ROLE PERCEPTION OF THE NURSE EXECUTIVE BETWEEN NURSE EXECUTIVES AND HOSPITAL ADMINISTRATORS

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The problem of the study was to determine the difference in the perceived role of the nurse executive between hospital administrators and nurse executives. A survey of 52 hospital administrators and nurse executives in a large metropolitan area of the southwest supported that there is a difference in the perceived role of the nurse executive.

The dimensions of the role which were investigated included: financial management, institutional policy, educational and staff development, professional responsibilities, community service, and research activities. The nurse executives were found to place more importance on dimensions of the role of the nurse executive than did the hospital administrators. These differences may contribute to role stress due to unclear expectations and differences in utilization of limited health care resources. With the identification of different role perceptions between nurse executives and hospital

administrators, nurse executives may seek to clarify their role expectations and reduce role stress.

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CHAPTER I

INTRODUCTION

In the past decade the health care industry has undergone drastic changes in response to consumer and economic needs. Nursing has responded to the challenge of such changes as higher patient acuity, shorter hospital stays, alternative care choices for the consumer, as well as changes within the nursing community (for example, staffing and schedule options, specialization certifications, advanced educational requirements, altered reimbursement sources). The history of nursing has shown nurses to be responsive to the changes in health care systems.

As hospitals have joined together in corporations in the business of health care, nurses have begun to achieve executive status. With the new title, "nurse executive," comes an expanded role with new responsibilities and expectations. As nurse executives take on the expanded role of administrator, these questions arise: What is the role of the nurse executive as perceived by the hospital administrators? How do the nurse executives perceive their newly expanded role?

Problem of the Study

The problem of the study was: Is there a difference in the perceived role of the nurse executive between hospital administrators and nurse executives?

Justification

The literature includes the examination of the nurse administrator's responsibilities (Simms, Price, & Pfoutz, 1985), educational preparation (Freund, 1985), and the role conception among nurses (Corwin & Taves, 1962; Ketefian, 1985; Kramer, 1968, 1970). There has also been a wide range of studies concerning nurses' role conflicts (Hafer & Joiner, 1984; Ward, 1986; Zahra, 1985). However, little has been done in examining the perceived roles of nurse executives. Description of the difference in the role perceptions among hospital administrators and nurse executives, may be the first step in role clarification.

Role clarification would improve effectiveness by decreasing role strain and stress. If the nurse executive understands the behavior expected by the hospital administrator as well as other nurse executives, then action may be taken to correct any false beliefs, or action may be taken to justify their beliefs. The unknown expectations would become known, thus reducing stress of role strain.

Clarification of the role would also improve interaction between the nurse executive and hospital administrator, improve goal attainment, improve quality of care, and increase commitment to the organization. Understanding role perceptions is a means for role clarification and reduction of role strain.

Conceptual Framework

The conceptual framework for this study was derived from role theory. Dimensions of the role of the nurse executive have been taken from current nursing administration literature. Role theory is an explanation and examination of the patterned forms of "real-life behavior as it is displayed in genuine on-going social situations" (Biddle & Thomas, 1966, p. 17).

There is a relationship between role and social position. A position is the recognized category of persons, who have common attributes, common behavior, or "common reactions of others toward them" (Biddle & Thomas, 1966, p. 29). An individual may hold many "positions" such as spouse, parent, child, employee, college graduate, and club member. A role is the prescriptive behavior, the expectations, of what the behavior of a position member should or ought to be. Role expectations are among the

most significant guidelines and standards in the control of human behavior (Biddle & Thomas, 1966).

A person enters a social position with its established rights and obligations by either being born into the position, known as ascribed status; or by achievement of status through accomplishments, talent, hard work, and education (Davis, 1966). Persons not only occupy various positions, but have role sets for a particular position. Merton (1968) described role set as the relationships within the position. Disturbance may occur within the role set when the role partner of a particular status has different values and moral expectations from those held by the occupant of the status in question (Merton, 1968). Role partners often occupy different social status positions.

When an individual perceives incompatible expectations within the role set of the particular position, a role conflict ensues (Biddle & Thomas, 1966). Role conflicts have been described as intrarole, within one position; and interrole, the incompatible expectations between multiple positions. The position member may believe that the expectations are legitimate or illegitimate. A legitimate expectation would be one that the "other" role partner has the right to hold, and an illegitimate expectation is one

that the "other" does not have a right to hold. The "legitimacy" of the expectations influences the process for role conflict resolution (Gross, McEachern, & Mason, 1966).

Biddle (1979) proposed that most role theorists use the concept of socialization to explain the evolution and development of roles. Socialization is a broad term for the whole process of learning behaviors so that individuals can function within a society or setting in which they live. Roles are taught to individuals by others, leading to greater ability of the individuals to participate in the social system. The success of the socialization is determined by the appropriate role expectations or behaviors induced in the individual (Biddle, 1979). The socialization process is a continuous one, beginning at birth and continuing on through adulthood.

Biddle (1979) also proposed that educational institutions provide the most help in the socialization process for role changes. Adults may assume many changes in their careers, family, and social status; and the educational process provides the means for preparation and attainment of the new roles. During the educative process adults take on some of the characteristics of the anticipated or aspired role prior to becoming a member of the aspired position, sometimes facilitating the initiation

to the role. This process is anticipatory socialization (Biddle & Thomas, 1966; Hardy & Conway, 1978).

At times persons have difficulty adjusting to their changing roles. Role conflict may occur as well as role ambiguity. Role ambiguity occurs when the role set expectations are incomplete or insufficient to tell the role member how or what to do (Biddle, 1979). Role overload has been described by Biddle as "too many role demands" placed on one person. Another source of difficulty within a role, termed role incongruity, arises when the role member finds that expectations for the role are inconsistent or opposite to his or her beliefs and values.

In summary, role theory has been defined by Biddle (1979) as:

> The subject matter that concerns behavior that is characteristic of persons within contexts and the various processes that are used to predict and explain those behaviors. Role theory provides concepts for both overt events (such as behaviors) and covert processes presumed to explain those events (expectations). (p. 333)

This conceptual framework examined those concepts of "the field of role" (Biddle & Thomas, 1966, p. 3) which would best explain the phenomena of the perception of a role: the expectations, behaviors, and strain. Most role theorists use the concept of socialization to explain the

appearance of roles. For adults this socialization takes place largely within the educative process. Role expectations are among the most potent influences of behavior (Biddle & Thomas, 1966).

This study focused on the expected role behavior--the perceptions of the role--for the nurse executive. Because hospital administrators and nurse executives have different educational backgrounds, it would be expected that their role perceptions and role behaviors would differ.

Assumptions

The assumptions of the study were:

1. Roles involve the expectation of certain behavior of significant others, especially role partners.

2. Roles are learned through socialization.

3. Persons of different social positions hold different conceptions for the same role.

4. Role stress occurs when different conceptions are held for the same role.

5. Analysis of role conceptions will facilitate role clarification.

6. Individuals hold many different positions.

7. Persons achieve their occupational positions (as opposed to ascribed).

8. Differences in social status will influence the relationships between role partners.

Hypotheses

The hypotheses of this study were:

1. There is a difference in the perceived role of the nurse executive between hospital administrators and nurse executives in the six dimensions of management.

2. There is a difference in the perceived role of the nurse executive between hospital administrators and nurse executives in management of institutional policy.

3. There is a difference in the perceived role of the nurse executive between hospital administrators and nurse executives in management of nursing education and staff development.

4. There is a difference in the perceived role of the nurse executive between hospital administrators and nurse executives in financial management.

5. There is a difference in the perceived role of the nurse executive between hospital administrators and nurse executives in management of professional responsibilities.

6. There is a difference in the perceived role of the nurse executive between hospital administrators and nurse executives in management of community service and relationships.

7. There is a difference in the perceived role of the nurse executive between hospital administrators and nurse executives in management of research.

Key Terms

The following terms were operationally defined:

1. Nurse executive--the top nursing service administrator of a health care institution, who reports to the chief executive officer.

2. Hospital administrators--any administrator of the health care institution on the same organizational level as the nurse executive or above, including the chief executive officer.

3. Perceived role of the nurse executive--the expected behavior of the nurse executive as perceived by the respondent, and measured by the survey questionnaire, Role Perceptions of Nurse Executives (Appendix A). The higher the score, the more important the dimension. There were seven indicators of perceived role used in this study. The questionnaire measures six dimensions of the dependent variable. The six dimensions are defined as follows:

(a) Institutional policy--those functions that the nurse executive participates in developing, evaluating, and enforcing policies of the institution.

(b) Nursing education and staff development--those functions that the nurse executive participates in which are associated with nursing education and assistance for staff professional and personnel growth.

(c) Financial management--those functions that the nurse executive participates in which influence the budgeting process, inventory control, and salary.

(d) Professional responsibility--those functions that the nurse executive participates in to maintain her professional status.

(e) Community service and responsibility--those functions that the nurse executive does to develop and nurture the institution's relationship with the community.

(f) Research--those functions that the nurse executive participates in supporting, interpreting, implementing, and creating nursing and other health related research.

Limitations

The limitations of this study were:

1. Individuals within the groups surveyed may have represented quite different social strata, therefore, their values and beliefs may have varied.

2. This study involved preexisting groups with the inherent weaknesses of self-selection: "preexisting differences in social class, personality, career goals, and so forth" (Polit & Hungler, 1987, p. 148).

3. As an ex post facto study, there may have been faulty interpretation of any relationships concluded from the data collected.

4. This survey questionnaire may have been limited in that subjects may have provided the data they believed to be socially or professionally acceptable.

5. Reliability of the instrument was unknown prior to data collection.

6. The convenience sample of available subjects might have been "atypical of the population with regard to the critical variables being measured" (Polit & Hungler, 1987, p. 210).

Summary

This study examined the expanded role of the nurse executive as perceived by nurse executives and hospital administrators. Description of the differences in the role perceptions between hospital administrators and nurse executives may be a first step in role clarification. This clarification in role may in turn increase effectiveness and efficiency and reduce role strain.

CHAPTER II

REVIEW OF LITERATURE

A search of the literature revealed that the nurse executive's (NE) role has been described by the use of the following categories: (a) responsibilities and functions, and (b) expected and actual characteristics. These role behavior categories have expanded to accommodate the expansion of the NE's scope of practice over time, as this literature review will reveal. There was no research found regarding this paper's focus of examining the difference of role perception between the NE and hospital administrator.

The functions of the NE, scope of practice of the NE, and educational preparation of the NE will be reviewed as these have evolved over the past 20 years. Occupational stress among nurse executives and the relationship between nurse executive and hospital executive will also be reviewed.

Functions of Nurse Executives

What are the functions of an NE? In this study the functions examined were those activities related to management of institutional policies, financial management, staff development and education, personal professional

development, management of community relationships, and management of research.

Poulin (1984) investigated the structure and functions of the position of NE in 1971 and repeated the study in 1980. Poulin acknowledged not only the managerial activities (planning, organizing, coordinating, and evaluating) of the NE as described in the National League for Nurses (1977) roles and responsibilities of the nurse administrator, but also indicated that the NE has been role-making, expanding the role to accommodate the complexities of the health care delivery system. The NE is responsible primarily for the quality of patient care. This remains true from the past, however, the NE now has little direct contact with patients or families except when dealing with problems.

Quality care is ensured through setting and implementing standards of care, developing control mechanisms through policies and procedures, and by providing competent personnel and material resources. Simms et al. (1985) found that the NEs within the long-term care system did participate more in direct patient care, but those NEs in the acute care and home care agencies practiced as facilitators of clinical practice. Simms et

al. (1985) supported Poulin's (1984) findings regarding the functions of the NE.

The NE of today must participate in long-range planning (Simms et al., 1985), not only as a nursing administrator, but also as a member of the hospital administration team. The planning functions include budget development monitoring; whereas, in the past, the NE was "given" a budget to monitor. A 1977 survey reported that only 50.8% of NEs were involved in the overall hospital budget (Aydelotte, 1984). In 1982, however, 82.6% of the NEs participated in the hospital budget planning process. Over 93% of the 1982 NEs had major responsibility for the establishment of the nursing budget as compared to 73.1% in 1977. Today's NE not only is responsible for the nursing budget, but shares the administration of the budget with the subordinate nursing managers. The "sharing" of the responsibility encourages growth and development of the first line and middle nurse managers and indicates a trend toward shared governance (Aydelotte, 1984; Simms et al., 1985).

Another function related to the budget and planning responsibilities is the management of human and capital resources (Simms et al., 1985). The NE in the past had time to intervene and mediate interpersonal relationships

among staff which required much time; today's NEs of smaller facilities still supervise staff. Today's NE utilizes a greater number of people in personnel management. The personnel manager and the nurse managers are involved in people management as appropriate. This trend also reflects the movement toward participative management and decentralization (Aydelotte, 1984). Not only must NEs manage and develop staff, but they must predict long-term staffing requirements as a function of planning.

There is much emphasis placed on the NE's role in the development of staff and future NEs. The NE plays a central role as an educator (both formally and informally), as a mentor and preceptor, and as a role model for nursing staff (Simms et al., 1985; Stevens, 1985). Creation of a learning environment is critical in the provision of well prepared, expert staff. This staff development and participative management seems to positively affect retention. Executives have a responsibility to set standards for the credentialing of nurses and "determine what professional nursing is and how it should be practiced" (Pfoutz, Simms, & Price, 1987, p. 141). NEs are often considered the spokespersons for nursing. The NE is also shown to be supportive of education by serving on

advisory councils to nursing schools, providing tuition reimbursement programs, serving as consultants and publishing scholarly writing, presenting seminars, and supporting separate nursing education departments within the facility to meet the needs of the nursing staff.

Research activity is another area of responsibility for the NE. Contemporary NEs recognize the need for research-based practice (Simms et al., 1985). They encourage research through collaboration with other departments or institutions and through granting access to client and staff populations. The NE may participate in research by writing grants or hiring nurse researchers. Most NEs, however, limit their role in research by participating in others' research and utilizing research findings in the development of science-based nursing practice, standards of care, and quality assurance.

Freund (1985) investigated what made Director of Nurses (DONs) effective. DONs and Chief Executive Officers (CEOs) were asked an open-ended question of what made DONs effective. Both DONs and CEOs perceived general management, especially fiscal and resource management and personnel management, as important. They also saw knowledge of nursing and health care issues as important. However, DONs recognized "political savvy and finesses as

important for effectiveness and considered CEO support important, but very few CEOs cited these" as important issues (Freund, 1985, p. 28).

Educational Preparation of Nurse Executives

The education of the NE has changed since the 1970s. The educational preparation of the NE reflects the evolving changes in responsibilities and scope of practice. Participation of the NE in long range planning, budget management, personnel development, and research requires self-development. The NEs reported continuing education as a primary source of development (Simms et al., 1985). All NEs of facilities greater than 500 beds reported having a Master of Science degree (MS) or higher (Aydelotte, 1984; Pfoutz et al., 1987).

More recent studies (Freund, 1985, 1989; Johnson, 1989) identified the trend for advanced preparation of NEs. The investigators of these studies not only examined the NE's highest degree held, but compared the educational backgrounds of the NE and the other top administrator of the hospitals. Freund (1985) found that 60.2% of NEs held MSN degrees, 8.2% held MBA/MHA degrees, and 4.7% held Ph.D/DNS degrees. In this same study, 81.6% of the CEOs of the hospitals were found to hold master's degrees, 4.8%

held doctoral degrees, and 5.6% were MDs. This 1985 study by Freund was the only study which differentiated the MS from the MBA for the NEs. In 1989 Freund found NEs and CEOs similarly prepared with 75% of the NEs holding a master's or higher while 76% of the CEOs held master's degrees and 4% of the CEOs were physicians. Johnson's (1989) study documented 60% of NEs holding master's degrees and 6% holding doctorate degrees, compared to 66% of CEOs holding a master's and 2% having a doctorate degree. These studies did not differentiate the major study of the advanced degrees.

Several research studies (Aydelotte, 1984; Kooker, 1986; Pfoutz et al., 1987; Simms et al., 1985) have related the changes in the practice and responsibilities of the NE to the changes in the educational preparation for well prepared NEs. The economics of cost containment, reimbursement systems, budget development, and management all require advanced financial preparation. Collaboration and negotiation skills are necessary in the educational preparation of today's NE. Additional leadership skills and managerial acumen are crucial in the advanced preparation of the NE who has a broader, more complex scope of practice.

Scope of Practice of Nurse Executives

Poulin (1984) presented findings that showed the "NE functions are not limited to inpatient care settings" (p. 11). NEs in the past were responsible for nursing service and opposed any expansion of their role to other areas (Poulin, 1984). As a coordinator of patient care, the NE of today has assumed responsibility for other areas augmenting patient care such as central supply, escort services, and unit management. Executives in nursing today find that they are administratively responsible for clinics and services in different geographic locations. The executive may manage the nursing service of "sister" facilities or direct the nursing service of one facility, but consult for several others. The multi-facility corporations have provided another dimension for the NE--that of a corporate level executive.

There have been significant changes in the reporting relationships and participation in hospital governance for NEs (Aydelotte, 1984). More contemporary NEs are members of the board or attend their hospital's governing board meetings. The majority of NEs participate on medical executive committees. Some 81.6% of NEs report to the top administrative officer, according to Aydelotte (1984). The size and number of employees influenced reporting

relationships in Aydelotte's sample. In hospitals with 600 or more employees under the management of the NE, 79% reported to the top level of hospital administration; whereas in hospitals with less than 300 employees, 89% of the NEs reported directly to the top level (Aydelotte, 1984).

NEs spend more time doing administrative activities than their predecessors. Their use of data based information systems has expanded decision-making. The NE of today may be the only clinical link for the hospital administration staff, increasing his or her responsibility as an advocate for patients and nurses. A NE may influence the quality of care provided in 1 to 100 facilities.

The NE's titles also reflect this higher level of authority and influence. The past Director of Nursing is now known as Vice President or Executive Director. Joint appointments are held by many NEs today, indicating their involvement in both practice and education. Many NEs are independent consultants or entrepreneurs in meeting the changing needs of the community. Contemporary NEs understand the power potential of their position (Poulin, 1984). Poulin's research indicated that there was a definite recognition and utilization of power among the respondents participating in that study.

Occupational Stress of Nurse Executives

Examination of the new role of the NE would not be complete without an investigation of the stress involved in this new role. Cohen (1989) pointed out that nurse executives were indeed under stress and the mitigation of that stress might influence the quality of the NE's performance and hence the delivery of care. Cohen utilized Selye's conceptualization of stress. Cohen defined work stress objectively and subjectively. Types of objective work stress were the "organizational properties of the work itself or its setting, time variables, job changes, or physical properties of the work environment" (Cohen, 1989, p. 42). Subjective definitions of work stress were "predominantly role-related" (Cohen, 1989, p. 42).

Zahra (1985) concluded that both role ambiguity and role conflict "are adversely related to major employee attitudes and performance" (p. 41). The Zahra (1985) study investigated the relative effect of role ambiguity and role conflict on employee attitudes and performance through the utilization of eight instruments. In the study two divergent samples consisted of 112 nurses and 208 data processing professionals. Both samples had similar responsibilities in their organizations. The study found

that role conflict and role ambiguity together affect employee performance and attitudes negatively.

A major source of stress for health care administrators is the complexity of the health care system. Five sources of stress within the organization have been defined by Cooper and Marshall (1978):

1. Factors intrinsic to the job (for example, quantity of work, time pressures, decision making).
2. Role in the organization (for example, conflict and ambiguity).
3. Career development (for example, promotion opportunities and job security).
4. Organizational structure and climate.
5. Relations within the organization.

Along this line of managerial stress is the study in 1970 by Arndt and Laeger in which the major stressors for 47 nursing service administrators were identified. Their study identified stressors as conflicts within the work role; interrole conflict; role overload and ambiguity; and tension between role demands and personal needs, values, and abilities. Poulin (1984) also referred to the increased role demands and role overload as sources of stress for the nurse executive.

The Arndt and Laeger (1970) demonstrated high stress scores among nursing directors. Since that study, however, there has been an increasing turbulence in the delivery of health care. Arndt and Laeger were concerned that little examination has been done recently regarding stress at the nurse executive level and that the nurse executive may be at risk because of the limited resources for social support.

Carey, Craighead, and Netzel (1988) examined the influence of educational preparation, experience, and employment setting on role expectations for the director of nursing position within hospital settings. Carey et al. discussed the concept of role dissonance within the director of nursing population. The authors defined role dissonance as the disparity of existing prescriptive role expectations and descriptive role expectations. This research suggests directors of nursing have expected styles of relating to subordinates and peers/superiors or be "two faced" as the authors described. The director of nursing was expected to be gentle, tactful, objective, and supportive as one "face" and persistent, superior, competitive, and tough as the other "face."

Carey et al. (1988) found that educational preparation influenced the prescriptive (ideal) expectations for the

Director of Nurses (DON) role and not the actual or descriptive functions (role). The work setting, however, influenced both role expectations. The DONs and their assistants were found to hold similar beliefs regarding the roles of the DON.

Of special interest was the finding that there were discrepancies between prescriptive (idealized) and descriptive (actualized) role expectations. The DONs were experiencing marked role dissonance in their work positions. This dissonance suggests one facet of role conflict that NEs experience.

Scalzi (1988) conducted a two-stage study to better understand the role stress of nurse executives and their coping strategies. There were 124 nurse executives in this study. The most pervasive source of stress identified among the group studied was overload. Overload was measured in the study as: "(1) conflicting expectations from hospital administration and the nursing department, (2) too large a span of control, (3) too many expectations for the job in general, and (4) difficulties related to managing personal time" (Scalzi, 1988, p. 35). Scalzi proposed that the overload appeared to originate from the necessity of maintaining working relationships with a wide variety of individuals from a variety of disciplines, such

as "hospital administration, nursing, medicine, patient support services, and other professional groups" (p. 35). Another source of the overload was a result of new expectations from the CEO without relinquishing or delegating some of the previous expectations for the nurse executive's position.

The most severe source of stress identified in the Scalzi study was the concern about the quality of patient care. Concerns associated with providing competent nursing and medical staff included concerns of ethical issues in delivery of care, cultural issues in the relationships of staff providing care, the cultural differences between the care providers and the patients, and the difficulties inherent in managing both technical and professional staff.

However, role ambiguity was found to be lower for nurse executives than other industry executives in the Scalzi (1988) study. The nurse executives believed that they had clear policies and guidelines to assist them in accomplishing their goals. Scalzi suggested that role ambiguity would increase dramatically as the nurse executive's role evolves to keep pace with changes in health care delivery.

Burke and Scalzi (1988) compared their independent studies investigating the role stress among hospital

administrators and nurse executives. Both researchers utilized questionnaires based on the instrument designed by Rizzo, House, and Lirtzman (cited in Burke & Scalzi, 1988) to measure role conflict and role ambiguity. Scalzi's sample consisted of 75 nurse executive respondents and Burke's sample consisted of 119 hospital administration executives (no nurses). With regard to role conflict and role ambiguity scores, the scores reported by Burke for hospital administrators were lower than the scores reported by Scalzi in her study of top-level nurse executives. The lower scores are indicative of lower role conflict and role ambiguity (Burke & Scalzi, 1988).

Nurse Executive and Hospital Administrator Relationship

Blair (1989) proposed a synthesis model for nursing administration. The current turbulent state of the health care environment calls for a new kind of executive team "characterized by more broadly shared responsibilities and greater interdependence in decision making" (Blair, 1989, p. 1). This new interdependence among nursing and hospital administrators requires positive and effective interdisciplinary relationships. The author declared that issues such as autonomy, power, role ambiguity, status, educational background, and professionalism of various

executive team members must be openly dealt with and resolved if effective, creative management is to be achieved.

The synthesis model proposed by Blair is a simple model to organize the requisite knowledge base and skills from the fields of nursing and administration. The model is conceptualized as two intersecting circles. One circle is the body of knowledge of nursing, including the practice, discipline, research and theory, values and ethics. The other circle represents administrative and management processes, including organizations, systems, and resources. The area of overlap represents nursing administrative practice. Blair (1989) proposes that this synthesis is unique and differs from a simple combination of content from the two separate fields. The nurse executive must have knowledge from both fields to be able to balance economy and quality of providing health care. Today the NE has the opportunity to develop creative patterns of interdependence among executive team members in the pursuit of high-quality, evenly distributed, cost-effective patient care.

The literature does not provide definitive information on the relationship between NEs and Chief Executive Officers (CEOs). Freund (1985, 1987, 1989) investigated

a few aspects of the relationship between the NE and CEO. In the 1985 study Freund investigated DON and CEO perspectives of "what" made DONs effective. This study found that CEOs and DONs agreed on the major issues of what made DONs effective such as general knowledge of management, finance, personnel management, and knowledge of nursing and health care. There was a difference, however, in how CEOs perceived the political nature of the DON position. The DONs perceived their position as more political than did the CEOs.

Freund (1987) also explored the relationship of CEO succession to Chief Nursing Officer (CNO) termination. The study found that over a 10-year period, 40% of the CNOs in the hospitals surveyed had been terminated for other than personal reasons. Despite this, more than 90% of the CNOs and CEOs polled reported effective, positive relationships with each other in the past, and 98% reported current positive relationships with each other. However, with the report of these positive relationships a question was raised when there was found to be a higher turnover rate among CNOs than CEOs. Freund questioned whether the positive relationship between CEO and CNO was exaggerated. This study found CEOs on average enjoy longer tenure and are not as susceptible to separation by request or mandate

as CNOs. It was also pointed out that the "phenomena of CNO tenure and termination are obviously complex, multifactorial, and interactive" (Freund, 1987, p. 30).

A more recent study by Freund (1989) investigated the compatibility and decision-making patterns of CNOs and CEOs. She proposed that since the CNO and CEO decisions impact the hospital organization, they must have a compatible working relationship. The investigator used the Myers-Briggs Type Indicator (MBTI) to measure the way individuals process information and draw conclusions--the decision-making style.

Contrary to the investigator's expectation, CEOs and CNOs did not differ in their decision-making styles. It was demonstrated in the Freund (1989) study that CEOs and CNOs were logical decision-makers and found them more alike than different in the way they organized and processed information. She described the CEOs and CNOs "as logical decision-makers and as tough-minded, executive, analytic, and instrumental leaders" (p. 18).

Another recent study investigated the equality of power among NEs and other executives with similar titles in a hospital organization (Johnson, 1989). Johnson utilized a Power Assessment Inventory to collect data from 96 NEs and 147 of their peer hospital executives.

Johnson declared that aspects for the establishment of the theoretical framework for nursing administration should not only include the leadership styles, bases of power, and role of the nurse administrator, but that the aspect of power equality should also be investigated. The researcher found NEs holding similar executive titles and other symbols of power. She had predicted a significant difference in power between NEs and other executives, expecting more powerful other executives. The result, however, revealed that NEs were "not only equal in power and responsibility of line management, but their power and responsibility exceed those of the other executives at the same level of management" (Johnson, 1989, p. 166). Johnson declared that nurses should stop referring to themselves and their profession as powerless and recognize that perhaps nurses are indeed prepared for leadership roles.

Summary

In summary, the expanded role for nursing administration demands advanced education and is truly an executive role. This dynamic role requires a high degree of leadership and management acumen in addition to knowledge of nursing science. In the current turbulent state of health care, an interdependence is created among NEs and other hospital executives. The NE utilizes

influence, power, and authority in shaping the practice of nursing and the quality of patient care in a much broader sense than in the past.

CHAPTER III

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

This study utilized an ex post facto, comparative design. Ex post facto, as defined by Polit and Hungler (1987), "is meant to indicate that the research in question has been conducted after the variations in the independent variable have occurred in the natural course of events" (p. 142). Comparative studies "examine the differences between intact groups on some dependent variable of interest" (Nieswiadomy, 1987, p. 146). There was no manipulation of the independent variables, as these were the inherent characteristics of the individuals within the intact groups examined.

This chapter describes the research setting, population and sample, and data collection methods. The instruments are described, as is the data treatment.

Setting

The survey questionnaire was addressed to the subjects by title and distributed by the United States Postal Service to the facilities where the subjects were employed. These facilities were located in a southwestern

metropolitan area. The subjects completed the questionnaires at their convenience and in the setting of their choice.

Population and Sample

The target population included hospital administrators and nurse executives. The accessible populations were those members of the target population who were located in a southwestern metropolitan area. A simple random sample was selected from the southwestern metropolitan hospitals, listed in the American Hospital Association reference guide. In the first mailing, 40 hospitals were randomly selected using a random numbers chart. The Hospital Administrator (HA) and Nurse Executive (NE) of the selected facility were chosen according to their title and address for participation. A minimum of 15 nurse executives and hospital administrators was accepted in each group. Less than 15 HAs responded from the first mailing of 40 hospitals. Another 12 hospitals were randomly selected from those hospitals not selected initially and a second mailing, addressed to both the NE and HA, was completed. The actual sample consisted of those invited subjects who chose to complete and return the questionnaires. Twenty-seven NEs and 15 HAs responded to the survey.

Nieswiadomy (1987) cautioned that a nonresponse rate of 20% may necessitate follow-up procedures. The study results would be questionable if more than 20% of the selected population did not respond.

Protection of Human Subjects

The questionnaires were anonymous, except as identified as a hospital administrator or nurse executive. Each questionnaire was accompanied by a front letter (Appendix B) explaining the research intentions and a statement that completion and return of the questionnaire constituted informed consent to act as a subject in this research. This study complied with Category I of the Risk to Human Subjects, as adopted by Texas Woman's University (Appendix C). The questionnaire research protected anonymity, except as identified by group membership (hospital administrator or nurse executive). There was no risk to subjects.

Instrument

The instrument, Role Perceptions of Nurse Executives (Appendix A), developed by the investigator, was divided into two parts. The first part was used to collect the demographic data. Demographic data included age, group membership, experience, sex, and educational status. These

data were used to describe the sample and identify the group membership of each subject.

The second part of the instrument was used to measure the respondents' actual perceptions of how the subjects ranked the importance of various dimensions of the nurse executive's role. The instrument consisted of statements designed to measure the following dimensions of the nurse executive's role: institutional policy, nursing education and staff development, financial management, professional responsibility, community service and relationships, and research. This instrument was developed by the investigator and was influenced by the instrument developed by Stanton (1975). The original form of the instrument, Administrative Behavior of Administrators, was designed to determine the relationship between actual participation in selected administrators' behaviors and the priorities assigned them by administrators. This instrument examines the perceived role functions of the nurse executive. The two instruments are similar in process, but different in content and purpose.

Using a Likert scale, the respondents selected the number which best described their perception of how the nurse executive actually ranked the importance of the function described in each statement. There were 48

statements selected equally from the six dimensions of the nurse executive's role. The higher the scores, the more importance placed on that function by the respondent. The higher the scores for a dimension, the greater the importance, as perceived by the respondent. The range for each statement is 1 = definitely not important to 4 = very important.

The dimensions are defined as follows:

1. Institutional-policy--those functions that the nurse executive participates in developing, evaluating, and enforcing policies of the institution.

2. Nursing education and staff development--those functions that the nurse executive participates in which are associated with nursing education and assisting staff to grow professionally and personally.

3. Financial management--those functions in which the nurse executive participates which influence the budgeting process, inventory control, and salary.

4. Professional responsibility--those functions that the nurse executive participates in to maintain her professional status.

5. Community service and responsibility--those functions that the nurse executive does to develop and nurture the institution's relationship with the community.

6. Research--those functions that the nurse executive participates in supporting, interpreting, implementing, and creating nursing and other health related research.

The six dimensions of the nurse executive's role function and the content of the statements in the questionnaire have been obtained from a review of literature pertinent to nursing management. The questionnaire was finalized after a panel of experts reviewed and ranked the best possible statements, from a preliminary form of the instrument, that were relevant to this study. Content validity may be established by utilizing a panel of experts to analyze the items of the instrument (Polit & Hungler, 1987). There is no other instrument available for comparison. This instrument has not been utilized before this study.

Once the instrument was finalized, a pilot study was made utilizing one institution. The instrument was distributed to the nurse executive, assistant to the nurse executive, hospital administrator, and the assistant to the hospital administrator. This pilot assessed readability and understandability of directions and statements of the instrument. Necessary changes were made after the pilot study, prior to collection of data. The same procedure for

data collection was utilized during the pilot study, thus improving reliability.

Data Collection

Data collection began after permission was received from the graduate school (Appendix D). Once the institutions were randomly chosen, the questionnaires were mailed to the person holding the position of Hospital Administrator and Nurse Executive. A request for the completion and return of the questionnaire within 1 week was included in the explanations of the study. The subject packet included the questionnaire and instructions, the cover letter, a stamped and pre-addressed return envelope, and a piece of sugar-free gum.

Treatment of Data

Descriptive statistics were utilized to summarize the demographic data of the instrument. Frequency and percentile values were used to describe the sample population (the two groups).

Inferential statistics were utilized to test the hypotheses. The raw scores of each dimension were calculated. The summed total score of the six dimensions was calculated. The *t*-statistic was used to test each of the hypotheses. Alpha was set at .05.

CHAPTER IV

ANALYSIS OF DATA

This study examined the difference in the perceived role of the nurse executive between nurse executives and hospital administrators. The sample which provided the data for this study is described. The results of the statistical analysis for the seven hypotheses are presented. This chapter concludes with a summary of the findings.

Description of Sample

The Demographic Data Sheet distributed with the research instrument was used to obtain information on the subjects' group membership (position), age, gender, experience in their present position, highest degree earned, hospital size, and corporate status. The population for the study consisted of practicing nurse executives and hospital administrators. The sample consisted of 27 nurse executives and 15 hospital administrators. Fifty-two hospitals were randomly selected from a list provided by the local hospital association membership list. The research questionnaires were addressed to the hospital administrator and nurse executive

of each of the selected hospitals. The response rate of nurse executives was 52% and the response rate of the hospital administrators was 29%.

The ages of the nurse executive group ranged from 31 to greater than 60 years with the majority in the 31-40 year range. The hospital administrator group ages ranged from 31-60 with the majority in the 41-50 range. The nurse executive group had 88.9% of the subjects in the range 31-50 as compared to 93.3% of the hospital administrator subjects. The nurse executive group was 88.9% female and the hospital administrator group was 80% male (Table 1).

The nurse executive group represented an even distribution of experience in their current position ranging from less than 1 year to more than 6 years. The hospital administrator group showed a near majority (46.7%) with more than 6 years experience in their current position (Table 1).

There was a variety of degrees held by the nurse executives. Fifty-five percent of the nurse executives held a master's degree. The master's prepared nurse executives varied in their major study, including nursing administration (6), cardiovascular (1), medical-surgical nursing (4), business administration (2), and health care

administration (2). There was one nurse executive with a doctorate degree in education (Table 1).

The hospital administrators were primarily master's prepared (86.7%), four held MBA degrees, and nine executives held HCA degrees (Table 1). Two hospital administrators in the sample held bachelor's degrees, one with 4-6 years experience, and the other did not respond to the experience question on the Demographic Data Sheet. No hospital administrators in the sample held a doctorate degree.

Both nurse executives and hospital administrators were similarly employed. Seventy-four percent of nurse executives and 80% of hospital administrators were employed by hospitals with 300 or less beds. The majority of the respondents, both nurse executives and hospital administrators, were employed by corporate hospitals, 66.7% and 60%, respectively (Table 1).

Table 1

Summary of Demographics of Nurse Executives and Hospital Administrators

Variable	Nurse Executives n	%	Hospital Administrators n	%
Age:				
31-40	16	59.3	6	40.0
41-50	8	29.6	8	53.3
51-60	2	7.4	1	6.7
> 60	1	3.7	0	0.0
Gender:				
Male	3	11.1	12	80.0
Female	24	88.9	3	20.0
Experience:				
< 1 year	6	22.2	1	6.6
1-3 years	7	25.9	3	20.0
4-6 years	7	25.9	3	20.0
> 6 years	7	25.9	7	46.7
			(1 no response)	
Educational Level:				
Diploma	3	11.0	0	0.0
Bachelors	8	29.6	2	13.3
Master's				
(M.S. in Nursing	11)		(MBA 4)	
(MBA, HCA	4)		(HCA 9)	
	15	55.5	13	86.7
Doctoral	1	3.7	0	0.0
Hospital Size:				
300 or less	20	74.1	12	80.0
greater than 300	7	25.9	3	20.0
Corporate Status:				
yes	18	66.7	9	60.0
no	4	14.8	4	26.7
	(5 no responses)		(2 no responses)	

Findings

The findings are reported for each of the research hypotheses. Tables are utilized to present the data.

The subjects' responses to the survey were totaled resulting in a score for each dimension measured. The higher the score, the higher the importance for that dimension. The mean scores for the different dimensions were arranged by rank order. The top rank dimension from the nurse executives' scores was the Institutional management whereas the top ranked dimension from the hospital administrator scores was Financial management. The remaining dimensions were in the same rank order for both the nurse executive and hospital administrator (Table 2).

Table 2

Rank Order of Mean Scores of Role Dimensions

Nurse Executives		Hospital Administrators	
Dimension	Mean	Dimension	Mean
1. Institutional	29.9	1. Financial	28.5
2. Professional	29.8	2. Institutional	28.2
3. Financial	28.8	3. Professional	28.1
4. Educational	28.4	4. Educational	27.1
5. Community	26.0	5. Community	24.1
6. Research	24.4	6. Research	20.0

The rank order of the role dimensions as perceived by nurse executives was "Institutional," "Professional," "Financial," "Educational," "Community," and "Research." The rank order of the role dimensions as perceived by hospital administrators was "Financial," "Institutional," "Professional," "Educational," "Community," and "Research" (Table 2).

Role

The first hypothesis stated that there is a difference in the perceived role of the nurse executive between hospital administrators and nurse executives in the six dimensions of management. The six dimensions are the management of institutional policy, management of education, financial management, professional development and activities, community activities, and management of research. The score for this overall role was the sum of the scores of the six dimensions. The mean score for the nurse executives was 167.4 with a standard deviation of 10.9. The mean score for the hospital administrators was 152.7 with a standard deviation of 15.8. A t-test was used to test the hypothesis (t (40) = 3.545, $p < .001$) (Table 3). The hypothesis was supported and indicates that nurse executives perceive their role differently than the hospital administrators perceive the role of the nurse

executive. To determine where the differences in the perceived role occurred, each dimension was analyzed.

Table 3

Summary of Results of t-test on Role Dimensions by Type of Administrator

Dimension	Nurse Executive M	Nurse Executive SD	Hospital Administrator M	Hospital Administrator SD	t	df	p
Role (overall)	167.4	10.9	152.7	15.8	3.545	40	< .001
Institutional	29.9	1.8	28.2	2.8	2.544	40	.01
Professional	29.8	2.0	28.1	2.3	2.405	40	.02
Research	24.4	4.5	20.0	4.9	2.944	40	< .01
Educational	28.4	2.7	27.1	2.7	1.437	40	.16
Financial	28.8	2.0	28.5	3.0	0.314	40	.75
Community	26.0	3.2	24.1	3.4	1.862	40	.07

Institutional Dimension of Role

The second hypothesis stated that there is a difference in the perceived role of the nurse executive between hospital administrators and nurse executives in management of institutional policy. The mean score for the nurse executives was 29.9 with a standard deviation of 1.8. The mean score for the hospital administrators was 28.1

with a standard deviation of 2.8. A t-test was used to test the hypothesis (t (40) = 2.544, p = .014) (Table 3). The research hypothesis was supported, indicating that nurse executives perceive their role in the development and management of institutional policies to be more important than the hospital administrators perceive that role of the nurse executive.

Educational Dimension of Role

The third hypothesis stated that there is a difference in the perceived role of the nurse executive between hospital administrators and nurse executives in management of nursing education and staff development. The mean score for the nurse executives was 28.4 with a standard deviation of 2.7. The mean score for the hospital administrators was 27.1 with a standard deviation of 2.7. A t-test was used to test the hypothesis (t (40) = 1.437, p = .156) (Table 3). The research hypothesis was not supported indicating that there was not significant differences between nurse executives and hospital administrators in the perceived role of the nurse executive in management of the education and development of staff.

Financial Dimension of Role

The fourth hypothesis stated that there is a difference in the perceived role of the nurse executive between hospital administrators and nurse executives in financial management. The mean score for the nurse executives was 28.8 with a standard deviation of 2.0. The mean score for hospital administrators was 28.5 with a standard deviation of 2.0. The results of the *t*-test were t (40) = .314, p = .754 (Table 3). This hypothesis was not supported, indicating that the nurse executives and hospital administrators' perceived the role of the nurse executive to be similar for the dimension of financial management.

Professional Dimension of Role

The fifth hypothesis proposed that there is a difference in the perceived role of the nurse executive between hospital administrators and nurse executives in the management of professional responsibilities. The mean score for nurse executives was 29.8 with a standard deviation of 2.0. The mean score for hospital administrators was 28.1 with a standard deviation of 2.3. The results of the t-test were t (40) = 2.405, p = .02 (Table 3). The research hypothesis was supported, indicating that there was more importance perceived by the

nurse executives in carrying out professional responsibilities of the nurse executive than the hospital administrators perceived in the role of the nurse executive.

Community Service Dimension of Role

The sixth hypothesis stated that there is a difference in the perceived role of the nurse executive between hospital administrators and nurse executives in management of community service and relationships. The mean score for nurse executives was 26.0 with a standard deviation of 3.2. The mean score for the hospital administrators was 24.1 with a standard deviation of 3.5. The results of the *t*-test were t (40) = 1.862, p = .066 (Table 3). The research hypothesis was not supported, indicating that the nurse executives and hospital administrators perceived no difference in the role of the nurse executive in management of community service and community relationships. However, significance at the .05 level was approached, indicating that there was a trend that nurse executives perceived the management of community service and community relationships more importantly than did the hospital administrators.

Research Dimension of Role

This hypothesis stated that there is a difference in the perceived role of the nurse executive between hospital administrators and nurse executives in management of research. The mean score for nurse executives was 24.4 with a standard deviation of 4.5. The mean score for hospital administrators was 20.0 with a standard deviation of 4.9. The results of the *t*-test were $t\ (40) = 2.944$, $p < .01$ (Table 3). The research hypothesis was supported, indicating that there was more importance perceived by the nurse executives in the role of the nurse executive in management of research than that perceived by the hospital administrators.

Summary of Findings

The findings of this study are summarized as follows:

1. The majority (59.3%) of nurse executives were in the age range 31-40, 10 years younger than the majority (53.3%) of hospital administrators in the age range 41-50 years.

2. The hospital administrators were predominantly male (80%), whereas the nurse executives were predominantly female (88.9%).

3. The hospital administrator participants overall had longer tenure in their positions than the nurse

executives. Forty-six percent of the hospital administrators reported more than 6 years in their current position, whereas 25.9% of the nurse executives reported more than 6 years in their current position.

4. Both groups were similarly employed by corporate hospitals of 300 beds or less.

5. The two samples varied in type of educational preparation. Fifty-nine percent of the nurse executives held advanced degrees with a variety of major studies including nursing administration, cardiovascular nursing, medical-surgical nursing, business administration, health care administration, and education. Almost 87% of the hospital administrators held advanced degrees in only two major study areas, business administration and health care administration.

6. There was a significant difference in the perceived role of the nurse executive between hospital administrators and nurse executives when considering all six dimensions of management together.

7. These differences were found in the "institutional," "professional," and "research" dimensions of the nurse executive role.

8. Significance at the .05 level was approached for a difference of perception of the "community service" dimension of the role of the nurse executive (p = .066).

9. The nurse executives and hospital administrators did not perceive the role of the nurse executive differently in the "educational" and "financial" dimensions of the role of the nurse executive.

10. The rank order of the scores, representing the amount of importance placed on the different dimensions, was similar between the hospital administrators and nurse executives, with only one difference. The nurse executives' highest mean score was for the importance on the "institutional" dimension whereas the hospital administrators' highest mean score was the "financial management" dimension. The rank order of the role dimensions as perceived by nurse executives was "institutional," "professional," "financial," "educational," "community," and "research." The rank order of the role dimensions as perceived by hospital administrators was "financial," "institutional," "professional," "educational," "community," and "research."

CHAPTER V

SUMMARY OF THE STUDY

This study was conducted to investigate the differences in the perceived role of the nurse executive between hospital executives and nurse executives. This chapter includes the summary, discussion of the findings, conclusions and implications, and recommendations for further study.

Summary

The problem of the study was to determine the difference in the perceived role of the nurse executive between hospital administrators and nurse executives. Seven hypotheses were investigated during the study:

1. There is a difference in the perceived role of the nurse executive between hospital administrators and nurse executives in the six dimensions of management.

2. There is a difference in the perceived role of the nurse executive between hospital administrators and nurse executives in management of institutional policy.

3. There is a difference in the perceived role of the nurse executive between hospital administrators and nurse

executives in management of nursing education and staff development.

4. There is a difference in the perceived role of the nurse executive between hospital administrators and nurse executives in financial management.

5. There is a difference in the perceived role of the nurse executive between hospital administrators and nurse executives in management of professional responsibilities.

6. There is a difference in the perceived role of the nurse executive between hospital administrators and nurse executives in management of community service and relationships.

7. There is a difference in the perceived role of the nurse executive between hospital administrators and nurse executives in management of research.

This ex post facto, comparative study was based on the conceptual framework derived from role theory. The dimensions of the role of the nurse executive were taken from current nursing administration literature. An instrument was developed to measure the importance of the different role dimensions of the nurse executive. The instrument content validity was supported by a panel of expert nurse administrators. A pilot study was made to improve reliability, however the reliability of the

questionnaire is unknown. The instrument consisted of the survey questionnaire and demographic data sheet.

The study was conducted in a large metropolitan area of the southwestern United States. The study instrument was mailed to the hospital administrator and nurse executive of the 52 randomly selected hospital association member hospitals. Two mailings were mecessary to obtain an acceptable sample size for hospital administrators. The participants completed the questionnaires at their convenience and in the setting of their choice. There were 27 nurse executives (52% response rate from the nurse executives) and 15 hospital administrators (29% response rate from the hospital administrators). The subjects' responses to the survey were totaled, resulting in a score for each dimension measured. The higher the score, the higher the importance for that dimension.

A summary of the findings from this survey of hospital administrators and nurse executives follows:

1. The ages of the majority of nurse executives ranged from 31-40 years. The ages of the majority of hospital administrators ranged from 41-50 years.

2. The nurse executive group was 88.9% female. The hospital administrator group was 80% male.

3. The hospital administrator group showed a near

majority (46.7%) with more than 6 years experience in their current position. Only 25.9% of nurse executives had more than 6 years experience.

4. There was a variety of advanced degrees held by nurse executives (59% held advanced degrees) whereas the hospital administrators (86.7% held advanced degrees) held similar degrees (MBA or HCA).

5. The majority of nurse executives and hospital administrators were similarly employed by corporate hospitals with less than 300 beds.

6. The top ranked dimension from the nurse executive scores was the Institutional management dimension, whereas the hospital administrators top ranked dimension was the Financial management dimension, otherwise the rank order was the same.

7. The rank order of the role dimensions as perceived by nurse executives was Institutional, Professional, Financial, Educational, Community, and Research. The rank order of the role dimensions as perceived by hospital administrators was Financial, Institutional, Professional, Educational, Community, and Research.

8. The overall role of the nurse executive was perceived differently between the hospital administrators and nurse executives.

9. The dimensions of the role that were perceived differently between the nurse executives and hospital administrators were Institutional, Professional, and Research.

10. The dimensions that were not perceived to be significantly different were Educational, Financial, and Community Service. Significance at the .05 level was approached for the community service dimension.

Discussion of Findings

The findings of this study suggest that hospital administrators and nurse executives perceive the overall role of the nurse executive differently. Since the "role" of a certain position member is the expectation of certain behaviors, this difference in the perceived role of the nurse executive may set the position member up for a certain amount of role stress. Biddle and Thomas (1966) claimed that role expectations "appear to be among the most potent factors in the control of human behavior" (p. 10). When individuals perceive incompatible expectations within the role set of a position, role conflict ensues. Another factor of role stress is that of role ambiguity, when expectations are incomplete or insufficient to tell the position member how or what to do. The literature has already presented findings of role stress among nurse

executives and suggested sources of the stress (Carey et al., 1988; Cohen, 1989; Poulin, 1984; Scalzi, 1988; Zahra, 1985). However, no one has linked the role perception of the hospital administrator and nurse executive as a source of role stress.

In times past the nurse executive/hospital administrator relationship may not have had the same implications. Today the nurse executive is a member of the executive team with the associated scope of practice and power. It is essential for these executives to understand one another's role in order to facilitate the accomplishment of the organization's mission. This study's identification of differences in the perceived role as well as the dimensions that contributed to the differences, may well be a first step in clarifying expectations. As the literature suggests (Burke & Scalzi, 1988; Scalzi, 1988; Zahra, 1985), role stress contributes to decreased job performance, job satisfaction, and productivity which ultimately affects the quality of patient care. Through shared expectations the nurse executive and hospital administrator may facilitate, develop, and nurture their interdependent roles in the pursuit of high quality, cost-effective patient care.

Biddle (1979) proposed that most role theorists use the concept of socialization to explain the evolution and development of roles. The socialization process in the preparation and attainment of new roles is helped most by educational experiences, where the member takes on characteristics of the anticipated or aspired role prior to becoming a member of the aspired position (Biddle & Thomas, 1966; Hardy & Conway, 1978). Differences in educational experiences may be one explanation for the difference found in the perceived role of the nurse executive between hospital administrators and nurse executives. The educational preparation of the nurse executives and hospital administrators in this study were different. The nurse executives' advanced degrees were varied, including nursing, business, and health care administration; whereas the hospital administrators educational preparation was either business or health care administration. The educational experience is one explanation for the difference in importance placed on the dimensions of the nurse executive role.

The importance placed on the different dimensions of role may also be influenced by the length of tenure in the position. Hospital administrators had more experience in their positions than did the nurse executives in their

positions. Since both the nurse executives and hospital administrators were similarly employed, the institutional differences are not considered an influencing factor in the perception of the position role. It is not clear what influence the difference in gender may have on the different role perceptions.

Nurse executives and hospital administrators place a different amount of importance on the various dimensions of the nurse executive role. When there is a difference in what the nurse executive perceives as an important dimension of the role, the nurse executive might invest resources accordingly. The nurse executive may invest time, money, and personnel according to importance. However, the hospital administrator might expect the resources to be utilized differently since there is this difference in importance on the role dimensions.

Conclusions and Implications

Based on the findings of this study, the following conclusion can be made. This conclusion may be limited due to sample size and the low response rate. Because differences were found between nurse executives and hospital administrators in three of the perceived role dimensions, role stress may occur within the nurse executive position.

The nurse executive must, therefore, seek clear expectations and clarification of the role from the hospital administrator. The nurse executive must share with the HA her expectations of the nurse executive role. Together a modified set of role expectations for the nurse executive needs to be developed. This clarification of role expectations should also be sought among the nurse executive population and would provide a basis in development of nurse executive practice standards. The clarification of role expectations within the nurse executive population could also provide educators guidance in curriculum development.

Recommendations for Further Study

The following are recommendations for further research based on the results of this study:

1. Further development of the instrument through a methodological study.

2. Replicate this study using a larger sample and over a larger geographic area.

3. Alter the demographic data collection to better obtain educational preparation, including undergraduate preparation and internship program.

4. Alter design to measure role perception and stress among partnered nurse executives and hospital administrators.

5. A similar study should be conducted examining other variables which could contribute to different role perceptions among nurse executives and hospital administrators.

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APPENDIX A

Role Perceptions of Nurse Executives and Demographic Data Form

COMPLETION AND RETURN OF THIS QUESTIONNAIRE WILL INDICATE YOUR CONSENT TO PARTICIPATE IN THIS STUDY

Role Perceptions of Nurse Executives

Below is a series of statements drawn from the literature which describe functions of nurse executives.

Please rate the importance of each item according to the following scale:

1 = definitely not important
2 = not important
3 = somewhat important
4 = very important

___ 1. Consults with nurse managers (head nurses and supervisors) prior to making major decisions.
___ 2. Participates in the recruitment of new nurse graduates.
___ 3. Consults with nurse managers in preparing nursing department budget.
___ 4. Collaborates with other nurse executives in the region to solve nursing problems common to the area.
___ 5. Collaborates with appropriate boards, community, and governmental agencies in direct planning for improving health and nursing care in the community.
___ 6. Collaborates with education agencies in research projects.
___ 7. Consults with hospital administrators prior to making major decisions.
___ 8. Acts as a resource person to the nurse managers in development of education programs.
___ 9. Administers the budget of the nursing department.
___ 10. Involved in a current continuing education program for self-improvement as a nurse executive.
___ 11. Participates as guest speaker at community group sponsored meetings.
___ 12. Encourages staff nurses to participate in nursing research projects.
___ 13. Collaborates with other administrators in determining institutional policies.
___ 14. Keeps current in the trends for nursing education.
___ 15. Oversees the nurse managers' use of the unit budgets.

1 = definitely not important
2 = not important
3 = somewhat important
4 = very important

___ 16. Evaluates patient care quality assurance program for the institution.
___ 17. Provides encouragement for staff to participate in community sponsored projects.
___ 18. Encourages staff nurses to participate in medical research projects.
___ 19. Encourages staff involvement in determining institutional policies.
___ 20. Participates in committees that develop institutional policies.
___ 21. Encourages staff to achieve personal, professional goals.
___ 22. Encourages staff to attend outside continuing education programs.
___ 23. Participates in institutional cost studies.
___ 24. Participates in the decisions for the institutional budget.
___ 25. Develops long-term goals for the nursing department.
___ 26. Offers educational materials to community groups for their use.
___ 27. Is a member of the institution's committee that evaluates potential research projects.
___ 28. Participates in medical committees.
___ 29. Encourages staff to attend institutions of higher education.
___ 30. Provides funds for staff attendance to continuing education programs.
___ 31. Routinely provides time to meet with staff nurses.
___ 32. Understands the overall functions of the institution.
___ 33. Acts as a central source of information on acquisition of health care for the community.
___ 34. Provides a channel for consumer input into health care delivery system.
___ 35. Guides staff in interpreting and applying nursing research findings.
___ 36. Provides time, funds, and encouragement for staff initiated research.
___ 37. Interprets institutional policies to nursing staff.
___ 38. Provides funds for staff attendance to continuing education programs.

1 = definitely not important
2 = not important
3 = somewhat important
4 = very important

___ 39. Assists nurse managers in preparing their unit budgets.
___ 40. Negotiates with nurses' best interest in mind.
___ 41. Initiates research of concern to the nursing department.
___ 42. Knows of current legislative activity related to nursing and health care delivery.
___ 43. Consults nursing research in planning and organizing nursing department activities and goals.
___ 44. Cooperates with universities and colleges in the educational process of new nurses.
___ 45. Interprets institutional policies to medical staff.
___ 46. Negotiates with the total organization's goals in mind.
___ 47. Is familiar with the costs of nursing department activities (i.e., orientation, new graduate program, maintenance of equipment, sick leave).
___ 48. Provides leadership for human resource development and personal management for nurse managers.

APPENDIX B

Cover Letter to Participants

Dear Participant:

I am a graduate nursing student at Texas Woman's University and am conducting a research study as part of the requirements for a Master of Science degree. You have been selected by a random process from nurse executives and hospital administrators of the Dallas metropolitan area hospitals. Your participation is important for the success of this study as your answers may influence the results.

Nurse executives have experienced an expansion of their role with new responsibilities and expectations. This study will examine the perceived role of the nurse executive. Role clarification for the nurse executive would improve effectiveness by decreasing role strain and stress.

The completion of the 48 statement questionnaire will take approximately 20 minutes. Please answer every statement as each has equal importance to the outcome. Select a time and place of your convenience and return the questionnaire within one week in the self-addressed envelope provided. I know of no potential risks that might occur as a result of participating in this study.

Your participation in this study will benefit nurses and administrators in the future. The role clarification for nurse executives will improve their effectiveness.

These questionnaires will be anonymous. Data will be collected only as needed to place you into the appropriate group: Nurse Executive or Hospital Administrator. To ensure anonymity, please do not include your name or hospital on the questionnaire. You may withdraw from this study at any time and for any reason without penalty.

If you have any questions concerning this study, please call me at 867-1465 (home) or 661-7200 (office). The results of this study will be presented in the completed thesis and may be published in a nursing journal. An abstract of the study results may be obtained by writing the researcher at 3124 San Simeon, Plano, Texas 75023.

Return of this questionnaire will indicate your consent to participate in this study. I appreciate your effort in completing the questionnaire. Thank you for your time and cooperation.

Sincerely,

Beverly Dorney

APPENDIX C

Research Review Committee Exemption Form

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING

PROSPECTUS FOR THESIS/DISSERTATION/PROFESSIONAL PAPER

This prospectus proposed by: Beverly Dorney

_____ and entitled:

Role Perception of the Nurse Executive Between Nurse Executives and Hospital Administrators

Has been read and approved by the member of (his/hers) Research Committee.

This research is (check one):

__xx__ Is exempt from Human Subjects Review Committee review because it is classified as Category I research.

_____

_____

_____ Requires Human Subjects Review Committee review because _____

_____

Research Committee:

Chairperson, Kirby M. Ziegler

Member, Susan Goad

Member, Margaret Mc Elroy

Date: Nov. 16, 1987

Dallas Campus x Denton Campus ___ Houston Campus ___

APPENDIX D

Graduate School Permission to Conduct Study

TEXAS WOMAN'S UNIVERSITY
DENTON DALLAS HOUSTON
THE GRADUATE SCHOOL
P.O. Box 22479, Denton, Texas 76204 817/898-3400, 800-338-5255

February 13, 1989

Ms. Beverly Ann Dorney
3124 San Simeon
Plano, TX 75023

Dear Ms. Dorney:

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
Dean for Graduate Studies
and Research

dl

cc Dr. Shirley Ziegler
Dr. Anne Gudmundsen