THE LIVED EXPERIENCE OF NURSE MANAGERS: A HEIDEGGARIAN HERMENEUTIC ANALYSIS

A DISSERTATION

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

IN THE GRADUATE SCHOOL OF THE

TEXAS WOMAN'S UNIVERSITY

SCHOOL OF NURSING

BY

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DECEMBER 1994

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August 3, 1994
Date

To the Associate Vice President for Research and Dean of the Graduate School:

I am submitting herewith a dissertation written by Melissa Brannon entitled "The Lived Experience of Nurse Managers: A Heideggarian Hermeneutic Analysis." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Nursing.

Major Professor

We have read this dissertation
and recommend its acceptance:

Accepted:

Associate Vice President for Research
and Dean of the Graduate School

DEDICATION

This dissertation is dedicated to nurse managers who live in the margin and struggle everyday to keep the nurse in the manager.

ACKNOWLEDGEMENTS

There were many people who contributed to this work. I want to acknowledge the support and generosity of my family, friends, colleagues and committee.

ABSTRACT

THE LIVED EXPERIENCE OF NURSE MANAGERS: A HEIDEGGARIAN HERMENEUTIC ANALYSIS

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DECEMBER 1994

This descriptive, interpretive study examined the lived experience of nurse managers. Although nurse managers represent a large group of nurses in practice, little research has been conducted from the managers' point of view regarding what they find meaningful about their experiences. The purpose of this phenomenological study was to reveal common meanings embedded in the experience of nurse managers to discover new possibilities for understanding nursing communities.

Nurse managers (N=16) were asked to submit a written narrative about their experiences. These narratives were analyzed using a Heideggarian hermeneutic methodology to identify common meanings, relational themes across texts and finally, constitutive patterns expressing relationships between themes. The analysis , carried out in a seven-stage process by a team of researchers revealed five relational themes and one constitutive pattern. The constitutive pattern of managing change emerged as the major finding of the research. This pattern exemplified how change had become pervasive in the lives of the nurse managers and linked the other relational themes.

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CHAPTER I

INTRODUCTION

Patricia Benner's (1984a) work has made visible the evolution of the nurse from novice to expert and the practical knowledge embedded in nursing practice. Nancy Diekelmann (1992) has extended this research to disclose the caring and expertise embedded in the practice of teaching. Other nurse researchers have focused on the lived experience of specific nursing practices such as nurse advocacy, the role of the preceptor, and expert nurse clinicians. Nurse managers connect to each of these facets of nursing through their work to shape the communities in which nursing is practiced and through their individual journeys as a nursing manager.

The nurse manager is critical to the quality of patient care and the environment in which nurses practice, yet the nurse manager position is often misunderstood and little studied. Nursing research on administrative and management personnel focuses primarily on the characteristics and functions of academic or service based executive leadership (Harrison & Roth, 1987; Poulin, 1984a; Ulrich, 1987; Zimmerman & Yeaworth, 1986). Studies related to nurse managers contain primarily surveys of job descriptions that determine common role expectations, the effect of leadership styles or job satisfaction.

Purpose of the Study

The purpose of this study was to describe the shared practices and common meanings embedded in the practice of nurse managers and to discover

thematic relationships in these common meanings. The review of literature revealed that research on nurse managers does not explore the experience from the perspective of the nurses who live it. What remains unclear is how the nurses themselves understand their experience and what is meaningful to them about their experience as managers. Heideggerian hermeneutic analysis of individual narratives was the methodology used in this study to interpret how the practice of nurse managers is shaped and influenced so that we can better understand the challenges inherent in the experience of managing nursing practice.

Significance to Nursing

Nursing management as part of a nursing community was shaped by the early history of nursing and health care. Historically, nurses are primarily employees of institutions that are predominately patriarchal bureaucratic organizations. Nurse managers are employees of institutions that prescribe specific activities and relationships to superiors and subordinates. The nursing profession is predominately female, and medicine and hospital administration have been predominately male. Nursing is in a subordinate relationship within an oppressive structure with physicians and hospital administrators established as a dominant group.

Although the institution views patients and families as a collective task to be processed efficiently, nurses have professional values and view patients and families as unique individuals with needs and rights that have a higher priority than organizational efficiency. Nursing's value of caring and medicine's goal of

curing can be equally disparate. Thus by definition, nurse managers must enact a role that is laden with conflicting values and loyalties. Nurse managers practice in the fringes, with one foot in the culture of the nursing profession and another within the organization. Nurse managers must develop behaviors and beliefs that accommodate these conflicting values and expectations.

If nursing is to thrive within the patriarchal health care system we must begin to understand how to create and develop collegial communities supportive of nursing praxis. The experience of the nurse manager is key in this process. The voices of experienced nurse managers can provide a new understanding about the politics and powers in which we practice. These voices can help to create a language of possibilities for understanding many facets of the experience of managing nursing practice.

Philosophy of Heideggerian Phenomenology

Heideggerian phenomenology provides a way to study experience. This philosophical framework, whose concern is to disclose and understand the meanings embedded in the everyday world of lived experience, offers a useful approach (Dreyfus, 1987). Heideggerian phenomenology seeks to explicate the nature and meaning of Being. Being does not refer to an entity; Being is the being of whatever is. Human being is just one manifestation of Being, where Being is the condition for the possibility for anything to occur (Heidegger, 1962). We come to understand some of the possible meanings of Being through our experience of the world and our own being within it. Everyday experience as it is lived is thus the focus of attention; the concern is to render lived experience

intelligible as this is where the meaning resides. Yet precisely because our lived experience is everyday and seems ordinary, much of its meaning remains hidden. Heideggerian phenomenology explicates the meanings embedded in lived experience.

Heideggerian phenomenology holds that our foundational mode of existing is interpretation and understanding. Understanding is grasping one's own possibilities for being, within the context of the world in which one lives. Understanding is thus the appropriation of meaning, the meaning of what it is to "be." As such, understanding is constitutive of the way we are. Understanding always operates contextually, within a set of already interpreted historical and temporal relationships, and is made explicit through interpretation, i.e., through language. Language does not merely represent our being, it discloses what it is to "be" (Dreyfus, 1992).

Hermeneutics is a systematic approach to interpretation. As explained by Heidegger (1927/1962, 1953/1959), the purpose is to bring to light the meaning of those beings whose mode of existence is interpretation. Thus, hermeneutic research studies the description and interpretation of people's experience, as written or spoken text (language), to disclose the meaning. Because persons in a particular situation share a common language, history and set of cultural practices that were handed down to them, not derived individually, interpretation can bring an intersubjective understanding of meanings of experience and the meaning of Being.

Heidegger (1953/1959) described the hermeneutic process as circular, a continual movement from the parts to the whole and back. The whole text is examined in order to find the overarching meaning that sustains it, meaning that is not explicit but envelopes it. Then interpretation moves to parts of the text, to delimit specific areas opened up by the text. The two interpretations are compared to look for conflicts and similarities, grounding an understanding of the whole in relation to the parts, and vice versa. Whole texts are compared to whole texts in the same manner, revealing new themes, issues, and questions. Hermeneutic interpretation seeks to go beyond what is explicitly formulated in the text to disclose hidden meaning; a thinking dialogue between the interpreter and the text moves understanding into the realm of the transpersonal, disclosing meaning that was not apparent to either the author or the interpreter as individuals.

The texts (data) for the hermeneutic interpretation of the experience of nurse managers in this research consist of transcripts of narratives or written stories told by nurse managers themselves. Patricia Benner (1984a, 1984b, 1985; Benner & Wrubel, 1989) introduced the particular method used for data analysis into nursing research, and later it was refined it into a seven step process (Diekelmann, Allen & Tanner, 1989). The research team, that included myself as principal investigator, conducted the analysis.

Benner (1985) described three stages of hermeneutic analysis for revealing configurational and transactional relationships in texts. These are paradigm cases, exemplars, and thematic analysis. A paradigm case is a whole

case that stands out as a strong instance of a particular pattern of meanings; it is reported intact to preserve all the nuances of its meanings. Exemplars are smaller vignettes that capture the meaning in a situation so that the reader can recognize the same meaningful transaction in other situations (which may appear to be different). Thematic analysis is the third interpretive strategy. The interpreter identifies common themes in the data and extracts sufficient excerpts to present this evidence to the reader. All three modes of presenting data maintain the context of the situation. They also allow the reader to participate in validation of the findings.

Diekelmann et al. (1989) developed a seven stage process of Hermeneutic analysis. The purpose of the multiple stages of interpretation is to expose contradictions, conflicts, and inconsistencies by allowing for reappraisals and comparisons. Multiple interpretations at every stage also serve as bias control, exposing unsubstantiated meanings and inaccurate interpretations not supported by the texts. Expert consensual validation by those living out the meanings is a major strength of the method.

As an interpretive researcher, I am a participant in the research. A joint reflection on a phenomenon alters the understanding of both the interpreter and participant. "It is through the seeing of that that is neither only *you* nor *I* but *our* between that we learn about each other" (Weber, 1986, p.68). A narrative evokes both participants' lived experience, seeking shared understanding that moves beyond the individual's personal understanding. This shared

understanding or "fusion of horizons" (p.68) only emerges within the context of involvement.

Research Question

Intention of the Study

The review of literature demonstrated that existent research on nurse managers did not adequately explore the experience from the perspective of the nurses who live it. The intent of this study was to explore how the nurses themselves understood their experience and what was meaningful to them about their experience as managers. Nursing research on management has focused primarily on the characteristics and functions of academic or service based executive leadership roles. The research is also limited by methods which do not focus on the study of persons as situated within the context of their experience in which the person and situation are an integral whole (Polkinghorne, 1988).

The method of Heideggerian hermeneutic analysis was used to interpret individual written narratives to gain understanding of the lived experience of a nurse manager. The goal was to gain an understanding of how we establish the communities in which nursing is practiced and how those meanings shape our practice and understanding of the essence of nursing.

Description of the Phenomenon

Nurse managers work at the cross roads of the health care delivery system and must coordinate and integrate a myriad of diverse, often conflicting

needs and priorities within their clinical domain. To understand this experience, it is first necessary to appreciate both the historical and current context within which nurse managers function. At present, practice settings in health care are in chaos, driven by costs, technology, changing values and bureaucracies. The cost of health care exceeds what consumers are willing to pay either through either private insurance or taxes. Current health care reform proposals abound, and universal coverage and health maintenance organizations continue to be proposed as cost efficient solutions. In addition to these profound changes in health care delivery, advances in medical technology require nurses to develop new clinical competencies.

These changes are pronounced among hospital-based nurses, who are increasingly aware of the impact on 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 increased use of nurse extenders and variety of skill mixes in staffing patterns adds to the complexity and skills needed by clinical nurses and their managers. Nurse administrators are experimenting with a variety of organizational models designed to improve cost effectiveness and efficiency of care delivery while supporting the professional practice of nurses and the new trends in health care. Thus, hospitals are rapidly changing in structure, complexity and even conceptually as health care moves beyond the walls of the traditional institution. These new models of practice often increase the responsibility, accountability and span of control of the first line manager. Increasing economic, social and ethical issues

will continue to drive these changes (Coddington, Palmquist, & Trollinger, 1985; Gilmore & Peter, 1987; Silva, 1984).

The impact on the nurse manager is substantial as they manage systems and people in a constantly evolving environment. Developing staff is a continuous challenge of the nurse manager. This development must include acquisition of new skills and the ability to respond to complex ethical dilemmas created by the revolution in health care. Traditional bureaucratic hierarchies used to manage departments are recognized as ineffective, and nurse managers face the development of new systems (Althaus, Hardyck, Pierce & Roger, 1981; Fine, 1977). Although the competencies nurse managers need to be successful in this environment are critical, selection and development of nurse managers is often an intuitive process with little understanding of the experience and development needed to meet these expectations and demands.

Statement of the Research Question

The participants were asked to respond to the following statement:

> Tell me about a time, one you'll never forget because it reminds you of what it means to be a manager. Include as much detail as possible and stay in the telling of your story, rather than stepping back and analyzing it or describing it from afar. After you have given the details of your story, please describe why this story is important to you and what it means to you. Your story can be a current one or one from years past. It can be a story of breakdown when nothing went right or one of making a difference.

Summary

This study will add to the body of knowledge by describing nurse managers through their everyday experiences. Their participation in the

research is a part of their own, ongoing, hermeneutic process of consciously reflecting on their lived experience and interpreting/putting into words meanings which disclose new possibilities for their being-in-the-world. Heidegger refers to this process as "entering the circle" (Heidegger, 1962).

CHAPTER II

REVIEW OF LITERATURE

The literature review begins with an overview of historical events that shaped the formation of the role of the nursing manager and their continuing influence through the middle of the 20th century. Next, the role of the first line manager within the economic, social and health care context of the 1970s and 1980s is examined. Finally, the research from the last 20 years is reviewed as well as the experiences of the nurse manager 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 19th century. Understanding this historical context is essential to understanding the contemporary phenomenon. The historical background will be traced and examined in light of beliefs, behaviors and values of the study participants. These roots include: the majority of nurses are women; the majority of nurses work as employees of institutions; and nurses seem to work in subordination to physicians and administration (Hedin, 1985; Strauss, 1966).

Events Prior to the 1900s

Although nursing had flourished throughout recorded history as a set of skills and attitudes handed down from generation to generation, it first

developed as a hierarchical system in Western Europe where the Catholic church and the military assumed responsibility for the sick, poor and wounded soldiers (Strauss, 1966). By the 18th century in Catholic European countries and their new world settlements, religious orders managed most of hospitals, leaving clear imprints on nursing. A hallmark of the order of St. John, for example, was "strict obedience" to authority, and the Sisters of Charity established strong traditions of selfless charity (Jensen, 1943, p. 104).

As part of the Protestant Reformation, Catholic convents and monasteries were dismantled, and religious orders were banned, including those who cared for the sick and 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 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 19th 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 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 because they have not had 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, 1977, p.77)

"The essential women were often dismissed with thanks from 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" (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 19th 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 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 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, the 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 (Smith, 1983). Whereas the rich had been able to avoid hospitals by providing care in their own homes, curing was a more specialized and industrialized 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 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, or head nurse, 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 student nurses 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 nurses (Kalisch & Kalisch, 1986). The needs of the hospital for greater stability and expertise from its nursing staff, and the need of 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 when "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. (p. 393)

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

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

Staff nurses were eventually relieved of some of these responsibilities when hospitals hired ward helpers in response to the Goldmark report (1923). However, head nurses were not. As a representative 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. Head nurses' 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 1940s care had become more complex, and the head nurse was both teacher of new skills and primarily responsible for monitoring conditions of the patients.

World War II Through 1970

During the first half of the century nursing management evolved through steady incremental steps. But from the 1940s 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 nurse 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 1900s 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 head nurses were spending approximately 30 percent of their time on clerical functions (Barrett, 1963). Although they had less responsibility for the hotel functions, their duties as organizational manager required them to report, record, regulate and coordinate all activities of staff, patients, physicians, and numerous personnel from other departments that passed through the unit (Mauksch, 1966).

By the 1960s the head nurse's role as clinical expert and teacher of students had also changed. Schools were now providing clinical instruction, dividing the head nurse's previous clinical role into service and education, creating two distinct groups which, over time, developed different values. Early research on this issue found that these values discrepancies were problematic both for new staff and for patients (Ondrack, 1975; Smith, 1965). Head nurses

valued behaviors that expedited the task at hand, while educators were more focused on individuality and creativity. Anderson (1964) suggests that the manager's values were the result of the bureaucratic aspects of the role.

Head nurses 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 distribution of nurses that occurred at the close of World War II were chronic by the end of the 1960s (Ginzburg, 1967). Staffing shortages and the addition of new categories of personnel to remedy 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 8 hours as a consequence of the elimination of split shift assignments (Lamberton, 1953). However, the model seemed to further alienate nursing administrators from their increasingly dissatisfied care givers (Bloom & Alexander, 1982).

Within the team model of practice, managers gave less direct care than was the case under functional models (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 technically competent, and were acquiring basic and advanced degrees in universities, but many 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 the position as the physician surrogate. Many physicians continued sitting 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 (Hughes, 1988). However, nursing's continued progress toward professionalism began to create instability in these relationships in the hospital.

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 20 years. These changes will be explored briefly to develop the context before examining the literature about the expanded role of the nurse manager.

Changes in the 1970s and 1980s

The steady incremental change that was the hallmark of health care and nursing prior to the 1960s accelerated dramatically in the 1970s and 1980s. 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 and were becoming the third largest industry in the United States (Litman & Robins, 1984). The title of head nurse was replaced by nurse manager in response to shifting expectations and hospital organizational structures (Kalisch & Kalisch, 1986).

These changes overwhelmed the centralized and hierarchical organized nursing service organizations (Fine, 1977). Nursing administration was plagued by inflexibility, loss of initiative, poor communication and dissatisfaction, which resulted 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 (Marcinszym, 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 possible 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 from industry, several nursing administrators applied decentralization 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 focused operational authority is 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 (Marcinszym, 1971). Both positive and negative aspects of these changes are similar to findings reported in industry (Deardon, 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 1980s is replete with strategies to manage cost containment and the resulting effects on staff (Fanning & Lovett, 1985; Salmond, 1985). Many of the strategies have continued to vary. Proponents cite the achievements of cost containment, job satisfaction and patient care goals (Altaus et al., 1981; Fanning & Lovett, 1985; Spitzer, 1986). However,

Wellington (1986) points to problems in coordination, the lack of nurse managers capable of performing expanded manager roles and the limited number of clinical 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, shared-governance and other structures are being tried and evaluated. Each form of management is attempting to respond to the desire for autonomous professional practice expressed by many nurses (Hinshaw, Smeltzer & Atwood, 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 manager (Althaus et al., 1981; Fine, 1977; Hodges, Knapp, & Cooper, 1987; Marcinszym, 1971).

The authority and accountability of these new management roles typically includes: (a) fiscal accountability for personnel and operational budgets of several million dollars; (b) authority to hire, fire, evaluate, determine salaries, establish staffing patterns and schedules, and conduct personnel actions for 30-100 staff; and (c) accountability for professional practice including standards of care, development of staff and quality improvement 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 and cost efficient patient care, little is known about the everyday practice of these first line managers who, like the chief nurse executives of the 1800s, 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. 19). By 1986, the Journal of Nursing Administration (1990) pointed out that there were only 11 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. Five additional studies have since been published.

The literature is rich with opinion and anecdotal observations about the role of the nurse manager, yet research articles are minimal. Therefore, this review will include published research on nurse managers.

Nurse Manager Behaviors

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

Role Task Behaviors

An early study by Jones and Jones (1979) used observation and interviewing to determine that nurse managers' 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. Jones and Jones 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 percent of their time in direct patient care and 39 percent on patient care management issues even though the role was described as managerial. The disparity between written job descriptions 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 that identify nurse manager role tasks were conducted by Beaman (1986), who surveyed all Los Angeles county hospitals, and Hodges et al. (1987), who questioned 288 chief nurse executives randomly selected from the American Organization of Nurse Executives (AONE).

Beaman (1986) found that 50 percent 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). Beaman found no relationship between the types of tasks and the size of the hospital.

Hodges et al. (1987) found that 76 percent of the chief nurse executives reported that their departments of nursing were decentralized, but did not define the term. Fifty-eight percent of the chief nurse executives ranked the manager position as the most important position in achieving organizational goals. An analysis of functions found the role increasing in autonomy and responsibility in a centralized organizational structure. Eighty-seven percent stated masters prepared head nurses would be more cost effective, and 95 percent reported they would hire such nurses if possible.

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

All of the four studies that examined 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 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). 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 & Henley, 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 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 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 nurses' perception of high autonomy head nurse leadership style may significantly influence the staff's sense of personal efficacy.

A study by Nieburh, 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. This could explain some of the weak correlations found 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 the study findings difficult to evaluate.

Although the nurse manager's style of role enactment seems to clearly affect the nursing staff, which behaviors are related is unclear. 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 suggests 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 permanent head nurses toward the rotating house staff in a neonatal intensive care unit (NICU). Many nurses tell stories of "Attila the Hun" who "brought them up." Yet little is known about the affect of nurse managers 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 10 years. The source of

this stress is described in various ways including 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 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 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 study data did not support this. 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 was 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 propose 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 10 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 (Gribbons & 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 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 by not only type but also amount of stress perceived. No generalization 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, the research does not describe it (Boccuzzi, 1979; Dodwell & Lathlean, 1987; Dooley & Haube, 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 (Gribbons & Marshall, 1984; Hyndman & Personius, 1983). Nursing management is unanimously perceived to be a critical and demanding job. However, support for these beliefs has not progressed beyond tentative problem identification (Journal of Nursing Administration, 1990).

Nurse Manager Values

Smith (1965) 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. Smith 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 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. The literature supports that many nurse managers are inadequately prepared to meet the managerial demands of their role. One factor 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 (Bergan, Stockler, Shavit, Sharon, Feinburg & Danon, 1981; Price, Simmons, 1980). Institutional reorganization is 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 (Bocccuzzi, 1979; Hutchinson & Murphy, 1985). As the discrepancy between skills and capabilities has increased, many hospitals have developed in-house courses or have sent managers to a myriad of continuing education courses (Kirk, 1987).

The search for ways to select and prepare first-line nurse managers has included traditional and non-traditional directions. The expectation is for managers to have advanced degrees (Department of Health and Human Services, 1988). The number of nursing administration programs awarding masters and doctoral degrees is 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).

Vocational behavior theory has been explored with the assumption that successful managers as a group have personal attributes that enhance not only their ability but also satisfaction in their role. Hansen and Chater (1983) explored this concept using Holland's (1973) Vocational Preference Inventory to distinguish personality profiles of management and non-management master's level nursing students. The two groups could be differentiated by personality variables but not by using demographic or career data. Those with management interests were significantly more realistic, social, conventional, enterprising, artistic and acquiescent. The sample was drawn from a graduate student population with an expressed interest in management, rather than practicing managers. However, this has been a productive approach to career counseling 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; Rotovitch, 1983; Wallace and Cory, 1983). At Stanford, del Bueno and Walker (1984) piloted a program to explore this issue empirically. Bachelor of Science in Nursing (BSN) graduates with 1 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 on other than in academic programs?

Expanded Role of the Nurse Manager

Although there is little published about the new role of nurse managers, there are many job 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 roles were combined, the new role would require an awesome range of competencies.

The current 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). This role is not easily categorized, being viewed by some as middle management and by others as a first-line management position.

The scope of the role usually includes 24 hour 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 this current role addresses various aspects of leadership responsibility, primarily in the area of personnel management. Managers have traditionally evaluated staff performance, but most now do so in a manner that promotes staff growth and development, 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 interfactional skills (Calabrese, 1982; Schmieding, 1987).

Additionally, many organizations now expect self-managed, empowered teams as a part of the organizational structure. Many testimonials attest to the terrifically high output of self-directed empowered teams, and it has become an expectation of administration and staff. Nurse managers are expected to create self-governed teams and move from empowering people to empowering teams. An important transition for the nurse manager is to move from director, controller, inspector, and planner into roles that can empower the team (Kerfoot & Uecker, 1992).

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 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).

Heideggerian Phenomenology

Heideggerian phenomenology represents a radical shift in what it means to be human. The dominant philosophical view which underlies modern thinking about human existence can be traced to Descartes' 17th century formulation "ego cogito, ergo sum" ("I think, therefore I am") (Packer, 1969; Polkinghorne, 1983). In Descartes' formulation the solution to philosophy's traditional epistemological question "How do I know?" was answered by the ontological question "How do I exist?" Descartes held that the mind and body are distinct entities. In Descartes' formulation, the mind exists in time only, whereas the physical body exists in space. The mind, the subjective self, cannot come into direct contact with the world, so it operates with representations of the world which are approximations of reality. The contents of the mind are private and idiosyncratic; since the body is the mind's only vehicle for expression, behavior

is the only information a person can use to understand another person's mental experience. In the Cartesian view, there is only consciousness and the objects of consciousness, i.e., a split between the knower and what is known. What is known is whatever objects the conscious mind represents to itself; one's own body even becomes an object to the subjective mind, to be known in terms of fixed attributes, just as all that exists in the world becomes objectified and categorized (persons, animals, and things). The corollary to this Cartesian position of ontological privilege is found in the Platonic position of epistemological privilege that detached, theoretical, abstract knowledge is the only "true" knowledge. Both positions are pervasive in Western thought and constitute the underpinnings of the dominant scientific paradigm.

Heidegger (1927/1962) believed that the ontological question "How do I exist?" had precedence over the epistemological question "How do I know?" The question of being is prior to the question of knowing. Further, the answer to the question of being is constitutive of the answer to the question of knowing.

According to Heidegger (1927/1962), a person is a self interpreting being who becomes continually defined in the course of living. That is, our being, which always already is, is gradually unveiled as we live our life in the context of the world. Because we dwell in our being all the time, we can never be clear of it or clear about it. Yet being is always already understood, as it is the background pre-understanding which allows us to make anything intelligible. An inescapable background, being cannot be spelled out in rational, context free

principles. Heideggerian phenomenology seeks to illuminate our understanding of being without making that understanding totally explicit (Dreyfus, 1992).

People have a non-reflective pre-understanding of their being-in-the-world because they are always situated in a meaningful context and can grasp meaning directly. The meaning of a situation for the person is directly apprehended based on taken-for-granted meanings embedded in the skills, practices, and language of the culture. People are also obviously capable of reflective or conceptual thinking, but such deliberative thinking is only one way in which we encounter the world. Anytime you stand outside a situation you are in a reflective position. However, most of the time we are involved in the situation, not standing outside it. Heidegger's concern was to illuminate our understanding of everyday, involved situations of living (such as practicing nursing) i.e., "lived experience."

Understanding, in Heidegger's terms, is grasping one's own possibilities for being, within the context of the world in which one lives. Understanding is the appropriation of meaning (Heidegger, 1927/1962). Understanding is a mode of being; it is constitutive of the way we are. An important characteristic of understanding is that it always operates contextually, within a set of already interpreted historical and temporal relationships or a relational whole. Understanding is rendered explicit by interpretation, as in language for example.

In everyday involved experience, the world appears to us in a context of meaningfulness. The immediate grasp of meanings in a situation is made possible by four aspect of humanness. One aspect lies in the fact that our

bodies are knowers as well as our minds. This embodied intelligence enables us to move smoothly through situations in rapid, nonreflective ways. A second aspect is that we are brought up in a background of meanings through which we come to understand the world. Thirdly, things matter to us. As persons, we have the capacity to care, and our caring helps define us. Fourth, because we largely encounter situations as involved participants versus detached observers, situations have the capacity both to engage us and constitute us.

Embodied Intelligence

Embodied intelligence subsumes all the various non-explicit and nonconscious ways we have of grasping the significance of a situation for the self. From the recognition of familiar faces and objects, to maintaining posture, to the skills of a chess player (Dreyfus, 1982) or an expert nurse (Benner, 1984a), embodied intelligence is involved in a wide range of activities. Embodied intelligence allows us to be in a situation in a meaningful way, dwelling in them comfortably. As a mind body unity, we are at home here--we recognize our world. As Benner and Wrubel (1989) state, "see how dehumanizing it would be to live in a world of distractions. What a deprived existence it would be, what impoverishment of life, if one were unable to recognize a glove, a rose, the faces of one's spouse, children, or friends" (p. 44).

As we grow up the body also learns cultural meanings, the use of tools and skilled behavior. An example of the culturally skilled habitual body is our ability to learn culturally appropriate distances for standing by people in different situations. It is permissible to pack closely together in subways to get to work,

but this close distance is not permissible once you reach the work place. No one ever told you how many feet and inches to stand apart from others, and if you had to consciously think about it for every encounter you would be exhausted by the end of the day. The habitual cultural body is taken for granted and virtually invisible to consciousness.

Background Meaning

Heidegger (1927/1962) described background meaning as neither subjective nor propositional. It is what the culture gives us from birth--a shared, public understanding of what is. Thus background meaning is handed down, not individually derived. Background meaning is not a thing, but a way of understanding the world. As such, background meaning can not be made fully explicit or rationalized. Like our pre-understanding of being, we can neither be completely clear about our background meaning nor completely clear of it. Background meaning is like light; without its luminance you see nothing, but you cannot see the light itself (Merleau-Ponty, 1962). This notion of background pre-understanding is a major distinction between Heideggerian phenomenology and Husserlian (transcendental) phenomenology (Benner, 1985; Packer, 1969; Polkinghorne, 1983).

Because of our embodied intelligence, we begin talking in cultural and background meanings from birth. Background meanings are taken up in individual ways, but only within the range of what a culture makes possible. For instance, personal control is a cultural background meaning in the United States (widely studied as internal/external locus of control). Background can never be

made fully explicit by studying attitudes or beliefs because it is also known in bodily ways, and it is embedded in cultural practices and skills. Further, background meanings are not static. As people in a culture live them out, background meanings are modified over time. Language and culture are key aspects of our background meanings.

Language

Heidegger (1947/1977) stated that "language is the house of Being and the home of human beings" (p.239). By this he meant that every thing in the human world comes into existence in language. Language does not merely represent our reality, it discloses our reality. "Words and language are not wrappings in which things are packed for the commerce of those who write and speak. It is in words and language that things come first into being and are" (Heidegger, 1953/1959, p. 13). Thus, language is ontological, a mode of human being which unveils Being. We are what we say. "It is precisely in the naming...and in the transmutation of the world into word, that the real conversation, which we ourselves are, consists" (Heidegger, 1936/1949, p.279). Language is, therefore, constitutive of being.

As constitutive of being, language is also constitutive of experience. Experience as a fundamental mode of being in the world, is engaged activity, not detached knowing. Everyday involvement with the world in situations of engaged activity (lived experience) is the foundation for other modes of being in the world, such as detached knowing. Experience is not transparent and must

be interpreted to uncover meaning (in the same manner that being must be interpreted).

Further, language is constitutive of the world. "Language ...is the situation coming to explicitness in words...As a disclosure not of the speaker but of being of the world, it is neither a subjective nor objective phenomenon but both together, for world is prior to and of both" (Palmer, 1969, p.139). Thus, the world, being "itself," is also brought to appearance by language. In this manner, language constitutes both us and the world, the individual and the universe.

Heidegger (1927/1962) placed great emphasis on the shared and public nature of all the background meanings (language, practices, skills) that mediate human awareness. He noted that even our self-interpretations are largely determined by the possibilities laid open to us by the shared culture's images and roles for coherent behavior. This is because language and cultural practices handed down to us are, themselves, already laden with interpretations of what it means to be human in our world. This means that our self-interpretation is predicated on the meanings available in our own background, culture, and language. We are neither radically free to choose our interpretations, nor are they wholly determined for us. We have what Benner and Wrubel (1989) term "situated freedom and situated possibility," based on our own personal history and the history of our culture.

In the same manner that we are not wholly free to choose our self-interpretations, we are not wholly free to choose our interpretations of experience. Therefore, common meanings, common themes and common

concerns would be expected to emerge among human beings in common situations who share common cultural practices and language. It is in this sense that Heideggerian phenomenology transcends the personal and idiosyncratic (Benner, 1985).

Since human existence is in a lifeworld which is linguistic in nature, we never find ourselves outside language. "Experience, thinking, and undertaking are linguistic through and through." (Palmer, 1969, p.203). Thus to seek to understand the human experience we must participate in dialogue (written and spoken). "Through dialogue, we get to think things through, glancing at the mirror the other holds up to us, discovering not only the other, but ourselves" (Weber, 1986, p.66).

As a way of being in the world through language, dialogue seeks shared understanding of a phenomenon. Again, Weber (1986) reminds us "it is the 'between' (entre) that reveals, that permits understanding. It is through the seeing of that which is neither you nor I but is rather our between that we learn about each other" (p. 68). Each person's speaking functions to disclose. Since human being happens in speaking, what is disclosed is both the subject matter and the matter-of-the-subject. The process of understanding is a move from the separate positions of the individuals to a synthesizing position that subsumes relevant aspects of each (Stewart, 1983). This is what Gadamer (1960/1975) and Ricoeur (1981) mean by "fusion of horizons." Dialogue is thus private and confidential, as well as social and public (Diekelmann, 1992).

Further, in the fusion of horizons, dialogue has a creative quality. All persons in the dialogue participate in the ongoing process of constituting meaning, whether dialogue occurs as a conversation characterized by genuine interpretive listening, or between an interpreter and the author of a text or work of art. The process is one of producing understanding, not reproducing it. This is because understanding is always provisional and contextual, open to present and future change.

Culture

As has been previously discussed, a major aspect of our cultural context is language. Culture is also constituted by rituals, skills, practices, and artifacts. It is assumed that a range of common background meanings are embedded in all of the afore mentioned aspects of culture, which transmit an implicit understanding of what is meant to be. Together, these cultural aspects form the contextual background against which all human experience takes place, and from which no one can be free.

For example, consider a sacrificial chalice. What constitutes it as the thing that it is? The silver of which it is composed is only part of the answer.

> For it only exits as a sacrificial chalice in a particular sort of world--its world. It arises and is sustained as the thing that it is only in the world of a particular living cultural tradition, and when this world decays the chalice in its essential nature decays, such that now it exists only as a collected object which, perhaps we may admire aesthetically...It is its world which enables it as the thing that it is.

> This [world] conditions its physical form, the appropriateness of its material, its 'sacrificialness' and, importantly, it--the chalice--at the same time plays a part in enabling its world, for a culture is nothing without its thing. (Bonnett, 1983, pp.24-5)

Although Bonnett was not quoting from Heidegger, he formulated this exemplar of the chalice in order to help explain Heidegger's views on the importance of culture to our context.

In Heidegger's later work, he developed the notion of cultural paradigms. He gave the example of the Greek temple which focuses the meanings scattered in the language and practices of the culture. The temple as paradigm has the effect of focusing our understanding and preserving the practices and serious issues of the era. Heidegger (1960/1971) described the Greek temple as an instance of truth disclosed an art:

> It is the temple work that first fits together and at the same time gathers around itself the unity of those paths and relations in which birth and death, disaster and blessing, victory and disgrace, endurance and decline, acquire the shape of destiny for human being. The all governing expanse of this open relational context is the world of this historical people. (p. 42)

Heidegger's discussion of paradigms relates to his exposition on nihilism, and how paradigms are one means of saving whatever nonobjectified shared, historical, cultural meaning remains.

Concern

Central to the phenomenological view of the person is the notion of caring or concern. Part of what it means to be human is that persons, events, and things matter to us, and so we become involved in the world. Heidegger (1927/1962) called this way of being involved concern. As persons we do what we do through concern, through involvement with the world, and others. As a way of being in the world, concern creates both us and our world.

"Although embodied intelligence and background meaning can account for how the person can be in the world and grasp meaning directly, concern accounts for why" (Benner & Wrubel, 1989, p.48). Traditionally, questions of why we do things have been studied under "motivation." These mechanistic theories separate people from their world, looking at motivation in terms of internal drives, needs, or traits (person as object). Motivation becomes a nonquestion of one's view of the person phenomenologically, as involved in a context, inhabiting the world. The person does what he or she does through concern, through involvement with the world and others. Rather than having a subject-object relationship, the person is defined by his or her concerns.

Heidegger (1927/1962) distinguished between the way we are concerned about things and the way we are concerned about other beings. Our concern for others is termed "solicitude," which can take one of two forms: (a) solicitude which "leaps in" and "takes over for the Other that with which he [sic] is to concern himself"; and (b) solicitude which "leaps ahead...not in order to take away his [sic] 'care' but rather to give back to him authentically" (pp.158-159).

The first kind of solicitude can slip into domination, whereas the second kind of solicitude can empower the other to be "free-for" understanding new possibilities of being.

Where caring tends to slip into domination, reciprocity has been lost. What is meant by the term "reciprocity" is that caring, as the most basic human way of being in the world, may bring about mutual realization. "Caring for others contributes to a world where one can care and expect to be cared for" (Benner & Wrubel, 1989, p. 367). When we allow others to care for us we bring more caring into the world, constituting it as a caring place. Not only are we replenished and nourished by the care of others, we also give them the gift of experiencing their caring for us, caring which creates new possibilities for being. Thus, the nature of caring is transformative, not transactional. As important as it is that we care for others, it is equally important to allow them to reciprocate and care for us.

Using Heidegger's formulation of care/concern, Benner and Wrubel (1989) studied nursing practice and found that various modes of caring are primary to nursing. That is, nursing is primarily a caring practice. Benner and Wrubel determined three ways in which caring is primary to nursing. First, because caring sets up what matters to a person, it also sets up what counts as problems or stressors, and what options are available to cope with them. In this manner, caring creates possibility. Second, persons are situated caringly in a connected and involved manner. This can enable the person to discern aspects of the situation as more or less relevant, enhancing both the recognition of

problems and possible solutions, and the speed with which solutions can be implemented. Finally, caring sets up the possibility of giving and receiving help. That is, a phenomenological understanding of caring can set up a context which allows one to feel cared for and to appropriate the help being offered. Diekelmann (1992) has argued that, in a like manner, caring is primary to the practice of teaching nursing.

Caring is devalued in our individualistic and technological society. As described in sociological work (Bellah, Sullivan, Swidler, & Tipton, 1985), the ethos of "utilitarian individualism views society as arising from a contract that individuals enter into only in order to advance their self-interest" (p.336). This notion can be traced to Locke, and was popularized in the American culture by Benjamin Franklin (Bellah et al., 1985). Its center is the autonomous individual, rationally choosing roles and commitments based on the likelihood of self-gratification. It is from this notion of utilitarian individualism that we derive a basically economic view of people which contains meaning to cost/benefit language, taking ends as given and focusing only on the means to achieve them. Such a view of persons is isolating and ultimately nihilistic, for it is but a step to the notion that we define our own values and freely choose meanings based on our idiosyncratic preferences which are their own justification (self-interest). If we can choose our own values, then common societal values and morals hold no authority for us; rather than giving meaning to our lives, they show us that our lives have no intrinsic meaning, and nihilism is complete.

By contrast, the Heideggerian phenomenological view is that serious meanings and issues are shared and are embedded in a web of historical and social networks and practices. This heritage of shared and essentially human concerns (love, morality, dignity, suffering, etc.) is preserved in caring practices traditionally devalued or trivialized in our individualistic and technological culture, such as nursing, parenting, and teaching. We can struggle to arrest the spread of nihilism by uncovering and preserving such shared meanings (Heidegger, 1955/1977; Bonnett, 1983; Dreyfus, 1984).

Situation

Because of concern, persons are inhabiting their world, not living in an environment, and are involved in a context. Because of embodied intelligence, background meaning and concern, people are able to grasp a situation directly in terms of meaning for the self. This direct apprehension is what is meant by phenomenology. Further, because we inhabit our world, we are solicited by it and constituted by it. Our context or situation is not merely a Cartesian abstraction.

Embodied, self-interpreting people live in a real world, in contexts that change over time. Changes such as marriage, divorce, promotion, etc., alter the lived in situation and also render our old self-understandings less relevant. "It is only in the changed context that the hitherto unnoticed background meanings, habitual body understanding, and concern are seen to no longer allow for smooth functioning. People become aware of them and reflect on them. This

breakdown in smooth functioning is what is meant by stress" (Benner & Wrubel, 1989, p.50). Such times of breakdown involve the person as a whole.

The "Will to Power" and Nihilism

One final formulation of Heideggerian phenomenology which is germane to the concerns of this research project is found in Heidegger's later writings (1960/1971, 1967/1977, 1955/1977) as a critique of what he called "the will to power," the expression of the essential nihilism of the modern age.

> When God and the gods are dead...and when the will to power is deliberately willed as the principle of all positing of the conditions governing whatever is, i.e., as the principle of value-positing, then dominion over the earth passes to the new willing of man [sic] determined by the will to power. (Heidegger, 1955/1977, p.99)

Heidegger traced the roots of the will to power to "objectification," which began with Plato and culminates with Descartes, ie., the notion that what is known is separate from the knower, that there is a split between subject and object. The subject becomes the root of certainty--Descartes' "ego cogito, ergo sum" (I think, therefore I am)--and "man becomes that being upon whom all that is, is grounded as regards the manner of its Being and its truth. Man becomes the relational center of that which is such" (Heidegger, 1955/1977, p.128). Subjectivity appears to be the essence of reality; the subject even represents itself to itself as an object. Through subjection of all it encounters (ie., Being) as object, the subject exercises its mastery over everything; the "will to power" is complete.

Through the activity of representation, the subject fashions its own image or picture of the world. Nothing is allowed to appear as it is in itself. It is in seeing the world as a picture that nihilism, the loss of a sense of meaning and seriousness in our lives, becomes explicit. For ideas, principles, and values are not just objects we represent to ourselves, they are also options we can choose among. Once we see values as the result of something we do, they lose all authority for us; rather than giving meaning to our lives, they clarify that our lives have no intrinsic meaning. Private experience becomes all that matters, and nihilism is complete.

We live in an age where the will to power is evident in our drive to control the world through technology and science. Heidegger (1955/1977) traced the root of the word "technology" to the Greek "poisesis," which means coming into the present out of the not-present. This "bringing-forth" was manifest both in "physis," where bringing forth arose from within the thing itself, and in "techne," where bringing forth lay in another (the handwork of arts and crafts). Arts of the mind were called "techne" also. Through the gradual dominance of objectifying thinking, the meaning of "poisesis" came to be more associated with "techne" than "physis." Fabrication became the meaning of technology.

The will to power is revealed in techne/technology. "Enframed" by science and technology, natural and human resources of the world (as picture) appear to be an undifferentiated supply Heidegger (1955/1977) called "the standing reserve," open to the manipulation and control of powerful persons as self-securing, self-conscious subjects. The danger of "enframing" as a way of

thinking is that all other ways of knowing will be lost and Being will not be allowed to presence as it is.

The challenge to "enframing" is a new mode of thinking, genuine thinking as a person's most essential manner of being human. Genuine thinking (Heidegger, 1954/1968, 1955/1977), is not defined in the usual sense of having an opinion (opining), representing or having an idea, reasoning (ratiocination), or as systematic. Instead, thinking is a way of living or dwelling. Thinking is a response to a call which comes from Being; in thinking, the relation between persons and Being manifests itself. We must be open to the call to think, which comes from Being, for in thinking we will discover our own nature as well as the nature of Being. Because Being manifests itself continually anew, thinking is never static, but a journey down a path or road. Through genuine thinking we arrive at the clearing, that place of openness where we can let what is be, and open ourselves to the ruling of Being. Freedom governs the clearing.

Freedom is not the opposite of control. Freedom is being free for one's own most potentiality for being, that is, comportment which opens oneself to one's own possibilities for being. Freedom also means to let other beings be, to allow things and others to show themselves in all their possibilities. In the disclosure of the being of all that is we see new possibilities for our own being (Heidegger, 1927/1962). Freedom is the essence of being and so does not belong to humans. It is instead the ground for being human; "freedom...possess man [sic]" (Heidegger, 1967/1977, p.129). Thus, to be free for one's own possibilities and the discourse of Being, one must let others "be" (i.e., "free-for"

their own possibilities). To restrict others is to conceal their potentialities as well as our own. To restrict others is to restrict ourselves. In this sense, power is truly a fool's errand (Heidegger, 1955/1977). The will to power, as embodied in technological and objectifying thinking, is actually disempowering.

Our mode of being in the world is that we care about our own essence and thus are open to its authentic discourse to the self ("resoluteness") (Heidegger, 1927/1962). "Resoluteness" and caring (solicitude for others and concern for things) also allows us to let others "be" in their own most potentiality for being. When we let other beings "be" we engage in unconcealment and enter "the clearing." In the disclosure of their being we see new possibilities for our own being within the world into which we have been thrown, a world which exists as it is, as it has to be, in its own facility. However, in our everyday existence we are "falling" away from authentic disclosure of Being, falling away from concern and solicitude, and becoming fascinated by techne and fabrication.

Heidegger believed a path to the clearing is to return to the origins of modern thought, the Greek, and reinterpret the roots of our thought. The call of genuine thinking to be attentive to things as they are, not as we have represented them in our theoretical and objectifying mode of thinking, knowing that, is a call to return to knowing how. Knowing how is embedded in our cultural skills and practices and constitutes our understanding of what it means to be human and relate to others. Such understanding can never be made totally explicit, for to objectify it would be to destroy it. However, this understanding is focused and preserved in the nonobjectifying practices which

have been devalued and marginalized by our technological culture. These ancient caring practices, our essential way of being human, such as teaching, nursing, and child care, preserve their shared meanings and know how as cultural paradigms. Paradigms focus and collect "the scattered practices of a culture, unifying into a coherent possibility for acting, and holding them up to people who can then act and relate to each other in terms of this exemplar" (Dreyfus, 1984, p.145). Serious issues and meanings are publicly displayed so that there can be disagreement and history can begin anew. Recovering an understanding of these ancient caring practices is one way to unfold new possibilities for being in the world in which we have been thrown. It is also a way of being which does not contribute to the problem of nihilism.

Heideggerian Phenomenology as a Mode of Critique

The Heideggerian formulation of the will to power and nihilism represents an important philosophical critique of research grounded in the modern Cartesian view of persons. Heidegger saw that the Cartesian split of mind and body, and the representational theory of knowledge and truth have led to notions of objective reality and a belief that rationality is the path to all understanding.

> The person is viewed as an agent who engages in rational calculation to determine what goals to set and how to attain them, and the journey through the life course is conducted on the basis of a cost benefit analysis...the only relationship the person has to the world (and for person, read here mind) is a representational one. (Benner & Wrubel, 1989, p.51)

The technological view which sees the world, the self, and others as essentially raw materials is indeed an impoverished and alienating understanding. If things and people no longer matter in essential ways (love, morality, dignity, suffering, etc.), outcomes or ends are the only issue.

Further, when people are studied objectively, their connection to and embeddedness in a situation is left out. Researchers who try to acknowledge this relationship of context and culture "objectively" are forced into a position of proliferating variables which ultimately leads to confusion. Human existence cannot be captured out of its context.

The Cartesian mental representation view of the mind also does not allow for precognitive intentionality--meaningful purposive behavior based on skilled practices, habits and language. This has led to the modern view of radical freedom, an idea that people choose their meanings all of the time. Such a view has led to a blame the victim mentality i.e., people choose to be depressed, or people choose to remain oppressed (consciously or unconsciously). This view ignores that the choice of meanings is based on meanings available in the person's own background, culture, and language. People are neither radically free nor unfree; they have situated freedom, as well as situated possibility (Benner & Wrubel, 1989).

These misunderstandings of what it means to be human lead ultimately to nihilism. Our culture today is increasingly defined in terms of technological paradigm, which focuses and preserves the meaninglessness of being. The real danger is not science and technology, it is our worship of science and

technology, or scientism. Thus, it is from the stance of a philosophical critique that Heideggerian phenomenology offers an important new lens with which to view the world of scientific research. Heideggerian phenomenology opens up the possibility of a new way of thinking about and studying the experience of nurse managers.

Summary

Nurse managers are influenced by a variety of factors which make up the context in which they practice. Some of these factors include: nurses work primarily as employees of an institution; the majority of nurses are women; and nurses historically have worked in subordination to physicians and administration. These factors have been examined tracing the evolution of the role of the nurse manager and placing it in an historical and contemporary context. Research concerning nursing management is sparse and often influenced by the methodology used. Some data has been gathered related to the role behaviors and values of nurse managers. There are also studies which examine the manager's leadership style and the effect on staff, and the stress experienced by the manager as a result of role responsibilities. The one aspect that seems to be most thoroughly understood is the demand of managerial competence that is beyond what can be obtained in a basic nursing program, and therefore requires some form of additional education. But it is unclear to what extent these findings reflect the world of the practicing nurse manager within the context in which they function.

CHAPTER III

METHODOLOGY

This chapter will describe the phenomenon studied and provide an explanation of Heideggerian hermeneutics, the methodology chosen for this study, and describe the study design. As Heideggerian phenomenology grounds the entire research project, including the hermeneutic method, a description of Heideggerian phenomenology is also presented.

Research Design

Method of Inquiry

A Heideggerian hermeneutical analysis was used in this study. This method of analysis is used to search for the meanings embedded in experience rather than generating knowledge that leads to prediction or explanation (Dreyfus, 1987). The use of hermeneutic phenomenological inquiry in the form of a written narrative is a means for exploring and gathering experiential information to develop richer and deeper understandings of human phenomenon.

Naturalistic Setting

The setting chosen for this study was nursing management as practiced in an acute hospital setting. Demographic data was collected to assure that managers had similar responsibilities.

Participants

The design of the study includes interpretation and analysis of 16 written narratives of nurse managers. Nursing management was defined as a leadership position with direct-line responsibility for a nursing department, unit, or clinical area, with fiscal, personnel and management responsibilities. In order to receive a rich and varied data set, no additional restrictions as to demographic characteristics were imposed on the selection criteria. A letter was sent to potential participants explaining the study along with a consent form. Recruitment was continued in this manner until a total of 16 responses were received that met the criteria.

Protection of Participant's Rights

Each participant was invited to participate in a letter from the researcher explaining the purpose of the study, the methods used, and assurances of confidentiality. The participant was asked to give informed written consent and was given a copy of the form. The consent form requested permission to contact participants for clarification of aspects of their story and to validate interpretations and analysis. The information was coded to ensure anonymity. Before distributing to members of the research team all identifying information was removed from the texts.

Data Collection

The participants were asked to write a story about what it means to be a nurse manager in response to the research question. They were also asked to

submit demographic information. The resulting texts were analyzed for the study. A purposive sample was created which included nurses known for their experience with nurse management through writings or personal contact. The research protocol was approved by the Texas Women's University Human Subjects Committee prior to initiating the study.

Data Analysis

The texts or data for the hermeneutic interpretation of the experience of nurse managers described in this dissertation consists of the stories generated by the participants in response to the research question. Analysis of the interview texts was carried out by a team of researchers that included myself as principal investigator, a nursing professor skilled in interpretive research, a graduate nursing student working with interpretive research, and an expert practicing nurse manager. Texts were analyzed according to the seven step hermeneutic method described in Diekelmann et al. (1989) as follows.

Stage one: The entire set of interviews was examined as a whole by each member of the research team to obtain an overall understanding of the texts.

Stage two: The text of each interview was summarized by each member of the team with possible themes identified. Written interpretations were supported with excerpts from the interviews. The research team discussed the interpretations of each interview. Team members discussed analysis and textual evidence with group consensus being the ultimate goal.

Stage three: In further independent analysis, each team member's interpretation was compared with the investigator's for similarities and

differences. Any discrepancies in the interpretations were clarified by referring back to the text.

Stage four: Material generated in previous stages was reread and studied to see if similar (common) or contradictory meanings were present in various different texts. The purpose of this stage was to identify relational themes arising out of common meanings, which cut across all texts. Extensive documentation provided support for the identification of common themes.

Stage five: During this stage of analysis, a constitutive pattern emerged. Constitutive patterns are present in all texts and express the relationships among relational themes. Constitutive patterns are the highest level of hermeneutical analysis.

Stage six: The purpose of this stage was to validate the analysis with persons not on the research team but familiar with the content area and/or research method. Validation of the relational themes and the constitutive pattern was also sought from a subset of the interview participants.

Stage seven: The last stage was the preparation of the final report (dissertation), using sufficient excerpts from the interviews to allow for validation of the findings by the reader.

The purpose of the multiple stages of interpretation was to expose contradictions, conflicts, and inconsistencies by allowing for reappraisals and comparisons. Multiple interpretations at every stage of the analysis also served as bias control, exposing unsubstantiated meanings and inaccurate interpretations not supported by textual reference. The openly dialogical nature

of the inquiry increased understanding by a constant revising of the interpretations and was a strength of the method. All interpreters attempted to be "true" to the texts and not read into them any meanings which the evidence did not support.

The process of obtaining expert consensual validation in the sixth stage of data analysis was such an important contribution to the trustworthiness of the findings that it required further clarification. The sixth stage of analysis began with a draft of the data analysis which was distributed to persons not on the research team, but familiar with the content of the research or interpretative method. These experts were practicing nurse managers or persons who have conducted research with nurse managers or are experienced with hermeneutic research. The experts reviewed the first draft of the analysis. Common meanings which were not adequately substantiated with excerpts for the texts were deleted from the analysis as a result of the experts' recommendations. A second draft of the analysis was then distributed to research participants who were contacted to request their participation in the data analysis. This possibility was discussed with them at the time of the initial interview. These research participants validated all of the themes in the second draft of the analysis, as well as the constitutive patterns. The participants not only assured the accuracy of the analysis in terms of their lived experience, and but also described their experience participating in the study. Their participation in the research was a part of their own, ongoing, hermeneutic process of consciously

reflecting on their lived experience and interpreting/putting into words meanings which disclose new possibilities for their being-in-the-world.

Despite many facets, the meaning of a text cannot be thought of as indeterminate. Although there may not be a single meaning, neither is it the case that anything is acceptable. "Methodological individualism is avoided by finding a commonality and therefore teleological explanation and prediction based in background skills, meanings, and practices shared in a people with a common history and common situations" (Benner, 1985, p.7). It is assumed that if the interpretations offered are based on shared cultural meanings they will be recognized by readers who share the same culture. It is in this sense that the analysis is universal. This sense of the universal is very different for the concept of generalizability used in positivist research, where generalizability is established a priori to the analysis by the manner in which the sample is derived. Persons from the culture of nursing as well as nurse managers participating in the study recognize the analysis of data as valid.

The reader of the research report is always an active participant in the validation process of Heideggerian Hermeneutics (Benner, 1984a, 1985; Benner & Wrubel, 1989; Diekelmann et al., 1989; Packer, 1969). In narrative or interpretive research, "valid" retains its ordinary meaning of well grounded and supportable (Polkinghorne, 1988). Conclusions in the interpretation of data can thus be defended by the use of informal reasoning. Much like a lawyer to a jury, the researcher presents evidence to support conclusions and demonstrates why alternative conclusions are not as likely by presenting the reasoning by means

of which the results were derived. The argument is one of likelihood, not certainty or statistical probability. In this context, an argument is valid if it is convincing and can resist challenge.

The results of narrative, interpretive research such as Heideggerian Hermeneutics cannot claim exact correspondence with "truth." Research in this realm aims rather for what Popper(1959) termed verisimilitude, or the appearance of reality. The conclusions of the research remain open-ended, and new information may convince scholars that the conclusions need revisions. "Narrative research then, uses the ideal of a scholarly consensus as the test of verisimilitude rather than the test of logical or mathematical validity" (Polkinghorne, 1988, p. 176).

The ordinary meaning of "reliable" is dependable. In the dominant paradigm of positivist research this term has come to mean the consistency and stability of measuring instruments. Reliability in narrative research refers to the dependability of the data. Attention has been directed to the trustworthiness of interviews and field notes. The phenomenological position is that interviewing needs to be understood as dialogue, a joint reflection on a phenomenon which alters the understanding of both interviewer and participant. Because language is used to make understanding explicit, the listener/researcher actually contributes to the meaning in a dialogue. This is not some kind of contamination. Instead, the listener's understanding involves the rendering explicit of what may be thought of as already existing, albeit implicitly, in the original dialogue. Meaning is made intelligible by language, so meaning resides

not in the "mind" of the individual speaker but in the dialogue itself. Weber (1986) reminds us, "It is the 'between' that reveals, that permits understanding. It is through the seeing of that which is neither only you nor only I but is rather our between that we learn about each other" (p.68). Thus, the listener plays a positive role in that "fusion of horizons" characteristic of all understanding, enriching rather than contaminating the interpretation (Sass, 1988).

A test of the results of a Heideggerian hermeneutical analysis would be to ask if the identified themes would produce the specific stories given in the original data. Adequate analysis does not produce idiosyncratic results; other researchers, given the same data, can agree that the results follow. Analysis moves between the original data and the emerging description of the themes and constitutive patterns, known as the hermeneutic circle, systematically and rigorously. Subjectivism is avoided by taking the interpretation beyond the original, unreflective understanding of the participant. "By finding meaning in experience and then expressing this meaning in words, the [researcher] enables the community to think about experience and not just live it" (Polkinghorne, 1988, p. 30).

In conclusion, the final validation of Heideggerian hermeneutical research lies in the knowledge uncovered. The process of understanding can never achieve finality. To understand is to understand differently. But this does not meant that the interpretations offered by this type of research are arbitrary or distortive, or merely personal and idiosyncratic. Because common practices and situations are studied, the insights achieved in interpretation have broad

applicability. This research thus represents a new way to view nurse managers, but does not claim to be the sole explanatory vantage point of this phenomenon. No one paradigm in the human sciences can assure the perspective of privilege that it provides an explanatory system from which to view all the problems of human beings.

Hermeneutic Methodology

A research method does not operate independently of its system of inquiry. The philosophical assumptions behind the methodologies influence the conduct and outcomes of the study. Hermeneutics means interpretation. Because Heideggerian phenomenology is concerned with the discourse of those beings whose foundational mode of existing is interpretation and understanding, hermeneutics evolved with Heidegger as ontology, as well as methodology. Central to Heideggerian phenomenology is the assertion that interpretation is not a tool for knowledge but the way human beings are. We are all hermeneuts; we exist hermeneutically, finding significance and meaning everywhere in the world. Thus, from beginning to end, Heidegger was concerned with the hermeneutic process and how it brings to light the hidden meaning of being.

The ancient discipline of hermeneutics has been traced to the early Greeks (Palmer, 1969). Greek root words of hermeneutics refer to a process of bringing to understanding through language. Some thing or situation is brought from unintelligibility to understanding via a processes of explanation, translation and interpretation. Hermeneutics has evolved as a systematic approach to interpreting oral and written texts. In the 17th century, the rules and methods of

hermeneutics became primarily associated with Biblical exegesis; each portion of Biblical text was supposed to be understood as it related to the intention and composition of the whole scripture. Interpretation of the Bible and other classic literary works consisted of two forms--grammatical and psychological. Grammatical interpretation was to be in reference to the language shared by the author and the author's original public (language is historical). Further, according to canons written in 1819, the meaning of every word in a passage had to be "determined in reference to its coexistence with the words surrounding it" (Polkinghorne, 1983, p.220). Psychological interpretation was to take into account the totality of thought of the author.

In the 19th century, hermeneutics was redefined by Schleiermacher as the art of understanding any utterance in language (Palmer, 1969). No longer was hermeneutics seen as a discipline belonging merely to theology, literature, or law. Dilthey continued this evolution in thought about hermeneutics, asserting in 1900 that the same mental operations used in this method of interpretation could be applied to our understanding of life and other persons (Polkinghorne, 1983). Hermeneutic knowledge could be applied to any structure of interactive forces where there is a relation of parts to the whole, in which the parts receive meaning from the whole and the whole receives sense from the parts (Polkinghorne, 1983, p.221). Dilthey believed we could use hermeneutics as a method to provide an objective understanding of the expressions of life.

Heideggerian hermeneutics builds upon Dilthey's work. As has been stated, the difference in Heideggerian hermeneutics is that interpretation is

viewed not as a tool for knowledge but as the way human beings are. Persons are self-interpreting beings who are continuously defined in the course of living. Our being, which always already is, is the gradually unveiled as we live our life in the context of our world. As such, being must be studied as it presents itself in the everyday world of practices and lived experience. Since both experience and being are intrinsically language-imbued and involve public or shared contexts of significance, the description and interpretation of experience in the language with which people actually represent themselves is required. The task for Heideggerian hermeneutics is thus to explore our understanding of what it means to "be" in the world, which has already come about through language, although some meanings of being remain concealed (Polkinghorne, 1983).

Thus, in the Heideggerian tradition, persons are the beings who bridge the gap between concealment and discourse of Being. Being is disclosed language. However, our written and spoken texts conceal much of Being. A thinking dialogue with the text brings further disclosure. In An Introduction to Metaphysics, Heidegger (1953/1959) described three phases to a hermeneutical analysis of texts. The first phase is an effort to find the overarching meaning which sustains the whole text, a meaning which is not explicit but envelopes it; it is the truth of the text, Being coming to light. The second phase takes place in light of the first. Now the interpretation moves back to parts of the text, to delimit the specific areas opened up by the text. A comparison of the two interpretations is undertaken to look for conflicts and similarities, and to ground an understanding of the whole in relation to the parts and vice versa. The

shifting back and forth between the parts and the whole is known as the hermeneutics circle and reveals new themes, issues and questions in the process of understanding the text itself. In the third phase, one takes a stand in the center of the text, on the border between concealment and disclosure which was established in the author's creative act of naming Being. Then the interpretation seeks to go beyond, to what was not said. "The hermeneutic process in its essence comes not in the scientific explication of what is already formulated in the text; it is rather the process of originative thinking by which meaning comes to light which was not explicitly present" (Palmer, 1969, pp. 157-158). This thinking dialogue between the interpreter and the text moves understanding into the realm of the transpersonal, disclosing meanings which were previously not apparent to either the author or the interpreter as individuals.

The hermeneutics researcher seeks commonalities in meanings, situations, practices, and bodily experiences in the depiction of the lived experience. Three strategies are used in hermeneutic research to reveal configurational and transactional relationships in the data--paradigm cases, exemplars, and thematic analysis (Benner, 1985). Paradigm cases are whole cases which stand out as a strong instance of a particular pattern of meanings. They cannot be broken down into smaller units without losing important nuances and aspects of the pattern, so they are reported intact.

Exemplars are smaller vignettes which capture the meaning in a situation so that the reader is able to recognize the same meaningful transaction in other

situations which look objectively quite different (Benner, 1985). Much of the data is reported in exemplar form. The difference between exemplars and paradigms is one of complexity; both strategies capture the meaning in a situation, but paradigms link multiple meanings into a pattern or meaningful whole. Both exemplars and paradigm cases are strategies which allow the depiction of persons within context of their situation, with the intentions of the actors and the meanings on the situation reported intact.

Thematic analysis is the third interpretive strategy described by Benner (1985). The interpreter identifies common themes, appearing in multiple texts, and extracts sufficient excerpts to present evidence of these themes to the reader. Such experts may take the form of single sentences or thoughts, or they may be exemplars or paradigms which demonstrate the common theme. Note that all three presentation strategies, paradigm cases, exemplars, and thematic analysis, allow the reader to participate in the validation of the findings. As is the case with paradigms and exemplars, thematic analysis also preserves the context of the situation. As the goal of hermeneutic analysis is to discover meanings and achieve understanding, not to extract theoretical terms or concepts at a higher level of abstraction, such as in grounded theory, any attempt to decontextualize meanings would change the phenomenon. Recall that in Heideggerian tradition, persons appropriate meaning within the context of their world of experience. Thus, the meaning resides not solely within the individual nor solely within the situation, but in the transaction between the two. The individual both constitutes and is constituted by the situation.

The hermeneutic method described above was introduced into nursing research by Benner in her studies of stress in the work place (1984b), the practical knowledge embedded in professional nursing practice (1984a), and caring in nursing practice (Benner & Wrubel, 1989). This method of data analysis has also been used by Diekelmann (Diekelmann et al., 1989) to study nursing education and practice. Dickelmann et al. (1989) clarified the more general process of Heideggerian hermeneutics described above into a systematic, seven step method for textual analysis.

Summary

Through the study of narratives it is possible to see the phenomena more clearly by studying people rather than variables (Polkinghorne, 1988). This study will add to the body of knowledge by describing the nurse manager through their every day experiences. A review of literature described the current research and provided an historical perspective of the role of the nurse manager. Data was generated through interpretation of their stories. Analysis was performed according to the seven step hermeneutic method described by Diekelmann et al. (1989). Excerpts and exemplars were selected from the texts to illustrate themes and constitutive patterns found in the texts. A research team as well as the participants were asked to validate the accuracy of the analysis. Their participation in the research was a part of their own, ongoing, hermeneutic process of consciously reflecting on their lived experience and interpreting/putting into words meanings which disclose new possibilities for their being-in-the-world. Heidegger refers to this process as "entering the circle" (Heidegger, 1962).

CHAPTER IV

DATA ANALYSIS

The hermeneutic analysis of the data of this study employed the philosophy of Heideggerian phenomenology to identify five relational themes and one constitutive pattern in the texts of the nurse managers. The requests for narratives were mailed to 50 nurse managers. There were a total of 16 narratives returned which included enough of the demographic data requested to be considered for this study. The analysis examined the 16 texts for salient common meanings either implicit or explicit in the nurses' perceptions of their lived experience as nurse managers. These common meanings were then systematically compared and contrasted to identify themes which express the relationships between them, as well as patterns that express the relationship between themes. Although the specific steps of the Heideggerian hermeneutical method used were explained in Chapter III, Chapter IV will review how the process was specifically applied in this research.

Each member of the research team received a copy of each of the texts. Prior to each meeting, members composed a written summary of the transcripts to be analyzed at that particular meeting. Summaries described all relevant aspects of the narrative (i.e., topics described, feelings expressed, implicit and explicit meanings, etc.). Excepts were provided to support all analytic claims. Sessions typically began with each team member reading aloud their summary of the transcript. Dialogue which ensued after each person's presentation

centered on whether the summary represented an accurate and complete description of the narrative. Careful attention was paid to areas of agreement between the analyses of the various team members. All areas of disagreement were resolved by returning to the text for clarification. Analysis proceeded until group consensus was achieved as to the various meanings of the narratives.

Next, the team concentrated on similarities and differences between the text under consideration and previous texts which had been analyzed. Tentative themes were proposed to link common meanings between several texts. Themes were always kept open and changed frequently as new meanings emerged in the ongoing hermeneutic process.

After each analysis session, the author returned to the texts for additional independent analysis, based on new understandings brought forth in group dialogue. The author then wrote a composite analysis of the text, using the written summaries of the team members and notes taken during group discussion. A list of tentative themes and excerpts which described them was developed. At the conclusion of the initial analysis of the texts, a list of major themes describing the most salient meanings of the nurse managers was agreed upon by the research team. The next step was with an independent analysis, looking for conceptual patterns (constitutive patterns) which might connect themes. At the end of this process the author submitted a first draft of a tentative pattern to the research team and nursing experts outside the team. Based on their suggestions, the constitutive pattern "facilitating change" emerged in the second draft of the composite data analysis.

The final step was to obtain validation of the constitutive pattern and relational themes from the research participants. These participants not only validated themes and patterns which had emerged, but related how powerful it was for them to come to new understandings of their experience. The final report of this study incorporates the contributions of all persons involved in the analytic process.

The analysis is presented in two chapters. Chapter IV describes the five relational themes of process categories, task categories, attitudes and values, essential skills and skill acquisition. Analysis of this data yielded one constitutive pattern which helps to describe the relationship among the themes of the nurse managers' experiences. Chapter V describes the constitutive pattern of facilitating change which was present in all texts and helps to provide an understanding of the context in which nurse managers work.

As the research progressed three groups of nurse managers emerged: the novice manager with less than 2 years experience; the experienced manager with up to 5 years experience; and the veteran manager with over 5 years experience. Composite speakers were developed for the purpose of highlighting differing perspectives based on levels of experience and were assigned fictitious names to assure confidentiality of the participants (Marshall & Rossman, 1989). Liz represents the composite of the veteran manager, Sara the experienced manager and Anne the novice manager. Demographic profiles appear in appendix A.

Role Overview

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. Liz, a veteran manager, summed up the 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 enough air. 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. But the everyday experiences of nurse managers are much more focused on relationships.

The nurse manager has a complex and intricate role that as one manager stated, "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. Anne, a new manager of a critical care unit, offered this general observation:

> I tell new nurse managers 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 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, Liz, and an experienced manager, Sara, illustrate the concern with conflicting expectations. The first describes the problem, and the second 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 stated 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:

> 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 have to do it! I have 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 yet gives the opportunity for control that provides each manager with the options to enact the role in their own style. It lacks routines and yet the mundane can become overwhelming. The manager must "constantly switch hats." 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 going to happen first, and then I'm going to do

> this and them I'm going to 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 a 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 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 novice manager with responsibility for an active medical/surgical unit describes:

> 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 the 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, the veteran 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 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 manager's role emerged from their descriptions it became clear that this was not a role for the "faint of heart," as one participant put it. It is a role with many coexisting contradictions. For example, professional values focus on the individual in terms of patient needs, yet managerial values place a high value on organizational goals of efficiency and sacrificing individual rights for the good of the group. It is also a very structured environment, yet offers enough flexibility for managers to enact a personal style and discretionary decision-making. 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 of metaphors of social processes, such as resourcing, social control, communication and change, rather than the language of management tasks. The next section considers the more intricate themes of the managers' everyday experiences as described by the relational themes and process categories which include the subthemes of social control, resourcing, communication and facilitating change.

Theme: Process Categories of the Nurse Managers' Role

Even first year managers who were openly concerned with mastering the tasks the role requires used process terms 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!

There were four themes described by the managers: social control, "resourcing," unit-based translating/interpreting/negotiating, and ultimately, facilitating change.

Subtheme: Social Control

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" (p. 113) of staff is modified so that the work of the unit/program can proceed in accordance with institutional norms. In nursing terms these would be the standards of practice. In management terms, it is performance standards. And, as Sara labeled both processes, it is "mothering."

The process of social control occurred frequently in this study and typically involved establishing, monitoring, and maintaining standards, the terms used by managers. 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 the unit's culture. Managers recognize and accomplish this in a variety of ways.

The following exemplar came from Sara, the 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, the novice, 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 and fiscal reports, 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, the 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 exemplar 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 sustaining a productive work environment by enforcing unit based cultural standards of behavior.

> 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.

Subtheme: Resourcing

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 the staff's desire to have a resource manager:

> 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 want 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 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 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 exemplars 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, the veteran, 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.

The resourcing aspect of the manager's role is the behavior that they feel is most valued by staff.

> 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.

Subtheme: Communication

The third process in the nurse manager role is one of communication. The manager's role in the study hospitals is what Kotter (1978) and Zangi (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.

Nurse managers do not have the option, if they are dissatisfied with pharmacy or respiratory services for example, to negotiate for those services outside the institution. The individuals and groups with whom the manager must interact 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 use 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 <u>may</u> 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 nurses' 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.

Subtheme: Facilitating Change

The fourth and final major process described by nurse managers was facilitating change. The rate of change at hospitals was staggering and a major concern for all nurse managers. Small changes happened daily; new ordering forms or drugs from the 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 nurse managers' role that it emerged as a constitutive pattern and will be discussed in detail in Chapter V. Facilitating change involves a synthesis of social control, resourcing and translation/interpretation/negotiation.

Theme: Task Categories

The managers' description of their role must include a brief discussion of the one aspect presented in task terms, paperwork. 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 as experienced as Sara is, in the first quote, or less experienced as Anne is, in the second quote.

> The two things that consume most of my days are meetings and paperwork, but at least there is productive work accomplished at the meeting, but the paperwork 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 paperwork 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.

Paperwork 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 paperwork. 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, perspective, and priorities among constituent groups for the purpose of accomplishing the work of the clinical area; and facilitating change.

Theme: Power and Control

The nurse managers share many attitudes, experience and values. The themes of power and control and essential skills for nurse managers emerged as common characteristics. The most striking similarities among the managers was that they all spoke in terms of "power and control." 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 easily 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 be 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. Greenberger, Strasser and Lee (1988) 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" (p. 405). 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 Sundstom (1989), in their analysis of research on gender and power in organizations, used the 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" (p. 51). 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 savvyness. If you want to accomplish any thing...political savvyness, power dynamics is just essential to getting work done.

Theme: Essential Skills

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, clinical skills and staff development.

Subtheme: Interpersonal Skills

Interpersonal skills, especially communication, were described by some as the single most essential group of skills for managing. Managers used the

terms such as an integrated concept and presenting interpersonal competence as essential to and indistinguishable from effective communication. As Liz described:

> 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 manager's role is the capacity to communicate not only "facts" but cultural beliefs, values and behavioral expectations. The manager must communicate so effectively that the co-participant of the exchange is satisfied, and where necessary compliant, with overt or covert expectations implicit in the message.

Subtheme: Flexibility

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 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 on my list for the next day and feel okay with that.

Subtheme: Political Savvy

Managers were well aware of the need to be attuned to the political issues in their hospitals. Although this clearly related to their awareness and

use of power, Anne's and Liz's perspectives respectively illustrated the need for this skill.

> 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.

Subtheme: Strong Sense of Self

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 sense of self. The preponderance of this response from ICU managers maybe 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 going to re-look at it and come up with a better one." I think you have to have a good ego to get into this position...

Subtheme: Clinical Competence

The next skill identified by 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 4 managers who were not practitioners in the area they managed, 3 were veteran managers with more than 6 year's experience each and the fourth was a relative novice with less than 1 year's experience. Liking the clinical work done in the area significantly influenced their job competence and commitment. Liz and Anne, both experienced 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.

Subtheme: Staff Development

The managers' final common skill was their emphasis on their ability for staff development, not only as an essential skill but one in which they derived satisfaction. As Anne, first and Liz, second, expressed it:

You must be good at staff development. 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 real enjoyable to watch them, 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 can help them grow. And I've gotten some really positive response from that. ... there's a lot of people, four or five, I felt I was really able to give constructive suggestions to 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.

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 that 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.

Theme: Skill Acquisition

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 the study.

Subtheme: Education

Liz reflects the attitudes of many of the managers in this study 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.

Managers felt that what they gained from master's education was 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.

Subtheme: Mentoring

Nurse managers who had developed mentoring relationships spoke with strongly positive feelings about these relationships. 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 a 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."

Subtheme: Trial and Error

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.

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.

Managers who felt 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.

Conclusion

Managers viewed their role in terms of the process of management. The tasks of management in the job descriptions were easily learned. 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; communication or 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 interpersonal expertise, flexibility, political savvy, a strong ego, clinical competence and staff development.

CHAPTER V

CONSTITUTIVE PATTERN: MANAGING CHANGE

Chapter IV identified four processes that nurse managers describe as critical aspects of their role: social control, resourcing, communication and facilitating change. As data analysis continued, a constitutive theme, a theme present in each of the narratives which links critical aspects of other themes, emerged. This chapter analyzes the constitutive theme of managing change, a synthesis of the first four processes and the most difficult aspect of the role to manage. Managing 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.

Hospitals nationwide are experiencing rapid change driven by numerous economic, technological and social forces (Greene, 1988; Odiorne, 1988). Some changes have had no apparent impact; others have created enormous distress among managers and staff. As the study progressed it became apparent that one of the fundamental roles of the managers was to create a culture that was adaptable to these constant inevitable changes. This activity was so critical and pervasive that participating nurse managers across all 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.

Theme: Facets of Difficult Change

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, organizational complexity and stability.

Subtheme: 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 manager 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.

Subtheme: 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 American Nursing Association (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 going to do with the schedule, what are you going to do with rotations, what are you going to 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, one of the managers described 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 required that an Registered Nurse (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 intensive care units (ICU's) come first but the "fact" implicitly relegates the needs and work of the floor nurse to a status of less importance.

Although changes of lesser emotional impact may evoke only subtle feelings of loss, these changes were legion in the hospitals as listed by one of the nurse managers:

> It seems like we are always experiencing some kind of change...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. You have to be there for the staff. Sometimes its just these little things that add up.

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, as previously discussed, the nurse managers were able to identify three additional facets that affect the degree and kind of response the staff will exhibit to change.

Subtheme: The Presence or Absence of Foreknowledge

Foreknowledge is a third critical facet of change. Foreknowledge or "warning" may be as simple as notification or it may 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...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 detail.

Subtheme: 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. As reported by the nurse managers of this study, 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" were 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 standards 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 individual 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 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 divergence of perceptions and the 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 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 input into our nursing hours per patient day based on a national average and local region statistics so number one we needed to abide by those hours, and number two cut FTE's. So if 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 going to 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 going to be most directly involved with any of the decision, meaning the support staff, would have been without them. And, I didn't feel that was a fair thing to do. They would have heard it 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, and 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 communication plans and repeatedly meet and endorse the change needed until the staff can accommodate to the changes.

Subtheme: 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 an organization that have previously gone unnoticed become 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) 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 increase until values, roles and relationships can be experienced or 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 it is to achieve even modest change.

Not surprisingly, many of the managers and their staffs 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 among 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 mistrust 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 occur in an unstable or distrustful organizational climate.

Theme: 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.

Subtheme: 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.

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 described 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 upset months 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. 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!"

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 enjoy it where I can provide 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 terms of 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 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, everyday, 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, 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. 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 would not 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.

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 of 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 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 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. The importance of "feeding staff" was initially raised by one of the assistant managers. 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 had difficulty getting to dinner the manager sent 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 norms. One manager was a novice, the second very senior and experienced. 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.

Subtheme: Construction of Reality

Stage setting is not only the process of establishing trust and camaraderie, but it also involves communicating specific information, or

anticipatory guidance, about how change is perceived. Through face-to-face interactive communication with staff, the manager guides the construction of the social reality. Ideally this reality is highly 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 going to 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.

Dissemination of Information. Traditionally, formal communication 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 mis-perceptions 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 "mis-perceptions," 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. 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. 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, assistants and 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 managers.

Theme: Facilitating Change

Managers made a distinction between change that they control on a unit basis and change beyond their control, usually initiated by the hospital administration. Involuntary change 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 the era of nursing shortage at the time of this study, 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 feel 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. The hospital implemented alternative shifts and pay practices to deal with recruitment issues. Then when the market conditions changed and nurses were being laid off, many of the pay practices were changed as well.

The plan was sold to staff as a trial and was highly successful in meeting recruitment goals. One year later changes within the hospital brought on by

downsizing required a revision in pay practices that not only discontinued the alternative shifts, but altered how overtime would be paid, creating a slight decrease in pay for more senior staff, 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.

> 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 in the head nurse group and through budgetary processes but explaining that to the 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, here's the standard in the community, the research that was done looking at 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 ?" And, going through the whole process was probably the biggest thing I had to do.

Sara rehearsed how she would deal with the issue. She was able to anticipate questions and prepare how she would discuss things with the staff.

> I knew what they were going to think like. 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 yet we're paying night people more because it's harder to get people to work nights. 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 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 began by stage setting and interpreting/translating fiscal concepts into nursing values, beliefs and language. She did this while resourcing, trying to return some sense of esteem and personal control to staff. She gave them choices but reiterated their established cultural or unit based standards by pointing out that she already knew what their answer would be.

Sara's approach to facilitating significant change was guided by principles that veteran managers described 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."

Subtheme: "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" and "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 possible 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.

Subtheme: "Maintain Control"

Akin to "getting it straight" is to "maintain control" of 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 put 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 failed, intellectual control was sought to avoid feelings of powerlessness, both for the manager and the staff. The ideological work of getting it straight for the manager, putting it in perspective, and gaining personal control through understanding was an essential first step so that the manager 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. 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 then Liz describe 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.

Subtheme: "Keep People Talking"

"Keep people talking" is a multifaceted 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 units that had alternative shifts 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.

Subtheme: "Protect Resources"

The final principle, "protect resources," also reflects 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. Lois a very experienced nurse, reamed out an orientee last night and had her in tears. You just can't treat people like that, no matter what they did. 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 job].

Across each manager and a wide variety of change, the four basic techniques were 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.

Theme: Resistance to Change

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.

Managers 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."

Subtheme: Raising a 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 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.

Subtheme: Controlled Venting

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 going to 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 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.

When concerns were intense and generalized, managers 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.

Subtheme: Examining Options

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 that we all have choices. I care about them and want them to be happy. 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.

Indicators of resistance to change 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 i.e., examining options, to assure valuing.

Theme: Successful Change

"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.

Subtheme: 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 were 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.

Subtheme: 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 councils. 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 councils 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 councils 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.

Subtheme: 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 manager's 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 hour 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 hour 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 of 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

This chapter explored the facilitation of change, one of the more complex and demanding aspects of the job of the nurse managers. 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, status and the acquisition of new values. Berger and Luckman'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 change successfully.

Nurse managers first assessed the various facets of change. They described all changes 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: a change which was 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, and

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 monitored 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 looked 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 IV, managers identified the process of facilitating change as a critical aspect of the role of the nurse manager. Among 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. 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 VI

DISCUSSION AND IMPLICATIONS

The purpose of this study has been to describe the shared practices and common meanings embedded in the practice of nurse managers. The research methodology of Heideggerian hermeneutic analysis was used to interpret 16 narratives of nurse managers practicing in a variety of hospital settings. 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.

Assumptions

This research was shaped by assumptions stemming from the author's own work experiences as a manager and a review of the historical and current literature concerning the role's status, structure and evolution. This chapter, therefore, begins by comparing and contrasting the view of the nurse manager as presented in the literature and the day-to-day reality presented by 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 the author

believes this is how "reality" is constructed as a sociological construct, it was surprising to discover the process explicitly stated as a critical role expectation. 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/program.

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 described learning where and how to "bend the rules," to communicate information selectively, "marketing" or "selling" the needs or expectations of one group to another. They were equally direct concerning their expectation to interpret "facts" as "opportunities" rather than "constraints." 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.

Nurse Manager as Institutional Employee

A second assumption which can be derived from current literature about nurse managers is that the nurse managers' activities would be prescribed by the bureaucracy of the organization in which they 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 complied with institution expectations and then incorporated the expectations into their own values. It was this ability to integrate differing needs/goals that distinguished the 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 acquire new values.

The author 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!" 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. Constructing a productive, viable reality of such disparate parts is a key challenge.

As presented in the data of Chapters IV and V, 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. 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."

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. What seemed 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 could not 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

There is much written about the conflicting values of medicine and nursing. Although this was true in some instances, 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. 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. Liz lamented, "How to deal with the physicians is something they never taught us in school, but they should!"

Nurse managers in this study were expected 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 take-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 areas was so "assumed" that most experienced managers described this as a skill that they "resourced" for staff in their units.

Positional Power of the Nurse Manager

The final assumption, that effective nurse managers hold powerful positions, was strongly supported by the data. The managerial position was key to the delivery of high quality patient care. As one manager 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]." 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.

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 theme 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.

First-line nurse managers in this study characterized 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, communicating, 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.

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.

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 can create a caring and curing social reality for all participants in the unit's culture.

Implications

The phenomenon of first-line nursing management presented by the participants in this study has both implications for practice and implications for research. To create an effective health care system one must recruit, retain and

support a group of effective nurse managers. Following is a description of the implications the patterns of practice described here have for selecting and developing nurse managers and then a look at implications for future research.

Selection and Development of Nurse Managers

Based on the experiences of nurse managers in this study two implications for selection and development emerged: the usefulness of advanced education and supported experiential learning. Managers in this study agreed on the skills essential to the nurse managers' role. They were communication, interpersonal skills, flexibility, clinical knowledge, strong ego and political savvy. They also considered academic preparation beyond basic nursing important. This perspective is well supported in the literature. In two major studies described in Chapter II, the managers and administrators used somewhat different terms, but identified similar criteria (del Bueno & Walker, 1984; Sullivan, Decker & Hailstone, 1985).

Advanced Education. There was general agreement that advanced education is strongly linked with the nurse manager's effectiveness and is thus heavily considered in the selection process. Hodges et al. (1987) reported that of the 288 randomly selected members of the American Organization of Nurse Executives, 95 percent identified master's level preparation as desirable for the nurse manager role. Whether an administrative master's degree is more efficacious that a clinical one is debated in the literature (Hodges et al., 1987; Wallace & Corey, 1983). Although administrative master's curricula offer

important topics 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 master's 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. Examples that were discussed previously include how to write and present a report, how to chair a meeting, how to develop and present a program proposal, how to conduct and interview, and how to develop written documentation on a personnel issue.

Equally important was the ability to understand group dynamics and group leadership. Most managers identified both one-to-one communication skills and the ability to work with groups as essential. The basics of formal and informal communication are theoretically founded and thus are the province of academic graduate education. Once acquired their theories can be supported in their application through experiential learning.

Despite this belief in the value of graduate education, only 7 of the 16 nurse managers had a master's degree although 4 were seeking their master's degree. This presents a recruitment dilemma in that there are insufficient numbers of applicants with advanced degrees. This highlights the need for continuing development of nurse managers after being hired into their role.

Experiential Learning. Development of the nurse after hire is critical and appears to best be achieved using various methods of "formalized" or supported experiential learning. Of the five needed skills identified, flexibility and strong ego are primarily personality characteristics rather than skills to be taught. Experiential learning is thus directed toward the first three skills: communication skills, clinical knowledge and political savvy.

The experiential learning of skills and values has been studied by Kramer (1974) and Benner (1984a). Kramer presented the concept of reality shock as a factor in the loss of these new graduates. Reality shock was the reaction of the new graduate when exposed to the reality of hospital nursing. Reality shock can also happen when nurses change roles, such as from clinical nurse to nurse manager. 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 adjusting to the new culture could be reduced through support systems, such as group meetings of nurses new to their role. Benner also identifies the use of mentoring, another guided support technique, in assisting nurses to accommodate to new roles. This format allows novices to share their experiences, along a model of guided support, bridging their education, work beliefs and values, thus facilitating their development of a bicultural identity. 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 meeting their needs.

The transition from staff nurse 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 invested in them and their success as a manager. They quoted and still used "pearls of wisdom" from their mentors who had helped them develop a personal style of management and who guided them through the political realities of hospital management.

Within the safety of these relationships managers analyzed both their success and failures. Although mentors, who were primarily direct supervisors, did not eliminate the pain or 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 additional supportive one-to-one relationships for new managers. 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, a veteran manager designated as a preceptor might provide support for the transition into the new role. Kramer's (1974) suggestions for bridging activities points to a second aspect of experiential learning. The managers in this study also recommended several alternative or supplementary guided learning experiences. For example, providing learning experiences which might help

staff nurses prepare for or examine their interest in becoming new managers this would create a potential pool of new managers and also begin the development process.

In addition, the study suggests that new and experienced managers might profit from group meetings with no agenda beyond sharing with each other, processing changes, discussing management strategies, success stories and stories of failure. 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 one aspect of management development. Managers and administrators in such forums 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 managers will benefit from formal and 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 the guided learning experiences ranging from one-to-one mentoring to group discussion and even open lectures. These techniques may compensate in part for the small pool of applicants with ideal credentials and may help in the retention and development of all nurse managers.

Directions for Future Research

The phenomenon of first-line nursing management presented in this study represents the shared meanings and common themes of the day-to-day reality of nurse managers on the hospital setting. As such, it can only be a first step in understanding the role within the confines of the particular hospitals and organizations. The next step is to explore practice patterns in similar settings. Numerous research studies seeking to identify specific leadership traits are inconclusive, yet there is widespread agreement in the literature and among managers that certain personality traits are essential for first-line managers. 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 process, 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 Hansen and Chater (1983) as they distinguished managerial and clinical career interest in master's students; by head nurses in the del Bueno and Walker (1984) project for identifying competencies; 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 managers. Given the shortage of qualified managers, research to develop a tool that would measure these characteristics or research

into whether or not they can be developed would aid in career counseling and/or selection.

Span of control is a second area for future research. It varied widely in the managers 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 (Alidina & Funke-Furber, 1988) that examines factors for understanding the impact or meaning of the widely divergent spans. Such a discrepant paramount warrants a close examination in the future.

Although it was not identified as a relational theme, some of the managers related stories of high stress and of the coping strategies used to deal with it. Four areas were identified by the participants that created stress: work load, level of experience, inadequate resources and stress that seemed to be gender related. While the data in this study merely identified these traits in a few of the managers, their potential significance warrants further study. Perhaps a more focused approach could expand on these themes in future study.

Humor is the fourth area for future study and again, while it was not described in sufficient detail to include in the analysis of this study, it warrants future research. Humor was identified as a coping strategy and ranged from highly charged, gallows humor, to the use of teasing and word play. It seemed to serve a variety of purposes: discharging anger, reducing ethical or care related tension, relieving unrealistic bureaucratic expectations 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 and you can laugh, and frankly, I'd rather laugh." While the use of humor seems to be ubiquitous as a management technique it has not been explored in the context of nursing management. Because humor is being used to cope with the most sensitive subjects, it would be particularly important for future work.

The influence of gender on management and decision making, levels of trust, empathy and moral perspectives have been raised in the literature (Carrocci, 1988; Cooper, 1989; Gilligan, 1982) but did not surface in this study. Because these elements can significantly influence the process of first-line managers and because there are more and more men in nursing and management and more women in administration, they require further study grounded in the experience of the practicing nurse manager.

Summary

An exploration of the beliefs, values and behaviors of nurse managers has revealed a culture involving a complex process of human interactions. This study has focused on both interpreting the meaning of who nurse managers are and how they characterize their everyday management of their clinical area and programs.

Although education credentials, social history and clinical managerial experiences of the participants in this study varied widely, they held in common the day-to-day process of management that spanned all participant's clinical

areas, programs and 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 others and their families. Their environment 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, 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 power of personality.

The manager's skills, characteristics and processes depicted in this study carry implications particularly as they relate to the selection and development of nurse managers who will be effective, stable and satisfied with their role. This study comprises a beginning step in understanding the meaning of being a nurse manager.

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APPENDICES

APPENDIX A
Participant Profile

Participant Profiles

Gender and Age:			
	Gender	1M, 15F	
	Average Age	37.8 yrs	
Educational Status:			
	Master's Degree	7	
	BSN	8	
	Diploma	1	
	Seeking Doctoral Degree	2	
	Seeking Master's Degree	4	
Experience:		No. in Group	Span of Years in Management
	Novice (<2 yrs exp.)	6	.8-1.5
	Experienced (>2 yrs, <5 yrs exp.)	3	2.8-4.0
	Veteran (>5 yrs exp.)	7	5.6-26

APPENDIX B
Prospectus Approval Letter
Human Subjects Review Committee Approval Letter

TEXAS WOMAN'S UNIVERSITY
DENTON DALLAS HOUSTON
THE GRADUATE SCHOOL
P.O. Box 22479, Denton, Texas 76204-0479 817/898-3400 FAX 817/898-3412

November 30, 1993

Ms. Melissa Brannon
4320 Bellaire Dr. S, #228
Fort Worth, TX 76109

Dear Ms. Brannon:

I have received and approved the Prospectus for your research project. Best wishes to you in the research and writing of your project.

Sincerely yours,

Leslie M Thompson

Leslie M. Thompson
Associate Vice President for Research
and Dean of the Graduate School

dl

cc Dr. Maisie Kashka
Dr. Carolyn Gunning

APPENDIX C
Explanation of Rights to Participants
Letter to Participants

Dear Colleague,

I am a doctoral student in the College of Nursing at Texas Woman's University in Denton, Texas. In my dissertation, I will seek to describe the shared practices and common meanings of being a nurse manager. I hope to make visible some of the practical knowledge embedded in our practice and describe how nursing practice shapes our lives as managers.

In this study, nurse managers will describe their day-to-day lived experiences. I am asking you to tell me your story. The interviews will be unstructured at a time and place convenient for you. They will last approximately one and a half hours. If you prefer, you can write or tape your story or we can arrange a telephone interview. If you are interested in participating in this study please return the consent form to me with your written story or a method of contacting you to arrange an interview by October 1, 1993.

If you would like to tell your story, please reflect on your experience in nursing, no matter how recent or long ago. Your story may be about deciding to become a nurse manager, learning to be a nurse manager or being a nurse manager. I am interested in your feelings and thoughts as those things occur.

> Tell me about a time, one you'll never forget because it reminds you of what it means to be a manager. Include as much detail as possible and stay in the telling of your story, rather than stepping back and analyzing it or describing it from afar. After you have given the details of your story, please describe why this story is important to you and what it means to you. Your story can be a current one or one from years past. It can be a story of break down when nothing went right or one of making a difference.
>
> If possible, please eliminate names and references to specific places. Your story can be written or tape recorded. If you agree, I may contact you again for clarifying information after I have read your story, if that is necessary. Or, if you agree, I may ask you to read an interpretation to see if you agree or can help clarify the meanings of your experience.

If you have any questions please do not hesitate to contact me. If you have any friends or colleagues who are interested in telling their stories of management, you may share this consent and letter with them. Thank you.

Sincerely,

Melissa Brannon, MSN, RN
4320 Bellaire Dr. S., #228
Fort Worth, Texas 76109
817-926-4366

APPENDIX D
Consent to Participate

TEXAS WOMAN'S UNIVERSITY
Subject Consent to Participate in Research

Title of Study:
The Lived Experience of Nurse Managers:
A Heideggerian Hermeneutical Analysis

Investigator:
Melissa Brannon

Phone numbers:
817-898-3375 TWU Office of Research and Grants
817-878-5002 Office
817-926-4366 Home

You are invited to participate in a research project designed to explore the nature of nursing management through the eyes of nurse managers. Participation is completely voluntary.

1. What does the study consist of?

You will be asked to write about what it is like to be a nurse manager. It is possible that you would be contacted by phone or letter to clarify the meaning of your story or to review interpretations made by the researcher to validate their accuracy. If you agree to be contacted, please indicate by placing your initials here_____

2. Are there any risks ?

It is possible that through discussion and recollection of certain stories, that painful memories or thoughts could occur. Although steps will be take to ensure anonymity, it is possible that through the reporting of certain portions of actual text that a participant will be recognized by circumstances surrounding a particular situation.

3. Are there any benefits ?

It is possible that you could experience some degree of improvement in your well being as a result of telling your story.

4. Who will have access to the interview material ?

Any identifying information from the text will be removed. The original text will be identified anonymously with numbered codes. Your story will then be shared with a research team consisting of myself and three others interested in this research. Quotes from your story may appear in reports or publications from the study but no individual identities will be included.

5. What if you change your mind ?

You are free to withdraw from this study or refuse permission for the use of your transcript at any time.

Before you sign this form please ask any questions about the study that are unclear.

Authorization: I,_____, have read and decide to participate in the research project described above. My signature indicates that I give my permission for information I provide to be used for publication of a dissertation or research articles, books, and/or teaching materials, as well as for presentation at scholarly conferences. Additionally, my signature indicates that an offer to answer all of my questions regarding the study has been made and I have received a copy of this dated and signed consent form. A description of the possible attendant discomfort and risks reasonable to expect have been discussed with me. I understand that no medical service or compensation is provided to the subjects by the university as a result of harm from participation in research. I understand I may terminate my participation in the study at any time.

If you have any concerns about the way this research has been conducted, contact the Texas Women's University Office of research and Grants Administration.

If you need further information, please contact me;

Melissa Brannon,MSN, RN
4320 Bellaire Dr South
Fort Worth, Texas 76109
817-926-4366.

Signature_____ Date_____

Telephone number_____

APPENDIX E
Demographic Data Form

DEMOGRAPHIC INFORMATION

Please complete the following demographic information sheet and return with your story.

Age _____ Gender _____

Number of years/months in nursing:

Educational status:

Briefly describe the management positions you have held.

Position	#Years/Months	Setting
Example 1. Head Nurse	3 years	large urban hospital

Please use back if additional space is needed. Thank you.