to supply goods and services that cannot be obtained elsewhere.

The nurse managers in this study did not have the option, if they were dissatisfied with pharmacy or respiratory services for example, to negotiate for

those services outside the institution. The individuals and groups the manager must interact with are fixed and therefore the manager is dependent upon their good will to accomplish the work of the unit/program.

In addition to being fixed in the organization, many of the groups are very specialized in their activities and have a unique language to speak about their services. The manager must be fluent in both languages and perspectives to translate from one group to another.

Nurse managers in this study were acutely aware of this process and spoke in terms of "marketing" or "selling" one group's perspective to another. Managers spoke of themselves as "linguists" and spoke of negotiating insights and skills developed under a mentor's tutelage. As Liz described the process:

> Of course you need to have an understanding of specific outside groups such as the JCAH requirements...a strong knowledge of billing and third party reimbursers. Probably a stronger awareness of finances. Both, beyond just the budget, operational and capital budgets, the bigger understanding of what happens within the organization...a strong knowledge of physician financial matters is necessary...why are they reacting, responding on this type of thing that doesn't appear to really affect anything important... well it may have something to do with the financial impact on them.... You know what I am, I'm a linguist! I talk fiscal, I talk physician and staff nurse.... I'm always talking!

Liz presents the reality of interpreting staff needs to administration and negotiating a compromise:

> One of the things I learned along the way is, yes you have to support your staff to administration. It's really an important part of the role but why cut your nose off to spite your face in some instances. I do filter what I say from staff somewhat, although I represent them well I also do a lot of marketing to administration about what staff needs are.

Anne emphasized this process with patients:

> There's a whole lot that can be avoided just by understanding the perception the patient has of what's occurring at any given moment. Understanding their perception or lack of perception about how the unit is made up, how it works, why four different people are coming into their room saying the same thing to them, who means what to them, someone has to get a handle on that, and get a handle on what the patient's handle on that is.

Nurse managers in this study worked with a broad spectrum of groups, each with their own perspectives and priorities that were often opposed to one another. For example, the staff nurse's perspective on the level of services required for patient care, as well as their own need for salaries and benefits are frequently in direct opposition to the hospital administrator's need to "do more for less." Likewise, an individual patient's and family's need for care and attention may be at odds with the staff nurse's triage decisions based upon the need of all patients on a unit; or the

physician's need to cohort patients to facilitate his/her work as opposed to the hospital's desire to group patients in order to cut costs. Ultimately, the manager must be able to negotiate the perspectives and priorities of all these constituent groups in order to effectively deliver patient care.

The fourth and final major process described by nurse managers was facilitating change. The rate of change at both hospitals was staggering and a major concern for all nurse managers. Small changes happened daily: new ordering forms or drugs from pharmacy or personnel standards altered charting pay practices. Large changes occurred almost as frequently, managers resigned, institutional structures reorganized, and new programs came on line.

Facilitating change is such a large component of the manager's role that it will be the focus of Chapter 5. Facilitating change involves a synthesis of social control, resourcing and translation/interpretation/ negotiation.

The managers' description of their role must include a brief discussion of the one aspect presented in task terms, paper work. The cry of the typical staff nurse is "I can either write about it or I can do it, but I haven't got time for both!" These managers

felt much the same frustration whether experienced as Sara is, as in the first quote, or Anne, a novice, in the second quote.

> The two things that consume most of my days are meetings and paper work, but at least there is productive work accomplished at the meeting, but the paper work is just repetitive and often worthless...it feels as if it's increasing by the day. I file by just stacking things in piles on the desk and then I lose it or I get interrupted and I can't remember where I was. A secretary would make a world of difference in my life.

-and-

> I feel as if I'm drowning in paper work all the time. My only choices are to stay late, to take it home or to come in on the weekends. Mostly, I stay here to do it because every time I try to take it home, I've forgotten another piece of information that I need to complete what I have. So, mostly it's stay late or come in on the weekends.

Paper work included a vast array of memos, personnel evaluations, committee reports and minutes, program descriptions all needing preparation, typing and filing. At the time of the study, only two managers had dedicated, full time secretarial support, which was recently implemented. Although others had minimal access to secretarial support, most found it essential to do this work themselves. As Liz ironically described it, "the single most valuable skill I possess is my ability to type."

Thus, the managers' descriptions of their day-to-day experiences are all process oriented with the exception of paper work. The processes are social control or the establishing, monitoring and maintaining of standards; "resourcing" or the provision of emotional support, goods and services; translating/interpreting/ negotiating multiple languages, perspectives, and priorities among constituent groups for the purpose of accomplishing the work of the clinical area; and facilitating change.

The Administrators' Description of The Managerial Role

The interviews with nursing administrators in this study were much shorter than those with the nurse managers, lasting only one to two hours each. One of the goals for these interviews was to determine if there were differences between how managers and administrators defined the role as has been suggested by several authors (Stahl, et al, 1983). Such differences in expectations might well be a source of considerable stress. However, I did not find this to be true in the study hospitals. On the contrary, managers and administrators agreed about the responsibilities of the nurse managers differing only in emphasis. The next section presents the administrators' description of the managers' role and

is followed by a concluding section about the differences in the emphasis.

Like the managers, administrators speak of the processes of social control, resourcing, translation/interpretation/negotiation and facilitation of change. As described by two of the administrators:

> The role is a balancing act, you know. They need, you know, to satisfy not only the quality but the financial standards, objectives and outcomes of the organization. They need to support staff, to bring their staff along when they need to, and cater to physicians. I mean it's probably the most difficult position in the nursing organization...in my mind, the most critical. You know, they set the tone for everything that happens...if the head nurse values and expects a care plan to be written, they are written. If she doesn't, they're not written. If she expects patient teaching, and so on. I mean they really set the whole tempo for what nursing practice is going to be. Irrespective of what I say at this level...they're really the people who operationalize it and they make it happen.

-and-

> It's the leadership component of the role is what's important. It's the manager's ability to create a work environment that's appropriate, to remove obstacles, to guide staff to do their best and getting the right people to do the job and keeping the mission of delivery of high quality patient care in front. The manager sets the tone by labeling things as problems, restraints or assets and tells the staff how to think about a particular issue at any given time.

As is apparent in these descriptions administrators' focus on social control or the process

of establishing, monitoring and maintaining standards; or "setting the tone," "setting the expectations." Although I had anticipated a major emphasis on fiscal standards, I believe it is so pervasive that the emphasis of the administrator was to maintain a clinical standard in the face of fiscal constraints. This point is also illustrated later in the chapter as administrators describe the fatal flaws of managers seeking to negotiate their role.

Unlike staff nurses who identify the resource aspect of the role as most critical, administrators seem to view "resourcing" more as a process necessary to maintain standards. Likewise, the process of translation, interpretation and negotiation that managers speak of so clearly seem to be addressed by administrators in terms of "processing," "moving staff along" or as an obvious component of facilitating change, i.e. more of a means rather than an end in itself.

Like managers, administrators describe the manager role in terms of process rather than tasks but emphasize different aspects. Of the four components the managers identified, administrators emphasized social control or the establishing, monitoring and maintaining of standards.

Role Incumbents: Characteristics and Essential Skills

Stodgill (1948) reviewed the literature about the behavioral characteristics and experiences or traits of successful leaders and found the research contradictory and generally unsuccessful. Yet the Holland Vocational Preference Inventory (1973), a vocational analysis tool, has successfully identified some general characteristics of managers. Recent management researchers make strong distinctions between the concepts of management and leadership (Bennis & Nanus, 1985; Burns, 1978; Schriesheim, Tolliver & Behling, 1978). They also point out that all first-line management roles vary considerably, particularly in the areas of dependency, constraints on decision-making and organizational structure (Child & Ellis, 1973; Kotter, 1978; Stewart, 1976).

Managers in the study setting described many similar personal behaviors and values, and some significant differences. I will describe these characteristics, essential skills and values from both the perspective of the managers and then of the administrators.

From the Perspective of Nurse Managers: Characteristics and Essential Skills

The nurse managers share many attitudes, experiences and values. Stemming from that basis, I will present what managers identify as the skills and experiences necessary to be an effective manager, how they have developed their skills, and skills they would like to have but do not.

Common Experiences, Attitudes and Values

The most striking similarities among the managers was their work history and their reason for choosing a management career. All had worked continuously since obtaining their entry level nursing education, three of the managers having started careers in other fields before changing to nursing. All had worked as staff nurses, most within the generic area they now managed. Only one manager had never worked in more than one hospital. However, three quarters of the managers had careers of five years or more in their current setting.

More important, however, are the similarities in reasons for choosing management. With the exception of one manager, they all spoke in terms of "power and control." A secondary but equally powerful theme was the need for stimulation and change.

As Sara, an experienced manager, presented her

history:

> Power! As a clinical specialist you don't have a lot of power...you are asked, your opinion...But the ultimate decision, what takes place, usually rests with the manager...I wanted to be able to make some decisions and to implement some of the things I thought were important as well. It doesn't mean that I don't appreciate input and that I have to be, you know, the all powerful person, but I felt the unit manager and clinical specialist should work together...

As Liz explained it:

> I don't do real well with routine. And there's absolutely nothing about this job that's routine, ever! I'm critical of myself because I get bored <u>easily</u> and I found that most of my jobs got to be boring after a while...I think that what was attractive to me about management in general is that you really have the ability to make change... frankly I like the power. I think we have a tendency to see power negatively. [She laughs] If somebody says they are a power seeker and like that we don't say "oh great, we need more of those" [and laughs]. I guess I don't see seeking power as negative... Plus, I've always enjoyed staff development and felt I could change the work environment so that it would a more satisfying work...

Although managers used terms such as power, control and status, they all felt a management position would provide the base from which they could produce desired change. Greenberg, Strasser and Lee (1988, p. 405) use the term "personal control" to define this attitude: "an individual's beliefs, at a given point in time, in his or her ability to affect change in the desired direction." The authors then further

differentiate personal control into beliefs about what is possessed and what is desired. These managers expressed a clear desire for control and a surprising satisfaction with the control they perceived they possessed. Liz presents this clearly:

> I have a lot of independence in this position to make things run on the floors pretty much the way I want to. But as long as my budget's on line and staff are happy, I pretty much have the freedom to do things the way I want to. Everybody's got so much to do we pretty much stay out of each other's way. We handle a lot of our problems on the unit and between managers...I've a pretty good rapport with most of the managers..."Hey, I think we've got a problem here, let me send these on and maybe you can look into investigating this." ...pretty much we're running on our own most of the time.

Ragins and Sundstrom (1989, p. 51), in their analysis of research on gender and power in organizations, used the following working definition of power, "as influenced by one person over others, stemming from position in the organization, from interpersonal relationship, or from an individual characteristic." Managers did not use the terms positional or interpersonal power but they were acutely aware of what they called politics or political savvy and described it as an essential skill. Kotter (1978) strongly supports their position given the dependent nature of the jobs they possess. Liz says:

> One of the most important things that I've

> learned is that you have to have some power skills. You have to understand power dynamics and have some political savviness. If you want to accomplish anything... political savviness, power dynamics is just essential to getting work done.

The managers' final common characteristic was their emphasis on the importance and satisfaction they found in staff development. As Anne expressed it:

> Staff development is my greatest pleasure in this job. Watching an employee come to me with a certain skill level or certain growth areas and actually helping them to work through it, even develop into a self competent prudent nurse. Especially I think new graduates fresh out of school... It's real <u>real</u> enjoyable to watch them, you know, be kind of, not necessarily fearful, but unsure of themselves and learning the techniques and watching them become a real confident assertive individual.
>
> -and-
>
> I spend a lot of time on people's evaluations because I think that's one of the ways you help them grow. And I've gotten some really positive response from that. ...there's a lot of people who haven't liked their evaluation. But even a lot of people, four or five, you know I felt I was really able to give constructive suggestions so and that they've appreciated it and I've seen change based on those suggestions. I think that's a major part of our job to help people grow personally and professionally.

<u>Essential Skills</u>

There was surprising agreement among nurse managers concerning the skills necessary to accomplish their role. The skills they identified were

communication/interpersonal, flexibility, political savvy, strong ego and clinical skills.

Communication/interpersonal skill was identified as the single most essential skill for managing. Managers used the terms as an integrated concept presenting interpersonal competence as essential to and indistinguishable from effective communication. As Liz told me:

> Communication, positive communication skills and if I look beneath that, that general umbrella that term, the ability to listen to people. I think it's important to really hear what they're saying to you. I think that you also need to have the ability to be empathetic, as well... To be able to put yourself in the situation where they're at. And what is the motivation for their perspective. Also part of that is strong conflict resolution skills to be able to if at all possible, come up with a solution that does indeed result in a positive experience for both parties. I think you also need to be articulate...and able to represent yourself in a concise manner...to communicate the message that you want to communicate.

Anne expressed it this way:

> I really admire her [an experienced manager in the same institution] because she's such a powerful communicator. She's very straight forward with people and I think you need to be honest in this job. I think you need to be able to tell people what the expectations are so that they have a frame of reference. She's clear and concise and she's able to communicate to people what they need to know about what she expects of them in a way that they can accept.

Liz described her role as "80% personnel issues."

Social control, resourcing, interpreting/translating/ negotiating and facilitating change are all interpersonal processes requiring expert communication skills. The essence of the managers' role is the capacity to communicate not only "facts" but cultural beliefs, values and behavioral expectations. The manager must communicate so effectively that the coparticipant of the exchange is satisfied, and where necessary compliant, with overt or covert expectations implicit in the message.

The second skill most frequently identified by nurse managers was flexibility, often as it related to stress and change. It was most often characterized as the ability to "switch gears quickly" or to reexamine a belief or standard in the context of changing expectations or unique circumstances. Given the instability of the work environment and the expectation that managers be instrumental in facilitating change, flexibility as a behavioral characteristic or essential skill is axiomatic. The staff in one clinical area that had recently experienced a high degree of stress and change gave their manager a small Gumby doll, which she proudly displayed on her self in her office, to symbolize her flexibility. As Sara expressed it:

> The most important thing you need for this role is flexibility. Without flexibility

> they'd have to put you away somewhere. When I first started out, if the rules said that at the end of four months of an LOA a person would lose their benefits, then at the end of four months I would take them off their benefits. Now I fudge things a little bit. I know the rules are there to be bent. The standard I try to use is would I be comfortable doing this for everyone. If the answer is yes, I go ahead and do it for this one person.

And from Liz's perspective:

> I'd say I'm a pretty organized type of person even though at times I look real scattered. I'm flexible in the sense that I don't get real frustrated if like everything on my list that day that I had wanted to accomplish and I've only accomplished one thing, I'm real comfortable about just being able to put it on my list for the next day and feel okay with that.

Managers were well aware of the need to be attuned to the political issues in their hospitals. Although this is clearly related to their awareness and use of power, I will add Anne's and Liz's perspectives.

> So you need political savvy just to survive. You need to know when to be quiet, when to talk, who to talk to, what to say to them and how to best represent the unit, your area and yourself. You have to have some strategy, some insight into the organization, who holds the power and who doesn't, and when and when not to talk.

-and-

> I know politically I probably need to pay more attention to positioning myself in the organization if I'm looking to being upwardly mobile, which I struggle with from time to time. I don't know, I just hate to play those kinds of games. I know what I should do. I should try to get on hospital

> committees, just be visible, hang out with people I don't really like, that sort of thing. But that's what you have to do.

One of the skills most often identified by less experienced managers and managers of intensive care units, regardless of their years of experience, was the need for a strong ego. The preponderance of this response from ICU managers may be related to the typically verbal and assertive/aggressive behavior among ICU staff. Sara, Anne and Liz, all ICU managers, each offer a different reason for their identification of this skill as essential.

> One of the things that helped me when I was a new manager was my mentor. She helped me with my own self esteem knowing...that not everybody was going to like you, that as long as you were fair you could sleep at night... So I learned that very early and it's helped a lot, that you have to be okay with that, that you really can't take the anger that gets directed at you personally.

-and-

> I'll tell you what you need to be able to do this job, a stable ego! [laughs]... You have to have a vision of where things should be going and how they could be better. And that keeps you reacting to some of the things that staff says. You have to have an ego that's strong enough, you know, to be able to feel good about the direction, about just the day-to-day activities, despite some of the responses...

-and-

> ...making mistakes. That's how I learn and I don't have any trouble admitting that when I've goofed. I'm certainly not perfect and

> the thing that's always been one of my strengths, if I do not handle a situation well I'll admit that to the staff, you know, "I could have done this better" or "I was wrong and in retrospect it was a lousy decision we made. Based on your feedback we're gonna relook at it and come up with a better one." I think you have to have a good ego to get into this position...

The final skill, identified by all managers as essential, was the knowledge of and capacity to deliver clinical bedside care. However, there was no consensus concerning how knowledgeable or skilled one needed to be. Of the four managers who were not practitioners in the area they managed, three were veteran managers with more than six years experience each, the fourth was a relative novice with less than a year. All of these managers were considered highly competent, but they themselves were quick to point out that liking the clinical work done in the area significantly influenced their job competence and commitment. Liz and Alice, both veteran managers are typical of the different opinions on this issue.

> I feel I have to maintain my clinical competence, perhaps more strongly than a manager would in another area because I manage ICUs. I need to particularly stay on top of current data to keep the units up to speed. I need to be able to negotiate with physicians about the purchase of new equipment, I need to be able to understand what's real about what's happening with patients or I can't staff appropriately. And I really can't trouble shoot or forecast what's going to happen unless I stay really

> competent in the care. I don't mean that I'm an expert at delivering care. It takes me considerably longer than it used to. I am safe and I do know what's going on.
>
> -and-
>
> I've had three different jobs since I've been here so that I know that I could manage an area in which I'm not clinically expert. But as long as the staff realize that, and are willing to help you learn that piece of the knowledge you need to be able to manage then it's not necessary to be a clinical expert. The fact that I've liked the care delivered in the area I've managed I think makes a huge difference... Not liking the work done in the area would make it very hard for you to get involved in the problems that are going on or to help staff see their area as a piece of the whole.

The role of clinical competence in management will be further explored in Chapter 5.

Individual managers identified a host of skills; for example, a sense of humor, high energy level, intelligence, and a positive "can do" attitude. It was not surprising to discover the skills they identified as essential are precisely the skills necessary to accomplish critical role processes. For example, social control, emotional support and translation/ interpretation/negotiation all require expert communication/interpersonal skills; facilitating change requires political savvy, flexibility and a strong ego.

How Nurse Managers Acquire Skills

Managers gained skills through education, mentoring and the most common, trial and error learning. The following descriptions concerning skill acquisition represent the most prominent themes in this study.

Liz reflects the attitudes of many of the managers in this study, and of a significant number of administrators generally, that there are knowledge requirements for the role that are well beyond basic nursing education.

> I think it's naive to assume that someone can have merely a strong clinical background and come in and be successful as a manager without having a background in personnel, management group theory, group dynamics, effective problem solving, especially in today's health care environment. I think that's essential. I think understanding the budget process, even my accounting class which I dearly despise, there's been real valuable information that helped me... It doesn't have to be a graduate level accounting class, but you need to be able to speak fiscal if you're going to be a manager in this day and age.

Most participants who did not have a master's degree were in the process of obtaining one (see Appendix A). Managers felt that what they gained from master's education was a broader understanding of the current issues in health care, research analysis and development. The status of a degree helped their

credibility when negotiating with medical center colleagues, many of whom were prepared at the master's level and doctoral level. Additionally, many nursing master's programs present in their core curriculum change theory, systems theory, motivation, decision-making, communication and human resource management concepts applicable to both clinical and administrative roles. In fact, the critical issue identified repeatedly by managers was the concept of understanding the "bigger picture" of health care and presenting this to staff. This is particularly significant to stage setting in facilitating change and will be described in Chapter 5.

However, there was one exception to this endorsement of education. One veteran manager felt she had learned all she needed to know to enact her role experientially, and she expressed negative feelings about advanced education. The lack of recognition of her work experiences by the nursing academic community when she attempted to return to school had left her feeling "school won't give me anything I don't already know."

Nurse managers who had developed mentoree relationships spoke with strongly positive feelings about these relationships. Their definition of

mentoring was the active emotional support and problem solving guidance of a novice by an expert. Ideally they wanted a consistent relationship with someone who was knowledgeable generally about management and specifically about the organization and constituents with whom the manager had worked. Liz's description represents this ideal:

> ...a mentoring relationship helps you either prepare before you're ever confronted with it [potential problem] or helps you to learn how to most effectively deal with it once you're in it. Both of these ways are experientially based. And indeed it has been true for me. I've had good mentors and I hate to use that word lightly and I'm not, because mentoring is different than educating. [A current and previous supervisor] probably fall into the category of mentors for me. People that I can look to for guidance, leadership, for support who have my personal success as something that's important to them... I remember things like a little comment about when you're dealing with physician reactions...in terms of think how it hits their pocket book first, that was a direct statement given to me...and it served me well...

Anne's attitude is typical of those who did not have a mentor:

> I don't have anybody on a supervisory level that really helps me think through what's happening. I would love to have a mentor, even just for a short time, to talk about my day-to-day experiences and help me look at them in another way. I have some of that with peers but most of the time it feels as if we're all groping in the dark together and it's not a very secure feeling.

Many of the new managers expressed the desire for a mentor. They described reaching for the support they need from colleagues, supervisors and occasionally their own senior staff, but often felt these individuals were too overburdened, not interested or were dismissive of the everyday processes with which they were struggling. After several experiences of what they perceived as rejection, they "gave up bugging" their administrator or their peers with questions either because they feared "appearing stupid" or because "everyone is so busy" and they felt they should be able to "go it alone."

Learning the job by trial and error was the most commonly described method of learning. As Liz put it:

> So how did I learn this job? I learned it painfully. I learned it by falling on my face again and again and again and then trying to figure out what happened and not doing it again the next time.

As Anne graphically described her learning:

> I feel as if I'm groping in the darkness making one blunder after another. I started out thinking that staff would want to know everything that's going on in the organization all the time and be as much a part of decision making as I wanted to be. So I started out drowning them in information. I'd look at them in staff meetings and they'd be falling asleep and then the number kept dropping off and dropping off or they'd get confused and angry because things didn't happen the way I said they were going to. So, I slowly learned about how much information to give them, when

> to give them information, what information to give and what to keep to myself.

Bukszar and Connolly (1988) questioned the efficacy of learning from experience, identifying hindsight as a confounding problem. Because they studied students in classrooms, they cautioned that their research findings may not accurately reflect reality. They suggested longitudinal research involving real life situations.

Educational preparation, trial and error learning and mentoring as methods of skill acquisition will be discussed in detail in Chapter 6.

It is interesting to note that the most commonly expressed need for greater competence, by all managers, was in the area of formal communication. As stated by Anne and Liz:

> One of the biggest lacks I feel in myself is communication. At this level in this organization you have to be articulate and concise on paper, you have to be able to stand on your feet and present your ideas, your unit's needs clearly. I'm looking for school to help me with that.
>
> - and -
>
> I guess I keep coming back to communication because it's the most important aspect of my job... sophisticated communication, being able to combine or blend the roles of upper administration's objectives and the goals of how your staff is...I think those are learned behaviors as time goes on...I almost get scared to think of what I was like five years ago. It's like, I guess, you have a certain

> sense of maturity that just lets you learn by doing it.

The perception that there was no way to learn or explain the role of nurse manager other than experientially was echoed by all managers. The need for master's level preparation for the role was accepted as a given by all but one manager. Most of the managers expected advanced education to broaden their perspective in health care in general and nursing management specifically. Many were also looking to improve their formal written and oral communication skills, an area in which most felt ineffective.

The managers who felt most confident about their day-to-day management skills had experienced a mentoring relationship, usually with their immediate supervisor who had supported them in problem solving, critiqued their behavior particularly in the area of communication or conflict resolution and had pointed out what one manager called "little tricks of the trade." All managers described the often "painful" process of trial and error learning, most feeling that there was no alternative.

Characteristics and Essential Skills of Nurse Managers: The Administrator's Perspective

The administrators' descriptions of manager skills fell into three categories: first, as essential skills or baseline expectations, second, desired skills or "star" behaviors, and finally behaviors that prove to be fatal flaws in role enactment.

Essential Skills

Administrators considered social control, assuring compliance with standards, as the primary focus of the nurse manager role. The following description by one administrator identifies clinical knowledge, interpersonal communication, and the capacity to identify and incorporate a broad organizational perspective as essential parts of social control:

> We believe in this division that the baseline for nurse managers is that they be well grounded in a good standard of patient care in nursing practice. They have to know what a standard of care is and how to deliver it...they need to be able to do what we call process the staff and that's a combination of positive interpersonal skills, communication skills, the ability to empathize with staff, take staff and move them along through a change process...third we probably look at their ability to have a broader organizational perspective. For example, I would expect managers to be able to look at a situation and be able to say, well that one borders on what would not be considered a good standard.
>
> - and -
>
> ...their ability to work with people is real

> critical communication skills, problem solving skills, coaching and counseling, all those kinds of things. They've got to do all that while they're holding to the financial accountability for outcomes. They've got to hold that line on the budget and not lose the staff or make them angry while they're doing it.

Thus for administrators their emphasis on the role process of social control is linked to an equal emphasis on communication/interpersonal as an essential skill. They then identify standards that require "enforcing" as fiscal, clinical, social, ethical and broad institutional. Like the managers their attributes about how skilled the manager must be in actually delivering "hands-on" patient care ranged from "not necessary" to able to function at the level of a typical "senior staff nurse" within the area managed.

A strong ego and political savvy were cited by only one administrator as essential. Their perspective on flexibility will be addressed in the following two sections.

Expert Manager's Behaviors

Each of the administrators in the study had at least one manager whom they considered "expert," and most had several. All administrators identified initiative and flexibility as the essence of this expert practice. As two administrators characterized

expert practice:

> It's a combination of qualities that's unusual to find. For example, she has the ability to handle instantaneous kinds of change items that occur during the day or threats or crises, as well as long term crises... But Liz is able to take things in stride and prioritize well without getting rocked or tripped up by the every day foolishness.

-and-

> Sometimes, a lot of times, we have to switch gears fast and she's always able to do it. She's always able to stay on top of it and help move the staff along. If something has to be done she does it. There's not a lot of foot dragging and complaining.

For administrators, flexibility of the expert manager had multiple meanings. It was the capacity to shift from the concrete, here and now, issues of crisis intervention to conceptual analysis of program planning and implementation. It encompassed the ability to conceptually integrate new values and perspectives that often accompany organizational change and effectively facilitate staff in that process. As one administrator explained it, "They must get on the corporate bus or leave." Broadly, flexibility refers to the managers' capacity to function comfortably in the multiple realities of the hospital's culture.

Initiative was a two part behavior. It included both the capacity to anticipate needs or problems and

to act on them presenting the administrator "appropriately" conceived solutions rather than merely identifying problems and asking the administrator to problem solve.

"Fatal Flaws"

All participants in the study were identified as competent and effective managers. Each met the criteria that they would be rehired to their current position if their administrators were given that option. Therefore, when the issue of ineffectiveness was explored it was based upon the administrators' previous experiences. The concept of a "fatal flaw" emerged from administrators' descriptions of managers who had been ineffective to the point of dismissal. Although various ancillary characteristics were identified, the primary theme was inflexibility or the inability to adapt readily to change (this constitutes the opposite trait as compared to the expert manager). Two administrators' perspectives show that flexibility ranges from a response to a corporate initiative to manifestations of personal style.

> A manager must be able to present corporate change and policy positively to the staff or they must leave...with the exception of calling the organization on behavior they're having trouble with, "this is nonsense and I can't sell this to staff", they need to be confident enough not to be yes men. But they must be able to have the kind of relationship

> with themselves and their staff if they can adapt to corporate change.
>
> -and-
>
> It's been my experience that managers who haven't made it can't accept change that needs to be made within themselves or within the organization... I think that as mistakes are made and it's inevitable that that's going to happen, you've got to have the personality that says, "yes I blew that one but now what is it that I learned from that..." The individual who continually makes excuses for why a situation happened and are completely inflexible in their thinking are the ones that can't succeed.

Given these descriptions, essential skills become a continuum. For example, flexibility in expert managers is highly developed and often associated with initiative. It is also the skill which is most commonly deficient in managers who are unable to meet role expectations.

Like role processes, essential skills do not occur in isolation. Flexibility has its greatest utility as it is effectively communicated to staff.

Administrators expected managers to be widely knowledgeable, but emphasized clinical knowledge. The expectation that managers possess bedside clinical skills varied. However, the lowest common denominator was sufficient knowledge to establish, monitor and maintain clinical standards within their areas of accountability.

Like managers, administrators identified communication and interpersonal skills as the most critical for role enactment. Flexibility was assumed as exemplified by its identification as a facet of expert behaviors and its absence as a fatal flow. Only one administrator identified strong ego and political savvy as essential, however, these may also have been assumed as a component of communication/interpersonal skills.

Summary

Job descriptions and evaluations formally define the role and its evaluation. In general, managers were required to direct the work of their units in the areas of human resource management, fiscal resource management, quality of care and leadership. Each hospital had standards in the first three areas that managers were explicitly expected to meet.

The job description and evaluation criteria were not entirely congruent. The emphasis on satisfying constituents that occurred in the evaluation of manager performance was not apparent or only tangentially apparent in the job description. Nor was the emphasis on meeting exact fiscally driven standards which

occurred in the Valley Central evaluation.

Managers viewed their role in terms of the process of management. Both managers and administrators agreed that the tasks of management in the job descriptions were easily learned. Both groups felt the difficult part of management, addressed by the evaluation, is accomplishing the tasks in a manner that is satisfying to the manager's constituency, staff, physicians, patients and families, other managers and the administrator.

Managers described their role in terms of four processes: social control, the establishment, monitoring and maintaining of standards; resourcing, the provision of emotional support, goods and services; translator/ interpreter/negotiator among unit-based or related constituency; and facilitator of change, a synthesis of the first three processes.

Not surprisingly, the characteristics managers attributed to themselves are linked to success in their role. For example, managers described themselves as desiring the control/power inherent in the role in order to make changes they felt would be beneficial. Kotter (1978) describes their desire to have and to use power as essential to a management role that is dependent upon a fixed group to accomplish work.

Managers saw themselves as enjoying the stimulation of a changing environment and they derived particular satisfaction from staff development. For the manager these characteristics were true not only for themselves but essential for their role in general.

Similar parallels were found when managers considered their skills and the skills needed in the role. The skills were communication/interpersonal expertise, clinical knowledge and flexibility. Most managers added ego strength, and veteran managers all added political savvy, as did one novice and one experienced manager.

Although my interactions with administrators were considerably less than with managers, I found that administrators concurred on the whole with the managers' perceptions of roles, skills and characteristics. Managers did not emphasize one aspect of their role over another, but administrators focused on social control and staff nurses on resourcing. Administrators depicted expert or star managerial behavior as flexibility and initiative. They described fatal flaws as inflexibility or inability to adapt to change. Ideally, administrators wanted managers to demonstrate creativity and initiative, however at the least, they must keep staff in line with current and

changing institutional standards.

The synthesis of social control, resourcing and translation/interpretation/negotiation are essential to facilitating change and therefore are the focus of Chapter 5.

CHAPTER 5

FACILITATING CHANGE

Chapter 4 identified four processes that nurse managers describe as critical aspects of their role: social control, "resourcing," translation/interpretation/ negotiation and facilitating change. This chapter analyzes facilitating change, a synthesis of the first three processes, and the most difficult aspect of the role to manage. Facilitating change includes those activities necessary to assure that a given change occurs, as well as creating a work environment and staff that respond efficiently and effectively to new standards or expectations.

Like hospitals nationwide, Harbor View and Valley Central were experiencing rapid change driven by numerous economic, technological and social forces (Greene, 1988; Odiorne, 1988). Some changes had no apparent impact; others created enormous distress among managers and staff. As the study progressed it became apparent that one of the fundamental tasks of the managers was to create a working culture that was maximally adaptable to these inevitable changes.

This activity was so critical and pervasive that participating nurse managers across all clinical areas of

both hospitals articulated a set of principles for facilitating change and have developed a unique language that describes the process.

Managers do not view change as a singular process; it has multiple facets that influence their management strategies. Therefore, analysis begins with a description of these characteristics of change and proceeds to review the nurse managers description of four phases of the change process: preparing the staff, actually negotiating change, dealing with potential failure and methods to avoid failure.

Facets of Change that Affect the Difficulty of the Change Process

Nurse managers described five facets of change that influence how difficult the facilitation process will be. The first two facets are similar to those identified by Goffman (1952) who states that an individual's perception of the change will be influenced by whether it is voluntary or involuntary, and the level of emotional importance it holds for the individual. In order to encompass the descriptions given by managers, three additional categories were necessary: degree of foreknowledge of change, and organizational complexity and stability.

Voluntary or Involuntary Change

Nurse managers can facilitate change more easily if nursing staff perceive the change as voluntary. As Sara described it, "I approach things a lot differently if we have no control...a big part of nursing is you want control. Those are the biggest issues in nursing today, autonomy, independent judgment and control over your environment..."

Involuntary change may be unrelated to the individual's performance such as a shift in practice models from primary nursing to case management. Alternatively change may be due to an individual not meeting role requirements, such as a demotion or a dismissal. Thus, Goffman (1952) further distinguishes involuntary change by whether or not an individual is perceived by others as deserving the subsequent loss of roles, status and relationships.

Whether change is voluntary or involuntary, the individual may still experience a powerful sense of loss (Goffman, 1952). This point is supported in the nursing literature on role transition and was confirmed in this study by several nurse managers (Dooley & Hauben, 1979; Flake, 1987; Gleeson, Nestor & Riddel, 1983). Ironically, the voluntary transition from staff nurse to manager generated a loss of relationships. As one administrator described this loss: "there is a fundamental point in

whether or not a manager is going to survive; you have to decide that you don't care whether or not they like you."

Thus, according to nurse managers, the degree of control perceived by staff and their beliefs as to whether or not they deserve the losses due to involuntary change are both important and strongly influence how the manager approaches "facilitating the change process." However, the perception of control may not be the most significant or even an important aspect of a given change. Kline's (1989) recent proposal of an integrated control theory model strongly supports these managers' assertions.

Degree of "Emotional Charge"

Reaction to change is critically determined by the impact of that change on the core values or status of the individual or group (Kearns, 1988). Salary and benefits are a significant measure of status, as exemplified by the fact that the most active component of nursing's largest professional organization, the ANA, is the economic and general welfare section (Mottaz, 1988). In part, this may be due to the fact that in hospitals, where the majority of nurses work, there are few other status markers.

Therefore, it is not surprising that nurse managers identified conditions of employment, salaries, benefits or the number of staff available for work as "emotionally

charged" and thus difficult to change. Alterations in status, such as promotions, terminations or revisions of practice patterns are equally important but occur less frequently. Sara described this most succinctly when she said, "...it's anything that relates to the budget...or it's more, you know, I'm telling them what they can't have as a result of the money constraints."

Anne's experiences expand on this:

> The Professional Issues Committee [a unit-based committee] seems to get the hottest issues, like what are you gonna do with the schedule, what are you gonna do with rotations, what are you gonna do with the trauma problem [practice control] we were having...the turnout for these meetings was much bigger than even our staff meetings.

Changes that do not affect core values are of secondary importance. Although they may not be perceived by staff as a major threat, they are disruptive and may impact relationships and how business is conducted.

For example, in one of the study hospitals a group of nurse managers discussed the difficulties that had arisen with the addition of a pharmacy messenger to help reduce wasted nursing time. Going to the pharmacy to get PRN or non-standard drugs requires that an R.N. leave the floor and walk to the pharmacy, an activity usually viewed by staff as a waste of precious nursing resources. But, the proposal raised unforeseen issues of status and relationships. A

walk to the pharmacy can be a break as well as a nuisance. A few minutes relief from the noise and tension of the floor, and several words exchanged with the pharmacist may not only be a welcome break, but also gets the nurse what she wants and when she wants it. Utilizing a pharmacy runner not only removes the relationship but introduces the notion of status. Logically STAT orders from ICU's come first but that "fact" implicitly relegates the needs and work of the floor nurse to a status of lesser importance.

Although changes of lesser emotional impact may evoke only subtle feelings of loss, these changes were legion in the study hospitals: the Blood Bank, x-ray or labs have new order forms; infection control procedures have been modified; there are new drugs or treatments; the personnel department wants time cards filled out in a new way; the cafeteria can no longer manage hot meals at night, but will continue a deli section. Like issues of control, the impact of change on core values influences the degree to which the manager is required to actively "support the staff" in change. However, the nurse managers were able to identify three additional facets that affect the degree and kind of response the staff will exhibit to change.

The Presence or Absence of Foreknowledge

Foreknowledge is a third critical facet of change. Foreknowledge or "warning" may be as simple as notification or involve a complex process of interpretation/translation/ negotiation. Absence of foreknowledge may have extensive ramifications, particularly if the change is involuntary and affects core values. Liz summarized her experience with such a situation in the following way:

> It happened so abruptly with...for some reason time was of the essence. And I think that was an artificial time constraint and it just wasn't planned out. It was one of those moves that we've got to do it now and we've got to do it swiftly and we have to do it secretively and we have to do it without any input from anyone. Consequently, the physicians felt victimized, the nursing staff felt victimized and I think a fair number of our patients felt victimized.

Like Lefcourt (1982) nurse managers described the need for forewarning as a method of increasing staffs' perception of control, usually in the form of participation, in any change that involved conditions of employment. For staff, this would include adding a career ladder or choosing a practice model.

Lack of foreknowledge is of little importance in changes of lesser significance but is additive or even multiplicative in changes with emotional content or involuntary change. Thus, forewarning or anticipation can be very helpful in coping with instances of involuntary

loss, such as fiscal reductions where staff have no control. The actual techniques managers use to facilitate change will be discussed later in greater detail.

The Degree of Organizational Complexity

The examples given so far have focused primarily on programmatic changes that affect the entire nursing staff in a particular clinical area or hospital. However, managers are responsible for change at various levels of organizational complexity from those involving individual nurses all the way to change affecting everyone involved in the unit.

Each level of organizational change has its own nuances, difficulties and descriptive language. Most efforts to produce change on a one-to-one basis occurred because of some violation of overt or covert standards, norms or values. Change typically involved coaching or teaching of norms but could extend to serious and extensive counseling.

Managerial "coaching" was the most benign form of social control and usually occurred because of a failure to achieve a clinical standard or unit policy. The nurse involved was assumed to be merely missing a piece of knowledge that once acquired would result in a behavioral change. On the other hand, "counseling," "counseling out"

or more graphically "jerk 'em in the office" were stronger sanctions involved for serious or repetitive violations of standards despite earlier "coaching."

"Coaching" and "counseling" are key methods managers use to maintain standards, a process Berger and Luckmann (1966) label as social control. As discussed earlier, the manager's role was therapist or agent of social control for those who deviated from institutionalized definitions of reality and standards of behavior.

As Liz described her attitude and experiences with these activities:

> Basically, it happens all the time...one of the staff members was having some difficulty and a problem was identified and we would coach them along or possibly counsel them that this is a trend that we've noticed in a behavior, a behavior that they'd manifest, that really does not meet the standard or needs to improve. And that's usually verbal and more of a coaching session, unless we get into formal coaching and counseling where there's some written documentation.

After describing a particular patient incident for which she had just finished counseling a staff nurse Sara summed up the difficulty of exercising social control at this level of complexity:

> You know that's, the trouble with a lot of this stuff. One person sees one thing, one person sees another and there is not a way to reconcile those two points of view. The bottom line is that we cannot have families as upset as this particular family was...that's a hard lesson for some staff to learn.

Although facilitating these changes, particularly those in the latter category, are often unpleasant experiences for all involved, they are not nearly as difficult to manage as those involving entire groups.

Facilitating change affecting an entire group is quite different and requires complex strategies (Kearns, 1988). For example, the manager must deal with the mechanical challenge of communicating information to a large staff that is never in one place at one time, and the psychological challenge stemming from the feelings the loss engenders for the group.

The managers combined these challenges and other in the phrase, "processing the staff." It was a multi-faceted strategy dealing with conflicting values and world views, distortion, group contagion and re-enforcement of feelings, etc. Even if the change had low emotional content, the mere communication of information required attention of the manager. However, managerial involvement increased exponentially with the number of people involved, with the divergence of perceptions and emotional content of change.

One of many examples was provided by Liz as she described how she helped her staff of 120 through a financial crisis that required reduction in the number of staff providing direct care.

> I spent hours maneuvering. I really did, hours! Long, long hours. I know that there were daily staff meetings for, I think, two months. Processing staff, allowing them calm, vent, talk about their feelings, re-explain why, so... The people working here are very committed to patient care, and they are very committed to the staff who have to provide that care. It's tough being a hospital nurse.

She continued by giving a poignant description of a particular change about which she still has strong feelings a year later.

> We've had a lot of change here in the last year. The biggest one that I can think of, which is probably a good example because it was probably one of the poorest ones...was when we had to lay off support staff... One had been here 30 years. We had a mandate from administration to cut our FTE's. And, really adhere to our nursing hours per patient day. That happened at the same time. We had to...we had input into our nursing hours per patient day based on a national average and local region statistics and uh, so number one we needed to abide by those hours, and number two cut FTE's. So we attempted to live with those hours using our support staff, we would have about anywhere from 8-9 on any given day. Well, that's 8-9 nurses. And that's not for 24 hours. That was for one shift. So we were way over our hours. And we tried and it was terrible. The nurses just could barely stand it. They had almost twice the assignments. So, it became abundantly clear and also in our checking with other institutions in the community, as well as nation-wide that those who had those low hours per patient day didn't have support staff. They didn't feel they could. So we weren't doing anything revolutionary, but it was certainly different for here. So, we laid them all off and it had to be the managers who did that.

She goes on to describe the extraordinary measures the institution employed to support the staff who were being

laid off and then continues by describing staff nurses' response.

> But, nonetheless it was very bloody, and unexpected and it caused a great deal of, number one, disappointment and frustration and anger from the staff that we should do such a thing; number two, because we had to make the decision in a week, we didn't have time to set up alternate systems about who was gonna do the jobs these people did. We only consulted a few key people. ...we couldn't consult all those professional staff because that would have been telling them, giving them information that the people who were really gonna be most directly involved with any of the decision, meaning the support staff, would have been without them. And, I didn't feel that that was a fair thing to do. ...they would have heard it, number one and felt awful. It was terrible dealing with the staff after that. They felt cheated because they had not had a chance to say good-bye, and angry because they had to pick up all that extra work.

This vignette illustrates the processes managers use in meeting their responsibility for facilitating change. They begin as interpreter/translator/negotiator among the groups involved, between the staff who leave and those who remain; between administration and staff. They continually translate fiscal concepts and interpret their meaning to staff, negotiate how remaining work will be covered; exert social control to meet new fiscal standards; and "resource" the staff with emotional support.

In individual situations when organizational complexity is low, the nurse manager draws heavily on her interpersonal skills to either coach or counsel. In more complex.

situations, she must invoke complex communications plans and repeatedly meet and endorse the change needed until the staff can accommodate to the changes.

Organizational Stability

The final facet of change to be considered is the level of organizational stability. Economic, social and technological pressures currently exerted on hospitals are creating unstable work environments. The turnover at executive levels alone is a source of concern (Burke & Scelai, 1988). In an attempt to survive economically, hospitals are making more and larger changes, such as amalgamating, being purchased by for-profit corporations, down-sizing by closing programs and in some cases merely closing altogether (Greene, 1988). This maelstrom of change is felt within nursing units. As a result changes in one part of the organization that had previously gone unnoticed were now the source of wild rumors. As Anne depicts it:

> There were so many changes last year and people were so anxious that the rumors were getting crazy. This is a very big hospital and usually staff in one department have no idea what's happening anywhere else... But last year, if beds were closed because of a low census in one part of the hospital and people were flexing, rumors would start that the hospital was going to close.

Just as individual changes that formerly might have gone unnoticed were the source of anxiety, the cumulative effect of multiple changes were also distressing even if

core values were unaffected. Berger and Luckmann (1966, p. 57) describe the existence of a matrix of taken-for-granted routines in stable social groups allowing activities to take place with little attention or anxiety. This occurs because the participants have experience with one another and can predict the action and reaction of members of the group. As group members or tasks change, anxiety and attention increases until values, roles and relationships can be experienced and reincorporated. The greater the change, the fewer things that can be assumed by the group as "known" or non-threatening routines, and the more difficult to achieve even modest change.

Not surprisingly, many of the managers and their staffs in both hospitals were dubious about the stability and trustworthiness of their places of employment. Hospitals are experiencing so much revamping that little can be taken-for-granted and change is correspondingly more difficult (Kotter & Schlesinger, 1979).

The high level of turnover amongst nurse managers is one aspect of organizational instability that is particularly significant (Mottaz, 1988). These managers are the representatives of the hospital closest to the staff, and as such are charged with the facilitating of change. However, rather than a source of trust, a new unknown

manager is often viewed by staff as merely another source of distrust and instability.

This concludes the discussion of the five facets of change affecting strategies nurse managers use to facilitate change. The most difficult changes are those that are involuntary, affect core values, are precipitous or unanticipated, involve multiple individuals with divergent perspectives or values, or that occur in an unstable or distrustful organizational climate.

Setting the Stage

Even in the face of difficult change, the nurse manager must assure that the work of the clinical area is accomplished in accordance with the standards described earlier. A common social reality is essential to enabling the work of the group and consists of the values, roles, relationships and status, and establishes priorities of tasks and how they will be accomplished. Berger and Luckmann (1966) describe the development of this common social reality as habituation of interaction that reduces the tension created by the need to make decisions. Nurse managers called the process "building trust." The trust comes when staff know and accept the specific nurse

manager's values and are certain that manager's decisions will be made in accordance with established group culture.

Effective nurse managers developed a variety of mechanisms to create a culture that adapts to change. Goffman (1959) refers to this process as "setting the stage." Nurse managers described stage setting activities in terms of relationships and communication.

Developing and Maintaining Relationships

Because many of the participants in this study were new to their position and/or new to management, they focused primarily on the establishment of their role and developing trust relationships within their group. The techniques they used can be divided roughly between developing relationships which are part of the daily work of the clinical area and developing interpersonal or social relationships. The techniques differ somewhat between small work groups of under fifty and large groups of one hundred or more, and will be described accordingly.

Development of Work Focused Relationships

Managers described three common techniques to build trust: "doing clinical," evaluations and "fire fighting." Their goal in each instance was to clarify values, expectations and priorities.

The most common strategy used for building trust was "doing clinical." "Doing clinical" has a range of meanings from helping with direct care when short staffed to actually taking a patient assignment once a month to maintain clinical skills. In addition to building trust "doing clinical" is part of the process of "resourcing." Nevertheless, many managers feel ambivalent about "doing clinical." As Anne explained it:

> I feel a kind of pull in myself as to whether I should or shouldn't be doing clinical. I find it easier, to develop relationships with staff if you are there experiencing the same stresses and frustrations they're under. And, it keeps me able to empathize with their situation and able to problem solve a bit more passionately than if I stayed in the office.

The two groups most concerned with maintaining high level clinical skills were managers new to their positions or those managing intensive care units. However, the more established managers acknowledged that the capacity to step in was rapidly becoming "an illusion." As Liz describes it:

> I have a lot of clinical experience in my background and sometimes people will seek me out because of that, but that's diminishing quickly. I'm slow and the change in drugs alone is overwhelming...

Anne was still upset a week later as she related the following incident:

> They were really going under the other day so I offered to help. I made the first drug error of my career! It wasn't serious but I was horrified!

The use of "doing clinical" is a highly debated point among the managers and administrators I interviewed. As Anne described the dilemma:

> I have such mixed feelings. It's a nice way to interface with the staff and certainly is a simple way to get their respect. I mean when I come to work in these clothes everybody talks to me and says "hi," but when I come to work in my scrubs they say, "oh, you're working today," and I think, what did you think I did yesterday when I wasn't wearing scrubs? I even post schedules of where I am and what I'm doing, but they really don't value management, nor do they particularly care about it. They're focused strictly on what they have to do.

Among the newer managers reconciling the demands of management with the desire to maintain clinical expertise causes great emotional and physical stress. In their attempt to "win the trust and respect" of the staff these new managers often found themselves "sucked in" to the staffing patterns as a "free floating" or relief staff nurse. As Anne put it, "here I was working 60 and 70 hour weeks of days, nights and weekends!"

As data collection progressed, I discovered that one of the hallmarks of veteran managers was a resolution of the conflicting demands of management versus clinical. As Liz explained it:

> It's really not that important, the nits and details of clinical knowledge, at least not to my role now. I think clinical background and an understanding of nursing is definitely needed. I can say I <u>enjoy</u> it where I can <u>provide</u> it. I get a little stroke for myself when I can throw out a

> pearl...but I also think it's necessary to be able to pitch in in terms of a major crisis...the staff need to feel safe that I won't let them work unrealistic patient workloads...that I'll be there with them...I get nervous but I'm safe.

A second technique for building relationships with staff in smaller clinical areas was direct manager participation in performance appraisals, typically by directly writing evaluations or participating in some aspect of the peer review process. This process formally reviews with the staff member the values and standards of the clinical area and gives rewards based on the degree of adherence. The manager gave the highest rewards, money, promotions and desirable work schedules, to those staff who are not only competent at work tasks but who "support unit programs." As Anne relates it:

> I put a lot of effort into performance appraisals. I usually like to write a lot and give people the recognition for anything that they have done...to me performance appraisals are a tool...they let people know that they are doing well, especially with unit programs...but it also weeds out people you don't want. It's become a real value for them...I hear it if I'm late! I may have created a problem for myself because they are a lot of work!

In larger units this work of reinforcing the clinical area culture, values, beliefs and behaviors identified by the manager as desirable, or the process of social control, fell to assistant managers or specific senior staff. In some areas, they guided various forms of a peer review

process. These individuals often had closer ties to the staff than the manager of smaller units because they were usually more involved in direct care giving activities. As such, they were much closer to the work world of the staff and did not have to bridge a status gap to establish trust. These assistants were highly valuable in supporting change and will be discussed in greater detail as the process of enacting change is analyzed.

Here are two examples of how different managers used their assistants. Liz described how she structured her unit:

> Lead people are on each shift, and they're really what I call our front line people. They're the people who are out there every day with the staff at the bedside processing them. You know, the manager can't do that on every shift, and the manager's really critical role is to make sure that those people are well developed, coached in order to allow them to make this processing of staff we talked about, happen on a daily basis. You know, the delivering of the mission and values of the organization, our beliefs about patient care here and making that happen on every shift, every day, and informal ways, you know, the nurses griping as you're helping her change the bed and you're processing them at that time. And, I see that as their most important role is to really help to develop these key people we use. And, because as a first-line manager, there's no way I can have exposure to every staff nurse twenty-four hours a day so I have to make sure that this happens twenty-four hours a day and I do this through these lead people.

Sara offered a different perspective:

> From the leads, I get the information on regarding staff. Individual staff issues, staffing problems, um, morale of the staff. They're my pulse to what's real, because they are still part

> of staff and they've been staff people so the staff can identify, they're not associated as management completely, although they are to some extent. But the staff, they can pick up, they can perceive from the staff point of view issues or problems or things that are brewing so they're very valuable to me to find out what the real scoop is.

The third activity common to all was "fire-fighting" or rapid intervention into unit-based emergencies. The "fires" usually occurred due to inadequate resources or interpersonal conflict. Examples ranged from not enough staff or linen for the next shift to the "interruption of oxygen and electricity for bed spaces 6, 7 and 8." Interpersonal conflict was a drunk parent threatening the night secretary or a doctor and charge nurse who were not speaking and won't work on the same shift together.

In the process language of the managers this sort of fire fighting was called "resourcing," the provision of emotional support, goods and services. Effective fire-fighting was essential to trust because both implicit and explicit staff expectations were for the managers to provide whatever was necessary for the work to be done.

As Sara characterizes herself:

> I feel like I'm a fireman, some days I spend all my time running around with a hose. Some days they are only little ones, but that's what my life is all about.

Development of Social Relationships

Although the individual personality of the manager determined how social relationships were developed with the staff, all managers agreed that some form of status bridging was essential to group function. Several of the managers referred to their work groups as "family" and described numerous parties and activities outside work involving all staff. For example, Sara depicted her clinical area as a socially active group beyond the confines of work.

> We're really like a family on this floor. They [staff] don't mind if you have to bring your children [to social events] or if you can only attend for part of the thing, they just want to share their personal world with us and have us share our world with them.

At the other end of the continuum were managers who described themselves as having to put a great deal of conscious effort into being seen by the staff as open and approachable. As Anne said:

> When I first started as a manager I kept hearing through the grapevine that I was not available. I finally figured out that if I was going to be seen as approachable, then I had to be the one doing the approaching. I didn't feel like I'd changed when I became a manager and I'd always been considered friendly before. But I discovered that somehow when you become a manager, you become different.

Two forms of social bridging were very common, feeding or sharing meals with staff and daily face-to-face contact.

How food is exchanged among and between work groups and

status groups in hospitals is a ubiquitous and complex process. During the early observation phase of this study I was surprised to discover the extent of food-related activities in the everyday work lives of all personnel who had contact with the unit. Indeed, the importance of "feeding staff" was initially raised by one of the assistant managers. I then began to explore this phenomenon with them to understand its symbolic significance. For some managers candy and cookies at staff meetings was a standard quid pro quo: "you come to my staff meeting and listen, and I'll feed you." For others, providing food was nurturing; when the floor was busy and staff have difficulty getting to dinner the manager sends pizza. For still others, food was given as a reward for an odious task or praise for a difficult job well done.

Two managers felt the use of food was not professional and were offended by it. Both recognize this as antithetical to group custom and one even described her assistant manager bringing food to "make up" for her violation of the norms. One manager was a novice, the second very senior and experienced. Both are involved in advanced nursing education and are considered exceptionally committed to professional nursing by their peers. It is interesting to note that both of these managers were aware

that some of their staff had difficulty relating to them. As one manager said, "they think I'm cold and distant."

The second form of social bridging, direct face-to-face contact with staff, was described by every manager. Most managers sought such contact when they arrived in the morning. Many arranged their schedules to have contact with each shift each day. Although some of the contact was problem seeking or solving in nature, much of it fell into the category of what Anne called "meeting and greeting." This frequent social exchange was described as an acknowledgement of colleague status and a recognition that both managers and staff have lives beyond work that are important. According to Liz:

> I think that if someone feels there's an individual who perhaps has some direct authority over them or who is a person making decisions that affect them directly that they want to know who this person is and they want to feel as if they can express their perspectives on whatever they might be. I think there's also a large group of people out there who have IPR [interpersonal] needs. They'd like for you to ask them, "how are the kids, how is the husband" type things, "what's new." There are definitely others who don't need that, but those who don't need that still need to know that you are present and who you are. It's the consideration part of being a leader. I think different people need varying degrees of it.

Communication of Information and Construction of Reality

Stage setting is not only the process of establishing trust and camaraderie, but it involves communicating specific information, or anticipatory guidance, about how change is to be perceived. Through face-to-face interactive communication with staff, the manager guides the construction of the social reality. Ideally this reality is high flexible, anticipates change and prepares staff for change, particularly if it poses a threat to core values. Most managers were aware of and articulate about their stage setting activities. As Liz presents it:

> I spend a lot of time talking [to my staff nurses] about the value of change. Just in general. Nursing is not going to be static, especially in the health care environment it's going to change. So you have to start off with that assumption that my work environment is not going to stay the same. Technology that we're gonna have next year is going to be different from what we have this year. We have to maintain our flexibility and if an individual nurse can't do that, then this is probably not the right environment for them.

Information Dissemination

Traditionally formal communication had dealt with individual communications focused on yearly evaluations of individuals or counseling and group communications concerned with unit-specific problems or changes in clinical practice.

Having now experienced several years of major, precipitous change in areas affecting the primary core values of pay and benefits, these managers had extended their communications to update staff continually on the status of the hospital finances, the behavior of external regulating bodies and other areas that might be a source of major change. As two of the veteran managers described this approach:

> People tend to get very focused on your own institution, your own job, your own unit and while I need to put forth the idea that people need to be very proud of this institution and affiliate with their work group, they also have a larger affiliation to nursing as a whole, and I try to present things in that light. I try to put things in a larger context so that people can understand what's happening to them in context to what's happening generally in health care.

-and-

> I try to expand their horizons beyond their own part of the world and see the institution, the profession and everything more globally. We talk a lot about, is this a problem in the state or is this a problem in the nation, is this a problem on the unit or is this a problem in the department, or is this a professional problem? It helps them to get beyond the blaming to more understanding.

The primary form for most communication was in group staff or committee meetings. Managers therefore went to great lengths to encourage attendance using methods ranging from bribes to threats. The managers tried "feeding," paying staff to attend, and repeating meetings for every

shift every week. They noted presence or absence of individual staff at meetings on their evaluations, and in some circumstances a particular meeting was made mandatory. Ultimately, however, the meetings were almost always "sold" as decision-making forums for staff control over various aspects of their work environment.

The effort to communicate and promote the desired view of reality did not stop there. Minutes were kept of staff meetings in books in the nurses' station. They were posted in lounges and bathrooms and, in some cases, even mailed to each nurse at home. Equally rigorous attempts were made to monitor and correct misperceptions of the desired "party line." In large units, staff were assigned in groups to senior staff whose responsibility it was to "process the staff" until the official cultural and informational reality was incorporated. A detailed example of this activity is given in the following section on failure and resistance to change. One group of managers even posted a rumor board where questions could be posted anonymously; the answers were posted officially and signed.

Finally, there were the unofficial informants or monitors who kept managers posted on the development of "misperceptions," thus allowing the manager to approach the "misinformed" staff member and "process" them directly

toward the desired attitudes. This approach will also be explored in greater detail later.

Education as a Tool to Construct Reality

A final communication technique used by all managers for stage-setting was education. Some educational activities were specific, such as continuing education or conferences, designed to give concrete direction for specific changes, usually those geared to practice. Conferences, particularly those with regional or national attendees, had the additional advantage of exposing participants to the broader realities of multiple hospitals. As Sara tells it:

> I love it when they come back from conferences, particularly on the East Coast. Our pay practices and staffing are golden by comparison. It shows them we are doing some interesting things. We're not some backwater.

Formal generic education was also seen by many of the managers as having the effect of broadening staff perception and increasing their flexibility and adaptability. This attitude may simply reflect the settings where the interviews occurred. As stated previously, all but one of the managers placed a high value on advanced education for themselves and many concretely encouraged staff to return to school through supportive schedules and funds. As Liz discussed her attitudes:

> I do feel education, the educational level is very important as well. Many of my staff are back in school and we help anywhere we can. I don't know where that really comes in, but I have to say maturity, something about the expanded degree that has added to your maturity and gives you more resources in order to make decisions and in order to...understand change and how to implement change and do it in a good appropriate manner. I can feel it in myself. I really feel that given what I knew prior to getting my degree, I don't think I would have been as good a manager as I can be now given those skills.

In summary, stage setting is a process of building trust among the managers and the assistants, and the staff. It is an ongoing process of communication and relationship building, reenforcing cultural values and norms, and anticipatory guidance concerning potential change. Although a variety of mechanisms were used, managers affirmed both verbally and behaviorally Berger and Luckmann's (1966) thesis that face-to-face interaction is the most powerful tool for building trust and reducing distortion. "Staying close to staff" is specified as a high priority for most nurse managers.

Facilitating a Specific Change

Many managers made a distinction between change that they control on a unit basis and change beyond their control, usually initiated by hospital administration. I

have chosen to focus on involuntary change because it was the manager's primary concern and the most difficult to negotiate.

According to managers, such change was often disorderly or unplanned. Even when elaborate plans were developed, they often "derailed." Change frequently involved multiple individuals or groups, all with contradictory or conflicting priorities and world views. Attempts at rational control of the process were often little more than thinly disguised minute to minute ad hocing. As Anne characterizes it: "You've got to get loose, stay calm and be flexible!"

The ways these nurse managers described facilitating change conflicts dramatically with the prescriptions for and descriptions of orderly change portrayed in the management literature. The clearest way to present how managers actually facilitated specific changes is to look at a typical group change that required significant managerial intervention.

In this era of nursing shortage, recruitment and retention of nursing staff is a critical issue across the country. Hospitals are trying numerous promotion and professional practice models to attract staff, but the most common, visible and readily comparable recruitment technique is offering high wages and benefits (Mottaz, 1988; Perry,

1989). According to Herzberg (1966), such conditions of employment are not motivators but can demotivate, particularly in cultures where they are indices of status. Both managerial and administrative participants felt that changes in this area of core values were second only to job security in creating tension and speculation amongst staff. The following change, presented by Sara, is a clear example of a change with major influence on core values.

In an attempt to recruit for intensive care areas, where beds were closed because of inadequate staffing, a decision was made to conduct a one year trial using time-and-a-half pay and twelve hour shifts as inducements to nurses working in critical care areas. Nurse administrators and managers in the hospital where this took place considered it a painful decision, because it violated their strongly held belief that the work of nurses across clinical areas is of equal value and thus should be equally paid. However, unequal pay was a norm in the community. For the hospital to compete successfully for staff it needed to reflect those community practices.

The plan was "sold to staff" as a trial and was highly successful in meeting recruitment goals. One year later changes within the hospital required a revision in pay practices that not only continued the discrepancies between

acute and non-acute areas, but altered how overtime would be paid, creating a slight decrease in pay for more senior staff in the ICU's, and thus angered the entire nursing staff. Managers were then faced with a new set of practices to sell. The following is Sara's account of how she presented this revamped compensation program to her staff of medical/surgical nurses.

> So I had to start by explaining all of the things that happened a year ago and why we were changing. I understood it as we discussed it in the head nurse group and through budgetary processes but explaining that to nurses was a real challenge! ...trying to explain to them money...trying to explain to them FTE..that's our lingo how many FTEs and what's an FTE equivalent. So, I had to go from ground one. Here's how we decided the budgetary process, here's how we're trying to recruit, here are the number of openings the ICU has, here are the number of openings we have, here's the standard in the community, the research that was done looking at the ICU's being on 12 hours. I had to go through every single step with them to have them understand all the components and what we did. And, take them through the process, looking at the budget saying, "can we pay other people like that? If we do, how does that impact our total budget? Where would we have to take money from to pay people all equally?" And, going through the whole process was probably the biggest thing I had to do. Some of the arguments I got and being prepared for those arguments, okay what are they going to come at me with? ...and being ready to answer them. I knew what they were going to think like... "why do they get more money than us when we're just as valuable in delivering patient care as the ICU's are", and saying, "yes, but look at recruitment. Why do we pay all of you that work nights more money than we pay day shift people? They work just as hard taking care of the same assignments, the same type of care and yet we're paying night people more because it's harder to get people to work nights...the same in the

> ICU...it's harder to get people to work in the ICU. It relates to recruitment!" That was the challenge, to put it into their perspectives that they could grope with and understand it. The same thing with the FTE thing. I told you here's a hunk of money I could pay. The institution doesn't really care whether you're on 12 hours or 8 hours as long as it's not a financial change. The money is there. I could do that, but to do that meant that I had to take away money for FTEs, bodies of people, that their salaries would be gone and I would put that into your salary. I'm going on the assumption that you would rather be well staffed than to work short staffed and be paid more money, and they agreed with me. I kept trying to get across to them it's not an issue of your ability, it's the ability to get people to work in these areas.

Sara's change represents the highest level of complexity. It is involuntary, affects core values and requires communicating complex "facts" to a large group of staff. Although there was an element of forewarning that should have lessened the complexity, the multiple modifications of the change itself entirely negated any minor advantage of forewarning. Finally, this change was occurring in an organization that was experiencing many administrative personnel and programmatic changes simultaneously.

Sara begins by stage setting and interpreting/ translating fiscal concepts into nursing values, beliefs and language. She does this while "resourcing," trying to return some sense of esteem and personal control to staff. She gives them choices but reiterates their established

cultural or unit based standards, by pointing out that she already knows what their answer will be.

Principles or Techniques of Change

Sara's approach to facilitating significant change was guided by principles that veteran managers describe having learned through trial and error. Less experienced managers spoke of problems or mistakes they had made and identified the same principles as techniques they intended to try in the future. These principles were: "Have it straight in your own head first"; "Maintain control"; "Keep people talking"; and, "Protect your resources."

"Have it Straight in Your Own Head First"

Participants in this study were all professional nurses who were once direct care-givers and who still share many of the beliefs and values of their staff. The first step in handling any change was to find a way to understand and accept change on a personal level. Comments such as, "I knew how I was responding, so I could guess what they would say"; "I knew I couldn't tolerate another change, neither could they" were typical. Managers spoke frequently of their unwillingness to be dishonest but feeling the responsibility to "sell" administrative programs of change

to staff, hoping for acceptance, but willing to settle for "resistive compliance." The more that change affected core values, the more managers engaged in ideological work with colleagues, supervisors, significant others and sometimes consultants. As Sara put it:

> That's when you can get into trouble, when you don't buy it yourself first, then you can't possibly sell it to staff. If I don't agree with something, I try to understand why I don't agree with it to get clear about how I feel about it. But ultimately I think it's my job to share information in a way that I can get compliance from the staff, that's what I mean by selling.

"Maintain Control"

Akin to "getting it straight" is to "maintain control" of the change for both yourself and your staff. As eloquently put by Anne:

> I went over the whole process again and again looking for the carrot, with everyone I could find...I wouldn't go out there and say, "well the decision stinks but you have no choice." Who wants to be in that place? That's what getting a handle on it means.

Managers described a range of control for themselves and for the staff. The ideal was total control over whether or not a change would happen and if it did how it would be implemented. If the content of the change was fixed, such as "there will be staff reductions," then the next level of control was the process, "the timing of the lay-offs or which personnel," the "how" of change. When all else fails,

intellectual control was sought to avoid feelings of powerlessness, both for the manager and the staff. The ideological work of getting it straight for yourself, putting it in perspective, and gaining personal control through understanding was an essential first step so that you could do the same for staff.

Issues of control were negotiated differently if the manager and staff of a given unit had control over the entire change process.

> If it's a big change and we have control, we set up a task force or a committee that works on it. You know there's a lot of staff input to that. It takes a lot longer but that kind of change I think is a little easier on everyone.

The managers in this study all seemed to agree with the research on change and participation, that where possible, high levels of staff involvement, although time consuming, increase the chances that change will be negotiated successfully (Baloff & Doherty, 1989; Kotter & Schlesinger, 1979).

It is important to note that many managers explicitly described an ethical component to "getting it straight" and "maintaining control" that occasionally put them in an uncomfortable situation. Although they believed, and were strongly reinforced by their superiors, that their role required supporting administrative programs and not creating

a divisive "we/they" situation, they also felt a need for personal integrity; not "faking it." As Sara and Liz described it:

> It does happen occasionally, without question, and I have to be the mouthpiece but I have a strategy for that. I will not try to sell something I cannot support and believe in, in an enthusiastic, positive "isn't it wonderful" perspective.
>
> -and-
>
> I try and maintain some integrity about it. I don't pretend I like it if I don't, but I don't go on and on in a negative way about it. I'll just say, this is, and this is why and then we'll talk about their feelings which oftentimes mimic my own and I will have been through them so I can say "yes, I felt that too and this is how I've come to think about this in a new way."

Managers were acutely aware of the social control aspects of their role, and the inherent ethical issues entailed, particularly when it involved "getting staff to buy into administrative agendas" that managers knew staff would perceive as a loss. Only one manager spontaneously described engaging in such activities with a complete absence of "soul searching." She attributed this to her previous work experiences in a hospital that was so devaluing of its nursing staff that she was "in heaven" in her current work environment.

"Keep People Talking"

"Keep people talking" is a multipart principle, sometimes called "processing," "managing perceptions,"

"marketing" or "selling." For major changes affecting core values, managers and administrators described intensive, repetitive, face-to-face dialogues between staff and managers, both in groups and in one-to-one interactions. The goal was to provide a consistent message and reduce uncertainty, as well as a controlled forum in which to vent fears and frustrations. In particularly difficult situations or with resistant staff, outside resources were added, usually upper level administration but occasionally consultants. As described by Goffman (1952) the mere act of venting emotionally returns some measure of status and power to the person who is venting, particularly when the listener is someone of significantly higher status.

As clearly illustrated in the example, the principle of "keep them talking" allows a mutual construction of reality that preserves a measure of self-esteem for the individual who has experienced the loss. It also can be used as a way to explore options and increase personnel control. At another point in her description of the example of change given earlier, Sara reminded staff that they are free to transfer to the ICU if they wished, just as they are free to work straight nights. Thus, she further reduced the assault on their feelings of diminished value and affirmed their perception of a level of control. Sara describes this

approach as reminding staff they have choices.

"Protect Resources"

The final principle, "protect resources," is axiomatic in the current environment of nursing shortages but may also reflect the nursing and feminine moral ethic of caring (Cooper, 1989; Gilligan, 1982). Protecting resources is a loose collection of beliefs involving "fairness," "saving face," "second chances" or "salvage where possible." Managers were often accommodating in the extreme when organizing schedules around staff's non-work commitments, like school and family, or in the use of "coaching and counseling." Managers also described "resourcing" to make up deficits; transfers within the institution were encouraged; and terminations when necessary were managed with the utmost face saving discretion. Sara gave this example:

> You know, this group has a hard time allowing people to make mistakes. Remember we were talking about Lois [a very senior experienced nurse], well she reamed out an orientee last night and had her in tears. It's the second time I've talked to Lois but this time I told her I'd take her out of precepting if it happened again.

Anne gave me one of her experiences:

> Well I finally had to tell her [an experienced nurse, but new to the institution] she had to find another job, our patients are just too sick for her to handle and I've been resourcing her 1:1 for two and a half months now...it's not fair to everyone else, my staffing just won't handle it...but we'll try to keep her while she looks

[for a new job].

Across a number of nurse managers and wide variety of change, we see the four basic techniques in active use: "have it straight," "maintain control," "keep talking," and "protect your resources." Although many of these managers were consciously familiar with various change theories, they depended on and articulated these four principles of change which they had developed experientially.

Indications of Failure or Resistance and Managers' Responses

As a group, nurse managers felt that major changes in values were rarely totally accepted and that often the best that they could negotiate was a degree of "resistive compliance." Managers described: "listening carefully to staff," "watching to see how people act," "making it my business to be available in informal ways, especially to staff with a lot of influence," as "pulse taking" techniques, or as methods of watching for indications of failure or resistance to change. Goffman (1952) categorizes these indicators as active and passive, categories which were confirmed by managers.

Active and Passive Indications of Failure or Resistance

Although this study did not analyze why particular areas or individuals respond differently to change, many managers and administrators alike felt that they could predict responses with a high degree of accuracy. The primary rule of thumb was the more technically complex and the higher the acuity, the more likely the staff of a given clinical area were to resist actively or to, quote Goffman (1952), "squawk."

"Raising a squawk" takes many forms, but usually begins verbally in a staff meeting. As Liz stated emphatically, "the staff were furious with me! How dare I to question how they used their benefits!" Group expression can become extremely intense. One manager fondly referred to such staff meetings as "a gang bang." Anger that couldn't be dissipated in one or more meetings usually escalated into some form of appeal to a higher authority. Occasionally the appeal was institutionalized as a grievance procedure, but usually it was more informal. Participants described instances of the staff hiring lawyers, sending delegations to meet with corporate officers or writing letters to them, several attempts to unionize or looking to physicians for support as allies.

Managers described passive indicators as more difficult to confront, simply because they were covert and required deciphering secondary signs. As Liz summed it up:

> They get surly and uncooperative with each other, patients start complaining of rudeness, attendance at staff meetings goes down and sick days increase.

Managers Responses to Failure or Resistance

I was surprised to discover that, regardless of the passive or active nature of the indicators, managerial responses were similar. Managers' interventions were determined by the number of people involved. In all cases, the response of managers was to provide a controlled forum for venting. Liz's description is typical of a veteran manager's action when only one or two individuals were involved.

> If I hear that people are still stirring up trouble later, I'll go directly and talk to them about it. "You seem like you're unresolved in this situation, do you want to talk about it some more? Because basically it's not gonna change and we need to just talk about it and see what other options could be open to you. And maybe they're not, but I understand that dragging down everybody else because you're extremely upset about this, well you know there are other options." See I encourage if they really feel that strong about it to write a note to the person who designed the program and let them know about it. Of course, that always takes hits in the organization, at myself because I have these unruly staff that like to send petitions and things but I guess I feel like if they want to verbalize themselves then we have to be comfortable listening to that. I don't mind that people speak their mind. I'd rather people be able to be comfortable and tell me how

> they didn't like it instead of everybody sitting there and feeling like you're prodding them along.

In addition to controlled venting many managers used the approach of "helping staff to examine their options" which involves reminding staff that they are valued individually and have not been stripped personally of any status, that they "owe it to themselves" to work in a congenial work setting, and that they have the right to choose to be in another setting that more closely matches their needs. Liz describes this technique most powerfully as one she uses with herself whenever she feels angry about an administrative decision and one she uses openly and frequently with her staff.

> The staff were upset again in staff meeting yesterday and I reminded them what we were talking a lot about in Friday's class. "What did we say? We said that if you can't be happy in this work environment, there's a lot of professional opportunities. If you really want to work 12 hour shifts and it doesn't look like 12 hour shifts are a possibility and that's what's important to you in your work day, then maybe you need to look somewhere where there are 12 hour shifts. 'Cause every morning when we get up, we get to make that decision."

This approach must be used carefully because it is a two edged sword and can be seen as empowering or as threatening.

When concerns were intense and generalized, managers typically called a higher authority to listen to staff concerns. As Anne describes her use of this technique:

> I told him [hospital administrator] that staff

> weren't really angry with us, our level of management, as they were with upper administration and felt that the big heavies were there telling us we had to make this change and so I shared with him that I thought it was really important that he come down and meet with the staff and talk to them. I gave it a lot of emotion that way, telling him that he needed to do it, so we set up a time and he came down. There was a lot of anger and I felt like he needed to hear it directly.

Indicators of failed or failing change may be overt and focused or covert and diffuse; however, regardless of the symptom, the cures are similar. The primary technique sought to vent the emotion and reestablish a sense of personal or group status through acts designed to empower or reassert personal efficacy or to assure valuing.

Techniques for Failure Avoidance

"Change is a fact of life in hospitals. Nursing is not going to be static. So you have to start with that basic assumption and work from there." (Liz) This basic theme was echoed by all managers and although they often felt that there was little to be done to control the pace of change, there were three primary strategies they used to reduce the chances of failure or resistance: hiring strategies; information control; and timing.

Hiring Strategies

Concerns about hiring staff who had an appropriate skill "fit" for the clinical work being done within a unit was a major concern for managers. However, this was secondary to the search for staff who were interpersonally competent. Technical clinical skills appropriate to the work of the unit were of course highly desirable, but most managers felt these could be taught. Interpersonal skills are different. As Sara described it, the applicant "who feels like a blank wall, I won't hire no matter how technically competent they are because I don't feel that there's much I can do to make up that interpersonal deficit."

Interpersonal competence was variously described as "flexible with a good attitude," the "ability to communicate," "interpersonal skills" or "empathetic reaching out." As Liz put it:

> If they cannot communicate or if they're abrupt or there's an attitude problem, I wouldn't consider them at all...because at some point they won't be able to get along with patients or staff and you'll end up counseling them, and attitude is almost impossible to change.

Information Control

Unlike the consistency of opinion concerning hiring practices, the timing and content of information to be shared with staff varied among managers. The majority of

the managers did not want to withhold information from staff, but thought they should buffer staff from the confusion of bureaucratic negotiations and to communicate the outcome rather than the details of the process of decision-making. This buffering function was exercised solely in areas where staff opinion would have no impact on organizational decisions.

The following discussion came from Anne, who had just completed her first year of management and who had facilitated several major changes.

> After the confusion of that last change, I think I've learned that sometimes it's not appropriate to share information as fast as I have been. I'm much more cautious with waiting until I get a piece of paper with print on it and signatures before I share it with the staff. There really isn't any point in putting them through all those changes. I began to look at the institution and how decisions were made and realized that things can change from minute to minute and that staff don't need to have every little bit of information as it comes along. I could share all the information that I have, but after a while it gets to be miscommunication and things never seem to turn out the way they were planned or on the planned timetable.

At the other end of the continuum was Liz, one of the veteran managers, who took a much more aggressive approach.

> I've been in this institution a long time and I guess at this point in my career I consider myself a risk taker. When I hear a change proposed that I feel is outlandish and I know simply isn't going to fly, I sometimes take a risk and don't do it immediately or I don't communicate it to the staff. The two times that I've done this I was proved correct and, in fact, the system had to

> back off of some of the changes they proposed. I feel like I have a good sense of what's going to work and what isn't going to work and my staff are stressed enough with the work they do without upsetting them unnecessarily for something that isn't going to work anyway.

Many managers considered consistency of information as important as timing. Given the difficulties of communicating with large numbers of nurses many of the more senior managers have divided their nurses into smaller groups and assigned them to senior staff. These senior managers also happen to be responsible for the majority of the larger more active units. The communication is then handled as Liz presents it:

> When I know we have a big change coming that's going to be a problem for the staff, the first thing I do is get my senior staff together and communicate the information to them. We get their feelings and my feelings all straightened out and together we plan exactly how and what we're going to communicate to the staff. If it's a really big change I'm the one who communicates it again to the staff in staff meetings or when I'm making rounds. You know, I might say, "have you heard about...?" as I go around talking to staff. That does a couple of things. It gives me an opportunity to interact in a meaningful way and it also lets me know what they're hearing. You know, is the information getting down to them, and I also have a chance to see what their reactions are. So usually everything I try to give to the senior staff first.

A second veteran manager offers a slightly different perspective:

> I get the senior staff and we discuss what's going to be the party line. I've found that it's important that the staff hear the same thing from

> everyone. It reduces rumors and confusion. This is particularly important when the situation is one that's causing a high level of stress amongst the staff. The people from personnel sat in on my last staff meeting to see how staff were feeling about the new benefit package. They told me afterward that they were impressed with how calm the staff were. I didn't say anything but the truth is they have no idea how hard my senior staff worked before the meeting and will work again after the meeting to make sure everyone understands and has a chance to talk about what's happening.

Timing of Change

> Too much change too fast can get to be a problem even if they're little changes or things that people want. Everybody starts to get confused and anxious. That's when I start getting calls at home to solve problems that staff usually can manage on their own. If there are a lot of big changes happening then the rumors start. (Liz)

Most changes in hospitals are beyond the authority of the nurse managers' control. As the number and scope of the changes increased, the more experienced managers described a pattern of diffuse anxiety, an increase in rumors or distorted information, and a resurgence of anger over old losses. As Sara described it, "that's my signal to back off anything new that I can and stay close to the staff."

The changes managers have control over are usually unit-based and programmatic. As Anne described the change process:

> I knew we were going to have difficulty switching primary nursing from 8 hours to 12 hour shifts...but we did some pre-planning. In fact, I had a wonderful idea to use a co-primary nursing model, but it was too much for them right then and

> they told me in staff meetings and in one-to-one that it just would not work. I had done a model for them but I listened to them and I realized that it was just too much change all at one time. So, we just bit the bullet and said we'll let everybody get used to 12 hour shifts and then we'll really start looking at what we can do to get back on track with primary nursing. And, that's what we did. The Primary Nursing Committee then became more of the instigator that made the co-primary decision...I did a lot more split shifts. Twelve hours shifts were a major change and I discovered that I just couldn't push them faster than they were ready to go.

All nurse managers were acutely aware both of the inevitably of change and their responsibility for its successful facilitation. In order to reduce resistance or failure of change, more experienced managers specifically hired staff for their interpersonal competence and flexibility. They also reduced the stress by controlling the timing, content and delivery of information about change, as well as the type and number of changes a particular staff would experience during a given time period.

Summary

In this chapter I have explored the facilitation of change, one of the more complex and demanding aspects of the job of the nurse manager. Their descriptions of this process were organized using Goffman's (1952, 1959) concepts

of change as the loss of existing values and their attendant roles, relationships and status and the acquisition of new values. Berger and Luckmann's (1966) theory of the social construction of reality has been used to elaborate the process that managers use to prepare, transact and monitor the effectiveness of change as well as how they manage and/or avoid failure.

Nurse managers first assessed the various facets of change. They described all change as a process of transition from one set of beliefs and behaviors to another, but the degree of conflict and stress inherent in the transition and the most effective methods of facilitation were dependent upon the specific change.

The managers identified five modifiers of change which they described as both additive and interactive. The most difficult change to facilitate was one that combined all five: involuntary, affected core values, was unanticipated, involved multiple and divergent groups and which occurred in an unstable organizational climate.

Goffman's (1959) concept of "stage setting" succinctly captures the second component of change, preparation. "Stage setting" is a two part process. First, it is the broad establishment of interpersonal trust between the manager and the staff through the habituation of daily

social and work interactions. This assures staff that the manager's decisions will be made in accordance with established group culture. Second, "stage setting" involves the communication about the specific nature of change, how it is to be perceived, and knowledge, skills and resources necessary to enact the change.

The actual facilitation of change can be as straightforward as how to accomplish a new task or as complex as the alteration of a core value. Regardless of the complexity, managers describe their role in terms of "translation" and "selling." Their task was to translate the needs of the group initiating the change into words and concepts the staff would understand, and to "sell" the staff on the necessity of change, persuasively enough to obtain acceptance or at least compliance.

In order to accomplish this task the more experienced managers described four principles, "have it straight in your own head first," "maintain control," "keep people talking," and "protect your resources." Each principle is a specific technique to facilitate the ideological work necessary to give-up or modify one set of values and accept or incorporate another. Particularly with complex changes, managers would first talk among themselves. They would search for ways to reconcile conflicting values and beliefs

and to rationalize losses thus minimizing their own feelings of helplessness, anger, or victimization, thus increasing their feelings of control and esteem. Having accomplished this work for themselves, they were then prepared to support the staff through the same process.

Successfully facilitating change requires the integration of new values, beliefs and behaviors. It is an ongoing process or a transition over time. Managers monitor this process carefully looking for indications of resistance which, whether passive or active, were managed similarly by providing various forums for group or individual venting, an extension of the principle "keep them talking." By listening themselves or assuring that other powerful members of the institutional hierarchy listened to staff complaints, managers tried to problem solve and give messages of empowerment and valuing. Thus, they attempted to buffer any loss of status the staff might be experiencing.

The managers also were aware of and described three principles to avoid failure generically. These principles included hiring strategies, information control and timing of change.

When hiring staff, managers look specifically for indications of flexibility and interpersonal competence. In many cases they valued these traits above specific

technical skills, reasoning that technical skills could be taught but that the capacity to adapt to the stress of change could not.

Likewise, most managers attempted to control information about change and the timing of change. By limiting information, they sought to buffer staff from unnecessary stress and to assure the staff's adaptive capacity was not strained unrealistically by multiple, simultaneous demands.

As discussed in Chapter 4, both managers and administrators identified the process of facilitating change as a critical aspect of the role of the nurse manager. Amongst experienced and veteran managers there was a strong consensus about how this process was transacted. Newer managers were quick to describe the unsuccessful aspects of their attempts at facilitating change and to identify how they intended to alter future behavior.

There were varying degrees of ability to articulate the facets and process of facilitating change, with less complete constructs expressed primarily by novice managers. There were also several breeches as described in this chapter and Chapter 4 both in the area of stage setting, and in the area of necessary job skills.

The economic, technologic and social forces that are driving changes in hospital-based health care are likely to increase (Porter-O'Grady, 1989). Nurse managers will therefore continually need to improve their skills in the art of facilitating and managing these changes.

CHAPTER 6

DISCUSSION

The purpose of this study has been to describe and analyze the behaviors, beliefs and values that characterize the everyday practice of first-line nurse managers in their expanded role. The research methodology included observations and indepth interviews with sixteen nurse managers and six administrators in two tertiary acute care hospitals. An analysis of the data gathered from the study participants characterizes the managers as primarily concerned with managing human resources and establishing a viable reality or culture. Not surprisingly they are skilled communicators and interpersonal experts.

This research was biased by assumptions stemming from my own work experiences and a review of the historical and current literature concerning the role's status, structure and evolution. The chapter therefore begins by comparing and contrasting those assumptions of the day-to-day reality presented by the study participants.

The participants in this study depicted nursing management as a rich and complex phenomenon. In the course of gathering and analyzing the data several themes emerged that are important for a more complete understanding of the

phenomenon. This chapter concludes by exploring several of these issues including sources of stress, organizational culture and the influence of gender on management style, values and decision-making.

Assumptions vs. Reality of Everyday Practice

This study was based on the following assumptions: that social groups develop a common culture that shapes their everyday lives and creates an interpretative framework which through the "facts" of daily events are given meaning; that managers are employees of institutions whose specific activities and relationships to supervisors and subordinates are prescribed and proscribed by the organization; that there are disparate values and perspectives between the predominantly male profession of medicine and the female profession of nursing; and that nurse managers who are effective occupy a pivotal and powerful positions within their institutions.

Although I found these assumptions broadly supported by the data, they were not demonstrated in the day-to-day culture of nurse managers as I had anticipated. Therefore discussion of the findings will begin by comparing these assumptions with the everyday practice realities of the study participants.

Nursing Management as a Common Culture

This study began with the assumption that nurse managers would develop a common culture thereby creating a social reality that gives subjective meanings to objective "facts" (Berger & Luckmann, 1966). Although I believe this is how "reality" is constructed as a sociological construct, I was surprised to discover the process explicitly stated as a critical role expectation by both administrators and nurse managers. Thus, managers were not only participants in a common culture but also expected to give leadership to the construction of reality within their assigned units/programs.

Managers described themselves as "linguists" translating, interpreting and negotiating among groups and with individuals; taking the values, beliefs and expectations or needs of one group and explaining them to another. They explicitly describe learning where and how to "bend the rules," to communicate information selectively, "marketing" or "selling" the needs or expectations of one group to another. Administrators were equally direct concerning their expectations that managers would construct a positive "reality," that managers would interpret "facts" as "opportunities" rather than "constraints."

Both groups stated that once reality was constructed in the form of "standards" or behavioral and attitudinal norms,

it was the managers' responsibility to maintain the norms through various forms of social control, called "coaching," or "processing" and then support staff in the reality through "resourcing."

But simply constructing a shared reality was not enough. The almost continuous change in hospitals also required a continuous reconstruction of reality sometimes referred to as managing change. Therefore, one of the keys to managerial success was the ability to be flexible and "facilitate change" in staff.

Thus, multi-dimensional interactive patterns of practice emerged, focused within the area and programs for which the nurse manager was accountable. It required the managers' continuous interaction among all constituents related to their area/program for the purpose of constructing a stable but flexible social reality that supported the delivery of high quality patient care. The pattern was characterized as a continuous process of translating/interpreting/negotiating reality among area/program constituents. It was a process of supporting reality by "resourcing," enforcing reality through social control, and ultimately facilitating changes in reality. In short, the nurse manager managed people and definitions of reality.

I had anticipated there would be differences among the

nurse managers' beliefs and values about their role and that these would be influenced by organizational culture and acuity or type of patient care. Although these factors had some influence, they did not affect the fundamental focus of management described in the pattern. For example, one group of managers was experiencing an exceptionally high rate of organizational change and was having difficulty doing the ideological work necessary to incorporate the change and then supporting their staff in a similar process. Although as a group they were experiencing a high level of anxiety and organizational distrust, their management patterns of behavior were no different from colleagues in more stable circumstances.

Likewise, managers frequently stated that it was important for them to supervise areas where they enjoyed and understood the clinical work of the area. Their clinical interest meant they empathetically and knowledgeably incorporated priorities of the unit in the typical day-to-day problems of management. Although managers described the same management process or pattern of supervision, each clinical area had its own particular values and attitudes.

Nurse Manager as Institutional Employee

Initially I assumed that nurse managers' activities would be prescribed and proscribed by the organization in which the were employees. This assumption was supported by

the study. Despite the managers' wide latitude to develop a personal management style there were clear overt and covert standards to which managers must adhere, and negative sanctions for non-compliance. However, this study revealed the assumption to be incomplete. In actuality, nurse managers not only comply with such institution expectations but they go further and find ways of incorporating the expectations in their own values. It was this remarkable ability to integrate differing needs/goals that distinguished the truly effective nurse manager.

To create shared definitions of reality the nurse manager must understand not only the clinical context of her unit but the organizational context. Thus, the nurse manager may be the first level within the nursing hierarchy who becomes acutely aware of their employee status. This bridging status is further recognized by being the first level clearly designated with an institutional title "manager." For the first time the nurse must extend her identity beyond professional clinical nurse and must acquire new values.

I first became aware of this possibility while reviewing the data presented by Liz as she described a counseling session with a distraught staff nurse. In the middle of complaining about an institutional decision that had been made, the nurse wailed "I feel like an employee!"

Both Liz and I were struck at the time with what seemed to be an absurd notion, Liz described the difficulty she had not saying, "welcome to the real world!"

The recognition by new managers that they are both an "autonomous professional" and an "employee" illustrates the paradoxes and role conflicts that they will face daily, particularly in their transition from staff nurse to manager. These conflicts extend to balancing their clinical and management responsibilities, and the negative or dismissive attitudes of physicians and nurses toward the management aspect of the nurse managers' role. Constructing a viable reality of such disparate parts is a key challenge.

As presented in the data of Chapter 4 and 5, most staff were not interested in what the manager's role entailed and valued only the "resourcing" aspect of the role, as illustrated by such comments "you're going to work today" when the manager dressed in "bedside" nursing clothes or engaged in clinical activities. Managers were well aware that "doing clinical" built trust and was highly valued by staff. Yet, they were also aware that their role was to manage, not to provide care.

Economic reality in today's hospitals has created what Liz characterized as "a seller's market." Many of the clinical areas were staffed using a combination of full time staff, per diems and registry. Others were offering

intensive orientation programs for new graduates where formerly they would have hired only experienced staff.

Given these circumstances, many of the managers felt they must be clinically involved with staff in order to "fill holes" and provide essential resourcing to an inexperienced and unstable staff. The conflict of "doing clinical" while meeting managerial expectations was most acutely felt by novice managers, many of whom described difficulty setting limits on their clinical involvement. Several managers attributed this dilemma to nursing as a profession. According to Anne, "nurses somehow get the idea that they have to be equally good at everything." Sara ascribed the problem to gender beliefs: "I think it's just women. Who, but a woman, would think it's reasonable to have a family, a full time job and go to school?" Yet, the reality most palatable to all would involve a nurse who is able to gracefully and effectively handle such a load.

To embrace the role of manager, as had most of the veterans, and to acknowledge employee status and therefore joint alliance and identification with the institution as well as the profession of nursing was an evolutionary process for managers in this study. Of the six novice managers, only two were committed to management as a career choice; one of the three experienced managers remained ambivalent and one of the seven veterans planned to leave

management and return to bedside nursing. However, even the most veteran managers continued to derive pleasure from occasional direct clinical contact. What seems to emerge with longevity in the role and experience was the ability to interpersonally do the ideological work managers described as "seeing the broader picture of health care." This "seeing" allowed them to embrace institutional values and beliefs without abandoning professional values, developing in Kramer's (1974) terms a bicultural identity and thus a workable reality to share with staff. Managers who couldn't give up the sole focus of the individual patient for the collective good, remained lost in the clinical management conflict.

Thus, the nurse manager is bounded by prescription and proscription with some latitude to enact a personal style. However, nurse managers go beyond simply complying with these restrictions and seek to reconcile them with their own values, in effect creating a bicultural identity.

The Effect of Conflicting Values in Nursing and Medicine

I anticipated that the conflict between medicine's perspective of curing and nursing's focus on caring would be a source of conflict for nurse managers. Although this was true in some instances, which I will briefly describe, it was not primary. I will describe two sources of conflict

between nurse managers and physicians and the nurse managers' behaviors as they relate to role responsibilities of social control and translating/interpreting and negotiating. As Liz lamented, "how to deal with the physicians is something they never taught us in school, but they should!"

I was struck by the fact that in the nurse manager's job description there was clear reference to assuring the quality of care delivered to patients within a distinct clinical area, but only two descriptions mentioned limiting that assurance to the delivery of nursing care. This broader responsibility for the quality of care was also reiterated by administrators and managers. Managers were explicitly expected to "cater" to physicians but also be ready to go "toe-to-toe" over a variety of clinical and managerial issues.

The clinical issues included treatment regimens, ethical issues, type of equipment and patient or family interactions. The economic or management issues related primarily to admissions and/or discharges such as whether or not a patient had an appropriate payer status, was a "dump," or whether or not there were adequate staff to accept an admission. In retrospect, such wide ranging expectations are not surprising. How could one create a reality on a nursing unit that did not incorporate the physicians?

Yet, social control was to be exerted while being perceived as catering to physicians or exercising the translating/interpreting negotiation aspect of their role. The skills necessary for this behavior were often described as developed under the tutelage of a mentor. For example, one experienced manager told of the care she took on entering a new system to meet important physicians to "see what they were about and how they would respond" in anticipation of negotiating future confrontations. Another described the importance of committee participation with powerful physicians to "build political alliances" and always looking for the "economic impact on physicians" when trying to anticipate their response to change. Liz explained her technique of always listening carefully and never saying no even when she knew the ultimate outcome of the decision would be no.

Conflict between medicine and nursing was not a major source of concern. In fact, only one novice manager discussed negotiations with a particular physician as a major source of conflict for her. For the majority of the managers, it was no greater or lesser problem than dealing with any other potentially disruptive, influential member of the clinical area staff, despite the inherent gender and power issues which I will discuss separately.

Nurse managers in this study were expected through

their job descriptions and by administrators to be the cultural arbiters within their clinical areas and programs, to exercise social control with the staff who were not meeting standards within the manager's designated areas of accountability, including physicians. However, the social control was to be exercised through interpreting, translating and negotiating so that physicians, like other staff, would be compliant and also remain "satisfied." Yet, this was such a taken-for-granted skill among nurse managers that it comprised no more or less an issue for them than the other disparate groups with whom nurse managers had to negotiate. The expertise in this area was so "assumed" that most experienced managers described this as a skill that they "resourced" for staff in their units.

The Positional Power of the Nurse Manager

My final assumption, that effective nurse managers hold powerful positions, was strongly supported by the data. Without exception administrators stated that the managerial position was key to the delivery of high quality patient care. As one administrator expressed it: "...clearly, in my mind [the role] is the most critical...they set the tone for everything that happens...they're really the people who operationalize [the goals and values of the organization]."

Managers were aware of the potential power of the role and were drawn to the role because they wished to use that

power to enact change. The need to exercise power and control for the purpose of influencing how the work of the clinical area or program is accomplished was a common characteristic of nurse managers in this study. It became clear through the course of the research that the capacity to understand and to use power effectively was an essential skill required to create a shared reality.

The nurse manager's job is highly dependent upon a fixed group of independent professionals over whom the manager must exercise social control in a manner that these professionals will find acceptable. The manager must "resource" these individuals, negotiating and facilitating change where necessary. Although I have described this process in a broad sense, understanding how nurse managers obtain and use power and control is critical to understanding in greater detail how they learn their role and the nuances of its enactment (Langer, 1983; Lefcourt, 1982).

Additional Factors Affecting the Manager Role: Gender and Stress

By contrast, I made no formal assumptions concerning gender and stress nor were they presented as discrete categories in the data analysis. However, they were key

issues in the everyday culture of nurse managers. I will present an overview of these areas and discuss their inter-relationships with the practice patterns of nurse managers.

Gender

Except for one administrator and one manager, all the participants in this study were women. While exploring the effects of gender on role behavior, beliefs and values with nurse managers, it became apparent that gender type was the issue rather than the biologic fact of being male or female. For example, most managers felt that men would not have difficulty in the nurse manager role if their management style reflected feminine values and behaviors. Two units, four of the sixteen managers, disagreed with this view for their areas. The staff on one unit were, by history and tradition, unaccepting of male nurses at any level within their group and the other was an obstetrical service where women, by cultural tradition, were more acceptable.

When study participants discussed gender style differences they stated that women were more empathetic, had greater difficulty setting limits and emphasized the process rather than outcome of any task. By contrast men or masculine style lacked empathy, set exact limits and were goal directed emphasizing outcome or "the bottom line" rather than process.

Most managers stated that one of their greatest assets

was empathy. They felt that this was critical when managing a primarily female staff who had multiple commitments and responsibilities outside work. As Sara explained it, "you have to really understand how important it is when they ask you at the last minute to be rescheduled because of an unanticipated piano recital." As Liz described it, "I really know what it feels like when your whole world revolves around a baby sitter who walks in late or doesn't show at all!"

For the managers, the obverse of empathy was limit setting. As Sara groaned, "If I were a man, I wouldn't be so torn about setting limits, but I feel all the pain of trying to do it all and being too tired to do any of it right." Learning to set realistic limits on empathy also appeared to be evolutionary in nature. Although veteran managers continued to value empathy they did not describe the pain of establishing limits that were in their words "fair."

Regardless of the managers' level of experience they spoke of the difference between the primary institution/masculine emphasis on the outcome of management and the nursing/feminine emphasis on process. The process of management was strongly emphasized by the nurse managers in this study. They describe their role in terms of the process of management, not the tasks, even converting the

noun "process" into a new verb: "to process" or "processing."

Many of the managers felt that males in the institutional hierarchy were interested only in "bottom line" outcome and were uninterested in the process required. As Liz stated, "They think that all you have to do is tell people things are going to change, they have no idea nor do they care what's involved in making it actually happen."

Luthans, Hodgetts and Rosenkrantz (1988) in their study of "real managers" differentiated effective and successful describing effective managers as those who emphasized communication and human resource management as the cornerstone of their work. Because their study included many levels of managers in different occupations, and because they described what managers do, rather than how they do their job, it is only pertinent to this study in a general way. However, it is interesting to speculate as to whether the nursing/gender style issue is the root cause of the communication emphasis or whether it is just part of a broader pattern of "effective" managers.

Because there are not studies available in the management literature about how first-line managers, male or female, actually perform their role, it is unclear whether the behaviors described by managers in this study are truly gender related, or are due to the nature of first-line

management work. The male/female differences may represent a traditional split occurring between managers' process orientation and institution/administrators' emphasis on outcome.

Because nursing is primarily a woman's profession and will in all likelihood remain so for the foreseeable future, it will continue to be important to understand the influence of gender in such critical areas as management behaviors, values and beliefs.

Stress

Many of the managers in this study were experiencing a level of stress and anxiety that was physically and emotionally debilitating to the point that they were questioning their choice of a career in management. During the course of this study, unresolved stress and dissatisfaction with their current role was the reason given by three managers for leaving the role, and by seven managers who were considering returning to clinical work, jobs in other institutions or leaving nursing altogether. The sources of stress were threefold and related to work load, amount of experience, and gender.

Workload problems for managers were created primarily by the current status of healthcare economics, "do more for less," coupled with a shortage of skilled nurses (Aiken & Mullinix, 1987).

Unlike most managers of comparable rank in hospitals, only two managers in this study had dedicated secretarial support to carry an enormous bureaucratic burden. In addition to paper work the process of obtaining experienced nurses, particularly those with specialty skills to conduct the work of caring for patients is becoming a daily and time consuming chess game. These were the principal challenges of the manager's direct workload.

Most of the clinical areas I observed used full time, part time, per diem and registry staff, resorting to various combinations of straight time and over time pay to staff on any given shift. Nurses might be known to the clinical area or not, they might be orientees at various stages of skill development or be full time staff with vastly different levels of expertise. There were staff who were on restricted service because of illness or injury, or those who were present but couldn't be counted on for patient care because they were teaching classes, attending classes or assigned to particular projects. The unit's workload and its impact on staff was part of the indirect workload on the manager.

As Sara described it, "you know it gets old, just when I think I've got things stabilized enough to move forward something happens and it all crashes. The same problems keep repeating." According to Liz, "It's amazing, these new

nurses coming out! I interviewed a new graduate the other day who wanted to work half time straight days...she thought, maybe, she could manage to work every other weekend! She was an extreme but not the only one."

The greatest stressors for managers that could not be ignored or deferred were inadequate staff resources. As Liz described it, "The one thing that will drive me out of this role is the demand that I get more involved with management, when I can't safely staff the floor for clinical, if that keeps up too much longer I'll have to leave."

In many cases, the degree of stress was related to the manager's inexperience. Novice managers were most often trapped by their inability to set limits on "doing clinical," responding to all "crises" and paper work equally. As Liz put it, "Part of learning the role is learning what you have to pay attention to and what you can safely ignore." This was a distinction that many novice managers in this study had not yet made.

The final source of continuous stress for many of the managers was gender based. Twelve of the managers were married and two were divorced, eleven of the managers had children or cared for elderly parents, and six were themselves attending school. This pattern of numerous demands and commitments outside work did not begin with assuming the management role. Most of the managers had

worked full time since graduating from their basic nursing educational program. However, the addition of management responsibilities magnified an existing situation.

Both popular literature and professional research have addressed the stresses of working mothers many of which apply to nurse managers. Firm boundaries between work and home described in the literature as reducing stress and enhancing productivity seem fluid at best for managers in this study (Pugliesi, 1988). I experienced through direct observation with four managers and indirect report by numerous others that there was frequent intrusion of home problems at work and work problems at home.

The balance of school, work and home was a common theme. Liz describes a typical manager's attitude:

> I'm very smart, I know I can get all A's in school, but I have to be content with just getting by. I use work problems for projects at school whenever I can, you know kill two birds with one stone...and home, you know, we get by, my husband helps but he has to, we need my salary...my child care system is better this year and even my back-up systems have back-ups, but if they fold, so does my whole world, last year was just awful...it's a good thing I don't need a lot of sleep...but we get by.

Summary

First-line nurse managers in this study characterize their role in terms of the processes of their day-to-day

management activities directed at constructing or maintaining a group social reality. These processes were continuous and interactive and included social control; "resourcing," translating/interpreting/negotiating; and facilitating change. The decision-making discretion of the manager was bounded by overt and covert rules and behavioral norms promulgated by numerous professional organizations and institutional and external regulating bodies.

How managers chose to enact their role was influenced by many factors. Those identified in this study included: years of experience in management, organizational structure and the economic realities of limited resources. Although gender appeared to influence management beliefs, behaviors and values, gender seemed to be more linked to style choices than the "fact" of being male or female.

Managers characterize themselves as desiring to influence the work of their clinical areas, and to enjoy the stimulation of change and staff development. They all identified essential role skills as communication/ interpersonal expertise, clinical knowledge and flexibility. Many added ego strength and political savvy. These skills and characteristics can all be logically linked to the managers' description of their role.

The managers described an experiential model for learning their role. Managers who had mentors characterized

this relationship as significant to their development; those who did not expressed a desire for such a relationship.

Advanced academic preparation served as a secondary socializer for managers by enhancing their integration of organizational cultural beliefs and values into existing professional beliefs. Such educational experiences provided instruction in the language, beliefs and values of institutions, the basis for developing bicultural identity and enabling the process of nursing management.

Finally gender and stress were briefly described as phenomena that impact the process of nursing management. Gender appears to influence style and may also influence the process management but because of the preponderance of women managers these links can only be speculative.

The sources of stress identified by managers seemed to vary with the managers' level of experience. However, most managers identified that stress related primarily to the paper work of the bureaucratic processes, inadequate resources, and non-job related commitments such as families and advanced education. These stressors were identified as major sources of job dissatisfaction and turnover.

Nurse managers are entrusted with and challenged to create a social reality that links a wide range of goals and demands. They first find an internal or personal

integration of reality and then disseminate that view through extensive social interactions. These interactions may coerce adherence to standards (social control), lure compliance ("resourcing"), or intellectually interpret (translating). Collectively these social processes are used to facilitate change - the very basis of a modified reality. By managing people, the nurse manager creates a caring and curing social reality for all participants in the unit's culture.

CHAPTER 7

IMPLICATIONS

The phenomenon of first-line nursing management presented by the participants in this study has two implications. However the practice construct represents only the first stages in developing a nursing theory grounded in the experiences of these first-line nursing managers. Therefore the management practice patterns constructed from the cultural description in this study cannot at this time be rigorously generalized beyond the study participants.

To create an effective hospital one must recruit, retain, develop and support a group of effective nurse managers. I will begin by describing the implications their patterns of management practice have for selecting and developing first-line nurse managers. Next I will explore the relevance of these practice patterns for other health care and human service managers and will conclude with a discussion of potential directions for future research on this subject.

Implications for the Selection and Development of Nurse Managers

Based on this study two clear implications for selection and development of managers emerged: the usefulness of advanced education and supported experiential learning. First a brief discussion of the competencies required in the role sets the stage for considering the implications in detail.

The selection and development of nurse managers who will be effective, stable and satisfied in their role was identified by both managers and administrators as essential to the delivery of cost-effective, high quality patient care. Managers and administrators agreed about what managers do and the competencies necessary for their role. Also many managers in this study were effective, satisfied with and stable in their roles. Yet turnover and dissatisfaction, particularly among new managers, remains high.

Managers and administrators in this study primarily agreed on the skills essential to the nurse managers' role. They are communication/interpersonal skills, flexibility, clinical knowledge, strong ego and political savvy. They

also considered academic preparation beyond basic nursing requirements as highly desirable.

The study participants' perspective is well supported in the literature. In two major studies at academic teaching hospitals described in Chapter 2, the managers and administrators used different language, but identified similar criteria (del Bueno & Walker, 1984; Sullivan, Decker & Hailstone, 1985). As discussed earlier del Bueno & Walker (1984) did not weigh clinical experience as heavily.

Advanced Education

There is general agreement that advanced education is strongly linked with the nurse manager's effectiveness and is thus heavily weighted in the selection process. Unfortunately the supply of such individuals is limited.

Hodges, Knapp & Cooper (1987) report that of the 288 randomly selected members of the American Organization of Nurse Executives 95% identified master's level preparation as desirable for the nurse manager role. Whether an administrative master's is more efficacious than a clinical one was debated by the managers and administrators in this study and in the literature (Hodges, Knapp & Cooper, 1987; Wallace & Corey, 1988). Although administrative master's curricula offered important theory such as accounting and personnel management, nurse managers in this study sought

status, career flexibility and an understanding of the "bigger picture" in health care. Either an administrative or a clinical masters program could meet these goals.

The skill many managers felt they lacked and would like to develop were formal communication skills. Graduate education enhances those skills generally, however, one clear implication from this study was that managers need specific communication skills. For example how to write and present a report; how to develop an agenda and chair a meeting; how to develop and present a program proposal; or how to conduct an interview or develop written documentation on a personnel disciplinary action.

Equally important was the ability to understand group dynamics and group leadership. Most managers had developed excellent one-to-one skills but now were faced with the need to work with groups.

The basics of formal and informal communication are theoretically founded and thus are the province of academic graduate education. Once acquired these theories can be supported in their application through experiential learning.

This belief in advanced education was demonstrated in all the nurse managers' job descriptions which required or preferred a master's degree. However, only 7 of 16 nurse

managers in this study had a master's degree; thus highlighting a recruitment dilemma: insufficient number of applicants with advanced degrees. Administrators would consider all the criteria discussed earlier to select a nurse manager regardless of degree and seek to develop in time the missing perspectives in those hired but lacking an advanced degree. The development of a nurse manager after hiring is also illustrated in this study, because four of the nine without advanced degrees were enrolled in master's programs at the time of the study.

Experiential Learning

The second implication stems from the first: development of a nurse manager after hiring is critical and appears to best be achieved using various methods of "formalized" or supported experiential learning. Of the five needed skills identified above, flexibility and a strong ego are primarily personality characteristics rather than skills that can be learned or taught. Experiential learning is thus directed toward the first three skills: communications/interpersonal skills, clinical knowledge and political savvy.

The experiential learning of skills and values has been extensively studied by Kramer (1974) in her analysis of transition of new graduate nurses from student to professional. In that study she presented the concept of reality shock as a causative factor in the loss of these new graduates. Reality shock was the reaction of the new graduate when exposed to the backstage reality of hospital nursing. Reality shock happens to all new nurse managers regardless of education preparation. Kramer (1974) identified two fundamental approaches to mitigate the adverse effects of reality shock: one to one support or mentoring and various group techniques. She suggested that the shock of learning the backstage reality of the culture of hospital nursing could be reduced by support systems, such a group meetings among new staff nurses. This format allowed graduates to share their experiences, along a model of guided self-help groups, bridging their education and work beliefs and values thus facilitating their development of a bicultural identity. Such support systems would be another strategy for manager development.

New managers in this study expressed a similar reality shock and characterized a mentor relationship as one approach to their needs. The shock of transition from staff to manager is well documented in the literature (Darling &

McGrath, 1983; Dooley & Hauben, 1979). Experienced and veteran managers who were most comfortable with their roles attributed this comfort, in part, to early experiences with a person who was invested in them as individuals and their success as managers. They quoted and still used "pearls of wisdom" from their mentors who had helped them develop a personal style of management and who had guided them through the political realities of hospital management.

Within the safety of these relationships they analyzed both their successes and failures. Although mentors, who were primarily direct supervisors, did not eliminate the pain or the necessity of trial and error learning, they did provide a supportive forum for the analysis of decision-making and problem solving.

The managers' strong positive perspective on mentoring, presents a clear implication for an additional supportive one-on-one relationship for the new manager. A mentoring relationship in its classic mode is not one that can be dictated, although the word has begun to be used more loosely in the current literature (Hamilton, 1981; O'Connor, 1988). However, the need for managers to become bicultural, to make the transition from professional clinical nurse to employee manager, incorporating the beliefs and values of two distinct cultures, is as acute as the transition from

student to professional nurse.

Therefore, as an adjunct to the usual support provided to a new manager by his or her administrator, a veteran manager designated as a preceptor might facilitate the enculturation process. Because the veteran manager officially chose this relationship, it would reduce concern about "bugging" overstressed colleagues or appearing "stupid" to the administrator, both fears expressed by new managers.

Kramer's (1974) suggestions for "bridging" activities points to a second aspect of experiential learning. The managers in this study also recommended several alternate or supplementary guided learning experiences. For example, one strong recommendation was a career ladder that paralleled clinical advancement programs currently in place in many hospitals. Although many managers stated that there was no way to understand the scope of the role without actually being a manager, they did feel that a career ladder would provide experience with choices and would create a potential pool of new managers for the hospital.

In addition new and experienced managers might profit from group meetings with no agenda beyond sharing with each other, "processing" changes, discussing management strategies and decision-making. Many of the managers stated

that they learned a great deal by watching and listening to others problem solve.

Zander (1983) suggests ongoing management seminars conducted by nursing administrators within the hospital. To the extent that administrators are willing to prepare and present programs and engage in open dialogue with managers such an approach represents an ideal solution to manager development. Managers and administrators in such a forum would have an opportunity to develop trust and to construct a management culture within the institution based on shared beliefs and values.

This study suggests that prospective nurse managers will benefit from formal and/or informal educational experiences to help them frame a broader context for role understanding and enactment. Advanced degrees certainly help provide such a context but all new managers would probably benefit from guided learning experiences on the job ranging from one-on-one mentoring to group discussion and even lectures. These techniques may compensate in part for a small pool of applicants with ideal credentials and may help in retention and development of all nurse managers.

Relevance Beyond Nursing

Most of the observations and findings of this study stem from a group of characteristics that underlie most of

the study. To the extent that groups of managers share most or all of those characteristics, I would expect to find manager practice patterns similar to those found in this study. After reviewing those characteristics in some detail, several examples of other management situations will be considered to illustrate how these characteristics or criteria might be used to assess the applicability of this study to the other situations.

The first characteristic is that the nurse manager is obliged to persuade or coerce others in order to do the work of the unit. Worse yet, these other people are not even under the direct authority of the nurse manager. Secondly, the manager functions in a setting with multiple conflicting beliefs and values within the staff and among the other supporting areas. Thirdly, resources are limited and access to those resources must be negotiated and may fail. Fourth because of scarce resources the manager is faced with incompatible competing clinical and managerial role demands. Lastly, there is a high rate of organizational change.

The literature highlights some of these issues. Kotter (1977) points out that the degree to which the manager is dependent on others to accomplish work determines how much the manager resorts to power oriented behaviors. Bolman and Deal (1984) suggest that the need to negotiate and use power

strategies is increased in situations with limited resources and conflicting belief systems. The managers in this study not only echoed these ideas but added rate of change and conflicting managerial and clinical demands as additional factors.

To the extent other health professionals such as pharmacists, respiratory therapists and social workers are managing in similar circumstances then I would expect to find many parallels to this study. For example the pharmacist who manages the pharmacy depends on many of the same people as the nurse manager--housekeeping, delivery services, etc.--and must negotiate with physicians who may not always share the same beliefs and values as the pharmacist. Resources are limited and conflicts between the need to supplement clinical activities and the need to meet managerial responsibilities, as well as conflicts between professional values of the pharmacist and the needs of the organization are likely. For the pharmacy manager most of the aspects of this study should apply. New managers in pharmacy would likely benefit from mentoring and guided experiential learning; advanced degrees would help; creative use of power would be necessary to accomplish role requirements; and stress would be significant and offset by a sense of being able to constructively influence the care

environment. Only the gender issues from nursing would not be duplicated because pharmacy departments are not primarily female.

Other professionals around the hospital would not closely resemble the nursing manager. For example the pastoral care program in hospitals is typically headed by an ordained minister, a professional with beliefs and values that may at times be in conflict with the organization. Yet even if the minister is the manager for a group of such professionals, the dependence on others is very much reduced compared to the nurse manager and the required resources are not particularly limited. Although the minister and the pastoral program seek to establish a social reality, it is for individuals and not for an entire group of people. Not only is there obvious ideological conflicts, but the conflict is also both expected and sustained. No requirement for reconciling these differences is placed on the manager of the program. Given this set of circumstances I would expect relatively little generalization of this study.

It is interesting to consider these criteria for managers entirely outside the health care setting and to see the applicability. Consider an architect-manager responsible for a small team of architects involved in a

design project that includes working with landscape architects from another firm and with structural engineers from yet a third firm. To successfully complete the design project on time the architect-manager must persuade or coerce others to collaborate, reconcile conflicting values and beliefs, manage scarce resources and cope with professional needs that may conflict with the organizational needs for the project. The parallels with the situation of the nurse manager are extensive and I would expect the architect-manager to face many of the same challenges and dilemmas. I would also expect that many of the promising approaches for supporting and developing nurse managers would have parallels for budding architect-managers.

Directions for Future Research

The phenomenon of first-line nursing management presented in this study represents the day-to-day reality of a small number of nurse managers in two study hospitals. As such, it can only be a first step in understanding the role even within the confines of the participant hospitals. The next step in theory development should explore practice patterns in other similar settings. In light of my experiences with this study, certain issues should be

considered for inclusion in any subsequent work. The issues are personal manager traits, span of control, stress, humor and the influence of gender on management style and decision-making.

Numerous research studies seeking to identify specific leadership traits have proved inconclusive, yet there is widespread agreement in the literature and among managers in this study that certain personality characteristics are essential for an effective first-line nurse manager. The characteristics are variously described as: interest and motivation or risk taking and enterprising; strong ego, resilience, assertiveness, high self-esteem; flexibility; communication and interpersonal skills, social skills, group processes, oral and written skills. Despite the variety of names, all reflect the managers' ability and strength in dealing with social reality.

These attributes were identified by managers in this study and by Hanson and Charter (1983) as they distinguished managerial and clinical career interest in master's students; by head nurses in the del Bueno and Walker (1984) project as selection criteria for project participants; and, Sullivan, Decker and Hailstone (1985) as criteria for selecting new managers using an assessment center.

Such broad agreement suggests that there are personal characteristics typical of effective first-line managers. Given the shortage of managers, research to develop a tool that would measure these characteristics as an aid to career counseling and potential selection would be of considerable value to administrators, educators and potential managers.

Span of control is the second area for future research. It varied widely in the units studied. The nurse managers wished to increase independence and professionalism by extending their span of control, but the rate of change and staffing challenges combined to make this difficult. There is some literature (Aldine & Funke-Furber, 1988) that examines factors that influence control but there is very little basis for understanding the impact or meaning of the widely divergent spans. Such a discrepant parameter warrants a close examination in the future.

Stress constituted the third area for future research. Unacceptable levels of stress were a major problem, primarily for new managers but also for some of the more experienced managers. Most of the veteran managers had periods of stress but had developed personal and professional coping strategies to manage these episodic occurrences. There were four areas that created the majority of stress for managers; work load, level of

experience, inadequate resources and stresses that were gender related. Beyond identifying these groups, I did not pursue them further. These will be important to understand in more detail.

Humor is the fourth area for future research and was widely used in coping with stress. Other coping strategies included such approaches as religious beliefs, exercise and support of peers and significant others. Humor was the most pervasive strategy. Humor ranged from highly charged, raw sexual and "gallows" humor to the use of teasing, nursery rhymes and word play. It seemed to serve a variety of purposes: discharging anger, reducing ethical or patient care dilemmas or bureaucratic expectations to absurd conclusions, thus releasing tension and allowing problem solving. It was also used to define status relationships, delineate "safety zones" allowing the discussion of otherwise taboo subjects and to facilitate group cohesion. As Liz put it, "You have two choices here, you can either let it get to you and cry or you can laugh, frankly, I'd rather laugh!" Humor in this study and in hospitals generally is ubiquitous, particularly in its more graphic forms. Yet, its content and purposes in nursing management has not been explored. Because humor is being used to cope with the most sensitive issues, it would be a particularly

important focus for future work.

The influence of gender on management style and decision-making, levels of trust, empathy, and moral perspectives were discussed earlier (Carrocci, 1988; Cooper, 1989; Gilligan, 1982). Because all these elements influence the process of first-line management they require exploration grounded in the experience of practicing nurse managers.

Summary

An exploration of the beliefs, values and behaviors of inpatient first-line nurse managers in Harbor View and Valley Central has revealed a culture involving a complex process of human interactions. This study has focused on two aspects of the culture describing who nurse managers are and how they characterize their everyday management of their clinical areas and programs.

Although educational credentials, social history and clinical and managerial experiences of the participants in this study varied widely, they held many characteristics, beliefs and behaviors in common and described a day-to-day process of management that spanned all participants' clinical areas, programs and both hospitals.

They characterized first-line nursing management as an interpersonal interactive process of creating and maintaining an environment that enables the work of caring for sick patients and their families. It was bounded by overt and covert professional and institutional standards that are continually changing in response to technological, economic and social forces. Effective enactment of the role required that nurse managers possess clinical nursing and technical management competencies, and expert human resource management skills. Although aware that many of these skills are based upon theoretical constructs, the managers uniformly specified experiential learning as their primary source of skill acquisition.

Taken altogether, the role of the nurse manager emerges as being the manager of social reality on patient care units. Right and wrong, good and bad, acceptable or unacceptable were judgments required of the nurse manager daily, along with the responsibility of enforcing those judgments through exercise of personal skills and force of personality.

These skills, characteristics and processes depicted in this study have many implications particularly as they relate to the selection and development of nurse managers who will be effective, stable and satisfied with their role.

However, because the phenomenon is grounded in the experiences of a small group of managers, and significant influences were identified, such as stress and gender, that remain unexplored, this study comprises a beginning step in the understanding of the phenomenon of first-line nursing management.

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APPENDICES

APPENDIX A

PARTICIPANT PROFILES

The following profile on formal study participants is presented in a composite form to assure their anonymity. Many staff nurses, senior staff and assistant managers contributed informally at various points in the study, but will not be included in the demographic analysis.

Categories of participants in formal interviews:

2 Vice Presidents for Patient Services *

4 Department of Nursing Directors *

16 Nurse Managers

* The categories of Vice President and Directors are hereafter collapsed into a single category of Administrators for the purpose of confidentiality.

Participant Categories Sex and Age:

Category	Sex	Age
Administrators	1 M, 5 F	N/A
Managers	1 M, 15 F	37.8

Marital Status:

Category	S	M	D
Administrators	1	3	2
Managers	2	12	2

Family Constellation:

Categories	Number w/ Children	Numbers in age ranges 0-10y	10-18y	Adult
Administrators	5	3	2	
Managers	10	4	3	3

Educational Status:

Categories	Highest Degree Obtained	Degree Being Sought
Administrators	6 Nursing Master's	1 Nursing Doctoral
Managers	2 Nursing Associate	2 Nursing Bachelor's
	1 Nursing Diploma	0
	6 Nursing Bachelor's	4 Nursing Master's
	7 Nursing Master's	2 Nursing Doctoral

Categories of Managers:

Number in Group	Span of Yrs. in Management	Ave. Age	Avg. Yrs. in Management
Novice: 6	.8 - 1.5	35.5	1.1
Experienced: 3	1.6 - 4.5	34.3	3.8
Veteran: 7	4.6 - 26.0	41.1	10.3

Composite Speakers

During the course of the research three separate groups of managers emerged, characterized primarily by their level of work experience. In order to assure confidentiality of the participants while highlighting the values, beliefs and behaviors of each group, the following profiles of composite speakers were developed. Anne represents the novice managers, Sara the experienced and Liz the veteran.

Anne is a novice manager with one year experience. She came through the ranks of Valley Central Hospital and now manages where she had previously been a staff nurse. Although she has worked in other hospitals, she has been at Valley Central for the past five years. When the management position on her thirty bed medical/surgical service became available she actively pursued it, based on the belief that there were things happening that she would like to change to make the service run more effectively and harmoniously.

Anne is married with two school age children. She has been an active full time nurse since graduating from a bachelor of nursing science program in 1982, and she is thinking of returning to school for her master's degree on a part time basis. Anne has thought about her long term career goals only occasionally, but when

she does, she is not sure that management is the career choice she wishes to make.

Sara is an experienced manager with over four years experience. She was hired for her present position as manager of a step-down intensive care unit, which she has held for one year, because of her management and clinical experience in developing a similar program for patients with acute and long term ventilatory needs.

Sara is married with one school-age child. She has worked full time since graduating from a B.S.N. program in 1983. Several years ago she completed a master's degree in nursing. She is not sure what her long term career goals are, but often feels "burned out" and wonders if management is where she belongs. Sara dreams of the "good ole days" when she went home after eight hours and "forgot the place."

Liz is a veteran manager who has worked at other hospitals in other cities but all of her management experience has been at Harbor View. She began by managing one intensive care unit but after various hospital reorganizations she manages a step-down unit plus a cardiac transport program.

Liz will soon be 42 years old and has "seen it all." She is divorced and remarried with teenage

children. Liz graduated from a diploma program and went back to school for her B.S.N. and Master's degree and occasionally thinks about a doctorate. She has committed herself to a management career track and upward mobility. If no opportunities open in her current place of employment, she will look in another institution for career opportunities once her children have left home.

APPENDIX B

INTERVIEW STRUCTURE AND GUIDES

Interview Structure and Guides

Much of the data for this study was gathered using an open-ended semi-structured interview presented in Chapter 3. The following is a description of the interview process including the guides.

The participants in this study were 16 nurse managers, 4 associate directors of nursing, and two chief nurse executives. After the initial observation period with the primary informant subsequent manager interviews began with an introductory meeting describing the research and an observation period of the clinical area. The observation period ranged from a walking tour to several days of observation. Interviews were usually conducted in the managers' office at their convenience during two to three different time periods resulting in three to five hours interviewing.

The taped portion of the interviews usually began with broad demographic questions. Occasionally they began with a discussion of what the manager had been involved with just prior to the interview. Regardless of the opening, the manager directed the interview focusing on issues that they felt were important. Although most questions in the accompanying interview guide were addressed by each informant, they were rarely explored in the sequence or

format of the guide. This approach allowed participants to describe their beliefs and values concerning their role and their management behaviors by probing situations presented rather than interpreting their description with a set direction of specific questions.

Interviews with administrators followed a similar pattern but explored a different set of questions.

Interview Guide

Chief Nurse Executive and Directors

1. I'd like to begin by talking about your work history and educational history beginning with where you got your basic education.

2. Are there people or events that influenced your career in the direction of administration?

3. What do you consider the primary task of the first-line nurse manager?

4. When you are hiring first-line managers, what do you look for, what is your ideal?
   - Style, characteristics,skills,credentials, etc.

5. What is the bottom line or what you will settle for if you are unable to meet your ideal?

6. Who on your staff is closest to meeting these ideal characteristics?

7. What about them makes them an effective manager?

8. Could they or someone like them be equally effective managing an area other than the one they currently do?

9. Think of someone you've had to counsel out. What about them made them an ineffective manager? Were there any critical deficits or fatal flaws?

Role Characteristics

1. When did you change to the expanded role model?

2. What were the precipitating factors that triggered the change?

3. What about the role has been most successful?

4. Is there anything about the role that has been problematic?

5. Where do you expect these managers to spend the majority of their time, engaged in what activities?

6. What level of clinical expertise do you expect these managers to maintain?

7. What role, if any, do you think clinical expertise plays in their function?

8. What do you see as their major source of stress?

9. Think of a major event, a change in the hospital affecting the units. Think of one of your managers who helped their unit successfully negotiate the change.
    - What did you expect them to do?
    - What did they do?

10. Now think of someone who did not manage the change well.
    - What were their problems?

11. Do you think someone could remain effective in this role indefinitely or does it have a life span?

12. What characteristics would someone need to be able stay in this role? What would be the most likely cause of their eventual ineffectiveness?

Topic Guideline for

Indepth, Semistructured

Interviews with Head Nurses

(Revised: 1/10/89; 2/15/89)

I. Demographics

A. Professional:

1. Educational History (levels, areas of concentration, timing, breaks, etc.)

2. Job History

3. What or who influenced your choice to become a nurse in _____ (clinical specialty)?

4. Were there any people or events that influenced your choice to become a nurse manager (first-line manager)?

B. Personal

1. Age

2. Current marital status

3. Family structure

4. Current: Age and sex of children or members of immediate family

II. Unit Based Structures

A. Work Patterns

1. Do you have a routine or a way you like to structure your day? For example, describe what you did yesterday from the time you arrived until you left.

- Is that typical?
- If not, how was it different?

2. Describe a day you would consider hectic.

3. What are the most common "events" that disrupt your routine?

4. Are there things that you do on a daily (or regular) basis that you try to do no matter what else happens?

5. What hours do you work and why?

6. Who is in charge of the unit when you are gone? Daily? Vacations?

7. How or from whom do you find out what's happening when you are not here?

   - On the unit?
   - In the nursing department generally?
   - Hospital?

8. Under what conditions are your staff required to call you at home?

   - When would you expect them to call you at home?
   - When would you like to be called at home?

B. Staff Characteristics

1. How many FTE's do you have on your staff?

2. How are they distributed (part-time, full time, etc.)?

   - By job type? (RN, LVN, etc.)

3. What would your ideal distribution be?

   - What would this distribution accomplish that you are having trouble with given your current staffing patterns?

4. What are the most important characteristics you look for when you are hiring staff?

5. What are you willing to settle for if you can't meet your criteria?

6. What kinds of information are you concerned about communicating to your staff?

   - How do you go about getting the information to them?

7. If you have meetings with your staff, what kinds of meetings?

   - How often?
   - How long?
   - Who attends?

8. In general, what kinds of things get discussed at these meetings?

   - Can you remember the most recent meeting and what was discussed?

9. Can you think of a recent situation where a significant change occurred affecting your unit?

   - What was involved in the event?
   - What was your role in managing the change?

10. To what extent do you find that you are involved in presenting administrative agendas to staff for the purposes of gaining, if not their acceptance at least their compliance?

    - How much of your time, if any?
    - Can you give me an example of such a situation?

11. When you are presenting an administrative agenda, do you include your own opinion or do you pass it along without comment?

    - Example

12. To what extent is the converse true, staff agendas to administration?

    - Modify or pass it along as you hear it?
    - Example

C. Job Characteristics

1. In general, what do you believe are the most important skills or characteristics a nurse manager needs to function in the expanded role?

2. What are the nurse manager skills or characteristics that are particularly important for a clinical area like yours?

3. What is the most satisfying part of your job?

   - What about _____ makes it satisfying?

4. What do you consider your most important or primary task?

5. What task or activity consumes the most time in your day? (What do you spend most of your time doing?)

6. What aspects of your role create the most stress for you?

   - Give me an example of a recent event that was stressful
   - What did you do to manage the situation?

7. What do you do to cope with the residual tension?

   - At work?
   - At home?

8. If you could eliminate some part of your job, what would it be?

9. If you could have an extra hour in your day, how would you use it?

D. Roles, Multiple/Conflicting

1. How important do you feel it is for the nurse manager to have direct care skills?

2. Does the nurse manager need to be a clinical expert in the patient care area she manages?

3. If the clinical expertise is important, how do you stay current?

4. How do you use your clinical knowledge to manage?

5. What is the most critical role you play for your staff?

6. What is the greatest asset you bring to your staff?

7. How have you learned to be a first-line manager?

   - Has this been effective? Please explain.
   - What kind of learning would help you grow from here? (Content and Style)

8. If you have a complex problem, who is your best resource for working it out?

   - On the unit?
   - In general?

9. Could you give me an example of one problem and who helped you work it out?

10. If you could snap your fingers and immediately acquire a skill or an attribute to help you in your role, what would it be?

    - How would it help?

11. Do you have a nurse manager or an administrator you admire?

    - What about their style/characteristics, etc. do you like?

E. Role as a Woman and Nurse

1. How do you think things would change for your staff if your position were filled by a male nurse?

2. How would things change in nurse manager meetings?

3. How would things change if your supervisor were a male?

   - Or an MBA (non-nurse)?

4. What parts of your job are easier because you are a woman?

5. What aspects of your job are more difficult because you are a woman?

F. General Questions

1. If you were going to open a hospital and you could take any other two nurse managers with you, who would they be and why?

2. Would "X" be as good a manager if she were a nurse manager on "Y" unit?

   - What are some examples of how she works that would transfer successfully or be a problem in another unit?

3. How would you describe your role to an aspiring manager? A nurse manager is _____ ?

4. What would you tell them they need to get ready for this role?

5. Are you planning to stay in this role or do you have other, long range career plans?

6. Have we missed anything?

APPENDIX C

CONSENT FORM GIVEN TO INTERVIEWEES

Consent Procedure

Approval for this research was granted by the University of San Diego Committee for the Protection of Human Subjects (see Appendix D) and the research review boards of Harbor View and Valley Central Hospitals. Each review board deemed a verbal consent adequate protection for study participants because of the limited risk.

However, in addition to the verbal consent, all managers and administrators received a copy of the attached informed consent, for their own information, during the initial interview. At Valley Central each participant also received a copy of the Experimental Subjects' Bill of Rights. None of the participants were asked to sign and return consents to the researcher.

Consent Form

You are being invited to participate in a study of the expanded role of the first-line, unit based, nurse manager as seen from the perspective of the nurse manager. If you agree to participate, you will be asked questions about how you perform your work on a day-to-day basis. Data will be collected through an interview which will be tape recorded and later transcribed in written form. The interview will last about one and one-half hours, and may be followed with a brief second interview to clarify or expand the points raised initially. The interview will be informal so that you may talk freely on topics as they are brought up or may decline to comment as you choose.

To preserve anonymity, all names or other identifying information will be removed from the interview transcripts, and this consent form will be held in a separate file. The data on the study will be held in strict confidence. Answers to questions will be analyzed in group form which will further maintain anonymity. The demographic data questions, which do not contain your name, will also become part of the group data.

No discomfort is expected to ensue from this study. Your participation is voluntary. You may refuse to participate or may withdraw from the study at any time. While there is no immediate benefit to you for participating

in this study, you will be afforded an opportunity to review the findings at the completion of the study.

There is no agreement, written or verbal, beyond that expressed on this consent form. Please ask any questions you may wish at any time. Thank you.

I have read the above and have been given a copy of "The Experimental Subjects' Bill of Rights", questions have been answered to my satisfaction. I agree to participate in this study on head nursing.

Signature of Subject	Date
Location	Date
Signature of Researcher	Date
Signature of Witness	Date